ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC004374
Case Name	COLE,BUENTA v. CHICAGO TRANSIT AUTHORITY
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remanded Arbitration
DecisionType	Commission Decision
Commission Decision Number	21IWCC0260
Number of Pages of Decision	
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Al Koritsaris
Respondent Attorney	Elizabeth Meyer

DATE FILED: 6/1/2021

/s/*Kathryn A. Doerries, Commissiner*
Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BUENTA COLE,

Petitioner,

vs. NO: 19 WC 04374

CTA,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, temporary total disability, medical expenses, and prospective medical, 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 Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

The Commission, herein, corrects a scrivener's error in the Arbitrator's decision, page 2, under the *Findings* section, striking "for a total credit of $0" and replacing with "for a total credit of $22,052.53," so the sentence shall read as follows: "Respondent shall be given a credit of $22,052.53 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $22,052.53." The Commission notes the parties stipulated to the aforesaid credit amount for TTD benefits paid by Respondent.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 9, 2020 is, otherwise, 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.

JUNE 1, 2021

o-5/18/21
KAD/jsf

/s/*Kathryn A. Doerries*
Kathryn A. Doerries

/s/*Maria E. Portela*
Maria E. Portela

/s/*Thomas J. Tyrrell*
Thomas J. Tyrrell

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

21IWCC0260

COLE, BUENTA
Employee/Petitioner

Case# **19WC004374**

CTA
Employer/Respondent

On 4/9/2020, 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 0.16% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4564 ARGIONIS & ASSOCIATES LLC
AL KORITSARIS
180 N LASALLE ST SUITE 1925
CHICAGO, IL 60601

0515 CHICAGO TRANSIT AUTHORITY
ELIZABETH MEYER
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

B. Cole v. CTA, 19 WC 4374

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)

Buenta Cole
Employee/Petitioner
v.
CTA
Employer/Respondent

Case # **19** WC **04374**

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 **Jeffery Huebsch**, Arbitrator of the Commission, in the city of **Chicago, Illinois**, on **September 12, 2019**. 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

B. Cole v. CTA, 19 WC 4374

FINDINGS

On the date of accident, **February 2, 2019**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**62,065.12**; the average weekly wage was $**1,193.56**.

On the date of accident, Petitioner was **64** years of age, *single* with **0** dependent children, per the Parties' stipulation.

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

Respondent shall be given a credit of $**22,052.53** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $795.71/week for 23-1/7 weeks, commencing February 3, 2019 through July 15, 2019, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $7,217.96 as provided in Sections 8(a) and 8.2 of the Act and as is set forth below.

No prospective medical treatment is awarded.

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

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

Signature of Arbitrator

April 7, 2020
Date

ICArbDec19(b)

APR 9 - 2020

FINDINGS OF FACT

Petitioner is employed by Respondent as a Bus Operator. She has been so employed since January 21, 2013.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of her employment by Respondent on Saturday, February 2, 2019. Petitioner was driving a bus westbound on 47th Street and her bus was hit by an eastbound car. The car crossed into Petitioner's lane and the point of impact on the bus was at the driver side front panel in the area where the driver sits. Petitioner said that the bus was knocked kind of sideways and the impact was "heavy."

Petitioner was transported to the St. Bernard Hospital via CFD ambulance. (PX 5) She testified that at the ER, she could hardly breathe and had a little pain in her back. She thought that she was having an asthma attack, but later found out that it was an anxiety attack. The records show that she arrived on a stretcher via CFD, for feeling lightheaded after MVC. The workup was for vertigo/dizziness "Restrained driver hit by small car (sideswipe) struggled to control bus from hitting wall on R side." Anxious, hyperventilating, no neck pain, no back pain (documented 2 times). The musculoskeletal exam and the back exams were said to be normal. Pain was 0/10. She was given Tylenol for right sided lumbar paraspinal achiness. The discharge diagnosis was Panic Attack. Petitioner was discharged home to follow up with her PCP, come back to ER if symptoms worsen or if you deem necessary. Petitioner was triaged at 8:28 am and discharged at 10:05 am. There does not appear to have been an off-work note issued. (PX 5) Petitioner testified that "I was told if I felt worse to seek out probably a specialist for the back."

Petitioner testified that the next morning she felt a little worse, so she sought treatment. This was on a Sunday, so Petitioner had trouble finding a medical facility that was open. She was given the name of a clinic by a co-worker and she went there to get paperwork that was required by Respondent. The clinic was Chicago Pain and Orthopedic Institute and Petitioner went there for an initial evaluation on February 11, 2019. Petitioner was seen by Melanie Coderre, PA-C with complaints of right greater than left axial low back pain with pain extending down her posterolateral thigh, calf into the bottom of foot and fourth and fifth toes. Physical exam showed TTP over the lumbar paraspinal musculature, right greater than left. She had 4+/5 strength. "Right upper extremity (sic) TA EHL pain with extension." Normal extension of the spine. The impression was low back pain. Petitioner was given Lidopril lotion, lidocaine patches, meloxicam and pantoprazole. She was to start PT, get an MRI and follow up with pain management. She was to remain off work and follow up in 4 weeks. (PX 1)

The MRI was performed on February 16, 2019 and was said to show Mild spondylosis and facet arthrosis with no significant stenosis. A left foraminal protrusion was noted at L3-L4. A shallow disc bulge was seen at L4-L5 and a 1mm central protrusion was noted at L5-S1, without central stenosis. (PX 1)

Petitioner began PT at Advance Spine & Rehab Center. At the initial evaluation, on February 20, 2019, Petitioner presented with low back pain traveling to her right lower extremity. She rated her pain at 8/10. The SLR was positive at 40 degrees on the right in the supine position. The MRI was said to show mild spondylosis and facet arthrosis. Petitioner denied prior back injuries. (PX 2)

Petitioner was seen for follow up by Coderre, PA C (supervised by Steven Sclamberg, MD) on February 25, 2019. The MRI was said to show diffuse lumbar spondylosis. Her back pain had improved with PT. The pain was said to be right, greater than left and Petitioner denied radicular symptoms. Petitioner

testified that at this time she had increased pain in her lower back, "like this really bad burning going down my radiating—well, going down my right leg." Petitioner was continued excused from work. Petitioner was next seen by Dr. Rajesh Patel at Chicago Pain on March 18, 2019. His diagnosis was SI joint pain. Petitioner gave a history of the February 2 bus accident, saying that she was violently jerked in the accident and had an onset of right sided low back pain. She denied a history of pain in "this area." Pain was rated at 9/10, over the right SI joint, right buttock, occasionally radiating into the right lateral thigh. Per Dr. Patel, the MRI showed facet hypertrophy at L4-L5 and L5-S1 on the right, without significant stenosis. Normal muscle tone was noted, along with a negative SLR. Gaenslen's and Faber's maneuvers on the right were positive. Pain to palpation was noted over the right facet joints from L4 to S1 and along the right paraspinal muscles. Medications were changed and a right SI joint x-ray was ordered. She was continued off work, as cyclobenzaprine could make her drowsy. The last visit with Chicago Pain and Dr. Patel was on April 1, 2019. Petitioner complained of right sided low back and SI joint pain. The SI joint x-ray was nondiagnostic. She was continued off work and a right SI joint MRI was ordered. (PX 1)

Petitioner next elected to change medical providers. PT was not helping. She felt she was getting worse. She felt that Chicago Pain was trying to milk the CTA and they weren't paying attention to her complaints, so Petitioner began treatment with Illinois Orthopedic Network (ION) and Dr. Kenneth Koutsky, an orthopedic surgeon. The first visit with Dr. Koutsky was on April 4, 2019. Petitioner complained of lower back pain, radiating to the RLE with some numbness and tingling. The physical exam showed good strength in the lower extremities with decreased pinprick sensation in her right foot when compared to the left. DTR's were symmetrical and a positive right SLR was noted. Dr. Koutsky did not chart whether the positive SLR was in the supine or sitting positions, or both. Limited range of motion and paralumbar muscle tenderness and spasm to palpation were noted. The MRI was said to show desiccation at L3-L4 and L5-S1 with generalized protrusions at L3-L4 and L5-S1 contributing to some central and foraminal narrowing. An injection was discussed. The diagnosis was Right L5-S1 radiculopathy. PT and medications were continued. Petitioner was to remain off work. Petitioner was seen again by Dr. Koutsky on May 9, 2019. The physical exam was unchanged. An EMG was ordered, along with an injection. The EMG was done on May 22, 2019. It was said to show evidence of a right S1 radiculopathy. (PX 3)

Petitioner was seen by Dr. Koutsky on June 6. 2019. The MRI was said to show central to a right paracentral protrusion at L5-S1, contributing to central and foraminal stenosis and a generalized protrusion at L3-L4. They were awaiting authorization for injections. Surgery (right lumbar decompression at L5-S1) was offered. The risks of surgery were discussed. Dr. Koutsky charted that surgery was appropriate per ODG guidelines as the patient demonstrated weakness or symptoms of extremity pain in an anatomic distribution consistent with her radiographic findings, imaging studies revealing nerve root compression and lateral recess stenosis and the failure of conservative care. Petitioner was continued off work. On follow up on July 8, 2019, Dr. Koutsky charted that they were awaiting authorization for surgery. The last visit with Dr. Koutsky was on August 12, 2019. Petitioner had one ESI and was participating in therapy. The MRI was described as showing a right paracentral disc herniation at L5-S1. They were awaiting authorization for surgery, lumbar decompression and discectomy. Medications, continued PT and continued off work status were ordered. Petitioner was medically cleared by Dr. Ronnie Mandal for surgery on June 19, 2019. Petitioner had pain management treatment at Midwest Anesthesia and Pain Specialists by William Hayduk, ND, PA-C and Angie Osmanski, PA-C. Records from Midwest were included in the ION records and show that Petitioner had a Left LESI procedure on July 2, 2019, without any relief of pain, per the 7/11/2019 chart note authored by Osmanski. (PX 3)

Records from Hyde Park Same Day Surgicenter show that Petitioner underwent a Lumbar Interlaminar Epidural Steroid Injection Under Fluroscopic Guidance by Dr. Andrei Rakic, on July 2, 2019. The report does not detail whether the LESI procedure was a left or right approach. (PX 4)

Petitioner testified that she felt worse after the injection.

PT records from ATI were submitted by Petitioner. At the April 12, 2019 initial evaluation, the physical exam showed minimal pain on flexion and right lumbar rotation and Nil pain with other lumbar ROM. On May 28, 2019, Petitioner was said to be worse. On June 5, 2019 no improvement was noted and, therefore, HEP/discontinuance of skilled PT was recommended. On July 10, 2019, she was feeling worse, with no improvement after the LESI. The August 9, 2019 progress note documents constant back pain with no improvement, but Petitioner did feel stronger with therapy. (PX 10)

Petitioner was seen by Dr. Andrew Zelby, a neurosurgeon, for a §12 exam at Respondent's request. The exam took place on July 15, 2019. Dr. Zelby noted several inconsistencies in the examination of Petitioner. She was noted to rest and move with no pain behaviors consistent with her complaints. Tenderness to palpation was excessive. The supine SLR was positive on the right for back pain only. The sitting SLR was negative. The motor exam was benign. Non-organic findings were noted: she had pain on superficial light touch; decreased pain on distraction was noted, along with non-anatomic sensory changes. Dr. Zelby reviewed the 2/16/2019 and opined that it showed mild degenerative changes with some bulging discs that did not result in stenosis or neural impingement. The degenerative changes are less than typical age related changes. The MRI would be a normal study for the patient. The EMG was noted to show evidence of right S1 radiculopathy. The diagnosis was: Mild lumbar spondylosis without radiculopathy and Lumbar Strain. Petitioner has an essentially normal spine exam and a normal neurologic exam, except for a report of diminished sensation in the RLE that is inconsistent with any spinal condition. She reports symptoms radiating into the RLE but no findings of radiculopathy on exam. The MRI has no abnormalities that would result in a radiculopathy. Although Dr. Koutsky has diagnosed right L5-S1 radiculopathy, there were no findings of radiculopathy noted in his exams. The EMG does not have clinical correlation and Petitioner's radiating right leg symptoms are not a radiculopathy. Surgery is not appropriate as no nerve is compressed, ergo there is no need for a decompression. She exhibits 3/5 positive Waddell's signs. Her complaints are not related to an injury of the lumbar spine. Petitioner suffered a lumbar strain which should have resolved with 3 to 4 weeks of PT. There is no need for further injections and no need for surgery. Petitioner would be at MMI as of the beginning of May and is not in need of any further related medical care. Narcotics are not appropriate and OTC NSAIDs are appropriate. She is capable of full duty work and should pursue a HEP for the general health of her spine. (RX 1)

Petitioner testified that she did not receive a mileage check for the Dr. Zelby exam. Respondent should comply with §12 and make the correct payment to her.

Petitioner testified that she had a prior back injury, while working for Greyhound, 15 years ago. The injury resolved.

Petitioner's symptoms have not resolved. She is worse. She has not returned to work. Respondent has not approved the surgery. TTD benefits stopped after the Dr. Zelby exam. Petitioner testified that she cannot drive a bus because of the narcotics that she takes. Dr. Koutsky continues to excuse Petitioner from work.

Respondent paid TTD from February 3, 2019 through August 15, 2019 ($22,052.53, 27-5/7 weeks). (RX 5)

Petitioner claimed $19,812.88 in medical expenses. (PX 6, 7, 8, 9 and 11, ArbX 1) Respondent disputed the bills on the basis of liability and claimed a credit for bills that it has paid. The Parties agreed that awarded bills will be paid pursuant to §8.2 of the Act and will be paid directly to the providers.

Respondent claimed that Nature and Extent was in dispute. The Arbitrator declines to make a PPD finding, as there were not satisfactory proofs on the §8.1b(b) factors.

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 her claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between her employment and her 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)

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING ISSUE (F), IS PETITIONER'S CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?, THE ARBITRATOR FINDS:

Petitioner's current condition of ill-being is, in part, causally related to the injury. The causally related condition is lumbar strain, resolved, as stated by Dr. Zelby.

The Arbitrator bases this finding on the persuasive opinions of Dr. Zelby and inconsistencies in the treating medical records.

First, the St. Bernard ER records do not support Petitioner's claim. The diagnosis was Anxiety Attack. There are no findings regarding Petitioner's low back. She denied back pain at least 2 times and had 0/10 pain documented. The back and musculoskeletal exams were unremarkable. Petitioner was given Tylenol for right sided lumbar paraspinal achiness. With a history of a MVC, if Petitioner exhibited any back symptoms, there would have been a full work-up, including x-rays.

Next, Petitioner did not receive medical treatment for low back complaints until more than a week after the accident. If her injury was significant, she would have gone back to the ER or sought treatment earlier.

The MRI findings are consistent with degenerative changes and do not demonstrate a surgical lesion. There is no significant stenosis and no evidence of neural impingement. The radiologist, the physicians at Chicago Pain

and Dr. Zelby all agree that it shows spondylosis (spinal arthritis). Dr. Koutsky's opinion that the MRI shows a herniated disc (as of August 12, 2019) is not persuasive and is not consistent with the opinions of the other physicians. His records do not support a finding of radiculopathy beyond the EMG results, which may be an incidental finding. Radicular symptoms were denied to Melanie Coderre, PA-C as of February 25, 2019. Dr. Patel noted negative SLR as of March 18, 2019. Dr. Koutsky appreciated a positive SLR on the right, but did not chart that both the seated and supine SLR tests were performed. Dr. Zelby noted positive right SLR (for back pain!) in the supine position, but negative in the sitting position. Of course, the results should be the same and leg pain would be expected if there was spinal pathology that was symptomatic.

Dr. Zelby's findings and opinions are most consistent with the entirety of the evidence adduced and are relied upon by the Arbitrator in making his finding on the issue of causation.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING 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:

Petitioner claimed $19,812.88 in medical expenses. (PX 6, 7, 8, 9 and 11, ArbX 1) Respondent disputed the bills on the basis of liability and claimed a credit for bills that it has paid. The Parties agreed that awarded bills will be paid pursuant to §8.2 of the Act and will be paid directly to the providers.

The claimed bill from Chicago Pain and Orthopedic Institute is for the initial visit on 2/11/2019. (PX 6) **The said bill is awarded in the amount of $215.00.**

The claimed bill from Advance Spine & Rehab Center is for therapy from February 20, 2019 through April 1, 2019. (PX 7) It is in the amount of $6,501.91 and does not reflect any payments or reductions, although Respondent made payments. (RX 4) **The said bill is awarded in accordance with §§8(a) and 8.2 of the Act, with Respondent awarded a credit for the payments that it has made.**

The claimed bill from ION is in the amount of $510.59. (PX 8) **No portion of this bill is awarded.** First, there are 2 charges for transportation at $200.00 each. There was no showing of any medical necessity for these charges and they are denied. Second, the 8/12/2019 charge of $84.66 is denied, as this was for a Dr. Koutsky visit after the Dr. Zelby §12 exam finding Petitioner to not be in need of further treatment. Finally, there is a balance of $25.93 which is unexplained and will not be awarded.

The claimed bill from Midwest Specialty Pharmacy is in the amount of $12,084.23. (PX 9) **This bill is not awarded for the reasons set forth in the UR reports (RX 2 and RX 3) and in the report of Dr. Zelby (RX 1).**

The claimed bill from ATI is $501.15. (PX 11) This appears to be a typographical error, as the bill from 4/12/2019 in the amount of $501.05 appears unpaid. **Accordingly, the ATI bill is awarded in the amount of $501.05.**

The awarded medical expenses are found to have been for services that are reasonable and necessary to cure or relieve the effects of the injuries sustained. The award of medical expenses is in accordance with §§8(a) and 8. 2 of the Act and Respondent is to be given credit for all awarded bills that it has paid. Respondent will direct pay the awarded bills to the providers, per the agreement of the Parties.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL TREATMENT?, THE ARBITRATOR FINDS:

Petitioner seeks authorization for further medical treatment by Dr. Koutsky. Petitioner's claim for prospective medical treatment is denied, based upon the Arbitrator's finding above on the issue of causal connection.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING ISSUE (L). TTD, THE ARBITRATOR FINDS:

Petitioner claims to be entitled to TTD for the time period of February 3, 2019 through September 12, 2019, a time period of 31-4/7 weeks.

Respondent claims that Petitioner is entitled to TTD from February 3, 2019 through March 3, 2019, a period of 4-1/7 weeks.

Respondent paid TTD for 27-5/7 weeks.

The Arbitrator awards TTD from February 3, 2019 (the agreed start date) through July 15, 2019 (the date of the Dr. Zelby exam). Petitioner was medically authorized off work from February 11, 2019 (the first Chicago Pain visit) forward. Dr. Zelby endorsed MMI at the time of his exam (indeed hypothesizing that MMI would have been reached in 3 to 4 weeks post accident). The Arbitrator does not support ex-post-facto MMI opinions, which are obviously speculative to a certain degree. Based upon the controlling caselaw of Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission, 236 Ill.2d 132 (2010) Petitioner is entitled to TTD until she has reached MMI, which can be said to be July 15, 2019.

Accordingly, Petitioner is awarded TTD for 23-1/7 weeks, commencing February 3, 2019 through July 15, 2019.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING ISSUE (N), IS RESPONDENT DUE ANY CREDIT?, THE ARBITRATOR FINDS:

Respondent is entitled to a credit for $22,052.53 in indemnity benefits paid and for all awarded bills that it has paid.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC007280
Case Name	BUFF,JOLEEN P v. MAYCE CLARKSON DBA MAYCE'S
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0261
Number of Pages of Decision	19
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Molly Price
Respondent Attorney	Caitlin Fiello

DATE FILED: 6/1/2021

/s/ Barbara Flores, Commissioner

Signature

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

Joleen P. Buff,

Petitioner,

vs. NO: 17 WC 7280

Mayce's Competitive Edge and State Treasurer as Ex-Officio Custodian of the Injured Workers' Benefit Fund,

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by both the Petitioner and Respondent-Injured Workers' Benefit Fund ("IWBF") herein and notice given to all parties, the Commission, after considering the issues of §8(j) credit and the propriety of "hold harmless" language, 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.

I. FINDINGS OF FACT AND PROCEDURAL HISTORY

The Arbitrator's decision delineates the facts of the case in detail. Petitioner was employed by Respondent-Mayce's Competitive Edge ("Respondent-Employer") as a part-time Tumbling Coach. On December 7, 2016, she suffered an accident while demonstrating a roundoff to her students. She injured her left knee, leg, foot, and ankle. Petitioner eventually underwent three surgeries and physical therapy. She had ongoing left lower extremity complaints and was ultimately released to full duty at maximum medical improvement (MMI) on October 22, 2018. However, five weeks later her complaints elicited work restrictions from her treating physician. Petitioner has never returned to work for Respondent-Employer. Currently, she is a stay-at-home mom of two children, but has myriad complaints in relation to activities of

daily living, caring for her children, household chores, and sleeping. She also suffers from increased symptoms with cold weather, squatting, kneeling, and stiffness when stationary for extended periods. She is not as active as she was prior to the accident.

On the Request for Hearing form submitted at the arbitration hearing, IWBF disputed employer/employee relationship, accident, notice, causal connection, average weekly wage, its liability to pay medical expenses, and Petitioner's entitlement to a period of temporary total disability. The parties also placed the nature and extent of the injury in dispute. The Arbitrator ultimately awarded medical expenses related to several physicians and hospitals in the arbitration decision filed on July 20, 2020. The Arbitrator found that these bills were for reasonable and necessary medical treatment and ordered that "Respondent shall hold Petitioner harmless for any and all health insurance subrogation claims paid by IHFS and Tricare for reasonable and necessary medical services."

On July 30, 2020, Petitioner filed a timely Petition for Review disputing nature and extent, and noting that the "Arbitrator awarded hold harmless for any and all health insurance subrogation claims paid by IHFS and Tricare, but Respondent is not entitled to hold harmless under Section 8(j)[.]" IWBF filed its timely Petition for Review on August 31, 2020 also disputing nature and extent. Both parties filed briefs.

In her brief, Petitioner argues that, with respect to the $42,864.13 in medical expenses, the Commission should award this amount and order Respondent to pay it directly to her. Petitioner states that this amount represents the amounts paid by IHFS ($22,306.26) and Tricare ($20,557.87) for medical care related to the instant accident. Additionally, Petitioner argues for an increased award for the nature and extent of her injury.

In its brief, IWBF disagrees with Petitioner, arguing that the "hold harmless" language used by the Arbitrator with respect to expenses paid by IHFS and Tricare was not in error. Further, IWBF argues that "no monetary award related to health insurance subrogation claims should be made directly to Petitioner. IWBF also argues that the nature and extent award is excessive and should be reduced.

II. CONCLUSIONS OF LAW

A. §8(j) Credit and "Hold Harmless" Language

The Arbitrator ordered that Respondent shall hold Petitioner harmless for any and all health insurance subrogation claims paid by IHFS and Tricare for reasonable and necessary medical services. The Commission finds no evidence supporting the Arbitrator's hold harmless award with respect to payments made by IHFS and Tricare.

Section 8(j) of the Act states in relevant part:

> In the event the injured employee receives benefits, including medical, surgical or hospital benefits under any group plan covering non-occupational disabilities contributed to wholly or partially by the employer, which benefits should not have

> been payable if any rights of recovery existed under this Act, then such amounts so paid to the employee from any such group plan as shall be consistent with, and limited to, the provisions of paragraph 2 hereof, shall be credited to or against any compensation payment for temporary total incapacity for work or any medical, surgical or hospital benefits made or to be made under this Act. In such event, the period of time for giving notice of accidental injury and filing application for adjustment of claim does not commence to run until the termination of such payments. This paragraph does not apply to payments made under any group plan which would have been payable irrespective of an accidental injury under this Act. Any employer receiving such credit shall keep such employee safe and harmless from any and all claims or liabilities that may be made against him by reason of having received such payments only to the extent of such credit. 820 ILCS 305/8(j)(1) (West 2017).

Here, there is no evidence in the record establishing that Respondent-Employer contributed in whole or in part to either IHFS's or Tricare's group policy, which must be established before credit can be awarded under §8(j). Thus, there is no evidence in the record supporting the hold harmless language with respect to payments made by IHFS and Tricare. Moreover, the Request for Hearing form indicates a stipulation by the parties that Respondent is not entitled to any §8(j) credit. Parties are bound by stipulations made within the Request for Hearing. See *Walker v. Industrial Comm'n*, 345 Ill. App. 3d 1084 (2004).

There is no indication in the record that Respondent claimed or is entitled to a credit totaling $42,864.13 pursuant to §8(j) for payments made by IHFS and Tricare, or that the attendant hold harmless language is proper. Accordingly, the Commission modifies the Decision of the Arbitrator to reflect an §8(j) credit as stipulated and strikes the "hold harmless" language from the Arbitrator's award with respect to payments made by IHFS and Tricare.

B. Medical Expenses

With regard to the medical bills, IWBF does not dispute, on review, that there are valid health insurance subrogation claims for IHFS and Tricare related to the charges paid by each for Petitioner's work-related injury. However, IWBF argues that "no monetary award related to health insurance subrogation claims should be made directly to Petitioner." IWBF also argues that any monetary award representative of the charges paid by IHFS and Tricare paid directly to Petitioner would result in a windfall for Petitioner. IWBF further argues that IHFS and Tricare paid these bills, not Petitioner, thus payment made to Petitioner would not be a reimbursement, but an additional payment above and beyond that awarded for temporary total disability ("TTD") and permanent partial disability ("PPD"). Further, IWBF asserts if payment is made to Petitioner, IHFS and Tricare are not guaranteed reimbursement for bills that they paid, they would be dependent on Petitioner to voluntarily reimburse them, and such payment would not protect Petitioner from subrogation claims by IHFS and/or Tricare. Lastly, neither Respondent-Employer nor IWBF would receive a credit towards, or protection from, an IHFS or Tricare subrogation claim.

IWBF also argues that it is statutorily limited regarding the purpose for which payments

are disbursed. Under §4(d) of the Act, IWBF "shall only be used for payment of workers' compensation benefits for injured employees when the employer has failed to provide coverage as determined under this paragraph (d) and has failed to pay the benefits due to the injured employee." IWBF asserts that these benefits are payments of awarded TTD, PPD and medical bills, but do not include payment to Petitioner for medical bills not paid out of pocket by Petitioner.

In contrast, Petitioner specifically requests that the $42,864.13 be paid directly to her under §8(a) and 8.2 of the Act. The Act specifically requires "compensation…shall be paid to the employee." 820 ILCS 305/8; see *Springfield Urban League v. Illinois Workers' Comp. Comm'n*, 990 N.E.2d 284, 291 (4th Dist. 2013).

Section 8(a) of the Act states in relevant part:

> The employer shall provide and pay the negotiated rate, if applicable, or the lesser of the health care provider's actual charges or according to a fee schedule, subject to §8.2…for all the necessary first aid, medical and surgical services, and all necessary medical, surgical and hospital services thereafter incurred, limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury…. If the employer does not dispute payment of first aid, medical, surgical, and hospital services, the employer shall make such payment to the provider on behalf of the employee. 820 ILCS 305/8(a) (West 2017).

The Commission finds that §8(a) requires Respondent-Employer to pay Petitioner the amounts IHFS and Tricare paid to Petitioner's medical providers given the dispute of medical expenses prior to and at arbitration. These payments were made by IHFS and Tricare to the medical providers to cover medical expenses that were previously unpaid by Respondent-Employer and in dispute at the time of the arbitration. Had there been no dispute, payment of the bills could have been made by Respondent-Employer directly to the medical providers pursuant to §8(a) and reduced pursuant to the fee schedule or paid at a lower negotiated rate. Respondent-Employer did not avail itself of this provision and, indeed, has failed to provide any compensation or benefits to Petitioner at any time.

Accordingly, the Commission modifies the medical expenses award to include the total of $42,864.13 previously paid by IHFS and Tricare to be paid to Petitioner.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the "hold harmless" language in the arbitration decision with respect to payments made by IHFS and Tricare is stricken.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to all reasonable and necessary medical expenses related to her left lower extremity condition, including $42,864.13 previously paid by IHFS and Tricare, pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay $42,864.13 to Petitioner for medical expenses pursuant to §8(a) and §8.2 of the Act, representing the amounts paid by IHFS and Tricare.

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.

IT IS FURTHER ORDERED BY THE COMMISSION that the Illinois State Treasurer, *ex-officio* custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent-Employer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

JUNE 01, 2021

o: 5/6/21
BNF/wde
45

/s/*Barbara N. Flores*
Barbara N. Flores

/s/*Marc Parker*
Marc Parker

/s/*Christopher A. Harris*
Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BUFF, JOLEEN P
Employee/Petitioner

Case# **17WC007280**

MAYCE'S COMPETITIVE EDGE AND STATE TREASURER AND EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 7/20/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

6165 HASSAKIS & HASSAKIS PC
MOLLY E WEHKING
206 S 9TH ST SUITE 201
MT VERNON, IL 62864

0000 MAYCE'S COMPETITIVE EDGE
4A DO IT DRIVE
ALTAMONT, IL 62418

4948 ASSISTANT ATTORNEY GENERAL
CAITLIN M FIELLO
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

STATE OF ILLINOIS)
)SS.
COUNTY OF **MADISON**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
PETITIONER'S PROPOSED ARBITRATION DECISION

Joleen P. Buff
Employee/Petitioner

v.

Mayce's Competitive Edge and State Treasurer and Ex-Officio Custodian of the Injured Workers' Benefit Fund
Employer/Respondent

Case # **17** WC **07280**

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 **Linda Jean Cantrell**, Arbitrator of the Commission, in the city of **Collinsville**, on **June 4, 2020**. 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 **$803.26 in reimbursable medical expenses, $22,306.26 for IHFS' subrogation interest and $20,557.80 for Tricare's subrogation interest**

FINDINGS

On **December 7, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**6,240.00**; the average weekly wage was $**120.00**.

On the date of accident, Petitioner was **21** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, totaling **$280,956.22,** as provided in Section 8(a) and Section 8.2 of the Act. Respondent shall hold Petitioner harmless for any and all health insurance subrogation claims paid by IHFS and Tricare for reasonable and necessary medical services. Respondent is further ordered to reimburse Petitioner **$803.26** for out-of-pocket expenses.

Respondent shall pay Petitioner temporary total disability benefits of **$120**/week (AWW minimum rate) for **97-6/7ths** weeks, commencing **December 7, 2016** through **October 22, 2018**, for a total of **$11,742.84**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits to the extent of **50%** loss of use of the **left leg, or 107.5 weeks,** pursuant to §8(e) of the Act.

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

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

Signature of Arbitrator

7/13/20
Date

JUL 2 0 2020

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JOLEEN P. BUFF, Employee/Petitioner, v. MAYCE'S COMPETITIVE EDGE AND STATE TREASURER AND EX OFFICIO-CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND, Employer/Respondent.	)	Case No.: 17-WC-7280

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Collinsville on June 4, 2020. The parties dispute all issues. Petitioner filed an Amended Application for Adjustment of Claim on March 27, 2018 to add the Injured Workers' Benefit Fund as a Respondent. On February 19, 2018, Investigator Corey Brown of the Illinois Workers' Compensation Commission confirmed he has investigated this claim and according to the National Council on Compensation Insurance, Respondent Mayce Clarkson, d/b/a Mayce's Competitive Edge, did not have a workers' compensation insurance policy on 12/07/16. The exhibit reflecting no insurance is marked Petitioner's Exhibit 1.

TESTIMONY

Petitioner, Joleen P. Buff, was 21 years old on December 7, 2016 when she was injured while working for Respondent, Mayce's Competitive Edge. Petitioner was married with no dependent children on the date of the accident.

Petitioner testified that Mayce, the owner of Mayce's Competitive Edge, approached her in 2010 to work as a part-time tumbling coach in her gym. Mayce and Petitioner agreed to a rate of $10.00 per hour. Petitioner testified that when she started working for Respondent she had to complete an online training course to become a certified tumbling coach and Mayce paid for said training.

Petitioner testified Mayce directed and controlled her work, including what equipment to use, what routines/drills were to be performed with the gymnasts each session, and how long to perform each routine/drill. Mayce directed all routines/drills while Petitioner assisted. Petitioner

testified Mayce instructed her to wear workout clothes and to wear a shirt with "Mayce's Competitive Edge" at tumbling meets to represent Respondent's business. All students competed under Respondent's name. Respondent provided Petitioner with a specific work schedule and Petitioner had to request permission for time off work and reported directly to Mayce if there were any problems or concerns.

Petitioner testified she worked at Respondent's facility anywhere between ten (10) to twelve (12) hours a week. She was paid every two weeks in cash and Petitioner claimed that cash on her personal taxes at the end of the year. Petitioner testified that for the 52 weeks prior to December 7, 2016, she was making approximately $120.00 a week and was receiving $12.00 an hour during that time.

Petitioner testified that Respondent was her sole employer, she did not rent time from Respondent and did not pay for any of the equipment. Petitioner testified she never invested a sum of money in Respondent's business and all out-of-pocket expenses were reimbursed to her by Respondent.

Petitioner testified that on December 7, 2016 she attempted to demonstrate a roundoff when she fell and felt a sharp pain in her left leg. Petitioner testified she sustained injuries to her left knee, leg, foot, and ankle. Petitioner immediately asked another employee to call an ambulance and she was transported from Respondent's facility to St. Anthony's Memorial Hospital. Petitioner's husband reported the accident to Respondent a day or two after the incident.

Petitioner's left knee was dislocated and was put back in place on 12/8/16. Her left knee was placed in an immobilizer and she was transferred by ambulance from St. Anthony's Hospital to St. John's Hospital. On 12/9/16, Petitioner underwent a closed reduction with external fixators and was discharged on 12/12/16. On 12/22/16, the external fixators were removed and a tibia fracture was repaired with a plate and screws. On 5/16/18, Petitioner underwent a third surgery to remove the plate and underwent an ACL reconstruction and partial meniscectomy. Petitioner was transported to St. John's Hospital on 5/18/18 after losing consciousness. A venous duplex study was performed due to swelling in her left leg. Petitioner was released at MMI on 10/22/18.

Petitioner was off work from 12/7/16 through 10/22/18. Petitioner returned to Dr. Herrin on 11/29/18 complaining of sharp pain, popping, and grinding in her left knee. She was placed on a 30-pound lifting restriction and ordered to elevate her leg at least one hour per day.

Petitioner testified that her everyday life is a lot different than before the accident. Her left knee/leg is stiff in the morning and she does stretches for approximately five minutes to alleviate those symptoms. Petitioner has difficulty squatting to pick up her minor children. She has difficulty running due to sharp pain in her knee. Petitioner has to bear most of her weight on her right knee and extend her left leg out when kneeling to bathe her children. It is uncomfortable to play on the floor with her children.

Petitioner has popping, grinding, and sharp pain in her left and knee and it occasionally gives out. She has loss of strength and cannot lift as much weight as she could prior to the accident. She favors her left leg when ascending stairs and cannot bend her left leg as much as her right.

Petitioner testified her right hip pops and feels "weird" when her left knee gives out. When Petitioner's knee gives out her ankle will twist. Petitioner testified her ankle and foot swells every day and her left foot noticeably turns inward.

Petitioner testified she has trouble walking and often walks with a limp. She used to run almost every night for an hour, but knee pain prevents her from running now. Petitioner testified she is no longer able to do Zumba because it involves twisting, lunging, squatting and jumping which are all too painful. Petitioner has trouble sleeping on her left side and sleeps with a pillow between her knees. She can only sit for about an hour and a half as her foot and ankle tingle and her knee gets stiff and uncomfortable. Petitioner experiences soreness after forty-five (45) minutes of standing. Weather changes cause sharp pain in her left knee. She has trouble bending down to switch clothes over from the washer to the dryer, loading and unloading the dishwasher and taking the trash cans out to the road. Petitioner takes frequent breaks throughout the day due to her left knee/leg/foot symptoms. She no longer enjoys hiking, bike riding, running and working out every day because it is too painful.

Prior to the incident, Petitioner did not have any of the above issues with her left knee, leg, foot, ankle or hip. She elevates her knee at night and/or takes Tylenol to relieve her pain. Petitioner testified she does not have a day without pain in her left knee or leg. On the worst days, her pain is between an 8 or 9 out 10 and her best days are between a 3 or 4 out of 10. Petitioner testified she did not return to her occupation with Respondent because she did not feel she could do all of the kneeling, squatting, spotting, jumping and demonstrating that is required of her job.

Respondent did not call any witnesses and did not offer any exhibits into evidence.

MEDICAL HISTORY

Petitioner was transported by Altamount Ambulance Service, Inc. to St. Anthony's Memorial Hospital in Effingham, Illinois. Dr. John Downing noted Petitioner was in severe distress and had a deformity and effusion to her left knee. X-rays revealed a comminuted displaced fracture of the proximal left tibia with displacement of the medial tibial plateau. The fracture was intra-articular with a sizeable hemarthrosis. On 12/8/16, Dr. Didi Omiyi performed stabilization with closed reduction and splint immobilization. Dr. Omiyi instructed Petitioner to remain non-weight bearing on her left lower extremity. Petitioner was transported to St. John's Hospital in Springfield, Illinois on 12/8/16 for further surgical management.

On 12/8/16, Dr. Osaretin Idusuyi ordered a CT angiogram that showed a comminuted medial tibial plateau fracture with multiple intra-articular loose fracture fragments, avulsion fracture of the lateral tibial epiphysis and diffuse soft tissue edema. Dr. Idusuyi performed an external fixator placement to allow for joint stability while allowing the soft tissues to become appropriate for definitive fixation. His post-operative diagnosis was tibial plateau fracture with lateral knee dislocation. Dr. Idusuyi noted Petitioner would require open reduction and internal fixation of the plateau fracture when the swelling subsided. Petitioner was discharged on 12/12/16.

Dr. Idusuyi performed open reduction and internal fixation of the left tibial plateau fracture with bone graft and removal of the external fixator on the left leg on 12/22/16. His post-operative

diagnosis was left bicondylar tibial plateau fracture. Petitioner was discharged on 12/23/16 and prescribed Aspirin, Norco and Ativan, instructed not to bear weight on her left lower extremity and to have her knee immobilizer locked in extension at all times.

On 1/25/17, Petitioner reported to Dr. Tina Rozene at the Springfield Clinic she was having anxiety from not being able to do what she used to and having to rely on others. Dr. Rozene prescribed Lorazepam, Omeprazole, and a lower dose of Norco.

Petitioner treated with Dr. Idusuyi from 1/4/17 through 2/19/18 at the Orthopedic Center of Illinois in Springfield, Illinois. On 2/6/17, Petitioner reported sharp pain in her left leg despite taking Norco and Aleve. X-rays revealed good healing across the fracture site with callus formation. Dr. Idusuyi referred Petitioner to physical therapy. Petitioner returned to Dr. Idusuyi on 5/8/17 with complaints of swelling, discomfort, and sharp pain in her knee. Dr. Idusuyi noted maximal tenderness over the left knee, that Petitioner was off balance and had pain with stairs. Dr. Idusuyi ordered an MRI to rule out a left meniscus tear which was delayed due to Petitioner's pregnancy.

Petitioner complete forty-six (46) physical therapy sessions at Biomax Rehabilitation Services. On 10/19/17, it was noted Petitioner lacked full strength in her left lower extremity as compared to her right and her goals had been partially met. Petitioner was instructed to perform home exercises during her pregnancy. On 2/14/18, an MRI revealed a possible lateral meniscal tear. Petitioner complained of ongoing left knee pain and grinding along the anterior aspect of her knee. Petitioner walked with an antalgic gait and had a valgus thrust on the left. Dr. Idusuyi noted painful range of motion, pain with palpation of the left medial joint line and lateral joint line and instability of the left knee lateral meniscus. Dr. Idusuyi diagnosed a tear of the left lateral meniscus and referred Petitioner to Dr. Rodney Herrin for further evaluation. On 5/16/18, Dr. Herrin performed open removal of locking plate along the medial proximal tibia, anterior cruciate ligament reconstruction using tibialis anterior allograft and partial lateral meniscectomy.

On 5/18/18, Petitioner sought care at St. Anthony's Memorial Hospital for a syncopal episode. She stated she took Norco at 4:00 a.m. and then passed out. Dr. Sanjay Udani noted Petitioner was discharged on 5/16/18 without anticoagulation and that she had dizziness, light-headedness and lack of sleep due to the recent surgery. Dr. Udani was concerned about deep vein thrombosis and swelling and transferred her to St. John's Hospital for evaluation. On 5/19/18, Dr. Sonani Vallabhbhai Bhavin opined Petitioner's syncopal episode was likely secondary from narcotic use and overall fatigue and a Doppler was ordered after removal of the brace. Dr. Christopher Graves removed the 3D rehab brace and a venous duplex scan revealed no evidence of acute or chronic thrombosis in the deep or superficial veins and Petitioner was discharged.

On 5/30/18, x-rays revealed the tunnels related to the anterior cruciate ligament reconstruction appeared to be in a satisfactory position, but that the button on the femoral side was slightly off the femoral cortex. Dr. Herrin diagnosed closed bicondylar fracture of left tibial plateau, complex tear of lateral meniscus of left knee as current injury, left knee pain and rupture of anterior cruciate ligament of left knee. Dr. Herrin referred Petitioner to physical therapy.

On 10/22/18, Dr. Herrin noted good endpoint to Lachman's examination, instructed Petitioner to continue with a home exercise program and released her at MMI with no restrictions. Petitioner completed fifty-seven (57) physical therapy sessions between 6/5/18 and 11/1/18. It was noted Petitioner had not met her goals of having pain less than or equal to 1/10 in 4 weeks, ambulating without assistive device or an antalgic gait in 4 weeks, and stair ascent/descent with minimal asymmetry and no use of upper extremities on railing in 8 weeks. Petitioner had a 43% strength deficit in the left knee as compared to the right, decreased left knee AROM as compared to the right in terms of knee extension and flexion. Her therapist opined Petitioner was unable to return to her work duties, functional activities and physical activities that include quick pivoting, stairs, running or single leg tasks.

On 11/29/18, Petitioner returned to Dr. Herrin stating difficulty lifting over 35 lbs. and complained of swelling, popping and sharp pain in her left knee. Dr. Herrin noted a grade 1 effusion, pain with palpation of the left medial joint line, laxity in the medial collateral ligament and anterior to posterior laxity of the ACL graft. Dr. Herrin diagnosed left knee pain and placed her on permanent restrictions, consisting of no double shifts, no lifting over 35 lbs. and no repetitive kneeling or squatting.

Respondent did not call any witnesses.

CONCLUSIONS OF LAW

ISSUES (A) & (B): Was Respondent operating under and subject to the Illinois Workers' Compensation Act; Was there an employee-employer relationship?

The Arbitrator finds Petitioner provided unrebutted testimony of the relationship between Respondent and herself and in doing so established Respondent was subject to the Act and an employee-employer relationship existed. Mayce owned and operated a gymnastics gym open to the public by the name of Mayce's Competitive Edge on December 7, 2016. The Arbitrator finds Respondent retained the right to control the manner in which Petitioner's work was performed, retained the right to discharge, told Petitioner what days/hours to work, owned the equipment necessary to perform the work, and the relationship of the work performed conformed to the employer's purpose. Respondent paid for Petitioner's training and certification and instructed Petitioner to wear a shirt bearing Respondent's company name to all tumbling meets.

ISSUES (C), (D), and (E): Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent? What was the date of the accident? Was timely notice of the accident given to Respondent?

An injury is an accident when it is traceable to a definite time, place and cause and occurs in the course of employment, unexpectedly, and without affirmative act or design of the employee. *Matthiessen and Haegler Zinc Co. v. Industrial Commission,* 284 Ill. 378, 120 N.E.2d 249 (1918).

Petitioner provided unrebutted testimony that on December 7, 2016 she was injured while attempting to demonstrate a gymnastics routine. Petitioner was directed to perform such

routines/drills by Respondent as part of her job duties. Petitioner was immediately taken to the emergency room by ambulance. Petitioner testified her husband also reported the accident to Respondent a day or two after the accident. The time, location and mechanism of injury all support Petitioner sustained injuries arising out of and in the course of employment. Accordingly, the Arbitrator finds that Petitioner sustained injuries arising out of and the course of her employment on December 7, 2016, and timely notice of the accident was given to Respondent.

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

Petitioner provided unrebutted testimony that she sustained injuries to her left knee/leg and the medical evidence presented at trial corroborates her testimony. The medical evidence establishes Petitioner provided a consistent history of accident and symptoms. The Arbitrator finds Petitioner's current condition of ill-being is causally related to her work incident on December 7, 2016.

ISSUES (G), (H), and (I): What were Petitioner's earnings? What was Petitioner's age at the time of the accident? What was Petitioner's marital status at the time of the accident?

Petitioner provided unrebutted testimony that she earned $12.00 per hour in cash for the 52 weeks prior to December 7, 2016, working between ten (10) and twelve (12) hours per week. Petitioner was 21 years old on the date of accident, married, with no dependents. The Arbitrator finds Petitioner presented evidence that her average weekly wage was $120.00; she was 21 years old, and married on the date of accident.

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?

Based on the above findings regarding causal connection and the unrebutted testimony that the medical expenses were reasonable and necessary in the care and treatment of Petitioner, the Arbitrator finds that Petitioner is entitled to medical benefits itemized in Petitioner's Exhibit 13. The Arbitrator finds Respondent has not paid all charges relating to Petitioner's reasonable and necessary medical care. As a result, Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, totaling **$280,956.22**, as provided in Section 8(a) and Section 8.2 of the Act. Respondent shall be given a credit for any amounts previously paid under Section 8(a) of the Act for medical benefits and Respondent shall hold Petitioner harmless from claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

ISSUE (K): Is Petitioner entitled to receive TTD benefits?

The medical evidence presented at arbitration reflects Petitioner was taken off work from the date of accident through her release to return to work on 10/22/18. The Arbitrator finds Petitioner is entitled to 97-6/7th weeks of temporary total disability benefits for the period December 7, 2016 through October 22, 2018. Based on Petitioner's AWW of $120.00, the

Arbitrator finds that Petitioner is owed $11,742.84 in TTD benefits, using the minimum TTD rate (AWW rate) of $120.00.

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

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party submitted an impairment rating. 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 Petitioner did not return to her employment with Respondent. Petitioner's employment was not terminated by Respondent and Petitioner testified she did not quit her job. However, on 11/29/18, Petitioner was placed on permanent restrictions, consisting of no double shifts, no lifting over 35 lbs. and no repetitive kneeling or squatting. Petitioner worked for Respondent as a part-time tumbling coach for approximately six years prior to the accident. Prior to her employment with Respondent, Petitioner worked for approximately two years at Effingham Gymnastics Academy. Petitioner testified she is not currently employed and stays home to take care of her two minor children. Petitioner was 21 years old at the time of the accident, having worked in the field of gymnastics for eight years prior. In addition to Petitioner's permanent restrictions, Petitioner testified as to her physical limitations which would make it difficult to perform the job duties of a tumbling coach, including demonstrating gymnastic routines/drills. The Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 21 years old at the time of the accident. Petitioner is a young individual with a substantial number of working years ahead of her. It is reasonable to conclude that Petitioner will continue to experience pain and limitations for the rest of her life. Her symptoms are likely to inhibit or prevent her ability to do her regular activities and chores at home, enjoy life and function for a considerable amount of time. Based on her age, she will likely suffer from her symptoms and injuries for several years which will impair her future. Given Petitioner will have to work with her ongoing symptoms for an extended period of time, the Arbitrator gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes there is no direct evidence of reduced earning capacity. Although Petitioner testified she did not return to her prior employment, there is no evidence she cannot obtain suitable employment within her restrictions. The Arbitrator therefore gives greater weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner was a credible witness. Petitioner testified at Arbitration that she remains symptomatic in her left leg, knee, hip, foot and ankle approximately three and a half years after the incident and that she does not go a day without pain. Petitioner testified that her knee is stiff in the mornings and she has trouble squatting down to pick up her two children. She has difficulty kneeling down to bathe her kids and play with them. Petitioner testified she has popping, grinding, sharp pain and loss of strength in her left leg. She cannot pick up as much as she used to, bend her left leg as much as her right and favors her left leg when climbing stairs. Her left ankle is more swollen than her right every day and she has difficulty walking. She walks with a limp and her left foot turns in when she walks. She sits and take more breaks when walking long distances or for long periods of time. Petitioner has difficulty sleeping on her left side and standing and sitting for long periods of time. Petitioner testified she used to love hiking, bike riding, running and working out every day, but does not engage in those activities as it is painful and not as enjoyable. Cold weather also affects Petitioner's injuries in that she has sharp pains in her left knee/leg when it is cold. Petitioner has difficulty performing household chores, such as bending down to switch clothes over from the washer to the dryer, loading or unloading the dishwasher and moving trash cans. Petitioner testified she did not have any of these issues prior to her injury.

The Arbitrator finds that Petitioner's medical records corroborate her testimony. Medical records from Dr. Herrin on 10/22/18 note Petitioner had weakness in her quadriceps. Physical therapy records from 11/1/18 indicate Petitioner has ongoing pain in her left knee, she walks with an antalgic gait, and she has difficulty climbing stairs. It was also noted Petitioner has loss of strength in her left knee as compared to her right and decreased left knee AROM as compared to her right in terms of knee extension and flexion. Petitioner's physical therapist opined Petitioner was unable to return to her work duties, functional activities and physical activities that included quick pivoting, stairs, running or single leg tasks. In November, 2018, Petitioner stated she had difficulty lifting over 35 lbs., had swelling, popping, and sharp pain her left knee. Dr. Herrin noted grade 1 effusion, pain with palpation of the left medial joint line, laxity to her medial collateral ligament and anterior to posterior laxity of her ACL graft. Dr. Herrin placed Petitioner on permanent restrictions, consisting of no double shifts, no lifting over 35 lbs, and no repetitive kneeling or squatting. The Arbitrator finds it significant that the medical records corroborate Petitioner's testimony of ongoing problems and that Petitioner did not have any of these issues prior to December 7, 2016 and thus, 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 50% loss of the left leg, or 107.5 weeks, pursuant to §8(e) of the Act.

ISSUE (O): $803.26 in reimbursable medical expenses, $22,306.26 for IHFS' subrogation interest and $20,557.80 for Tricare's subrogation interest.

The Arbitrator finds Petitioner paid $803.26 to the Orthopedic Center of Illinois, Springfield Clinic, CVS Pharmacy, Altamount Pharmacy, Walmart Pharmacy in Vandalia, Illinois, Walgreens and Walmart Pharmacy in Effingham, Illinois for treatment of her injuries from December 7, 2016, as itemized in Petitioner's Exhibit 13, and that said charges were reasonable

and necessary. Furthermore, the Arbitrator finds that IHFS paid $22,306.26 and Tricare paid $20,557.87 for charges that were reasonable, necessary and related to Petitioner's work injury on December 7, 2016 and for which there are valid subrogation claims. Respondent shall hold Petitioner harmless for any and all payments made by IHFS and Tricare. Respondent is further ordered to reimburse Petitioner for out-of-pocket expenses in the amount of $803.26.

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event Respondent fails to pay benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent that are paid to Petitioner from the Injured Workers' Benefit Fund.

Arbitrator Linda J. Cantrell

7/13/20
DATE

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC018477
Case Name	WINSTON, TRACY v. NORTH STAR
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0262
Number of Pages of Decision	14
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	David Barish
Respondent Attorney	Jeffrey Rusin

DATE FILED: 6/2/2021

DISSENT

/s/ Thomas Tyrrell, Commissioner

Signature

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

Tracy Winston,

Petitioner,

vs. NO: 16 WC 18477

North Star,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 4, 2019, is hereby affirmed and adopted.

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

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

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

JUNE 2, 2021

o: 4/20/21
TJT/jds
51

/s/ *Maria E. Portela*
Maria E. Portela

/s/ *Kathryn A. Doerries*
Kathryn A. Doerries

DISSENT

I respectfully dissent from the opinion of the majority and would reverse the Arbitrator's Decision in its entirety. After considering the totality of the evidence, I believe Petitioner met his burden of proving by a preponderance of the evidence that he sustained a right leg injury arising out of and in the course of his employment on April 26, 2016.

Petitioner is a 55-year-old demolition supervisor. He worked for Respondent in this position for five or six years before the date of accident. It is undisputed that while Respondent maintains an office in Villa Park, Illinois, Petitioner was assigned to work at consistently changing project locations. Petitioner worked at an assigned site until the completion of the project, then Respondent would contact Petitioner with a new assignment located at a different work site. It is undisputed that Respondent directed Petitioner to each project site. While Petitioner could decide to not accept a particular project, Petitioner had no control over the locations of the work sites. It is also undisputed that as a supervisor, Petitioner would at times have to visit the company's office if he was responsible for driving the company truck to the work site. This truck contained various tools needed for the project as well as the job site book. The evidence shows that most of Petitioner's workdays were spent at locations away from Respondent's Villa Park office.

On the date of accident, Petitioner was supposed to begin a new project located in downtown Chicago. Per the usual protocol, the night before, someone from the main office contacted Petitioner through either text or a phone call with the details of the project. Petitioner credibly testified that while the project was to start at 6 p.m., the project manager, Jaime Aquino, told Petitioner to meet him at 5 p.m. to walk through the project site. Petitioner credibly testified that he parked in the public parking garage Mr. Aquino selected and that Mr. Aquino was supposed to pick him up from the public parking garage and drive Petitioner to the project site. Petitioner was carrying a bag with his personal tools as well as OSHA materials that had to be present at the

job site. Unfortunately, Petitioner fell down the stairs in the parking garage while carrying his work materials as he was on his way to meet Mr. Aquino. Petitioner's testimony regarding these circumstances is much more credible than that of Mr. Aquino.

After carefully considering the credible evidence, I believe Petitioner qualifies as a traveling employee; thus, his injury clearly arose out of and in the course of his employment. The undisputed evidence proves that a key element of Petitioner's job required him to perform work in locations away from the company's office. On the date of accident, Petitioner was once again assigned to work at a job site away from the company's office. This is a clear case of a traveling employee. The analysis for determining whether a work injury is compensable differs for traveling employees. Pursuant to Illinois case law, when a traveling employee is injured, the injury is compensable if the activity performed by the employee falls within one of the following three categories: 1) acts the employer instructs the employee to perform; 2) acts which the employee has a common law or statutory duty to perform while performing duties for his employer; and 3) acts which the employee might be reasonably expected to perform incident to his assigned duties. *See Venture-Newburg-Perini v. Ill. Workers' Comp. Comm'n*, 2013 IL 115728 at ¶18. Petitioner credibly testified that his supervisor, Mr. Aquino, instructed him to park in the parking garage where Petitioner ultimately sustained his injury. Furthermore, in traveling from the parking garage to the job site, Petitioner fell and sustained an injury partly due to the work supplies he was carrying to the job site. Petitioner credibly testified that he, as well as many other employees, routinely brought personal tools to job sites. Petitioner also credibly testified that as a supervisor, he was required to bring the OSHA materials that had to be present at every job site. Finally, it is certainly reasonable and foreseeable that Petitioner would drive to and park downtown to work at the assigned job site. I believe as a traveling employee, Petitioner's injury clearly arose out of and in the course of his employment.

After weighing the totality of the evidence, I believe Petitioner met his burden of proving he sustained an injury arising out of and in the course of his employment. For the forgoing reasons, I would reverse the Arbitrator's Decision in its entirety and would award appropriate benefits.

/s/ *Thomas J. Tyrrell*
Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0262

WINSTON, TRACY
Employee/Petitioner

Case# **16WC018477**

NORTH STAR
Employer/Respondent

On 2/4/2019, 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 2.45% 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:

0293 KATZ FRIEDMAN EAGLE ET AL
DAVID M BARISH
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0507 RUSIN & MACIOROWSKI LTD
JEFFREY T RUSIN
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

T. Winston v. North Star, 16 WC 018477

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

Tracy Winston
Employee/Petitioner
v.
North Star
Employer/Respondent

Case # **16** WC **018477**

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 **10/5/2018**. 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 _____

T. Winston v. North Star, 16 WC 018477

FINDINGS

On **April 26, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$59,630.40**; the average weekly wage was **$1,490.76**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **3** dependent children.

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

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

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

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

ORDER

Claim for compensation denied. Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on April 26, 2016.

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

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

Signature of Arbitrator

February 4, 2019
Date

FEB 4 - 2019

ICArbDec p. 2

FINDINGS OF FACT

Petitioner was employed by Respondent as a Demolition Supervisor. He had been so employed by Respondent and its predecessor for 8 to 10 years. Respondent does demolition and clean-up work. Petitioner was a working supervisor and his job tasks involved tearing down ceilings, tearing up tile, walls, concrete, etc. It was a physical job with a lot of lifting and bending and could involve heavy lifting and working with hazardous materials, such as asbestos, lead and mold. Petitioner was a member of Local 225 – Laborers' Union.

Respondent would notify Petitioner of a job via phone call or text. He would be advised of the job location, how many workers were on the job and whether Petitioner needed to bring Respondent's truck to the job site. The truck had a gang box with Respondent's tools for the job. The workers could bring their own tools to the job, or they could use Respondent's tools. If Petitioner brought the truck, he would stop at Respondent's offices in Villa Park and pick up the truck. If Petitioner did not have to pick up the truck, he would drive from his home to the job site.

Petitioner was scheduled to work for Respondent on April 26, 2016 at a job on Wacker Drive in Chicago. According to Petitioner, "Jimmy" (Jaime Aquino, a manager for Respondent) called him regarding the job on Wacker Drive and told him that the job was a 6:00 start (as was customary for Respondent) and that Aquino would pick up Petitioner at 500 West Monroe Street at 5:00 and take him to the job site on Wacker to discuss the job. According to Petitioner, Aquino had 2 jobs that night and wanted to go over the Wacker Drive job first. Petitioner parked at the Monroe St. lot because it was cheaper than others. At 4:35, Petitioner received a call from Aquino and was told that Aquino was running late. Petitioner parked at the Monroe lot and proceeded down to the street level. He had his hardhat, a tool bag and OSHA books. He was using a rolling cart. Petitioner testified that as a supervisor, he was required to bring Respondent's OSHA books to the job site.

To get to the street level, Petitioner had to go down 4 or 5 stairs. As he went down the stairs with the loaded cart, Petitioner felt a pop in his leg and fell down the stairs. He noticed that his right knee was facing the wrong way. Petitioner called Aquino and he came to help. An ambulance was called and Petitioner was taken to Northwestern Memorial Hospital for emergency care (PX 9, PX 2) Aquino took Petitioner's tools and OSHA books back to Respondent's office.

Petitioner testified that he felt "fine" before the accident. He had no prior right leg injuries and had no prior problems with his right quadriceps.

At Northwestern, Petitioner was seen for a right knee deformity and was diagnosed with a right quadriceps tendon rupture. He was given an immobilizer and was instructed to follow up with an orthopedic surgeon. (PX 2)

Petitioner was seen by Dr. Bradley Merk, MD, an orthopedic surgeon on May 3, 2016. Surgery was recommended and a Right Quadriceps Tendon Repair was done on May 6, 2016. (PX 3, PX 2)

Petitioner had follow up care with Dr. Merk through June of 2017. He had PT at Athletico for almost a year and was not released by Dr. Merk to heavy construction work. According to Dr. Merk's May 22, 2017 Narrative Report, Petitioner was not at MMI. He was in need of work hardening. He was incapable of heavy lifting. (PX 3)

Petitioner was seen by Dr. Kevin Walsh, an orthopedic surgeon, for a Section 12 exam on May 27, 2017. Dr. Walsh noted some pain behaviors on the exam. The diagnosis was status post quadriceps tendon repair. Petitioner was capable of returning to work at full duty and was at MMI. (RX 6) Dr. Walsh authored an Addendum Report on January 12, 2018. Prolonged PT was unreasonable. Petitioner was capable of lifting 100 pounds, as was said to be a job requirement. (RX 7)

Petitioner was seen by Dr. Kevin Tu, an orthopedic surgeon, for an IME at the request of a prior attorney, on October 19, 2017. The history given was that the patient was on his way to work when he fell down some stairs and injured his right leg. Dr. Tu noted 4/5 strength and atrophy. Petitioner's complaints of weakness and buckling were consistent with the objective findings. The diagnosis was quadriceps tendon rupture, causally related to the fall. Restrictions of 25 pounds lifting and no kneeling were recommended. Dr. Tu provided comments on the Dr. Walsh exam on March 5, 2018. He did not agree that the patient had 5/5 strength and could return to work at full duty. (PX 1)

Petitioner has not returned to work as a union demolition supervisor. Petitioner has been looking for work and anticipated being hired as a bus driver, shortly. The bus driver job will pay $15.00 per hour. Petitioner was earning $40.40 per hour as a demolition supervisor. (RX 5)

Petitioner testified that he has weakness in his right leg. It buckles. He can't squat. His right leg is painful. He has weather sensitivity. He drives with his left leg sometimes.

Petitioner testified that he worked more than 40 hours a week, sometimes. As a supervisor, he would have to stay on the job to finish it. Overtime was not regular. Petitioner testified that he could not turn down overtime.

On cross-examination, Petitioner testified that he picked up Respondent's truck once or twice a week. Petitioner identified RX 1 as Pictures of the staircase where he fell. The stairs weren't defective. The lighting was okay. Petitioner was not told to park at that lot. It is a public lot. The stairs are in an area that is open to the public. It was Petitioner's choice to bring the roller bag. He was not in a rush. He thinks that he was on the clock at 5:00, but he was not paid for April 26, 2016.

Petitioner was not paid for travel time. He was not reimbursed for travel or parking expenses. Respondent did not tell him how to get to the job or where to park. There were other parking locations closer to the job site.

Respondent submitted the testimony of David Fracassi, its General Manager. The demolition workers are union employees and could accept or reject job offers at their own discretion. Respondent does not direct or control the means, manner, or method, of how an employee gets to the job site. Respondent does not pay for travel or parking expenses. Employees and supervisors are not required to bring anything to the job site, such as tools. Petitioner was not required to bring an OSHA book to the job site. Respondent had no relationship with the 500 West Monroe Street parking facility. Petitioner was not paid for April 26, 2016. Overtime did not occur on every job and would have to be set up in advance. Employees are not required to work overtime.

Jaime Aquino testified at Respondent's request. Aquino works for Respondent as a Project Manager. He contacted Petitioner regarding the April 26, 2016 job. Aquino testified that the job was to start at 6:00. He did not tell Petitioner to meet him at 5:00 to walk through the job site early. He told Petitioner that he would pick him up at the Monroe address to take him to the job site. He did not direct Petitioner to park at 500 West Monroe. Respondent did not pay Petitioner for parking or travel. He knew that Petitioner parked at 500 West Monroe because parking there was cheaper. He was doing Petitioner a favor, so that Petitioner did not have to walk to the Wacker Drive address. Petitioner was not required to bring his personal bag and OSHA book to the job. Respondent's truck gang box has the tools for the job and the OSHA book and other documents in it. There was no other job that Aquino was involved in on April 26, 2016. Aquino intended on discussing the job with Petitioner at 6:00 when the job started. The other employees on the job would be engaged in set up activities while Aquino and Petitioner walked through the job site. Aquino disagreed that he would regularly meet with Petitioner before 6:00 to discuss how a job would go.

Petitioner presented the testimony of Frank Ramey. He worked for Respondent as a superintendent (site supervisor like Petitioner) from 1996 to 2016. He was so employed in April of 2016. Ramey testified that the OSHA book, a corporate safety manual and MSDS documents were required to be brought to the job site by site supervisors. Supervisors were also required to bring their own vehicle to the job (no one else testified about this and Petitioner obviously parked his vehicle more than half a mile from the Wacker Drive job on the day of the accident). He would meet with the project manager sometimes before the job started and sometimes at starting time. Ramey was not paid for the meetings before his start time. The other employees would be setting up if he met with the manager at starting time. Ramey received a subpoena to testify. (PX 10)

Aquino was recalled to testify by Respondent after Ramey testified. At the time of the accident, all required paperwork (OSHA book, MSDS, etc.) was in the gang box in Respondent's truck that was at the job

site. Supervisors were not required to have those documents. Supervisors may have been required to have the documents in the past, but not at the time of the accident.

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 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:

Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on April 26, 2016.

Petitioner's injury did not arise out of his employment. Any risk of injury was associated with Petitioner's own choice of parking at the 500 West Monroe St. facility, with its stairs down to the ground level and with Petitioner's choice to carry his tools and the OSHA book on his personal roller cart. The Arbitrator believes the testimony of Aquino and Fracassi that supervisors were not required to bring an OSHA book to the job site, as the same was contained in the gang box on Respondent's truck, along with other papers and tools necessary to the job. There was no documentation submitted that supervisors were required to carry the OSHA book at the time of the accident. Any risk of injury associated with Petitioner's choice of what to bring to a job and how to bring it is personal and not incident to Petitioner's employment by Respondent.

Petitioner's injury did not occur in the course of his employment by Respondent. He was not a traveling employee. He was not paid for travel or parking. The means manner and method of how to get to the job site on Wacker Drive were in Petitioner's sole control. The accident occurred at 5:00. His start time was 6:00 and he was more than half a mile from the job site when he was injured. The employment did not require Petitioner

to be where the accident occurred and at the time of the accident. The time of the accident was before Petitioner was to start. The circumstance of the accident was that Petitioner was going from the parking garage to the street, where he was expecting to get a ride to the job site. The injury did not occur in the course of Petitioner's employment by Respondent.

The claim for compensation is, therefore, denied.

WITH RESPECT TO ISSUE (F), IS PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, AND ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS:

As the Arbitrator has found that Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent, the Arbitrator needs not decide these issues.

WITH RESPECT TO ISSUE (G), WHAT WERE PETITIONER'S EARNINGS, THE ARBITRATOR FINDS:

Petitioner's Average Weekly Wage is $1,490.76.

The Arbitrator relies upon Respondent's Exhibit 5, the wage statement. That statement shows earnings in 40 weeks. All earnings in those weeks are part of the AWW, constituting a single week of earnings with more or less than 40 hours. The Arbitrator finds that overtime was required for Petitioner (a supervisor on a demolition team, working in off hours with a shift that began at 6:00pm) and hours worked in excess of 40 hours in a given week are included in the Average Weekly Wage calculation at the straight time rate of $40.40 per hour (the overtime premium is not included). The nature of off hours demolition work obviously requires that once the work starts the workers need to be there to complete the job, as Petitioner testified. This is especially true for the job supervisor. Fraccassi's testimony and common sense supports this finding as well. The Arbitrator can't believe that the demolition crew would be ordered off an unfinished job merely when it would require overtime to complete it. Some overtime was clearly a condition of Petitioner's employment. Thus, wages in excess of 40 hours in a given week should be included in the AWW.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC031485
Case Name	SMILEY, MATTHEW v. WILLIAM F MEYER
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0263
Number of Pages of Decision	19
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	Trevor Granberg
Respondent Attorney	Jeanmarie Calcagno

DATE FILED: 6/2/2021

/s/Maria Portela, Commissioner

Signature

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

MATTHEW SMILEY,

Petitioner,

vs. NO: 18 WC 31485

WILLIAM F. MEYER COMPANY,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses and temporary total disability benefits, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof, but corrects the scrivener's errors as outlined below.

We correct scrivener's errors in the body of the decision. On page 5 of the Arbitrator's decision, under enumerated paragraph 3, the Commission replaces the last sentence with "The surveillance video does not show the bundle of copper piping separating and Petitioner falling against the water heater."

Additionally, on page 6 of the Arbitrator's decision, in the 4th sentence under Number 3, the Commission changes the sentence to read: "Petitioner testified that he arrived at Normal Mechanical…"

Finally, on page 11 of the Arbitrator's decision, the Commission corrects the numbering of the paragraphs and changes the paragraph numbered "1" to be numbered "4".

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 16, 2020 is hereby affirmed and adopted.

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

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

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

JUNE 2, 2021

/s/ *Maria E. Portela*

MEP/dmm
O: 042021
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/s/ *Thomas J. Tyrrell*

/s/ *Kathryn A. Doerries*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SMILEY, MATTHEW Case# **18WC031485**

Employee/Petitioner

WM F MEYER COMPANY

Employer/Respondent

On 1/16/2020, 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:

1315 DWORKIN AND MACIARIELLO
TREVOR GRANBERG
134 N LASALLE ST SUITE 650
CHICAGO, IL 60602

2542 BRYCE DOWNEY & LENKOV LLC
JEANMARIE CALCAGNO
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF DUPAGE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MATTHEW SMILEY
Employee/Petitioner
v.
Wm. F. MEYER COMPANY
Employer/Respondent

Case #**18 WC 31485**

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 **Wheaton, Illinois on 3/8/19, 4/26/19, 5/15/19, and 10/16/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **10/15/18**, 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 with Respondent.

Timely notice of the alleged 10/15/18 accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the alleged 10/15/18 work accident.

In the year preceding the alleged injury, Petitioner earned **$39,520.00** The average weekly wage was **$760.00.**

On the alleged 10/15/18 accident date, Petitioner was **40** years of age, **single** with **0** dependents under the age of 18.

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

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

Respondent shall be given a credit of **$0** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$0.00**. It was stipulated that Respondent paid a portion of Petitioner's group health premium and is entitled to a Section 8(j) credit for any and all medical bills paid by Petitioner's group health carrier.

Respondent ***is not*** entitled to a credit of **$N/A** under Section 8(j) of the Act.

ORDER

Petitioner did not prove by a preponderance of evidence that he sustained a compensable accident that arose out of and in the course of his employment, as set forth in the Conclusions of Law which are attached hereto.

Based upon the failure to prove that Petitioner sustained a compensable accident that arose out of and in the course of his employment, all claimed relief is hereby denied.

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

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

Signature of Arbitrator

1/14/2020
Date

JAN 16 2020

Findings of Fact:

1. Petitioner's testimony regarding accident and Petitioner's recorded statement

Matthew Smiley (hereafter referred to as "Petitioner") testified that he worked for William F. Meyer Company (hereafter referred to as "Respondent") for more than 3 years prior to October 15, 2018. (T. 12). Petitioner's job required him to deliver plumbing materials to a variety of locations using Respondent's truck. (T. 12-13). The materials Petitioner delivered were loaded onto his truck the night before by a separate group of Respondent's employees. (T. 32). Petitioner testified that, on October 15, 2018, his delivery truck was loaded with copper pipes and a water heater. (T. 15, 34-35). The copper pipes consisted of a large bundle grouped with many smaller bundles. The large bundle was held together with straps and weighed 2,500 pounds. Petitioner testified the water heater was located in the middle of the truck between the bundle of copper pipes and PVC pipes. Petitioner testified the water heater was between the two sets of pipes. (T. 34-36).

Petitioner testified that, on October 15, 2018, he delivered materials to a different job site before arriving at Norman Mechanical. Petitioner was to deliver the bundle of copper piping at Norman Mechanical. (T. 14-15, 17, 30-31). Petitioner testified that upon arriving at Norman Mechanical, he went on the back of the trailer and attempted to re-strap the bundle of copper piping with another strap. Petitioner testified that has he tried to secure the additional strap the strap the bundle, the strap that was holding the bundle together came apart causing the bundle to unravel. Petitioner testified that the unraveling of the bundle caused him to fall between the water heater and a stanchion pipe and that his back struck the Stanchion pipe. (T.15). Petitioner testified he injured his lower and middle back. Petitioner testified that he was able to complete the job before returning to the shop, but he had to crawl into the cab of his truck. Petitioner testified that he returned to the shop at 6:45 a.m. and reported the incident to his manager, Mark Klein, before going to Sherman Hospital. (T. 17,18).

On cross-examination, Petitioner testified that he was on the top of the deck of the truck standing next to the water heater as he attempted to re-bundle the copper tubing when he was injured. (T. 37). Petitioner testified that the bundle spread apart rolled up his legs causing him to fall. (T. 44). Petitioner testified that he was in pain that it was very difficult to climb into the cab of the truck such that he had to crawl into the cab. (T. 54).

On October 23, 2018, Petitioner participated in telephonic interview with Brian Johnson. During the interview, Petitioner stated that the accident occurred at 6:30 a.m. Petitioner testified that he went to remove the strap on the bundle of copper pipe and to replace the strap with a bigger strap to he could move the bundle. Petitioner said the strap tore at the knot and the bundle came loose and caused causing to fall on a piece of pipe that was on the truck. Petitioner said the boom was out because he was getting ready to remove the bundle off truck. Petitioner said that he had shifted the load over with the boom and set the load back down to re-strap the load when the belt separated. Petitioner said the bundle came loose and rolled on the cribbing up his legs and threw him back against the water heater and a piece of plastic pipe. Petitioner said he then got up, put the straps back around the bundle and pulled the bundle of pipe off "because it was partly off the truck" and set the bundle on the ground. Petitioner said the put the boom back and crawled into the truck and drove back to the shop. (RX 2).

2. Video surveillance of Petitioner's delivery at Norman Mechanical on 10/15/2018

Surveillance video of Petitioner's delivery recorded at the Norman Mechanical loading dock on October 15, 2018 was admitted into evidence. (T. at 209; RX 6). The surveillance video does not show Petitioner being thrown back against a water heater after a strap separated from the bundle while he was on the back of the truck. The surveillance shows Petitioner unloading the bundle of copper piping using the boom when the load shifted and the strap broke and the load fell to the ground. When this occurred, Petitioner was standing next to the truck operating the boom. After the bundle fell to the ground, the surveillance video shows Petitioner picking up numerous bundles of copper piping off the ground and placing them onto to cribbing. The surveillance video also shows Petitioner climbing into and out of the cab of his truck numinous times. It took Petitioner approximately 30 minutes to pick up the piping that fell to the ground. Petitioner does not appear to be in pain during the 30 minutes he was picking up the load off the ground and placing it on the cribbing and Petitioner is not scene crawling into the cab of his truck. The surveillance video chronologically shows the following:

1. At 6:21 a.m. Petitioner pulls up to the loading dock at Norman Mechanical. A water heater is located on the trailer behind the passenger's side or right side. The copper piping is located on the driver's side of the trailer next to the water heater. The PVC piping is located in front of the water heater;
2. Petitioner exits the truck and pulls down the trailer's side doors and then pulls out the leg or brace of the boom. Petitioner is seen operating the boom. Petitioner positions the hook of the boom over the copper piping.

3. At 6:25 a.m. Petitioner grabs straps from the cab of the truck, climbs onto the trailer and hooks the strap to the hook to the boom and the bundle of copper piping. After securing the bundle of copper piping to the boom, Petitioner climbs down from the trailer and walks to the boom's controls. The surveillance video does show the bundle of copper piping separating and Petitioner falling against the water heater.
4. At 6:27 a.m. Petitioner is standing on the side of the trailer operating the boom. Petitioner picks up the bundle and swings it over past the trailer.
5. At 6:29 a.m. the load shifts forward, the strap breaks, and the load falls to the ground next to the truck.
6. At 6:30 a.m. Petitioner walks to the load, removes the strap from the hook of the boom and places wood on the ground to create a crib for the copper piping.
7. At 6:31 a.m. Petitioner begins to pick up the smaller bundles of the copper piping and places them into the cribbing. Petitioner is seen bending over and picking up the smaller bundles of copper piping, standing up, turning to the side, walking to the cribbing and bending down to set the bundle into the cribbing.
8. At 6:32 a.m., Petitioner receives assistance picking up the bundles for a few minutes from and individual who exists the warehouse.
9. At 6:34 a.m. Petitioner walks to the trailer, closes the side door of the trailer, maneuver's the boom back into place after pushing the boom's support back into position;
10. At 6:36 a.m. Petitioner climbs into the truck, backs the truck away from the loading dock to allow a forklift to drive pass. Petitioner returns and exists the truck. Petitioner does not crawl into the cab of the truck;
11. At 6:39 a.m. Petitioner resumes picking up bundles of piping and placing them into the cribbing;
12. At 6:41 a.m. Petitioner climbs back into the truck, backs the truck away from the loading dock to allow a forklift to pass. Petitioner returns and exists the truck. Petitioner does not crawl into the cab of the truck;
13. At 6:43 a.m. Petitioner walks into the building and returns with wood. Petitioner is seen building another crib for the remanding copper piping lying on the loading dock. After constructing the second cribbing, Petitioner resumes picking up the smaller bundles and placing them into the cribbing;
14. At 6:59 a.m. a second individual begins to assist Petitioner to pick up the remaining copper piping off the ground and places them into the cribbing;
15. At 7:00 a.m. Petitioner completes picking up the load off the ground. During the time Petitioner is seen picking up the load of copper piping off the ground and placing it into the cribbing, Petitioner does not appear to be experiencing pain or discomfort;
16. At 7:01 a.m. Petitioner climbs into the cab of the truck and grabs something out of the cab before walking to the back of the trailer;
17. At 7:04 a.m. Petitioner returns to the cab of the truck and climbs in to retrieve papers;

18. At 7:04 a.m. Petitioner returns to the cab of the truck, climbs in and pulls away. Petitioner is not seen crawling into the cab of the truck.

3. Petitioner's 5/15/19 Rebuttal Testimony

Petitioner was called as a rebuttal witness. Petitioner testified that he had reviewed the surveillance video in Respondent's Exhibit 6. (T. 331). On rebuttal, Petitioner testified that he was not injured on the loading dock. Petitioner testified that he Norman Mechanical at 6:00 a.m. and another truck in the loading dock so he parked the truck to the side of the building, outside the view of the surveillance camera, and prepared the load for delivery. Petitioner testified that he was injured while he was parked prior to entering the loading dock. Petitioner testified that he was injured during the 20 minutes he was parked on the side of the building prior to pulling into the loading dock. (T. 345). Petitioner testified that while he was parked on the side the building, he climbed onto the trailer to prepare the material to be unloaded. Petitioner testified that, it was at this time, the strap holding the bundle together opened striking his legs and causing him to fall back. (T. 349).

During the rebuttal cross-examination, Petitioner admitted that the load fell to the round and he had to move the piping onto the cribbing after being injured. (T. 361-363). Petitioner also admitted when he previously testified that he had to crawl into the cab of the truck after being injured he did not actually crawl into the truck. Petitioner testified that he was using "a figure of speech". (T. 363).

When Petitioner asked to explain why the events he described during his recorded statement were different than his rebuttal testimony, Petitioner "He didn't ask me exactly what happened. He asked me how that accident happened, and I gave him my account of what happened with the accident. The whereabouts where I was, where I was located on Norman Mechanical property, wasn't even asked.". (T. 371, 372). When Petitioner was asked why to explain why the events he described during his direct examination were different than his rebuttal testimony, Petitioner "I was never asked". (T. 372).

4. Petitioner's initial medical treatment:

Petitioner testified that after returning to the shop and reporting the accident, he went to the emergency room at Sherman Hospital. The medical records state that Petitioner reported being sandwiched between pipes when pipes broke loose and rolled into him and threw him against other equipment. (T. 18-19, 43-44; PX 1, at 6, 26). On cross-examination, Petitioner

testified that he never used the term "sandwiched" and that the doctor must have used his own words. (T. 43).

After being released from the Sherman Hospital, Petitioner followed up with Dr. Panchal whose records state that, October 18, 2019, Petitioner presented in a wheelchair and reported that on October 15, 2018, pipes rolled down on him and "pinned him down." (PX. 2). On cross-examination, Petitioner testified that he never used the term "pinned" and that the doctor must have used his own words. (T. 45-49). Dr. Panchal diagnosed a herniated L5-S1 disc causing radiculopathy and he restricted Petitioner from working through November. (PX 2).

5. Damien Savorgino's Testimony

Petitioner called Damien Savorgino, a co-worker on October 15, 2018, as a witness. Mr. Savorgino testified that he no longer works for Respondent. (T. 99-101). Mr. Savorgino testified that he did not work with Petitioner on October 15, 2018 and he did not see Petitioner acting injured. (T. 102-103). Mr. Savorgino testified that he understood the accident date to be October 16, 2018 and, on that date, when he saw Petitioner at approximately 7:00 a.m., and, at that time, Petitioner appeared to be in pain. (T. 104, 107). Mr. Savorgino testified that he helped Petitioner walk to the front of Respondent's shop. (T. 108). Mr. Savorgino testified that he did not see the accident and he was not at the Norman Mechanical job site. (T. 110). Mr. Savorgino testified that he is a friend of Petitioner and has gone out with Petitioner socially. (T. 110-111).

6. Michelle Kwasniewski's Testimony

Petitioner called Michelle Kwasniewski, his live-in girlfriend as a witness. (T. 120). Ms. Kwasniewski testified that on October 15, 2018, Petitioner called and texted her that he was injured at work and he needed her to come get him. (T. 121). Ms. Kwasniewski testified that she picked Petitioner up at his job between 7:20 and 7:40 a.m. and that she drove Petitioner to Sherman Hospital. (T. 121-122). Ms. Kwasniewski testified that Petitioner appeared to be in pain and he had difficulty moving. (T. 122).

7. Mike Schloss's Testimony

Mike Schloss testified for Respondent. Mr. Schloss testified that has been employed by Norman Mechanical as a Project Manager for approximately 7 years. (T. 147-148). In addition to Mr. Schloss' general duties, he was tasked with oversee the operation of surveillance cameras at Norman Mechanical. (T. 152). Mr. Schloss testified to the details and location in Norman Mechanical's warehouse that materials would have been delivered, loaded or unloaded on

October 15, 2018 and the location of company's surveillance cameras. (T. 159-162; R. Ex. 4; R. Ex. 5). Mr. Schloss also testified as to the details of the surveillance system used on October 15, 2018 and the surveillance video from October 15, 2018. (T. 167-171; R. Ex. 6). Mr. Schloss has been responsible for the surveillance system for over 4 years. (T. 190).

Mr. Schloss testified that, on October 15, 2018, Respondent was scheduled to deliver a water heater and copper tubing to Norman Mechanical. (T. 167). Respondent made one delivery of plumbing supplies to Norman Mechanical on October 15, 2018. (T. 165-66).

Mr. Schloss testified as to the contents of the October 15, 2018 surveillance video and noted that the video does not show Petitioner suffering an accident. (T. 176-80). Mr. Schloss testified that the surveillance system was motion activated and was very sensitive to motion. (T. 189-90). Once any motion, however small, is detected the surveillance system starts recording instantaneously. (T. 190-91). Mr. Schloss testified that the surveillance system was so sensitive that would pick up the movement of an insect or raindrops. (T. 228).

8. Mark Klein's Testimony

Mark Klein was called as a witness for Respondent. Mr. Klein testified that he is Respondent's operations manager. (T. 242-243). Mr. Klein testified that he was Petitioner's supervisor on October 15, 2018. (T. 244). Mr. Kline testified that Petitioner worked for Respondent as a delivery driver. (T. 244-45). Mr. Kline testified that, on October 15, 2018, Petitioner was scheduled to make deliveries at one location before going to Norman Mechanical, which was located at 1201 Gateway Drive, approximately 1.5 blocks away from Respondent's Elgin location. (T. 246-48, 253; R. Ex. 7).

Mr. Kline testified that, on October 15, 2018, Petitioner was driving one of Respondent's flatbed delivery trucks. (T. 248). Mr. Kline testified that completing his tasks at Norman Mechanical, Petitioner returned to Respondent's shop and told him that while at Norman Mechanical, a bundle of copper pipes had broken, rolled onto his legs and thrown him into a water heater. (T. 254-57). Mr. Klein offered Petitioner a ride to the hospital, however Petitioner declined, noting that his girlfriend was already on the way to pick him up. (T. 261-262).

Mr. Kline testified that the company delivery trucks have a boom arm, gates that fold down, and a company logo on the door. (T. 248-49). Mr. Klein testified that he reviewed the October 15, 2018 Norman Mechanical surveillance video which did not show Petitioner being tossed into a water heater, Petitioner banding the copper piping, the bundle breaking apart while

on the truck, Petitioner being thrown into any stanchion, and Petitioner crawling into the truck. (T. 248-61, 64).

Mr. Klein testified that he became suspicious about the events that transpired at Norman Mechanical after Petitioner detailed his accident history. (T. 265-67). Mr. Klein called Norman Mechanical to investigate and, upon finding that they have surveillance, asked for a copy of the footage from October 15, 2018. (T. 265-66). Mr. Klein testified that the details Petitioner provided raised numerous questions, including the ability to complete the delivery and the ability to re-bundle the pipes after the strap had allegedly broken loose. (T. 267-69).

Mr. Klein testified that the video showed Petitioner delivering the copper pipes to Norman Mechanical. (T. 271). The copper pipes were removed from the truck using the boom and were in one large bundle as they were lowered to the ground. (T. 271). It was only once the bundle was nearing the ground of Norman Mechanical's loading area that the bundle broke. (T. 271).

9. Dr. Kimberly Terry's Testimony

Dr. Kimberly Terry is a board-certified neurosurgeon and licensed to practice medicine in Illinois. (RX. 3). On March 7, 2019, Dr. Terry authored a Utilization Review report. (RX 8). After reviewing Petitioner's medical records, Dr. Terry rendered opinions pursuant to the ODG guidelines. Dr. Terry testified that:

1. She noncertified the recommended lumbar steroid injection as she deemed it not medically necessary;
2. She certified the recommended urological consult as being medically necessary;
3. She noncertified the recommended any additional physical therapy as not being medically necessary;
4. She noncertified the recommended EMG/NCV test for the bilateral legs as she deemed it not medically necessary. (RX 3).

10. Dr. Carl Graf's Testimony

Dr. Carl Graf is a board-certified orthopedic surgeon, who works for Illinois Spine Institute. (PX 6). Dr. Graf performed a Section 12 Examination. At the exam, Petitioner reported that he was injured on October 15, 2018 when he attempted to untie and retie a mis-wrapped bundle of pipes and the knot "frayed and pushed him backwards into a water heater and the pipe fell on his legs." Dr. Graf testified that he noted inconsistencies in Petitioner's examination, specifically stating that:

Q. What are the inconsistencies that you noted?
A. Pain out of proportion to the evaluation. He reported to me I believe his pain was up to a level of 9 out of 10, 7 to 9 out of 10. Pain in the low back to simulated axial rotation, which shouldn't be a cause of pain. As I noted previously, palpation of the thoracic spine produced low back pain.

Dr. Graf diagnosed an L5-S1 lumbar disc herniation and related Petitioner's injuries to his October 15, 2018 accident. Dr. Graf testified that if Petitioner's accident history differed from what he originally reported than his opinion regarding causation could change. Regarding Petitioner's ability to continue after working after his accident, Dr. Graf testified that:

Q. Would his ability to continue doing his job be altered or affected after getting – after being involved in this accident, if accurate?
A. It is possible. Again, I find it a little bit strange that he was injured enough to have a CT and an MRI scan but was able to work, but I was just relying on the history that was provided to me. (PX 6).

11. Additional testimony:

Petitioner testified that he has not worked since October 15, 2018 and that he has not received temporary total disability benefits. (T. 25). Petitioner testified that he had no prior or subsequent back injuries. (T. 28).

12. Credibility determination:

The Arbitrator finds Petitioner's testimony not to be credible. The Arbitrator credibility determination is based, in part, upon the following reasons.

1. Petitioner did not testify during direct and cross examination that his accident occurred prior to entering the loading dock area. Petitioner failed to testify during direct examination that when he was unloading the bundle with the boom, at the loading dock, a strap broke and the bundle fell to the ground. Petitioner failed to testify on direct examination that he picked up the bundle, which weighed 2,500 pounds, off the ground and place it into the cribbing after being injured. During direct examination Petitioner testified that he had to crawl into the cab of the truck after he was injured. In the video surveillance, Petitioner does not crawl into the cab of the truck and does not appear to be in discomfort while picking the 2,500 pounds of copper piping off the ground and placing it onto the cribbing. It was not until rebuttal, after Petitioner reviewed the video surveillance, Petitioner testified that he parked the truck at a different location and was injured prior to entering the loading dock. When asked to explain the difference between his direct examination and his rebuttal testimony, Petitioner responded "I was never asked". (T. 372).

2.. Petitioner's rebuttal testimony conflicted with his recorded statement taken on October 23, 2018. During the recorded statement, Petitioner did not say that he parked the truck, prior to entering the loading dock. and was injured at that time. Petitioner did not mention that the load of copper piping fell off the boom onto the

ground and that he had to pick up the load off the ground and place it on the cribbing. During the recorded statement, Petitioner said that when he was injured while in the back of the truck, when the boom was out, and he was getting the load ready to move off the truck. (RX 1, 2). During the recorded statement Petitioner said that he used the boom to lift the load and he had to set the load back down to fix a strap. Petitioner also said the load was partly off the truck after he set the load back down before the strap broke. During rebuttal, Petitioner did not testify that he had picked up the load with the boom and that the load was partly off the truck when he set it down to fix the strap. When asked to explain the discrepancy between his recorded statement and his rebuttal testimony, Petitioner testified that "He didn't ask me exactly what happened. He asked me how that accident happened, and I gave him my account of what happened with the accident. The whereabouts where I was, where I was located on Norman Mechanical property, wasn't even asked.". (T. 371, 372).

3. Petitioner testimony regarding the location of the items on the trailer was inconsistent with the location of those items on the video surveillance. Petitioner testified that the water heater was located in the middle of truck between the copper pipes and the PVC pipes. (T. 35, 36). On the video surveillance the water heater was located behind the passenger's side of the truck. The copper piping was located to the left of the hot water heater or on the driver's side of the truck. The PVC pipes were located in front of the water heater. (RX 6).

1. Petitioner testified that after he injured, he had to crawl into the cab of his truck. The video surveillance shows that after the alleged accident, Petitioner entered and existed the cab of his truck many times without crawling. The video surveillance also shows that Petitioner was able to bend over, pick up multiple bundles of copper piping, and place the copper piping into cribbing without showing any signs of being in pain or discomfort. It took Petitioner approximately 30 minutes to pick up the copper piping off the ground and place into the cribbing. Petitioner testified that copper piping weighed approximately 2,500 pounds. (RX 6).

Conclusions of Law

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law as set forth below. The claimant bears the burden of proving every aspect of her claim by a preponderance of the evidence. *Hutson v. Industrial Commission,* 223 Ill App. 3d 706 (1992).

Regarding Issue (C): whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds as follows:

A claimant bears the burden of proving by a preponderance of the evidence that his or her injury arose out of and in the course of the employment. *Baldwin v. Illinois Workers' Compensation Comm'n,* 409 Ill. App. 3d 472, 477, 949 N.E.2d 1151, 351 Ill. Dec. 56 (2011); *First Cash Financial Services,* 367 Ill. App. 3d at 105. Both elements must be present to justify compensation. *First Cash Financial Services,* 367 Ill. App. 3d at 105.

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that his injury arose out of and in the course of his employment.

The Arbitrator does not find Petitioner's testimony credible. The Arbitrator finds that Petitioner's testimony on direct and cross examination were inconsistent with Petitioner's rebuttal testimony. The Arbitrator finds that Petitioner changed his testimony during rebuttal after discovering that video surveillance showed that he was not injured as he originally testified. During direct and cross examination, Petitioner never testified that he parked his truck, prior to entering the loading dock area, climbing on the back of the truck and was injured. Petitioner did not testify, that while removing the copper pipe off the truck with the boom, the load shifted and fell to the ground and that he had to pick the load up off the ground to place on cribbing. Petitioner testified that after being injured, he had to crawl into the cab of his truck. The video surveillance showed that, after the alleged injury, Petitioner picked up approximately 2,500 pounds of copper piping off the ground and place it onto the cribbing without difficulty or appearing to be in pain. It took Petitioner 30 minutes to pick up the load off the ground ad to place in the cribbing. The video surveillance also showed that, after the alleged injury, Petitioner climbed into the cab of his truck, on multiple occasions, without crawling.

The Arbitrator finds that Petitioner's testimony during direct and cross examination to be consistent with his recorded statement regarding the location Petitioner originally claimed to have been injured. During the recorded statement Petitioner said that he was injured at 6:30 a.m. Petitioner said the boom was out and he was getting ready to remove the load off the truck when the incident occurred. Petitioner said that he shifted the load over using the boom, but he had to set the load back down to re-strap I and that's when he was hurt. During the recorded statement Petitioner did not say that parked the truck and was injured preparing the load prior to pulling into the loading dock. During the recorded statement, Petitioner did not say that the load fell to the ground when a strap broke on the boom. Petitioner did not say that he had to pick up the load off the ground and place the load into cribbing after being injured. During the recorded statement, Petitioner said that after putting the boom back, he crawled back into the truck and drove back to the shop (RX 1).

The Arbitrator notes that during rebuttal, Petitioner did not testify that the boom was out when he fell and, prior to being injured, he lifted the load and set it back down and that the load was partly off the truck when he was injured. Petitioner testified that he was not at the loading

dock when he was injured. The Arbitrator finds Petitioner's rebuttal testimony inconsistent with his recorded statement which makes Petitioner's rebuttal testimony implausible. If Petitioner was not at the loading dock than he would not have used the boom to lift the load before placing the load back onto the truck and leaving the load partly off the truck.

The Arbitrator finds that Petitioner changed his testimony after the video surveillance showed that he was not injured on the back of the truck. Credibility is the quality of a witness which renders his evidence worthy of belief. The Arbitrator, whose province it is to evaluate witness credibility, evaluates the witness' demeanor and any external inconsistencies with testimony. Where a claimant's testimony is inconsistent with his actual behavior and conduct, the Commission has held that an award cannot stand. *McDonald v. Industrial Comm'n*, 38 Ill. 2d. 396 (1968); *Swift v. Industrial Comm'n*, 52 Ill.2d 490 (1972).

Regarding Issue (F): Whether Petitioner's current condition of ill-being is causally related to the alleged injury, the Arbitrator finds as follows:

Based on the Arbitrator's decision finding that Petitioner failed to prove an accidental injury arising out of and in the course of his employment with Respondent, the Arbitrator finds that Petitioner's current condition of ill-being is moot and need not be addressed.

Regarding Issue (J): Whether medical services that were provided to Petitioner were reasonable and necessary, the Arbitrator finds as follows:

The Arbitrator finds that the issue of whether Petitioner's treatment was reasonable and necessary is moot an need not be addressed for the reasons set forth in Section C above.

Regarding Issue (K): Whether Petitioner is entitled to any prospective medical care:

The Arbitrator finds that the issue of whether Petitioner is entitled to any prospective treatment is moot and need not be addressed for the reasons stated in Section C above.

Regarding Issue (L): Whether Petitioner is entitled to any TTD benefits:

The Arbitrator finds that the issue of whether Petitioner is entitled to temporary total disability benefits is moot an need not be addressed for the reasons stated in Sections C above.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC008818
Case Name	CANNON,MISTI J v. PETERSEN HEALTH CARE
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remanded Arbitration
Decision Type	Commission Decision
Commission Decision Number	21IWCC0264
Number of Pages of Decision	15
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Tim Denny
Respondent Attorney	Matthew Brewer

DATE FILED: 6/3/2021

/s/Deborah Baker, Commissioner

Signature

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

MISTI CANNON,

Petitioner,

vs. NO: 19 WC 08818

PETERSEN HEALTH CARE,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed under section 19(b) of the Act by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causal connection, the reasonableness and necessity of medical expenses, prospective medical care, temporary total disability, and "TPD, Credit," and being advised of the facts and law, corrects and clarifies the Decision of the Arbitrator as set forth below, and otherwise, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

At the outset, the Commission clarifies that this case was heard by Arbitrator Michael Nowak in Herrin, Illinois, and decided by Arbitrator Edward Lee in reliance on the transcript at the agreement of the parties.

With respect to page five (5) of the Decision of the Arbitrator, the Commission redacts the first paragraph in its entirety as the information contained in this paragraph was based on a document that was not admitted into evidence. Further, the Commission corrects the date when Petitioner treated at the Union County Hospital Emergency Room from March 8, 2019, to January 8, 2019.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 31, 2020, as corrected and clarified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize, provide, and pay for the L1-L2 microdiscectomy recommended by Dr. Colle and the ancillary medical care in accordance with sections 8(a) and 8.2 of the Act as the Petitioner's condition of ill-being in the lumbar spine is causally related to the January 8, 2019 work accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $324.71 for temporary partial disability benefits as the evidence shows that Petitioner was not paid the entire amount she was owed for temporary partial disability benefits. 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 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, including but not limited to a credit of $2,871.00 for temporary total disability benefits, $4,599.91 for temporary partial disability benefits and $8,955.10 for other benefits paid for a total of $16,426.01.

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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

June 3, 2021

/s/ *Deborah J. Baker*
Deborah J. Baker

DJB/cak

O:4/20/21

/s/ *Stephen Mathis*
Stephen Mathis

43

/s/ *Deborah L. Simpson*
Deborah L. Simpson

21IWCC0264

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

CANNON, MISTI
Employee/Petitioner

Case# **19WC008818**
19WC014159

PETERSEN HEALTH CARE
Employer/Respondent

On 8/31/2020, 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 0.12% 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:

5404 LAW OFFICES OF FOLEY & DENNY
TIMOTHY D DENNY
BOX 685
ANNA, IL 62906

5354 STEPHEN P KELLY ATTY AT LAW
MATT BREWER
2710 N KNOXVILLE AVE
PEORIA, IL 61604

STATE OF ILLINOIS)
)SS.
COUNTY OF Union)

☐ 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)

MISTI CANNON
Employee/Petitioner

v.

Case # 19 WC 8818 and

Consolidated cases: 19-WC-014159

PETERSEN HEALTH CARE
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Chicago**, on **August 11, 2020**. 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, **03/06/2017 and 01/08/2019**, 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 **$20,698.08**; the average weekly wage was **$398.04**.

On the date of accident, Petitioner was **37 & 39** years of age, **married** with **2** dependent children.

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

Respondent shall be given a credit of **$2,871.00** for TTD, **$4,599.91** for TPD, **$0.00** for maintenance, and **$8,955.10** for other benefits, for a total credit of **$16,426.01**.

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

ORDER

The Respondent shall authorize and pay for the L1-2 micro discectomy recommended by Dr. Colle and all ancillary medical care in accordance with sections 8(a) and 8.2 of the Act as the petitioner's condition of ill being is causally related to the January 8, 2019, work accident. The Respondent shall receive credit for all amounts paid.

The Respondent shall pay petitioner $324.71 in TTD/TPD as the evidence shows the petitioner was not properly paid for her lost time associated with this 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

8/29/20
Date

ICArbDec19(b)

AUG 31 2020

Findings of Fact:

The Petitioner has filed two Applications of Adjustment of Claim. The first has a date of accident of March 6, 2017, and has the case number of 19WC14159. The second application for adjustment claims a date of accident of January 8, 2019, and has the case number of 19WC8818. (AT p. 6). The Respondent submitted a Motion to Consolidate these at Arbitration which was granted without objection. (AT p. 12).

The Petitioner, Misti Cannon, testified that at she is forty years old, married with four step-children, one of which is currently under eighteen. (AT p. 14). She is employed at Jonesboro Rehabilitation and Health Care Center which is also known Petersen Health Care. (AT p. 15). She has been employed at Petersen Health Care for four and half years and was initially hired as CNA but currently assists with activities. (AT p. 15).

In March of 2017 she was working as a CNA working shifts from eight to sixteen hours per day. (AT p. 16). Her job duties included helping residents with activities of daily living such as bathing, going to the restroom and helping them walk. (AT p. 16). On March 6, 2017, the Petitioner began having back problems after she got off work so she went to the doctor. (AT p. 16). She did not remember a specific incident that occurred that day but remembered her back starting hurting at work so she went to her physician who is Cheryl Fuller. (AT p. 17). As Cheryl Fuller gave her a medicine regiment of anti-inflammatories, muscle relaxers, and told her, she had a back strain and instructed the Petitioner to take one week off. (AT p. 17). After that week off the Petitioner returned to work and did not really have any problems from that injury. (AT p. 17).

The Petitioner was working on January 8, 2019, on the midnight shift when she and a coworker were assisting a resident out of bed. While the resident was almost to a complete standing position, he attempted to flop back down the bed jerking the Petitioner forward at which time she heard a big pop in her back with instant pain. (AT pgs. 18, 19). The Petitioner reported the accident to Candy Tucker who was the Administrator at the time. (AT p. 19). She went to the Union County Hospital emergency room where she underwent x-rays, provided pain medications, and recommended she follow up with her family physician. (AT p. 19). She followed up with Courtney Ledbetter at the Union County Convenient Care Clinic who obtained an MRI, recommended physical therapy as well as pain medication consisting of muscle relaxers. (AT p. 20). When the physical therapy did not work, she was referred to Dr. Colle who is a neurosurgeon at Cape Brain and Neurospine. (AT p. 20). She followed up with Dr. Colle who recommended an injection which did not provide relief. (AT p. 21). Dr. Colle recommended an L1-2 micro discetomy which the Petitioner wishes to undergo. (AT p. 21).

After the January 8, 2019 work accident, the Petitioner was taken off work by her doctor but then was told to return by her employer on March 29, 2019, and she has been working light duties since that time. (AT p. 22). Her light duty was initially two hours a day and they have gradually found more duties to accommodate her restrictions and moved the time period up to four hours. (AT p. 23). At the time of Arbitration, the Petitioner was working with the Activities Director. This is a position which she had been doing by herself before the new Activities Director was hired. This consists of playing games, coloring, putting in movies or baking to have a little fun to keep the residents busy. (AT p. 23). The Petitioner had applied for the activity position on a full-time basis which would have accommodated her restrictions for a full forty hour week but the position was given to someone else. (AT p. 24). At the time of Arbitration, the Petitioner would be scheduled by her employer to work twenty to twenty-five hours per week and then the work compensation carrier would also pay her some temporary partial disability benefits. (AT p. 24).

The Petitioner described her symptoms at the time of Arbitration as back pain with a sharp stabbing feeling like being zapped with cow prod or tazer that starts in her lower back, wraps around the side and goes to the front of her leg which sometimes affects her knee which will just give out on her. (AT p. 26). The Petitioner acknowledged that she had a prior back issue which was described as sciatica which was a pain down the back of her leg not down the front like the current issue. (AT p. 26). She also described the fact that the pain originates in a different spot in her back which was lower down. (AT p. 26).

On cross examination, the Petitioner confirmed that she is still working part time for the Respondent and sometimes she works more than twenty hours per week. (AT p. 28). She was asked to review what had been marked as Respondent's Exhibit 2 representing pay stubs and the Petitioner did not dispute the information in those documents. (AT p. 30). She also confirmed that she had not received medical bills and that it was her assumption that they had been paid by workers compensation. (AT p. 32). The Petitioner had been receiving $132.68 per week as temporary partial disability benefits since March 9, 2019. (AT p. 33). The Petitioner confirmed that prior to her January 8, 2019 accident she had previously filed a workers' compensation case. (AT p. 38).

The Petitioner did injure her right shoulder in the January 8, 2019 accident but it was not hurting anymore. (AT p. 40). She also confirmed that she was not actively treating for her right shoulder condition. (AT pgs. 40, 41). The Petitioner was cross examined extensively regarding her right shoulder condition which she indicated was not currently a problem and was not seeking any benefits for that at this 19(b) Hearing. (AT p. 42). The Petitioner did not recall reporting prior right radicular symptoms to Dr. Colle, but acknowledged having those prior problems that had resolved. (AT p. 45). She reiterated that she did have prior complaints before the January 8, 2019 accident but it was treated and it had gone away. (AT p. 45). The Petitioner confirmed that she did have prior pain in her back prior to the initial work accident. (AT p. 48). She also confirmed that is the condition that she had been diagnosed with by her family physician as sciatica. (AT p. 49). She confirms this condition was pain radiating down the right buttock to the outer thigh into her knee and she was provided muscle relaxers for this condition. (AT p. 50). She also confirmed that in February of 2016 she had received muscle relaxers for back spasms. (AT p. 51). The Petitioner clarified that her one time visit in 2017 was for the back strain that was work related not summarizing all of her preexisting conditions. (AT p. 54). She confirmed that in her direct testimony she was referencing this specific incident in of March 2017, but if you wanted to know about her entire life history as a CNA which consists of strenuous work that her back does hurt because of the lifting involved. (AT p. 55).

When asked how she able to differentiate the one visit in March of 2017 stemming from the work accident verses the other visits in 2017 for low back pain the Petitioner clarified; "Because the pain is different." (AT p. 55). The Petitioner discussed that on March 6, 2017, she did not recall a specific incident just that she went home and her back was hurting. (AT p. 57). She clarified that she did not have any other injuries, but she did have soreness and muscle aches. (AT p. 58). The Petitioner did not recall what she told Dr. Kitchens regarding her prior low back and right shoulder complaints. (AT p. 61). She did believe she had advised Dr. Kitchens that she had been placed on a limitation of an eight-hour work day. (AT p. 62). The IME with Dr. Kitchens was 15 minutes and she did not recall what she told him and what she didn't say. (AT p. 62). Dr. Colle placed the Petitioner on restrictions in March of 2017 which were still in place at the time of Trial. (AT p. 63). She confirmed that she does adhere to those restrictions and that she also wears the lumbar corset all of the time. (AT p. 63). She also marked that she did not have a back injury or back symptoms. (AT p. 69). The Petitioner was also questioned regarding whether she represented she had felonies convictions and the Petitioner indicated that she did not have any felonies convictions on her record. (AT p. 71).

[redacted]

On redirect examination the Petitioner reiterated she was not asking the Arbitrator to award any benefits related to her shoulder. (AT p. 74). She also clarified that she differentiates the treatment she received from Cheryl Fuller for the March 6, 2017 accident and records she viewed on cross examination that did not pertain to treatment she associated with its injuries. (AT p. 74). She specified the treatment Dr. Colle is addressing for this injury starts in her back wraps around and goes in the front of her leg sometimes to the knee and sometimes the leg falls asleep and gives out on her. (AT p. 75). The area Dr. Fuller was treating goes from the back by her tailbone down by her buttocks and the back of her leg. (AT p. 75).

The Petitioner also confirmed that prior to being hired by the Respondent in 2015 she had also worked for them in 2011 but quit to go to school. (AT p. 76). Prior to the January 2019 accident she was working full duty and doing her job as a CNA. (AT. p. 77).

The Respondent called Rachel Smith who is an investigator for Blue Eagle Investigations. (AT p. 78). Ms. Smith did not perform an investigation on the Petitioner nor did she prepare the report that was offered as Respondent's Exhibit 10. (AT p. 80). The investigator who performed the field surveillance no longer worked for the investigation company and Ms. Smith could not clarify why he was no longer with the company. (AT p. 86). When asked whether there was a dvd or video of the surveillance of the claimant, Ms. Smith testified that they did not actually obtain any video of the claimant. (AT p. 87).

Medical records from Union County Hospital Emergency Room were offered into evidence as Petitioner's Exhibit 1. The Petitioner was examined on March 8, 2019, with back pain located in the low back which began suddenly at work this am. (PE 1 p. 1). Petitioner was discharged with a strain of the muscle and fascia and tendon of the lower back. (PE 1 p. 3).

Medical records from Union County Hospital Convenient Care were offered into evidence as Petitioner's Exhibit 2. The Petitioner followed up with the Convenient Care Clinic where she was seen by Dr. Ledbetter on January 14, 2019. The Petitioner reiterated the history that she was helping a resident out of bed and when the resident went to sit down and threw the Petitioner forward, she heard a pop down the right side of her left leg. She noted that she had prior pain but nothing this severe in the past. (PE 2 p. 14). The Petitioner continued to follow up with the Convenient Care Clinic and was referred to Dr. Colle, a neurosurgeon, in Cape because she was experiencing shooting pain and numbness on March 25, 2019. (PE 2 p. 3).

Medical records from Union County Hospital Physical Therapy were offered into evidence as Petitioner's Exhibit 3. They document that the Petitioner underwent physical therapy in January and early February of 2019.

The medical records from the Regional Brain and Spine Clinic were offered into evidence as Petitioner's Exhibit 4. Dr. Colle believed the Petitioner had stenosis with intervertebral disc stenosis low back with sciatica spondylosis lumbar with radiculopathy and disc disorder disc displacement. (PE 4 p. 20). He specifically indicated there appears to be right disc herniation at L1-2 and recommended an injection at level as well as medications. The Petitioner followed up with Dr. Colle on March 26, 2019 after undergoing the L1-2 transforaminal injection for both diagnostic and therapeutic purposes. (PE 4 p.

1). Dr. Colle noted that the patient has a work-related injury and developed an L1-2 right herniated disc that has been symptomatic. The patient indicated that the injection was beneficial for approximately twenty-four hours and the pain returned. (PE 4 p. 1). Dr. Colle recommended an L1-2 microdiscectomy for the disc herniation at the right L1-2. (PE 4 p. 5).

The medical records from Rural Health were offered into evidence as Petitioner's Exhibit 5. The patient reported muscle aches and back pain and was prescribed medication on March 2017.

The Deposition of Dr. Kyle Colle was offered into evidence as Petitioner's Exhibit 6. Dr. Colle is a neurosurgeon who practices in Cape Girardeau, Missouri. (PE 6 p. 5). Dr. Colle testified that he first treated the Petitioner on February 26, 2019, and reiterated that her history of a 39 year old female who presented to the clinic after a request of Workers' Compensation and reported a two month history of eight out of ten aching, stabbing, and pins and needles sensation that radiates from the lower back to the right anterior lateral thigh. (PE 6 p. 7). She was examined by Tyler Greenwood, Dr. Colle's Physician Assistant, on that date which is typical protocol. (PE 6 p. 8). An MRI was also obtained which showed a multilevel degenerative disc disease and facet arthropathy meaning hypertrophied facets or enlarged facets and a right L1-2 foraminal disc herniation with abutment of the right L-2 nerve and some mild stenosis at L4-5. (PE 6 p. 10). He specified the significance of the herniated disc into the right L1-2 with compression on the L-2 nerve root. (PE 6 p. 10). Dr. Colle noted that the findings were consistent with the pain in her thigh region of the anterior thigh on the right lower extremity and some of the other muscle spasms were not consistent with just a L1-2 disc. (PE 6 p. 11). Dr. Colle's diagnosis was a symptomatic disc at L1-L2 which was the main reason for her symptoms for which they wanted to try a therapeutic transforaminal injection at L1-L2. (PE 6 p. 12). That injection was performed on March 8, 2019. (PE 6 p. 12). The Petitioner was seen again March 26, 2019, indicating the injection was beneficial for about twenty-four hours and that her pain returned. (PE 6 p. 13). Since the injection provided short term relief Dr. Colle believed that it was diagnostic, but not therapeutic because she only had twenty-four hours of pain relief with the injection and therefore it wasn't therapeutic to the point to continue with the injection, but diagnostic in that the found the pain generator. (PE 6 p. 13). At that time Dr. Colle recommended a right L1-2 microdiscectomy for the L1-2 foraminal disc herniation. (PE 6 p. 13). The purpose of the recommended surgery is to decrease the compression upon the nerves at L1-2 level on the right side and remove the herniation to allow more room and not allow the nerves to be compressed. (PE 6 p. 14). It also takes away the noxious stimuli from the herniated disc that is there because of the herniation. (PE 6 p. 14). Dr. Colle was not able to pursue with that surgery but continues to be his recommendation. (PE 6 p. 14).

Dr. Colle had placed the Petitioner on lifting restrictions of no more than ten pounds no highly repetitive bending, stooping, or twisting, no overhead work and flexion or extension of the spine. (PE 6 p. 15). Those continued to be his restrictions as of the time of his deposition. (PE 6 p. 15). Dr. Colle testified that with a medical degree of certainty that the Petitioner had a right L1-2 herniated disc due to a work injury. (PE 6 p. 15).

Dr. Colle disagreed with the conclusion of Dr. Kitchens that the patient was at maximum medical improvement with no herniated disc. (PE 6 p. 17). Dr. Colle disagrees with that and he does feel that the MRI shows a foraminal herniated disc at L1-L2 and the transforaminal injection was diagnostic for her pain. (PE 6 p. 17). When asked whether the Petitioner having some low back pain in the year prior to the injury would alter his opinion Dr. Colle indicated no. (PE 6 p. 18). Dr. Colle confirmed on cross examination that he had received medical records from Dr. Kitchens and the Petitioner's Rural Health's records prior to his deposition. (PE 6 p. 20). Dr. Colle reviewed a record of January 8, 2019 indicating the Petitioner had back pain. (PE 6 p 22). Dr. Colle confirmed that he did not provide any opinions or treatment regarding the Petitioner's right shoulder. (PE 6 p. 22). Dr. Colle was testified extensively

regarding the fact that he did not have any findings regarding the Petitioner's right shoulder. (PE 6 p. 24). When asked whether a change in the history would alter his opinion Dr. Colle indicated that it depends on what the change in symptoms would have been. Dr. Colle reiterated that she did not have any of the symptoms of the low back with the right radicular symptoms and that was and these symptoms starting with the work related injury. (PE 6 p. 25). Dr. Colle was again asked whether if the Petitioner did in fact have low back pain with similar or the same radicular symptoms that she had after the accident whether it could alter his opinions but Dr. Colle indicated that it would all depend on the review of symptoms and her radicular symptoms in the imaging that may have been involved with that treatment. (PE 6 p. 26). Dr. Colle went on to state that ninety percent of Americans have back pain so it depends if she had the same symptoms or if they are different symptoms. (PE 6 p. 27).

Dr. Colle encouraged Ms. Cannon to return to work assuming his restrictions could be met. (PE 6 p. 34). The purpose of the lumbar corset recommended by Dr. Colle was to restrict motion of the lumbar spine because when you have a herniated disc it is best to afford twisting and bending because it puts a lot more stress on the disc. (PE 6 p. 34). When asked whether his recommendation for surgery could be altered if the symptoms have been resolved Dr. Colle indicated that he would prefer to do an exam and discuss that with the patient. (PE 6 p. 37).

On the redirect examination Dr. Colle clarified that he had read the records from Rural Health indicating prior back symptoms which consists of a facial swelling in March of 2010. (PE 6 p. 40). Dr. Colle clarified that is a strain of the back muscle. (PE 6 p. 40). Dr. Colle further clarified the note indicates that the pain was associated with her work as a CNA as she had worked nine straight days and does a lot of heavy lifting. (PE 6 p. 41). Dr. Colle clarified that the diagnosis for the Petitioner on March 21, 2017 from the records was sciatica. (PE 6 p. 43). Dr. Colle testified that if a person does lifting on her job and has low back pain or sciatica and it resolves and that person returns to full duty without restrictions and then as of January 8, 2019, a lifting incident that prior history would not change of his opinions. (PE 6 p. 44).
The Respondent offered a check history from June 01, 2019 through November 25, 2019 into evidence as Respondent's Exhibit 2.

The Respondent offered a copy of the public aid lien into evidence as Respondent's Exhibit 3 illustrated that some of the Petitioner's medical records were paid by public aid and not by the Respondent.

The Deposition of Dr. Kitchens was offered into evidence as Respondent's Exhibit 4. Dr. Kitchens is a board-certified neurosurgeon who practices in the St. Louis area. (RE 4 p. 6). Dr. Kitchens examined the Petitioner on April 12, 2019. (RE 4 p. 7). The history the Petitioner provided to Dr. Kitchens was that she had injury on January 8, 2019, where a patient pulled her down and she had an onset of back pain into her right leg and she also had some pain in her right shoulder and arm. She stated she felt a pop in her back at that time. (RE 4 p. 9). Dr. Kitchens indicated that the Petitioner told him that she did not have a history of back pain. (RE 4 p. 9). At the time of the examination the Petitioner was suffering from pain in her back down her right leg to her thigh and the pain would occasionally go in to the knee and sometimes the foot into the toes on the right foot with the back pain being more constant and described as stabbing pain. (RE 4 p. 10). At the time of the examination the Petitioner had been off work since January 8, 2019, and had been back to work light duty since March 6, 2019. (RE 4 p. 11). Dr. Kitchens stated that he did not see evidence of lumbar radiculopathy or evidence of a spinal cord injury as a result of his physical examination. (RE 4 p. 14). Dr. Kitchens reviewed medical records that included those from Nurse Practitioner Fuller, x-ray reports, records from Union County Hospital, Physician's Assistant Ledbetter, and MRI study of January of 2019, as well as records from the Regional Brain and Spine Institute. (RE 4 p. 14). Dr. Kitchens believed the medical records from before the

accident showed that the Petitioner had been diagnosed with back pain and right-side sciatica which contradicts the history, she provided to him. (RE 4 p. 15). Dr. Kitchens believes that the MRI of January 16, 2019, indicates mild degenerative disc changes with a mild disc bulging on the right side of L2-3 with degenerative space narrowing at L1 to L2 with no evidence of a disc herniation or foraminal stenosis. (RE 4 p. 15). He did not believe any of the findings were acute. (RE 4 p. 16). He also does not believe that the Petitioner had any surgical pathology. (RE 4 p. 16). Dr. Kitchens provided a diagnosis of a musculoskeletal strain of her lumbar spine as a result of the work accident without evidence of the lumbar radiculopathy or an acute disc herniation. (RE 4 p. 16). His physical examination did not show motor weakness or a foot drop which would be classics signs of a L5 radiculopathy. (RE 4 p. 17).

Dr. Kitchens believed that the Petitioner could return to work without restrictions. (RE 4 p. 18). He also does not believe that the Petitioner needs any ongoing medical care as it pertains to the lumbar spine. (RE 4 p. 18). Dr. Kitchens agreed that the care and treatment provided up until the date of his examination had been appropriate for the lumbar strain that had been diagnosed. (RE 4 p. 18). He also believes that she is at maximum medical improvement. (RE 4 p. 19). Dr. Kitchens referenced the pre-accident radicular symptoms that were discussed in the notes as sciatica and noted that it was radiating pain down her right buttock and right leg which could be an indication of radicular symptoms. (RE 4 p. 20).

On the date of April 12, 2019, when he examined the Petitioner Dr. Kitchens saw a total of three patients, all of for the purpose of independent medical examinations. (RE 4 p. 21). Dr. Kitchens practice consists of ten to fifteen percent of injured workers in the State of Missouri where the medical care is directed by the insurer. (RE 4 p. 25).

Dr. Kitchens believes that the term sciatica in the petitioner's medical records refers to a broad term that generally refers to pain traveling down the leg although the sciatica nerve is the largest and longest spinal nerve in the body. (RE 4 p. 26). He also agreed that the sciatic nerve is formed by a combination of five nerves in the lower lumbar and sacral spine at the L4, L5, S1, S2, and S3 levels. (RE 4 p. 26). He also agreed that sciatic nerves start in the lower spine and follows along the path through the buttocks down the back of the thigh and leg and into the foot. (RE 4 p. 26). Dr. Kitchens confirmed that nerves can be pinched along different areas of the spine and an injury in to the L5 level would have different symptoms than an injury L2 level. (RE 4 p. 27). The Petitioner did fill out an intake form at the time of her examination. (RE 4 p. 29). Dr. Kitchen was not provided with the pain diagram from Dr. Colle's office for comparison. (RE 4 p. 31). Dr. Kitchens agrees that the pain symptoms the Petitioner marked that reflected pain in the front of her thigh is not sciatica. (RE 4 p. 32). He agreed that generally speaking the nerves that serve the upper and middle thigh are the L2 and L3 nerves. (RE 4 p. 34). He also agreed that there is a pinched nerve at the L2 level and consistent with the symptoms across that area of the thigh. (RE 4 p. 34). Dr. Kitchens did not believe that the problem was confined to just the L2 dermatome because she reported other symptoms but then also stated that she doesn't because of the MRI. (RE 4 p. 35). However, Dr. Kitchens agreed that part of the dorsum of the foot is generally in the L5 nerve and there are different symptoms associated with injury to the different part of the spine. (RE 4 p. 35).

Dr. Kitchens had an opportunity to look at the records before her examination, but did not ask her about the alleged inconsistency with prior history and her lack of reporting back pain. (RE 4 p. 36). Dr. Kitchens clarified that he assumed that she did not have this type of pain because the Petitioner told him she had not had this type of pain before and he did not confront her regarding the history in the records. (RE 4 p. 38). Dr. Kitchens did not believe there was pain reproduced on the straight leg raising indicating radicular pain. (RE 4 p. 45). Dr. Kitchens doesn't use work term sciatica very often unless someone telling him they told they had sciatica but general indicates pain down the leg. (RE 4 p. 49). He

did not agree that what Cheryl Fuller indicated was sciatica was a different condition than what the petitioner currently has because he does not know what Ms. Fuller was thinking. (RE 4 p. 49). He believes that the reference to sciatica is not a specific diagnosis but it is open to interpretation. (RE 4 p. 50). When asked about the definition of sciatica as pain that radiates from your lower lumbar spine to your buttock and down the back of your thigh and calf he did not disagree with the definition of sciatica. (RE 4 p. 51). However, Dr. Kitchens believes it is a general term and does not know that Cheryl Fuller was actually indicating a true sciatic nerve issue. (RE 4 p. 51). Dr. Kitchens agreed that the L2-3 level would not be something that would cause what is generally termed sciatica. (RE 4 p. 54). In general Dr. Kitchens just believes that sciatica is a general term and not referencing specific nerve root. (RE 4 p. 54). Dr. Kitchens disagreed with the radiologist that reviewed the MRI report that found the right L2 nerve root contacts a disc bulge where they form and maybe the source of the pain radiculopathy. (RE 4 p. 61). Medical Records from the Convenient Care Clinic were offered into evidence as Respondents exhibit 5. The most relevant portions of these records had been discussed previously in the Petitioner's exhibits as well as the Petitioner's testimony. However, the April 17, 2019, note indicates the patient presents today with right shoulder pain from an injury of work when she sustained an injury to her back. Now that she has returned to work and isn't taking any pain medication, she has noticed that her shoulder hurts terribly.

Medical records from Union County Hospital were offered into evidence as Respondent's exhibit 5. These records contain medical records from physical therapy as well as some office notes from the Convenient Care Clinic. Most relevant portions of these records have been discussed as Petitioner's exhibits as well as the testimony of the Petitioner.

Respondent's Exhibit 7 was a wage statement that was withdrawn because there was not a wage dispute at Arbitration. Respondent's Exhibit 8 were pay out sheets the first page of which documents the $8,955.10 of medical benefits paid and $7,470.91 of temporary total and temporary partial benefits paid. Respondent's Exhibit 9 was the Petitioner's personnel file. The portion of this document that was admitted was the employee health survey and immunization status that also contained the medical history.

The Arbitrator Hereby makes the Following Conclusions:

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

While the Respondent disputed that the Petitioner suffered an accident either on March 6, 2017, or January 8, 2019, no evidence was submitted to contradict her account of those injuries. At the time of the March 6, 2017, injury the Petitioner was working very long days and documented an increase in symptomology as a result of her work activities. While she documented a work-related injury that resolved with one office visit to the doctor and a few days off work. The Petitioner sought no benefits from this accident at the time of this 19(b) hearing. The Arbitrator finds the Petitioner did suffer an accident on March 6, 2017.

The January 8, 2019 accident is the primary accident at issue in this 19(b) Hearing as the Petitioner seeks prospective medical treatment as a result of this accident. While the Respondent disputed the Petitioner suffered an accident at Arbitration the Respondent's section 12 examiner, Dr. Kitchen's, agreed that the treatment rendered to the petitioner from the time of the accident through his examination was reasonable and necessary. (RE 4, p. 18). In addition to the Respondent's section 12 examiner conceding the accident issue, no evidence was produced to contradict the Petitioner's testimony. Having been presented no contradictory evidence regarding the fact that the Petitioner did in fact suffer in a work accident on January 8, 2019, that was documented in all of the medical records the Arbitrator concludes the Petitioner did suffer an accident that arose out of and in the course of her employment with the Respondent.

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

The Petitioner testified that she provided notice of this accident to Candy Tucker who was the facility administrator at the time of the accident. The Respondent did not produce a witness to contradict this testimony. The frivolous nature of the Respondent's dispute on causation is exposed by Respondent's Exhibit 8. The Respondent issued a payment for a prescription for the Petitioner on January 15th, 2019, 7 days after the accident. The Respondent issued a TTD payment on January 18, 2019, 10 days after the work accident. The Arbitrator concludes the Petitioner did provide notice in accordance with the Act as Respondent's Exhibit 8 illustrates they were aware of the accident within 7 days.

F. Is the Petitioner's current condition causally related to this injury?

The issue of medical causation in this case hinges upon whether you believe Dr. Colle or Dr. Kitchens. Dr. Colle diagnosed an L1-2-disc herniation that he states is impinging on the nerve and the primary cause of the Petitioner's symptoms. Dr. Kitchen's does not believe that the Petitioner has such an injury although the nerve impingement was also memorialized by the radiologist who reviewed the MRI. It is Dr. Kitchen's opinion that the Petitioner's condition is the same as the pre-existing condition of sciatica noted in her medical records. This is largely based upon the assumption that the providers did not know what the term sciatica means. This theory relies on inferences from the medical records that the providers do not know medicine. It is more logical to believe that a licensed medical provider does know basic medical terminology rather than assuming they do not. Dr. Kitchens wavered between the Petitioner not having a problem at L1-2 or that the problem prior to the accident diagnosed as sciatica is the same problem she has now. This combined with the fact his testimony was almost entirely based upon the alleged information provided by the Petitioner, but he did not offer the Petitioner's questionnaire to verify what she told him leads to the conclusion Dr. Kitchens was not credible. The Petitioner provided specific testimony that her prior injury of sciatic nerve had pain that went down the back of her buttocks consistent with sciatic pain. The current condition is a new symptom that both physicians agreed is associated with the L1-2 nerve distribution. Petitioner distinguished the prior sciatic nerve pain as an unrelated injury and did she claim the sciatic nerve pain was related to her work accident. Therefore, the Arbitrator concludes that the Petitioner's condition of ill being is causally related to the January 8, 2019, work accident.

J. Were medical services that were provided to Petitioner reasonable and necessary?

It is unclear again the Respondent's dispute regarding the reasonableness and necessity of medical treatment to date as even Dr. Kitchens agreed that the Petitioner's treatment to the date of his section 12 examination as of April 12, 2019, was reasonable and necessary. This case is a dispute about a prospective L1-2 micro discectomy and the Respondent presented no evidence to contradict the reasonableness and necessity of medical care the Petitioner's heave to date. Therefore, the Arbitrator concludes that the Petitioner's medical treatment to date was reasonable and necessary.

K. Is the Petitioner entitled to any perspective medical care?

Prospective medical was the primary dispute presented in this case. It is the opinion of the section 12 examiner, Dr. Kitchens, that the Petitioner does not suffer from an L1-2 herniation and does not need any additional medical care as it pertains to the work accident. The Petitioner's treating physician, Dr. Colle, clearly identified an L1-2 disc herniation that he associates with the current pain the Petitioner has. Dr. Kitchens simply did not observe anything on the MRI when disc pathology and impingement were identified both by Dr. Colle and the radiologist. Dr. Colle was precise in his recommendation for an L1-2 micro discectomy which he believes will resolve the petitioner's problem. Therefore, the Arbitrator concludes the Petitioner is entitled to perspective medical care consisting of the L1-2 micro discectomy proposed by Dr. Colle as well as the ancillary medical care.

L. What temporary total disability benefits are in dispute/is there a TTD/TPD overpayment?

The Petitioner did not believe that there was temporary total disability in dispute as she has worked light duty at the direction of the Respondent and did not participate in the TPD calculation process. The Respondent produced a wage statement from June 1, 2019 through June 16, 2019. The Respondent also produced the TTD/TPD pay ledger. Petitioner did not dispute information contained in either exhibit. With no wage information offered prior to 06/01/2019 the Arbitrator assumes the alleged overpayment is after that date. RE 8 does not contain wage information for 06/01/19 to 06/09/19. Putting RE 2 with RE 8 the Arbitrator must calculate the wage dispute as follows:

Based on RE 2, the Petitioner earned $5,654.12 from 06/16/15 to 11/25/2019. Petitioner was paid $2,653.60 from 06/17/2019 to 11/24/2019. This 25 3/7 week time period is the only full time period where the Respondent offered both Wage and TTD/TPD information. During this period the Petitioner would have earned $10,121.58 in the full capacity of her employment with the AWW of $398.04. Petitioner earned $5,654.92 during this time period for a difference of $4,467.46. Two-Thirds of the difference is $2,978.31 which is the TPD amount per the Act. Respondent paid $2,653.60 during this period and thus has documented a $324.71 TTD underpayment owed to the Petitioner.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC014159
Case Name	CANNON,MISTI J v. PETERSON HEALTH CARE
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remanded Arbitration
Decision Type	Commission Decision
Commission Decision Number	21IWCC0265
Number of Pages of Decision	15
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Megan Orso
Respondent Attorney	Matthew Brewer

DATE FILED: 6/3/2021

/s/Deborah Baker, Commissioner

Signature

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

MISTI CANNON,

Petitioner,

vs. NO: 19 WC 14159

PETERSEN HEALTH CARE,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed under section 19(b) of the Act by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causal connection, the reasonableness and necessity of medical expenses, prospective medical care, temporary total disability, and "TPD, Credit," and being advised of the facts and law, corrects and clarifies the Decision of the Arbitrator as set forth below, and otherwise, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

At the outset, the Commission clarifies that this case was heard by Arbitrator Michael Nowak in Herrin, Illinois, and decided by Arbitrator Edward Lee in reliance on the transcript at the agreement of the parties.

With respect to page five (5) of the Decision of the Arbitrator, the Commission redacts the first paragraph in its entirety as the information contained in this paragraph was based on a document that was not admitted into evidence. Further, the Commission corrects the date when Petitioner treated at the Union County Hospital Emergency Room from March 8, 2019, to January 8, 2019.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 31, 2020, as corrected and clarified above, is hereby affirmed and adopted.

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

IT IS FURTHER ORDERED BY THE COMMISSION that 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.

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.

June 3, 2021

/s/ *Deborah J. Baker*
Deborah J. Baker

DJB/cak

O:4/20/21

/s/ *Stephen Mathis*
Stephen Mathis

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/s/ *Deborah L. Simpson*
Deborah L. Simpson

21IWCC0265

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

CANNON, MISTI
Employee/Petitioner

Case# **19WC008818**
19WC014159

PETERSEN HEALTH CARE
Employer/Respondent

On 8/31/2020, 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 0.12% 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:

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TIMOTHY D DENNY
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ANNA, IL 62906

5354 STEPHEN P KELLY ATTY AT LAW
MATT BREWER
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PEORIA, IL 61604

STATE OF ILLINOIS)
)SS.
COUNTY OF Union)

☐ 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)

MISTI CANNON
Employee/Petitioner
v.

Case # 19 WC 8818 and
Consolidated cases: 19-WC-014159

PETERSEN HEALTH CARE
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Chicago**, on **August 11, 2020**. 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, **03/06/2017 and 01/08/2019**, 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 **$20,698.08**; the average weekly wage was **$398.04**.

On the date of accident, Petitioner was **37 & 39** years of age, **married** with **2** dependent children.

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

Respondent shall be given a credit of **$2,871.00** for TTD, **$4,599.91** for TPD, **$0.00** for maintenance, and **$8,955.10** for other benefits, for a total credit of **$16,426.01**.

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

ORDER

The Respondent shall authorize and pay for the L1-2 micro discectomy recommended by Dr. Colle and all ancillary medical care in accordance with sections 8(a) and 8.2 of the Act as the petitioner's condition of ill being is causally related to the January 8, 2019, work accident. The Respondent shall receive credit for all amounts paid.

The Respondent shall pay petitioner $324.71 in TTD/TPD as the evidence shows the petitioner was not properly paid for her lost time associated with this 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

8/29/20
Date

ICArbDec19(b)

AUG 31 2020

Findings of Fact:

The Petitioner has filed two Applications of Adjustment of Claim. The first has a date of accident of March 6, 2017, and has the case number of 19WC14159. The second application for adjustment claims a date of accident of January 8, 2019, and has the case number of 19WC8818. (AT p. 6). The Respondent submitted a Motion to Consolidate these at Arbitration which was granted without objection. (AT p. 12).

The Petitioner, Misti Cannon, testified that at she is forty years old, married with four step-children, one of which is currently under eighteen. (AT p. 14). She is employed at Jonesboro Rehabilitation and Health Care Center which is also known Petersen Health Care. (AT p. 15). She has been employed at Petersen Health Care for four and half years and was initially hired as CNA but currently assists with activities. (AT p. 15).

In March of 2017 she was working as a CNA working shifts from eight to sixteen hours per day. (AT p. 16). Her job duties included helping residents with activities of daily living such as bathing, going to the restroom and helping them walk. (AT p. 16). On March 6, 2017, the Petitioner began having back problems after she got off work so she went to the doctor. (AT p. 16). She did not remember a specific incident that occurred that day but remembered her back starting hurting at work so she went to her physician who is Cheryl Fuller. (AT p. 17). As Cheryl Fuller gave her a medicine regiment of anti-inflammatories, muscle relaxers, and told her, she had a back strain and instructed the Petitioner to take one week off. (AT p. 17). After that week off the Petitioner returned to work and did not really have any problems from that injury. (AT p. 17).

The Petitioner was working on January 8, 2019, on the midnight shift when she and a coworker were assisting a resident out of bed. While the resident was almost to a complete standing position, he attempted to flop back down the bed jerking the Petitioner forward at which time she heard a big pop in her back with instant pain. (AT pgs. 18, 19). The Petitioner reported the accident to Candy Tucker who was the Administrator at the time. (AT p. 19). She went to the Union County Hospital emergency room where she underwent x-rays, provided pain medications, and recommended she follow up with her family physician. (AT p. 19). She followed up with Courtney Ledbetter at the Union County Convenient Care Clinic who obtained an MRI, recommended physical therapy as well as pain medication consisting of muscle relaxers. (AT p. 20). When the physical therapy did not work, she was referred to Dr. Colle who is a neurosurgeon at Cape Brain and Neurospine. (AT p. 20). She followed up with Dr. Colle who recommended an injection which did not provide relief. (AT p. 21). Dr. Colle recommended an L1-2 micro discetomy which the Petitioner wishes to undergo. (AT p. 21).

After the January 8, 2019 work accident, the Petitioner was taken off work by her doctor but then was told to return by her employer on March 29, 2019, and she has been working light duties since that time. (AT p. 22). Her light duty was initially two hours a day and they have gradually found more duties to accommodate her restrictions and moved the time period up to four hours. (AT p. 23). At the time of Arbitration, the Petitioner was working with the Activities Director. This is a position which she had been doing by herself before the new Activities Director was hired. This consists of playing games, coloring, putting in movies or baking to have a little fun to keep the residents busy. (AT p. 23). The Petitioner had applied for the activity position on a full-time basis which would have accommodated her restrictions for a full forty hour week but the position was given to someone else. (AT p. 24). At the time of Arbitration, the Petitioner would be scheduled by her employer to work twenty to twenty-five hours per week and then the work compensation carrier would also pay her some temporary partial disability benefits. (AT p. 24).

The Petitioner described her symptoms at the time of Arbitration as back pain with a sharp stabbing feeling like being zapped with cow prod or tazer that starts in her lower back, wraps around the side and goes to the front of her leg which sometimes affects her knee which will just give out on her. (AT p. 26). The Petitioner acknowledged that she had a prior back issue which was described as sciatica which was a pain down the back of her leg not down the front like the current issue. (AT p. 26). She also described the fact that the pain originates in a different spot in her back which was lower down. (AT p. 26).

On cross examination, the Petitioner confirmed that she is still working part time for the Respondent and sometimes she works more than twenty hours per week. (AT p. 28). She was asked to review what had been marked as Respondent's Exhibit 2 representing pay stubs and the Petitioner did not dispute the information in those documents. (AT p. 30). She also confirmed that she had not received medical bills and that it was her assumption that they had been paid by workers compensation. (AT p. 32). The Petitioner had been receiving $132.68 per week as temporary partial disability benefits since March 9, 2019. (AT p. 33). The Petitioner confirmed that prior to her January 8, 2019 accident she had previously filed a workers' compensation case. (AT p. 38).

The Petitioner did injure her right shoulder in the January 8, 2019 accident but it was not hurting anymore. (AT p. 40). She also confirmed that she was not actively treating for her right shoulder condition. (AT pgs. 40, 41). The Petitioner was cross examined extensively regarding her right shoulder condition which she indicated was not currently a problem and was not seeking any benefits for that at this 19(b) Hearing. (AT p. 42). The Petitioner did not recall reporting prior right radicular symptoms to Dr. Colle, but acknowledged having those prior problems that had resolved. (AT p. 45). She reiterated that she did have prior complaints before the January 8, 2019 accident but it was treated and it had gone away. (AT p. 45). The Petitioner confirmed that she did have prior pain in her back prior to the initial work accident. (AT p. 48). She also confirmed that is the condition that she had been diagnosed with by her family physician as sciatica. (AT p. 49). She confirms this condition was pain radiating down the right buttock to the outer thigh into her knee and she was provided muscle relaxers for this condition. (AT p. 50). She also confirmed that in February of 2016 she had received muscle relaxers for back spasms. (AT p. 51). The Petitioner clarified that her one time visit in 2017 was for the back strain that was work related not summarizing all of her preexisting conditions. (AT p. 54). She confirmed that in her direct testimony she was referencing this specific incident in of March 2017, but if you wanted to know about her entire life history as a CNA which consists of strenuous work that her back does hurt because of the lifting involved. (AT p. 55).

When asked how she able to differentiate the one visit in March of 2017 stemming from the work accident verses the other visits in 2017 for low back pain the Petitioner clarified; "Because the pain is different." (AT p. 55). The Petitioner discussed that on March 6, 2017, she did not recall a specific incident just that she went home and her back was hurting. (AT p. 57). She clarified that she did not have any other injuries, but she did have soreness and muscle aches. (AT p. 58). The Petitioner did not recall what she told Dr. Kitchens regarding her prior low back and right shoulder complaints. (AT p. 61). She did believe she had advised Dr. Kitchens that she had been placed on a limitation of an eight-hour work day. (AT p. 62). The IME with Dr. Kitchens was 15 minutes and she did not recall what she told him and what she didn't say. (AT p. 62). Dr. Colle placed the Petitioner on restrictions in March of 2017 which were still in place at the time of Trial. (AT p. 63). She confirmed that she does adhere to those restrictions and that she also wears the lumbar corset all of the time. (AT p. 63). She also marked that she did not have a back injury or back symptoms. (AT p. 69). The Petitioner was also questioned regarding whether she represented she had felonies convictions and the Petitioner indicated that she did not have any felonies convictions on her record. (AT p. 71).

[redacted]

On redirect examination the Petitioner reiterated she was not asking the Arbitrator to award any benefits related to her shoulder. (AT p. 74). She also clarified that she differentiates the treatment she received from Cheryl Fuller for the March 6, 2017 accident and records she viewed on cross examination that did not pertain to treatment she associated with its injuries. (AT p. 74). She specified the treatment Dr. Colle is addressing for this injury starts in her back wraps around and goes in the front of her leg sometimes to the knee and sometimes the leg falls asleep and gives out on her. (AT p. 75). The area Dr. Fuller was treating goes from the back by her tailbone down by her buttocks and the back of her leg. (AT p. 75).

The Petitioner also confirmed that prior to being hired by the Respondent in 2015 she had also worked for them in 2011 but quit to go to school. (AT p. 76). Prior to the January 2019 accident she was working full duty and doing her job as a CNA. (AT. p. 77).

The Respondent called Rachel Smith who is an investigator for Blue Eagle Investigations. (AT p. 78). Ms. Smith did not perform an investigation on the Petitioner nor did she prepare the report that was offered as Respondent's Exhibit 10. (AT p. 80). The investigator who performed the field surveillance no longer worked for the investigation company and Ms. Smith could not clarify why he was no longer with the company. (AT p. 86). When asked whether there was a dvd or video of the surveillance of the claimant, Ms. Smith testified that they did not actually obtain any video of the claimant. (AT p. 87).

Medical records from Union County Hospital Emergency Room were offered into evidence as Petitioner's Exhibit 1. The Petitioner was examined on March 8, 2019, with back pain located in the low back which began suddenly at work this am. (PE 1 p. 1). Petitioner was discharged with a strain of the muscle and fascia and tendon of the lower back. (PE 1 p. 3).

Medical records from Union County Hospital Convenient Care were offered into evidence as Petitioner's Exhibit 2. The Petitioner followed up with the Convenient Care Clinic where she was seen by Dr. Ledbetter on January 14, 2019. The Petitioner reiterated the history that she was helping a resident out of bed and when the resident went to sit down and threw the Petitioner forward, she heard a pop down the right side of her left leg. She noted that she had prior pain but nothing this severe in the past. (PE 2 p. 14). The Petitioner continued to follow up with the Convenient Care Clinic and was referred to Dr. Colle, a neurosurgeon, in Cape because she was experiencing shooting pain and numbness on March 25, 2019. (PE 2 p. 3).

Medical records from Union County Hospital Physical Therapy were offered into evidence as Petitioner's Exhibit 3. They document that the Petitioner underwent physical therapy in January and early February of 2019.

The medical records from the Regional Brain and Spine Clinic were offered into evidence as Petitioner's Exhibit 4. Dr. Colle believed the Petitioner had stenosis with intervertebral disc stenosis low back with sciatica spondylosis lumbar with radiculopathy and disc disorder disc displacement. (PE 4 p. 20). He specifically indicated there appears to be right disc herniation at L1-2 and recommended an injection at level as well as medications. The Petitioner followed up with Dr. Colle on March 26, 2019 after undergoing the L1-2 transforaminal injection for both diagnostic and therapeutic purposes. (PE 4 p.

1). Dr. Colle noted that the patient has a work-related injury and developed an L1-2 right herniated disc that has been symptomatic. The patient indicated that the injection was beneficial for approximately twenty-four hours and the pain returned. (PE 4 p. 1). Dr. Colle recommended an L1-2 microdiscectomy for the disc herniation at the right L1-2. (PE 4 p. 5).

The medical records from Rural Health were offered into evidence as Petitioner's Exhibit 5. The patient reported muscle aches and back pain and was prescribed medication on March 2017.

The Deposition of Dr. Kyle Colle was offered into evidence as Petitioner's Exhibit 6. Dr. Colle is a neurosurgeon who practices in Cape Girardeau, Missouri. (PE 6 p. 5). Dr. Colle testified that he first treated the Petitioner on February 26, 2019, and reiterated that her history of a 39 year old female who presented to the clinic after a request of Workers' Compensation and reported a two month history of eight out of ten aching, stabbing, and pins and needles sensation that radiates from the lower back to the right anterior lateral thigh. (PE 6 p. 7). She was examined by Tyler Greenwood, Dr. Colle's Physician Assistant, on that date which is typical protocol. (PE 6 p. 8). An MRI was also obtained which showed a multilevel degenerative disc disease and facet arthropathy meaning hypertrophied facets or enlarged facets and a right L1-2 foraminal disc herniation with abutment of the right L-2 nerve and some mild stenosis at L4-5. (PE 6 p. 10). He specified the significance of the herniated disc into the right L1-2 with compression on the L-2 nerve root. (PE 6 p. 10). Dr. Colle noted that the findings were consistent with the pain in her thigh region of the anterior thigh on the right lower extremity and some of the other muscle spasms were not consistent with just a L1-2 disc. (PE 6 p. 11). Dr. Colle's diagnosis was a symptomatic disc at L1-L2 which was the main reason for her symptoms for which they wanted to try a therapeutic transforaminal injection at L1-L2. (PE 6 p. 12). That injection was performed on March 8, 2019. (PE 6 p. 12). The Petitioner was seen again March 26, 2019, indicating the injection was beneficial for about twenty-four hours and that her pain returned. (PE 6 p. 13). Since the injection provided short term relief Dr. Colle believed that it was diagnostic, but not therapeutic because she only had twenty-four hours of pain relief with the injection and therefore it wasn't therapeutic to the point to continue with the injection, but diagnostic in that the found the pain generator. (PE 6 p. 13). At that time Dr. Colle recommended a right L1-2 microdiscectomy for the L1-2 foraminal disc herniation. (PE 6 p. 13). The purpose of the recommended surgery is to decrease the compression upon the nerves at L1-2 level on the right side and remove the herniation to allow more room and not allow the nerves to be compressed. (PE 6 p. 14). It also takes away the noxious stimuli from the herniated disc that is there because of the herniation. (PE 6 p. 14). Dr. Colle was not able to pursue with that surgery but continues to be his recommendation. (PE 6 p. 14).

Dr. Colle had placed the Petitioner on lifting restrictions of no more than ten pounds no highly repetitive bending, stooping, or twisting, no overhead work and flexion or extension of the spine. (PE 6 p. 15). Those continued to be his restrictions as of the time of his deposition. (PE 6 p. 15). Dr. Colle testified that with a medical degree of certainty that the Petitioner had a right L1-2 herniated disc due to a work injury. (PE 6 p. 15).

Dr. Colle disagreed with the conclusion of Dr. Kitchens that the patient was at maximum medical improvement with no herniated disc. (PE 6 p. 17). Dr. Colle disagrees with that and he does feel that the MRI shows a foraminal herniated disc at L1-L2 and the transforaminal injection was diagnostic for her pain. (PE 6 p. 17). When asked whether the Petitioner having some low back pain in the year prior to the injury would alter his opinion Dr. Colle indicated no. (PE 6 p. 18). Dr. Colle confirmed on cross examination that he had received medical records from Dr. Kitchens and the Petitioner's Rural Health's records prior to his deposition. (PE 6 p. 20). Dr. Colle reviewed a record of January 8, 2019 indicating the Petitioner had back pain. (PE 6 p 22). Dr. Colle confirmed that he did not provide any opinions or treatment regarding the Petitioner's right shoulder. (PE 6 p. 22). Dr. Colle was testified extensively

regarding the fact that he did not have any findings regarding the Petitioner's right shoulder. (PE 6 p. 24). When asked whether a change in the history would alter his opinion Dr. Colle indicated that it depends on what the change in symptoms would have been. Dr. Colle reiterated that she did not have any of the symptoms of the low back with the right radicular symptoms and that was and these symptoms starting with the work related injury. (PE 6 p. 25). Dr. Colle was again asked whether if the Petitioner did in fact have low back pain with similar or the same radicular symptoms that she had after the accident whether it could alter his opinions but Dr. Colle indicated that it would all depend on the review of symptoms and her radicular symptoms in the imaging that may have been involved with that treatment. (PE 6 p. 26). Dr. Colle went on to state that ninety percent of Americans have back pain so it depends if she had the same symptoms or if they are different symptoms. (PE 6 p. 27).

Dr. Colle encouraged Ms. Cannon to return to work assuming his restrictions could be met. (PE 6 p. 34). The purpose of the lumbar corset recommended by Dr. Colle was to restrict motion of the lumbar spine because when you have a herniated disc it is best to afford twisting and bending because it puts a lot more stress on the disc. (PE 6 p. 34). When asked whether his recommendation for surgery could be altered if the symptoms have been resolved Dr. Colle indicated that he would prefer to do an exam and discuss that with the patient. (PE 6 p. 37).

On the redirect examination Dr. Colle clarified that he had read the records from Rural Health indicating prior back symptoms which consists of a facial swelling in March of 2010. (PE 6 p. 40). Dr. Colle clarified that is a strain of the back muscle. (PE 6 p. 40). Dr. Colle further clarified the note indicates that the pain was associated with her work as a CNA as she had worked nine straight days and does a lot of heavy lifting. (PE 6 p. 41). Dr. Colle clarified that the diagnosis for the Petitioner on March 21, 2017 from the records was sciatica. (PE 6 p. 43). Dr. Colle testified that if a person does lifting on her job and has low back pain or sciatica and it resolves and that person returns to full duty without restrictions and then as of January 8, 2019, a lifting incident that prior history would not change of his opinions. (PE 6 p. 44).
The Respondent offered a check history from June 01, 2019 through November 25, 2019 into evidence as Respondent's Exhibit 2.

The Respondent offered a copy of the public aid lien into evidence as Respondent's Exhibit 3 illustrated that some of the Petitioner's medical records were paid by public aid and not by the Respondent.

The Deposition of Dr. Kitchens was offered into evidence as Respondent's Exhibit 4. Dr. Kitchens is a board-certified neurosurgeon who practices in the St. Louis area. (RE 4 p. 6). Dr. Kitchens examined the Petitioner on April 12, 2019. (RE 4 p. 7). The history the Petitioner provided to Dr. Kitchens was that she had injury on January 8, 2019, where a patient pulled her down and she had an onset of back pain into her right leg and she also had some pain in her right shoulder and arm. She stated she felt a pop in her back at that time. (RE 4 p. 9). Dr. Kitchens indicated that the Petitioner told him that she did not have a history of back pain. (RE 4 p. 9). At the time of the examination the Petitioner was suffering from pain in her back down her right leg to her thigh and the pain would occasionally go in to the knee and sometimes the foot into the toes on the right foot with the back pain being more constant and described as stabbing pain. (RE 4 p. 10). At the time of the examination the Petitioner had been off work since January 8, 2019, and had been back to work light duty since March 6, 2019. (RE 4 p. 11). Dr. Kitchens stated that he did not see evidence of lumbar radiculopathy or evidence of a spinal cord injury as a result of his physical examination. (RE 4 p. 14). Dr. Kitchens reviewed medical records that included those from Nurse Practitioner Fuller, x-ray reports, records from Union County Hospital, Physician's Assistant Ledbetter, and MRI study of January of 2019, as well as records from the Regional Brain and Spine Institute. (RE 4 p. 14). Dr. Kitchens believed the medical records from before the

accident showed that the Petitioner had been diagnosed with back pain and right-side sciatica which contradicts the history, she provided to him. (RE 4 p. 15). Dr. Kitchens believes that the MRI of January 16, 2019, indicates mild degenerative disc changes with a mild disc bulging on the right side of L2-3 with degenerative space narrowing at L1 to L2 with no evidence of a disc herniation or foraminal stenosis. (RE 4 p. 15). He did not believe any of the findings were acute. (RE 4 p. 16). He also does not believe that the Petitioner had any surgical pathology. (RE 4 p. 16). Dr. Kitchens provided a diagnosis of a musculoskeletal strain of her lumbar spine as a result of the work accident without evidence of the lumbar radiculopathy or an acute disc herniation. (RE 4 p. 16). His physical examination did not show motor weakness or a foot drop which would be classics signs of a L5 radiculopathy. (RE 4 p. 17).

Dr. Kitchens believed that the Petitioner could return to work without restrictions. (RE 4 p. 18). He also does not believe that the Petitioner needs any ongoing medical care as it pertains to the lumbar spine. (RE 4 p. 18). Dr. Kitchens agreed that the care and treatment provided up until the date of his examination had been appropriate for the lumbar strain that had been diagnosed. (RE 4 p. 18). He also believes that she is at maximum medical improvement. (RE 4 p. 19). Dr. Kitchens referenced the pre-accident radicular symptoms that were discussed in the notes as sciatica and noted that it was radiating pain down her right buttock and right leg which could be an indication of radicular symptoms. (RE 4 p. 20).

On the date of April 12, 2019, when he examined the Petitioner Dr. Kitchens saw a total of three patients, all of for the purpose of independent medical examinations. (RE 4 p. 21). Dr. Kitchens practice consists of ten to fifteen percent of injured workers in the State of Missouri where the medical care is directed by the insurer. (RE 4 p. 25).

Dr. Kitchens believes that the term sciatica in the petitioner's medical records refers to a broad term that generally refers to pain traveling down the leg although the sciatica nerve is the largest and longest spinal nerve in the body. (RE 4 p. 26). He also agreed that the sciatic nerve is formed by a combination of five nerves in the lower lumbar and sacral spine at the L4, L5, S1, S2, and S3 levels. (RE 4 p. 26). He also agreed that sciatic nerves start in the lower spine and follows along the path through the buttocks down the back of the thigh and leg and into the foot. (RE 4 p. 26). Dr. Kitchens confirmed that nerves can be pinched along different areas of the spine and an injury in to the L5 level would have different symptoms than an injury L2 level. (RE 4 p. 27). The Petitioner did fill out an intake form at the time of her examination. (RE 4 p. 29). Dr. Kitchen was not provided with the pain diagram from Dr. Colle's office for comparison. (RE 4 p. 31). Dr. Kitchens agrees that the pain symptoms the Petitioner marked that reflected pain in the front of her thigh is not sciatica. (RE 4 p. 32). He agreed that generally speaking the nerves that serve the upper and middle thigh are the L2 and L3 nerves. (RE 4 p. 34). He also agreed that there is a pinched nerve at the L2 level and consistent with the symptoms across that area of the thigh. (RE 4 p. 34). Dr. Kitchens did not believe that the problem was confined to just the L2 dermatome because she reported other symptoms but then also stated that she doesn't because of the MRI. (RE 4 p. 35). However, Dr. Kitchens agreed that part of the dorsum of the foot is generally in the L5 nerve and there are different symptoms associated with injury to the different part of the spine. (RE 4 p. 35).

Dr. Kitchens had an opportunity to look at the records before her examination, but did not ask her about the alleged inconsistency with prior history and her lack of reporting back pain. (RE 4 p. 36). Dr. Kitchens clarified that he assumed that she did not have this type of pain because the Petitioner told him she had not had this type of pain before and he did not confront her regarding the history in the records. (RE 4 p. 38). Dr. Kitchens did not believe there was pain reproduced on the straight leg raising indicating radicular pain. (RE 4 p. 45). Dr. Kitchens doesn't use work term sciatica very often unless someone telling him they told they had sciatica but general indicates pain down the leg. (RE 4 p. 49). He

did not agree that what Cheryl Fuller indicated was sciatica was a different condition than what the petitioner currently has because he does not know what Ms. Fuller was thinking. (RE 4 p. 49). He believes that the reference to sciatica is not a specific diagnosis but it is open to interpretation. (RE 4 p. 50). When asked about the definition of sciatica as pain that radiates from your lower lumbar spine to your buttock and down the back of your thigh and calf he did not disagree with the definition of sciatica. (RE 4 p. 51). However, Dr. Kitchens believes it is a general term and does not know that Cheryl Fuller was actually indicating a true sciatic nerve issue. (RE 4 p. 51). Dr. Kitchens agreed that the L2-3 level would not be something that would cause what is generally termed sciatica. (RE 4 p. 54). In general Dr. Kitchens just believes that sciatica is a general term and not referencing specific nerve root. (RE 4 p. 54). Dr. Kitchens disagreed with the radiologist that reviewed the MRI report that found the right L2 nerve root contacts a disc bulge where they form and maybe the source of the pain radiculopathy. (RE 4 p. 61). Medical Records from the Convenient Care Clinic were offered into evidence as Respondents exhibit 5. The most relevant portions of these records had been discussed previously in the Petitioner's exhibits as well as the Petitioner's testimony. However, the April 17, 2019, note indicates the patient presents today with right shoulder pain from an injury of work when she sustained an injury to her back. Now that she has returned to work and isn't taking any pain medication, she has noticed that her shoulder hurts terribly.

Medical records from Union County Hospital were offered into evidence as Respondent's exhibit 5. These records contain medical records from physical therapy as well as some office notes from the Convenient Care Clinic. Most relevant portions of these records have been discussed as Petitioner's exhibits as well as the testimony of the Petitioner.

Respondent's Exhibit 7 was a wage statement that was withdrawn because there was not a wage dispute at Arbitration. Respondent's Exhibit 8 were pay out sheets the first page of which documents the $8,955.10 of medical benefits paid and $7,470.91 of temporary total and temporary partial benefits paid. Respondent's Exhibit 9 was the Petitioner's personnel file. The portion of this document that was admitted was the employee health survey and immunization status that also contained the medical history.

The Arbitrator Hereby makes the Following Conclusions:

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

While the Respondent disputed that the Petitioner suffered an accident either on March 6, 2017, or January 8, 2019, no evidence was submitted to contradict her account of those injuries. At the time of the March 6, 2017, injury the Petitioner was working very long days and documented an increase in symptomology as a result of her work activities. While she documented a work-related injury that resolved with one office visit to the doctor and a few days off work. The Petitioner sought no benefits from this accident at the time of this 19(b) hearing. The Arbitrator finds the Petitioner did suffer an accident on March 6, 2017.

The January 8, 2019 accident is the primary accident at issue in this 19(b) Hearing as the Petitioner seeks prospective medical treatment as a result of this accident. While the Respondent disputed the Petitioner suffered an accident at Arbitration the Respondent's section 12 examiner, Dr. Kitchen's, agreed that the treatment rendered to the petitioner from the time of the accident through his examination was reasonable and necessary. (RE 4, p. 18). In addition to the Respondent's section 12 examiner conceding the accident issue, no evidence was produced to contradict the Petitioner's testimony. Having been presented no contradictory evidence regarding the fact that the Petitioner did in fact suffer in a work accident on January 8, 2019, that was documented in all of the medical records the Arbitrator concludes the Petitioner did suffer an accident that arose out of and in the course of her employment with the Respondent.

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

The Petitioner testified that she provided notice of this accident to Candy Tucker who was the facility administrator at the time of the accident. The Respondent did not produce a witness to contradict this testimony. The frivolous nature of the Respondent's dispute on causation is exposed by Respondent's Exhibit 8. The Respondent issued a payment for a prescription for the Petitioner on January 15th, 2019, 7 days after the accident. The Respondent issued a TTD payment on January 18, 2019, 10 days after the work accident. The Arbitrator concludes the Petitioner did provide notice in accordance with the Act as Respondent's Exhibit 8 illustrates they were aware of the accident within 7 days.

F. Is the Petitioner's current condition causally related to this injury?

The issue of medical causation in this case hinges upon whether you believe Dr. Colle or Dr. Kitchens. Dr. Colle diagnosed an L1-2-disc herniation that he states is impinging on the nerve and the primary cause of the Petitioner's symptoms. Dr. Kitchen's does not believe that the Petitioner has such an injury although the nerve impingement was also memorialized by the radiologist who reviewed the MRI. It is Dr. Kitchen's opinion that the Petitioner's condition is the same as the pre-existing condition of sciatica noted in her medical records. This is largely based upon the assumption that the providers did not know what the term sciatica means. This theory relies on inferences from the medical records that the providers do not know medicine. It is more logical to believe that a licensed medical provider does know basic medical terminology rather than assuming they do not. Dr. Kitchens wavered between the Petitioner not having a problem at L1-2 or that the problem prior to the accident diagnosed as sciatica is the same problem she has now. This combined with the fact his testimony was almost entirely based upon the alleged information provided by the Petitioner, but he did not offer the Petitioner's questionnaire to verify what she told him leads to the conclusion Dr. Kitchens was not credible. The Petitioner provided specific testimony that her prior injury of sciatic nerve had pain that went down the back of her buttocks consistent with sciatic pain. The current condition is a new symptom that both physicians agreed is associated with the L1-2 nerve distribution. Petitioner distinguished the prior sciatic nerve pain as an unrelated injury and did she claim the sciatic nerve pain was related to her work accident. Therefore, the Arbitrator concludes that the Petitioner's condition of ill being is causally related to the January 8, 2019, work accident.

J. Were medical services that were provided to Petitioner reasonable and necessary?

It is unclear again the Respondent's dispute regarding the reasonableness and necessity of medical treatment to date as even Dr. Kitchens agreed that the Petitioner's treatment to the date of his section 12 examination as of April 12, 2019, was reasonable and necessary. This case is a dispute about a prospective L1-2 micro discectomy and the Respondent presented no evidence to contradict the reasonableness and necessity of medical care the Petitioner's heave to date. Therefore, the Arbitrator concludes that the Petitioner's medical treatment to date was reasonable and necessary.

K. Is the Petitioner entitled to any perspective medical care?

Prospective medical was the primary dispute presented in this case. It is the opinion of the section 12 examiner, Dr. Kitchens, that the Petitioner does not suffer from an L1-2 herniation and does not need any additional medical care as it pertains to the work accident. The Petitioner's treating physician, Dr. Colle, clearly identified an L1-2 disc herniation that he associates with the current pain the Petitioner has. Dr. Kitchens simply did not observe anything on the MRI when disc pathology and impingement were identified both by Dr. Colle and the radiologist. Dr. Colle was precise in his recommendation for an L1-2 micro discectomy which he believes will resolve the petitioner's problem. Therefore, the Arbitrator concludes the Petitioner is entitled to perspective medical care consisting of the L1-2 micro discectomy proposed by Dr. Colle as well as the ancillary medical care.

L. What temporary total disability benefits are in dispute/is there a TTD/TPD overpayment?

The Petitioner did not believe that there was temporary total disability in dispute as she has worked light duty at the direction of the Respondent and did not participate in the TPD calculation process. The Respondent produced a wage statement from June 1, 2019 through June 16, 2019. The Respondent also produced the TTD/TPD pay ledger. Petitioner did not dispute information contained in either exhibit. With no wage information offered prior to 06/01/2019 the Arbitrator assumes the alleged overpayment is after that date. RE 8 does not contain wage information for 06/01/19 to 06/09/19. Putting RE 2 with RE 8 the Arbitrator must calculate the wage dispute as follows:

Based on RE 2, the Petitioner earned $5,654.12 from 06/16/15 to 11/25/2019. Petitioner was paid $2,653.60 from 06/17/2019 to 11/24/2019. This 25 3/7 week time period is the only full time period where the Respondent offered both Wage and TTD/TPD information. During this period the Petitioner would have earned $10,121.58 in the full capacity of her employment with the AWW of $398.04. Petitioner earned $5,654.92 during this time period for a difference of $4,467.46. Two-Thirds of the difference is $2,978.31 which is the TPD amount per the Act. Respondent paid $2,653.60 during this period and thus has documented a $324.71 TTD underpayment owed to the Petitioner.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC014478
Case Name	ERWIN, KENNETH L JR v. AMERICAN COAL COMPANY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0266
Number of Pages of Decision	23
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Thomas Rich
Respondent Attorney	Gregory Keltner

DATE FILED: 6/3/2021

/s/ Thomas Tyrrell, Commissioner

Signature

21IWCC0266

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kenneth Erwin, Jr.,

Petitioner,

vs. NO: 16 WC 14478

American Coal Company,

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 vocational rehabilitation expenses, permanency rate and nature and extent, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated herein, all else otherwise affirmed and adopted, said decision being attached hereto and made a part hereof.

The Commission modifies the decision of the Arbitrator to find that Petitioner failed to prove his entitlement to vocational counseling services after 6/5/19. Petitioner's vocational counselor, Timothy Kaver, testified that after Petitioner graduated from computer skills training on 4/9/19 he was offered a position on 5/2/19 and started his current job on 5/5/19. (T.54). In a Status Report dated 6/5/19, Mr. Kaver recorded that Petitioner's new job was going well and that "England & Company will conduct follow-up services to ensure a successful and permanent job placement for Kenneth Erwin until otherwise advised." (PX22). The attached invoice shows Mr. Kaver charged a total of $1,127.20 (including $123.20 for mileage) for professional services from 5/3/19 through 6/5/19, the date of his Status Report. (PX22). The Commission finds that the services provided by Mr. Kaver up to the date of his follow-up report on 6/5/19 were reasonable and necessary in order to evaluate the appropriateness of Petitioner's new job and whether additional vocational rehabilitation services on his part were required. However, thereafter, it appears Mr. Kaver did little more than keep the file open and await further instructions. As a result, the Commission finds that Petitioner is only entitled to reasonable and necessary vocational counseling services with Mr. Kaver through the date of his 6/5/19 report.

Furthermore, the Commission modifies the Order found in the Arbitrator's Decision to include language to effect that the wage differential award pursuant to §8(d)1 of the Act is effective until the employee reaches the age of 67 or 5 years from the date the award becomes final, whichever is later, per the statute.

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 1/19/20 is hereby modified, as stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay vocational rehabilitation and mileage expenses through 6/5/19, pursuant to §8(a) of the Act, and that Respondent shall be allowed a credit for all such expenses paid.

IT IS FURTHER ORDERED BY THE COMMISSION that commencing on 5/5/19, Respondent pay to the Petitioner the sum of $741.40 per week until such time as the employee reaches the age of 67 or 5 years from the date the award becomes final, whichever is later, as provided in §8(d)1 of the Act, for the reason that the injuries sustained permanently incapacitates him from pursuing the duties of his usual and customary line of employment; Respondent shall be allowed a credit for any amounts paid in temporary partial disability and/or wage differential benefits prior to the hearing at arbitration.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

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

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

JUNE 3, 2021

/s/ *Thomas J. Tyrrell*
Thomas J. Tyrrell

TJT: pmo
o 4/6/21
51

/s/ *Maria E. Portela*
Maria E. Portela

/s/ *Kathryn A. Doerries*
Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0266

ERWIN JR, KENNETH
Employee/Petitioner

Case# **16WC014478**

AMERICAN COAL CO
Employer/Respondent

On 1/29/2020, 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:

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

5990 LITCHFIELD CAVO LLC
GREG KELTNER
222 S CENTRAL AVE
ST LOUIS, MO 63105

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

KENNETH ERWIN, JR.
Employee/Petitioner

v.

AMERICAN COAL CO.
Employer/Respondent

Case # 16 WC 14478

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **November 22, 2019**. 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 **Suitability of Petitioner's employment/wage differential award, vocational counselor charges subsequent to Petitioner's return to work on May 5, 2019.**

FINDINGS

On **February 9, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$56,160.00**; the average weekly wage was **$1,442.07**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **4** dependent child(ren).

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

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

Respondent shall be given a credit of **$101,631.60** for TTD, $- for TPD, **$42,641.53** for maintenance, and $0 for other benefits, for a total credit of **$144,273.13**.

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

ORDER

Respondent shall pay reasonable and necessary medical services outlined in Petitioner's group exhibit, as provided in § 8(a) and § 8.2 of the Act. Respondent shall be given credit for medical benefits that have been paid, provided that it holds Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in § 8(j) of the Act.

Respondent has paid or will pay all outstanding temporary total/partial disability benefits, as provided in § 8(b) of the Act

Respondent has paid or will pay all outstanding vocational rehabilitation expenses and mileage expenses, and shall have credit for any expenses paid.

Respondent shall pay Petitioner permanent partial disability benefits of **$741.40**/week until Petitioner reaches age 67, because the injuries sustained caused a loss of earnings as provided in § 8(d)1 of the Act.

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

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

Edward Lee — Signature of Arbitrator

1/25/20 — Date

JAN 29 2020

FACTS

Prior to the date of the accident, Petitioner had been employed as a stage loader operator/master control operator for American Coal Company for 15 years. (T.9-10) A stage loader operator communicates to all the people at the face of the mine, advances the first three (3) or four (4) shields, keeps them on wood, operates the tail piece, keeps the belts aligned, keeps the coal on the belt at all times, calls out to the employees on top and tells them productivity, measures the footage of coal, moves props, pulls shields, performs a lot of maintenance, cuts the links out of the chain, takes out flights, and lubricates the equipment. (T.10)

The parties stipulated that on February 9, 2016, Petitioner sustained accidental injuries at work when, while after tying a chain onto a prop holding up the roof and the rib, the prop fell, and Petitioner went to grab it. Unfortunately, the prop had "a bunch of mud" on it, which was probably mid-calf deep. He threw the rip on his shoulder and was going to take off, but it started popping. The shield that held the roof up slid back, the roof started to roll, and Petitioner tried to take off running and throw the prop off at the same time. The prop ran into the ceiling/roof of the coal, threw Petitioner's right shoulder back, and caused a pop. Petitioner also tripped over a piece of belt structure and rammed his head into a 200 pound M15 pump. (T.11-12) Prior to this accident, Petitioner had never sustained injuries to his right shoulder and/or his cervical spine. (T.12)

Following the accident, Petitioner was sent by Respondent to Dr. Ford which chief complaints of bilateral shoulder trauma and right hip injury. (PX3) The history of the injury was taken as:

> Patient presents today for evaluation of a right shoulder injury. This is a work comp injury. He works at American coal. He runs the stage loader on the long wall. The injury was on 2/9/16 at 2:30 pm. He was carrying a 100 pound prop on his right shoulder. The mud was about a foot deep. He tripped over a belt rail with his left foot, and attempted to throw the prop off the right shoulder. He felt a burning sensation in his right shoulder. He continued to fall forward, and hit his head over his hard hat on a M15 air pump and caught himself on the ground with his left hand. He felt a stinger in his head and the pain shot down his neck when he hit the pump with his head. He was able to finish the rest of the shift. The next day he was sore, but went in and worked. He put an injury report in on the day of the injury. This morning his pain was worse, he woke up several times last night and his arms were asleep. He has had some pain in his lower back on the right side. [Errors original]. *Id.*

Dr. Ford's examination showed swelling over the superior aspect of the AC joint in the right shoulder, tenderness to palpation in multiple areas, including the glenohumeral joint region and trapezius muscle, and pain on active abduction. *Id.* Petitioner's low back showed sciatic pain, muscle spasm, and left-sided positive straight leg raising. *Id.* It did not appear that Petitioner's neck was examined. *Id.* However, the assessment was:

- Sprained right superior glenoid labrum lesion.
- Complete tear of left rotator cuff tendon.
- Neck strain on right side.
- Neck strain on left side. Id.

Dr. Ford recommended an orthopedic referral for Petitioner's shoulder problems, prescribed Skelaxin, and kept him off work. *Id.*

Dr. Ford referred Petitioner at Respondent's request to Dr. Matthew Collard, whose diagnoses on the first page of his note included back pain, neck pain, and left shoulder pain. (PX5, 2/26/16) The record for the first visit of February 17, 2016, consists of only one (1) page with work limitations and the ordering of an MRI. (PX5, 2/17/16) This was done prior to Dr. Collard's second visit of February 26, 2016, and it showed a partial subscapularis tendon tear as well as degenerative tearing of the superior labrum, subcutaneous hematoma, and degenerative changes of the glenohumeral joint. *Id.* Dr. Collard's diagnosis was 1) right shoulder degenerative labral tear; 2) glenohumeral arthritis, chronic; 3) left shoulder sprain; 4) low back strain; 5) neck pain. *Id.* Dr. Collard referred Petitioner to physical therapy for his neck pain, injected his shoulder, and continued his medication. *Id.* He allowed Petitioner to continue working, but with extremely limited duties. *Id.*

Petitioner returned to Dr. Collard on March 18, 2016, for follow-up for his right shoulder, as well as left shoulder pain, neck pain, and low back pain. (PX5, 3/18/16) Petitioner reported that the left shoulder and low back pain had improved, but the stiffness in his neck continued. *Id.* Dr. Collard noted that Petitioner was still having significant right shoulder problems, and based on Petitioner's physical examination and the fact that he'd failed conservative treatment with physical therapy and injections, Dr. Collard recommended surgery to repair Petitioner's shoulder. *Id.* He continued Petitioner's physical therapy for his neck. *Id.*

Petitioner's surgery was performed on April 7, 2016, and Dr. Collard's post-operative diagnosis was:

1. Right shoulder degenerative SLAP lesion extending posteriorly.
2. Posteroinferior glenoid full –thickness chondrosis.
3. Inferior humeral head full-thickness chondrosis.
4. Degenerative tearing of the Posteroinferior labrum. (PX7, 4/7/16)

Follow-up visits after surgery show that Petitioner's therapy with regard to his left shoulder was improving his condition. (PX5, 5/10/16) He continued, however, to have pain in his right shoulder and neck. *Id.* On May 10, 2016, Dr. Collard recommended a cervical MRI, continued Petitioner's light duty restrictions, and continued his physical therapy. *Id.* He also continued Petitioner's narcotic pain medication. *Id.*

When Petitioner returned to see Dr. Collard on May 24, 2016, he reported that while Petitioner was somewhat improved, he continued to have right shoulder pain at night and was still using Norco. (PX5, 5/24/16) Dr. Collard reviewed the MRI done at Greater Missouri Imaging, and the radiologist's impression was, "Left subarticular osteophyte and protruding disc complex contributes to spinal canal stenosis at C5-6 and C6-7." (PX8) Based on those findings, Dr. Collard believed it would be appropriate for Petitioner to be evaluated by a spine surgeon, as he believed the pathology was contributing to his bilateral shoulder pain. (PX5, 5/24/16) He continued Petitioner on light duty with lifting restrictions and continued Petitioner's physical therapy and medication. *Id.*

He saw Petitioner back on June 15, 2016, and noted that Petitioner was not yet able to return to full duty work. (PX5, 6/15/16) He refilled Petitioner's medications and allowed him to return to work with restrictions of no lifting greater than 50 pounds and limited pushing and overhead activity. *Id.* He noted, however, at that time that Petitioner was still having right shoulder and neck symptoms, and was scheduled to undergo evaluation by Dr. Coyle, Respondent's selected spine surgeon, the next day. *Id.*

Petitioner saw Dr. James Coyle at Respondent's request on June 16, 2016. (PX10, 6/16/16) He took the consistent history of the injury, noted that Petitioner continued to have neck pain, and noted he was currently taking Ibuprofen and Tramadol. *Id.* He also noted Petitioner had failed conservative treatment with injections and physical therapy. *Id.* His examination showed pain with flexion and extension and normal reflexes and strength; however, Petitioner exhibited mild pain to palpation in the cervical spine and paravertebral muscles. *Id.* Dr. Coyle reviewed the MRI, and his impression was C5-6 and C6-7 cervical stenosis due to a combination of disc and osteophyte producing radiculopathy. *Id.* He believed that some of Petitioner's symptoms were coming from his cervical spine and recommended nerve blocks at C5-6 and C6-7 on the right for diagnostic and therapeutic purposes. *Id.* Dr. Coyle stated in his notes:

> Based on his history of injury including the mechanism of injury and the absence of pre-existing symptoms, his work injury was the cause of his current condition and need for treatment. *Id.*

Petitioner followed up with Dr. Coyle on July 19, 2016, and Dr. Coyle noted that injections had been done by Dr. Smith on June 21, 2016. (PX10, 7/19/16) Petitioner reported several weeks' worth of relief from the injections; however, his headaches were back, and he continued to have pain radiating into his shoulder along with significant pain on forward flexion of his cervical spine. *Id.* Dr. Coyle's belief was that Petitioner's symptoms were temporarily relieved by selective nerve blocks at C5-6 and C6-7, but he had returned to baseline. *Id.* Dr. Coyle advised him that surgery would be his only other option and recommended an anterior cervical microscopic decompression and arthrodesis/fusion at C5-6 and C6-7. *Id.* He urged Petitioner to think about it, talk about it with his family, and return. *Id.* He extended Petitioner's work restrictions. *Id.*

When Petitioner returned on July 26, 2016, he advised Dr. Coyle he wished to undergo surgery, as he was still having significant cervical pain along with residual right shoulder pain. (PX10, 7/26/16) Dr. Coyle recommended an anterior cervical fusion at C5-6 and C6-7, with allograft spaces and BMP. *Id.* He allowed Petitioner to keep working light duty. *Id.*

Surgery took place on August 23, 2016, by way of a two (2) level fusion at C5-6 and C6-7. (PX11) Petitioner saw Dr. Coyle after surgery on September 6, 2016, wearing his cervical collar. (PX10, 9/6/16) X-rays showed the hardware to be in good position, and Petitioner reported some relief from his symptoms. *Id.* Follow-up visits showed that Petitioner weaned off his cervical brace, and his fusion showed some bone consolidation. (PX10) On November 15, 2016, Dr. Coyle referred Petitioner for a course of physical therapy and range of motion exercises and gave him a prescription for Celebrex and Tylenol. (PX10, 11/15/16)

Petitioner was seen again on November 30, 2016, and Dr. Coyle noted that Petitioner had continued to experience pain in his low back, particularly on the right side, along with right-sided numbness in his toes. (PX10, 11/30/16) Dr. Coyle's neck examination showed only 60% to 70% of cervical rotation, but otherwise was reported as normal. *Id.* With regard to Petitioner's low back, he reported right-sided sciatic notch tenderness, and an MRI obtained the same day showed a small annular fissure at L5-S1. *Id.* Dr. Coyle recommended Mackenzie lumbar extension therapeutic exercises, and if those did not work, epidural injections. *Id.*

Petitioner saw Dr. Coyle again on January 26, 2017, and it was noted that Petitioner had been referred to Dr. Greg Smith for an epidural steroid injection at L5-S1. (PX10, 1/26/17) This initially flared up his symptoms, but gradually reduced them over time. *Id.* Dr. Coyle's cervical examination showed 90% of rotation to the right and 80% to the left with excellent strength, and he returned Petitioner to work observing normal safety precautions. *Id.* He believed that the next time saw Petitioner, he would be at maximum medical improvement from the standpoint of his cervical and lumbar spine. *Id.*

When Petitioner returned on February 21, 2017, Dr. Coyle noted ongoing low back complaints. (PX10, 2/21/17) Specifically, the activity of riding in a mantrip aggravated his low back and caused radicular symptoms down his right foot. *Id.* Based on these symptoms, Dr. Coyle recommended repeating an MRI scan of Petitioner's lumbar spine. *Id.* This was done on February 28, 2017, at Professional Imaging, and the radiologist's impression was similar to the prior MRI showing lumbar degenerative disc disease from L2-S1. (PX13) Dr. Coyle urged Petitioner to see his family physician/Dr. Lawler and have a complete blood count with a peripheral smear to rule out any abnormal conditions. (PX10, 2/28/17) Dr. Coyle noted that Petitioner wanted to get a second opinion, discharged him at maximum medical improvement, and returned him to work full duty with instructions to "observe normal safety precautions." *Id.*

Petitioner returned to his family physician, Dr. Lawler, in Marion, Illinois, who he saw on March 2, 2017. (PX9) He presented for two problems. *Id.* He reported to have a

cough/wheeze with sputum which was causing him to miss work. *Id.* Petitioner was also there for a referral for a second opinion on his spine. *Id.* Specifically, he stated, "Patient reports that the doctor that performed his surgery has messed him up." *Id.* He also noted that Petitioner was laid off from his job because of being injured. *Id.* He noted that Petitioner had undergone right shoulder and cervical surgery covered by workers' comp/St. Louis. *Id.* Petitioner also had continuing complaints of radiating pain in his lumbar spine. *Id.* Dr. Lawler recommended referral to a neurosurgeon at Barnes Hospital. *Id.* An addendum message in Dr. Lawler's notes showed that Petitioner called Barnes neurosurgery and tried to get an appointment, but "they do not do litigations." *Id.* Petitioner asked Dr. Lawler to refer him to Dr. Gornet. *Id.*

On May 4, 2017, Petitioner saw Dr. Matthew Gornet, a board certified spine specialist in St. Louis. Petitioner's main complaint was neck and low back pain, along with right shoulder pain mostly to the right trapezius and shoulder with stiffness and loss of motion. (PX14) Petitioner's low back pain was to the right side, right buttock, and intermittent tingling down his right anterolateral calf to his foot. Dr. Gornet took the history of the injury and noted that Dr. Collard had performed surgery on his right shoulder, and Dr. Coyle had performed a two-level fusion at C5-6/C6-7 on August 23, 2016. Petitioner told Dr. Gornet that the surgeries helped some of the numbness and pain in his forearm and hand and helped a portion of his shoulder pain; but his shoulder remained stiff with decreased range of motion, and he still had neck pain. He also advised Dr. Gornet that he was told he had an annular fissure in his back, but when he continued to have back pain, Dr. Coyle advised him nothing further should be done. Dr. Gornet reviewed cervical x-rays which showed the plate and screws in reasonable position; however, he noted a fissuring through the graft at C5-6. He also reviewed the pre-surgery MRI, which showed disc pathology with foraminal narrowing on the right and left at C5-6 and C6-7, but fragments at C3-4 and C4-5. He noted that the pre-surgery MRI contained no foraminal views. He also reviewed the MRI of the lumbar spine from November 30, 2016, and believed it showed a central herniation at L3-4, slightly to the right, and a suggestion of an annular tear centrally at L5-S1 while there was a central disc protrusion at L4-5 with the L2-3 level looking fairly clean. The MRI from February 28, 2017, continued to show the annular tear at L5-S1 and central disc protrusion slightly to the right at L3-4 along with fluid in the facet joint at L4-5. Dr. Gornet recommended a new CT scan of the cervical spine and recommended an MRI of the cervical spine with foraminal views, and potential CT discogram or MRI spectroscopy. (PX14)

Dr. Gornet also referred Petitioner to Dr. Nathan Mall for evaluation of his shoulder. (PX15) Dr. Mall saw Petitioner the same day, took the history and reviewed the right shoulder MRI, which he believed showed a subscapularis tear. Dr. Mall believed that an MRI arthrogram of the shoulder for further evaluation was warranted to explore the continued pain and weakness in his right shoulder. (PX15)

When Petitioner returned the same day to see Dr. Gornet after the CAT scan, Dr. Gornet noted a failed fusion at both C5 and C6. (PX14, 5/4/17) There was a rim around the screw on the right at C5, and rims around the top of the screws at C7. An MRI of the cervical spine showed

disc herniations at C3-4 and C4-5 foraminally. (PX17) This was consistent with the MRI of May 10, 2016, but was better visualized because of the additional foraminal views. Dr. Gornet stated:

> In short, this patient has continued disc pathology at C3-4 and C4-5 that is well-visualized as well as a failed fusion at C5-6 and C6-7. I believe this problem continues to be related to his original work related injury and subsequent treatment. Unfortunately, he has been unable to heal in spite of appropriate treatment and the use of BMP. He will require revision surgery in his cervical spine. I believe he will also require disc replacements at C3-4 and C4-5. As far as his low back, we will continue to monitor him with a new MRI and he will need an MRI arthrogram of his right shoulder. We will put all of this together. I have discussed all of this with him today. He is on light duty. He is definitely not at maximum medical improvement. (PX14, 5/4/17)

Both he and Dr. Mall believed that Petitioner was not at maximum medical improvement, and Dr. Gornet placed Petitioner on light duty with no lifting greater than 10 pounds and no overhead work. (PX14; PX15) Dr. Gornet believed Petitioner needed disc replacements at C3-4 and C4-5, as well as evaluation of his failed fusion at C5-6 and C6-7. (PX14) He noted that Dr. Mall was treating Petitioner's shoulder. *Id.*

Dr. Mall's follow-up visit of June 15, 2017, showed that Petitioner was still having shoulder pain, and his examination was markedly positive with only 3+/5 strength with subscapularis testing and pain to palpation over the biceps tendon. (PX15) He believed that Petitioner's biceps tendon was subluxing in the bicipital groove. An O'Brien's test was also positive. Dr. Mall reviewed the MRI performed prior to his initial surgery and believed it showed clear evidence of a subscapular tear. He also believed there was evidence of labral tearing. He reviewed the new MRI, which was an MRI arthrogram, and believed that Petitioner still had an unaddressed subscapularis tear, and the entire tendinous portion was torn from the lesser tuberosity. His biceps tendon was subluxing out of the bicipital groove, along with labral tearing superiorly and posteriorly. (PX15) Dr. Gornet and Dr. Mall both believed that Petitioner's symptoms were related back to his original accident. (PX14; PX15)

Surgery was performed by Dr. Mall on Petitioner's right shoulder on September 14, 2017, and Dr. Mall was rewarded with objective intraoperative findings of a completely torn subscapularis, and the lesser tuberosity was devoid of tissue. (PX7, 9/14/17) There was also extensive scarring surrounding the subscapularis, and Petitioner's biceps tendon was unstable anteriorly because of the subscapularis tear, and was subluxing into the rotator interval. *Id.* Dr. Mall performed extensive debridement of the subcoracoid space both superiorly and anteriorly of Petitioner's right shoulder labrum, extensive debridement/lysis of adhesions, along with a subscapularis repair. *Id.* Following surgery, Dr. Mall recommended physical therapy per status post subscapularis repair, and this was done at NovaCare rehabilitation. It was noted both in Dr. Mall's records and at Arbitration that this improved Petitioner's condition. (PX15) Dr. Mall's last visit with Petitioner was on March 7, 2018, and it was noted that Petitioner's strength had

improved to 5/5 with only a little bit of difficulty getting into the internal rotation position to test the push-off for the subscapularis. (PX15)

Dr. Mall believed that because Petitioner was still being worked up for his neck, he ordered proceeding with work conditioning at the completion of his cervical spine surgery. (PX15) If problems arose with his shoulder following the cervical surgery, he was welcome to be seen back; however, did not anticipate this happening. He recommended no further treatment to his right shoulder and placed him at maximum medical improvement for said body part. (PX15)

Petitioner returned to Dr. Gornet after shoulder surgery was completed. (PX14) Respondent then had Petitioner examined by Dr. Crane, who believed that Petitioner did not need his failed fusion repaired at C5-6, C6-7, or his adjacent discs. Dr. Gornet explained to Petitioner that the treatment of axial neck pain with cervical disc replacement was his specialty, and that the only way to treat the failed fusion would be making the area more structurally intact at C5-6, C6-7, along with C3-4 and C4-5. (PX14) Follow-up visits show that Dr. Gornet attempted to get approval for his surgeries. He believed that Petitioner's symptoms and disc abnormalities were present from the beginning, but were simply not seen because there were no foraminal views on the original MRI. (PX14)

On February 15, 2018, Dr. Gornet noted that Dr. Crane now agreed that Petitioner had a failed fusion from C5-C7, and recommended a posterior fusion; however, Dr. Gornet disagreed with said approach, believing it would lead to chronic pain and limit Petitioner's function. He continued to request approval for the surgery he recommended. (PX14)

Dr. Gornet performed surgery on April 18, 2018, and removed the hardware from C5 to C7, and redid Petitioner's fusion with plating and BMP. He also performed disc replacement surgery at C3-4 and C4-5. (PX18) Intraoperative findings showed dense scar tissue, which made the overall dissection extremely difficult, down to the plate and off to the right side, which compounded the entire dissection. Dr. Gornet removed the hardware and all screws, and noted there was no metal threading on the screws whatsoever. *Id.* Hence, they seemed loose in the bone and were easily removed. The findings at C3-4 and C4-5 showed foraminal herniations at both levels and disc replacements were fitted in Petitioner's cervical spine. With regard to the fusion, Dr. Gornet noted again that the plate was angled off to the right while the left-sided screw was actually at the center point. At C6-7, Dr. Gornet encountered the same problem and refitted the plate. *Id.* The entire procedure was videotaped. *Id.*

When Petitioner returned on May 3, 2018, he told Dr. Gornet he already felt a big difference from his preoperative symptoms, including his neck pain, particularly the right trapezius and right shoulder. (PX14) He showed Petitioner the intraoperative videos, including the scar tissue across both entire discs. He prescribed Petitioner pain medication and a bone stimulator, and continued to keep Petitioner off work. *Id.*

When Petitioner returned on July 26, 2018, he again reported to Dr. Gornet that he was doing reasonably well; however, still had some restriction in range of motion. (PX14) Dr. Gornet noted that Petitioner was still having low back pain to the right side, right buttock, and right hip. However, as long as his symptoms were tolerable, Dr. Gornet recommended simple observation. Petitioner's last visit with Dr. Gornet was on April 11, 2019, and he reported dramatic improvement compared to his pre-surgery state; however, still had a level of pain that affected him with overhead work. He told Dr. Gornet he was in vocational rehab. Dr. Gornet gave Petitioner permanent restrictions and placed him at maximum medical improvement with a 25 pound lifting limit and no overhead work.

Prior to trial, all medical issues were resolved, and Respondent acknowledged that Petitioner's condition was causally connected to work and agreed to pay all Petitioner's medical expenses, including the surgeries by Dr. Mall and Dr. Gornet pursuant to the Illinois Fee Schedule. As such, the issue before the Arbitrator is one of Petitioner's current vocational condition and the correct amount for a wage differential award.

Petitioner began a good faith job search in December of 2018. He was referred for vocational assistance in February 2019, and the initial vocational evaluation report was authored on February 18, 2019 by Timothy Kaver, a vocational rehabilitation counselor for England and Company. Both Petitioner and Respondent acknowledged that Petitioner has a restriction of no more than 25 pounds of lifting and no overhead work. Petitioner testified without rebuttal that his hobbies of lifting weights, bow hunting, helping with his child's football team, wrestling team and jujitsu sports have been adversely affected and curtailed. He does not participate in any of those outside activities.

From December until February, Petitioner looked for a job. He stated, "I just tried to find whatever I could, you know, to get a job, get my life back organized." (T.18) He did not have any success. After he met with Mr. Kaver, Mr. Kaver immediately got him on the Indeed website, helped him fill out applications, helped draft his resume, and advised him how to participate in interviews and look for a job. Petitioner testified he had been a coal miner for 16 years, and had no idea how to complete a resume. Prior to working in the coal industry, Petitioner worked at a grain processing plant processing corn and soy beans, which was also a heavy labor job.

Petitioner enrolled in computer classes at John A. Logan College and at Rend Lake College, both in Southern Illinois, at Mr. Kaver's direction. He completed his computer training skills on April 9, 2019, and advised Mr. Kaver he would like to move forward with direct job placement. In his April 4, 2019 report, he noted there were two potential job offers; one from All Seasons Ace Hardware and two from Precision Electrical, both in Benton, Illinois. In his May 2, 2019 vocational report, Mr. Kaver noted that Petitioner had been offered the position with Ace Hardware and accepted the job. This was a full-time job, no independent contracting, no self-employment, making $8.25 an hour consisting of cashiering, performing estimation on parts,

data entry for orders, customer service, helping customers locate parts, mixing paint, and cutting keys. Mr. Erwin's new employer was aware of Petitioner's prescribed work activity restrictions and indicated that the position was light-duty, no lifting greater than 25 pounds, and no overhead work. Following placement, Mr. Kaver continued to follow Petitioner to ensure that his re-entry into the labor force was going well. Petitioner testified at Arbitration: "They did a great job."

Petitioner also testified that he was aware of what a coal miner currently makes, as his brother-in-law works at Hamilton County Coal. He has secured a paystub from his brother-in-law, which was forwarded to Respondent, and testified without objection that coal miners are making $29 to $35 dollars an hour, not including overtime. (T.27)

On cross-examination, Petitioner acknowledged receipt of weekly checks from Respondent which made up the difference between his earnings for Respondent at the time of his injury, and his current employment. He testified that he received these payments and was ultimately paid up to date; however, the payments were not fluid. When asked by Respondent's counsel why he accepted an $8.25 an hour job while he was being paid TTD to look for work, Petitioner responded:

> Well, you know what, I don't like sitting at home. I'm a go-getter. I want to work. I want to feel like I'm providing for my family. I mean, I don't want to just sit at home. (T.32)

Respondent's counsel asked Petitioner if he had applied for any coal mine or other work that may have been out of his restrictions, and Petitioner candidly admitted that he had with the explanation that he hoped it would lead to something else with that company, perhaps "a warehouse job or something." (T.37) He acknowledged that Mr. Kaver discussed the option of retraining; however, he testified:

> Yeah, and I chose to – I'm not a school type person. I mean, I've worked heavy labor for 25 years. I mean, I would be starting all over. With four kids, it would be tough to start all over and go to school and do everything over. (T.37)

Mr. Kaver testified live at Arbitration. He is a Vocational Rehabilitation Counselor at England and Company Rehabilitative Service, and the parties stipulated that he possessed the requisite skills to testify. He indicated that he began working with Petitioner in December of 2018, performed some vocational testing, which included the wide-range achievement test, which tested Petitioner's reading at 7th grade level, arithmetic at 6th grade, spelling 4th grade, and also the adult basic learning examination called the "ABLE," which tests reading comprehension, with an equivalency of 7.6. Mr. Kaver testified that Petitioner's scores were not unusual for someone who had been out of school for an extended period of time, and because he did not read for pleasure, his reading skills had eroded.

Despite same, he testified that Petitioner was one of the most well-spoken, polite people that he has ever worked with, and that the tests did not measure IQ, but only his ability to read,

write, and do math. He acknowledged that Petitioner had limited transferrable skills due to his significant medical restrictions and because his past relevant employment all included heavy labor jobs. He anticipated that Petitioner would be employable with what he called "entry-level," a service related occupation that allowed for additional on-the-job training and movement up the ladder in the company, unless he went back to remedial training first to improve his reading skills, which "might take a year or two" and after that, go back to school. He acknowledged that he began by placing Petitioner in some remedial computer classes, which he completed, and that he found employment at Ace Hardware within his restrictions.

On cross-examination, Mr. Kaver acknowledged that Petitioner did not wish to go back to school, because there were no job goals identified that didn't involve returning to school. He believed that Petitioner could have been an electrician helper; however, it might involve overhead work for which he was not physically qualified, and an electrician helper position started at $9 an hour.

Respondent's counsel also asked Mr. Kaver about labor market surveys. In this case, he testified he did not perform a labor market survey, because he was actually contacting employers to obtain a job for Petitioner. He also testified that when Petitioner graduated from his computer skills training course, he was offered a position almost immediately and started work on May 5, 2019. He believed that Petitioner found a well-suited position that utilized his current skill-set, and that regardless of his position, Petitioner could expect to make anywhere from $8.25 to $10.00 an hour for an entry-level service-related job which allowed for additional training on the job with no previous experience. This was his opinion, because Petitioner had no transferrable skills in any other occupation besides entry-level training positions. Lastly, on re-direct examination, he testified that he continued to follow Petitioner to make sure that his job continued to be a good fit, that he was progressing and not having any difficulties. He stated:

> I tell you, I wish all my clients were as motivated as Ken Erwin because my job would be a lot easier than it is today. He was highly motivated, and I am very proud of him. (T.60)

Respondent had Petitioner's vocational efforts evaluated by Mr. Dan Minnich, a Vocational Rehabilitation Counselor located in Oak Forest, Illinois, a suburb of Chicago. He is the president of Aegis, a company which he owns. On direct examination, he testified he assists with job searches, develops vocational rehabilitation plans, and does so in conjunction with workers' compensation cases. (RX3, p.6) Limiting the area of inquiry to workers' compensation, he states that "pretty much all of it" is performed on behalf of employers. In civil litigation, he performs 85% to 90% of his work for employers or defendants. Although he lives in the suburbs of Chicago, he provides vocational services in Missouri, Southern Illinois, and several other states. He testified that he is familiar with the labor market in Southern Illinois as a result of his work done "down here." *Id.* at 7. He contacted Petitioner through his attorney and interviewed him with the understanding that Petitioner's work restrictions were a 25 pound lifting limit and

no overhead work. He testified he was "not too familiar" with the details of the injury, but believed Petitioner had received some treatment for his low back and shoulder. On February 6, 2019, he was unsure if Petitioner was performing a self-directed job search or participating in a formal vocational plan at the time. *Id.* at 10.

He testified that Petitioner was making $27 an hour at the time of the accident "but he said he earned a substantially higher income with overtime and bonuses or just overtime." He agreed with Petitioner taking computer classes and acknowledged, "Yeah, the fact that he couldn't work, couldn't return to his job, you know, so he's -- that's a tough -- that's a liability in a case where a person can't go back to their job or company." *Id.* at 13.

Mr. Minnich consulted the Dictionary of Occupational Titles, a resource that he and others rely on in providing vocational counseling services, which he acknowledged had been "updated last in the 90's and 80's." *Id.* at 14-15. He identified the Dictionary of Occupational Titles (DOT) codes that corresponded with Petitioner's work at the coal mine and at Bethel Grain and input this information into his report. *Id.* at 14-15. After doing so, he inserted the data into a "SkillTRAN" report, which is a computer program that limits its search to a physical limitation and factors in all the other attributes demonstrated in Petitioner's work history and focus on the ones that are appropriately related to him. *Id.* at 14-15.

Mr. Minnich testified that Petitioner's labor market was a 60 mile radius from his home, probably as far south as Cape Girardeau. *Id.* at 17. After he reviewed the SkillTRAN report, he narrowed his labor market survey down to jobs that could be identified locally. *Id.* at 18. He also completed a transferrable skills analysis, which he testified included management, supervisory work, sales work other than just retail sales. *Id.* at 19. He believed that Petitioner had such transferrable skills even though Petitioner has been a heavy laborer for the past 25 years. Mr. Minnich testified that he was able to identify available occupations for Petitioner that were comparable to his earnings at the time of his injury. *Id.* at 19-20. He testified that there were occupations out there in management and sales that could potentially reach the $100,000.00 level with experience; but from his basic search of physical jobs that were actually in the marketplace, it would be realistic for Mr. Erwin to get back into a job between $40,000 and $55,000 a year. *Id.* at 20.

Mr. Minnich testified he received this wage information from the Illinois Department of Employment Security. *Id.* at 20. He then had an assistant review the job titles and reach out to prospective employers in the labor market to verify employment wages and physical capacities. *Id.* at 22-23. He claimed that this added to his transferrable skills analysis by identifying direct contacts to verify that the information is accurate. *Id.* at 23. When asked how those wages compared with the wages he saw in the Department of Employment Security Data, he testified that the wages were consistent with the IDES published wages and consistent with the wages he personally found. *Id.* at 25. No specific job was identified. *Id.* He believed that Petitioner's job search logs were flawed because Petitioner was contacting employers that were not hiring. *Id.* at

26-27. He believed it would take 10 to 15 contacts before Petitioner developed a single job lead and to do that required a significant effort during the day, or a full-time effort. *Id.* He also was critical that Petitioner's job search logs provided no job titles. *Id.*

He noted that Petitioner's testing done by Mr. Kaver, which he described as a "one-day paper and pencil test" showed that Petitioner's reading comprehension was 7th grade, 4th grade spelling, 6th grade math, and 7th grade reading. *Id.* at 28-29. He objected to using the results of that test to restrict Petitioner in any way, when he had allegedly demonstrated in his work history significant reasoning math and academic performance. *Id.* He stated:

> . . . I would use his demonstrative performance in his work history as a much more reliable indicator of his future goals and future job placement than a one-time paper-and-pencil test, that's all. I mean, because sometimes people have a hard time taking tests. It's not as reliable as what people have already demonstrated they can do. *Id.* at 28-29.

He believed that Petitioner should be looking for management, sales, and supervisory work, and specifically identified companies that were hiring and put in applications. *Id.* at 29-30.

In August of 2019, after Petitioner found employment with the help of Mr. Kaver, Mr. Minnich was asked by Respondent to evaluate Petitioner's current options. He testified that Petitioner was now making $18 or $19 short of what he was making per hour at the mine, and "a lot less" than what he was making in total yearly compensation at the mine. *Id.* at 31-32. Although the job was within Petitioner's restrictions, it was not what he would classify as a "suitable occupation" for Petitioner. *Id.* at 31-32. Ultimately, he believed that in his opinion, Petitioner should have continued to look for work until he found an occupation that would lead to a career transition and mitigate against a wage loss using his "transferrable job skills." *Id.* at 33-34. He admitted, however, that Petitioner had an opportunity to make progress into management in his current position. *Id.* at 32-33. He noted:

> It has a lot of positive opportunities for Mr. Erwin. He's demonstrated in his past work history that he started off -- for example, his first job at the food production plant, he started there as a bagger or something, a clerk there too, and then a few years later he was a manager with a lot of responsibilities. So this job could turn into that on its own. He could -- it could develop into a general -- I could easily see him being a general manager of an Ace Hardware store. So that's something you always want to keep as an option or as a possibility. *Id.* at 32-33.

He then testified that he primarily objected to his employment at Ace Hardware because of the income level Petitioner started at. *Id.* at 33.

When asked if he recommended Petitioner quit his job and begin a job search all over again, he answered, "No." *Id.* at 34. He then testified that having a job was a good thing and added to Petitioner's resume. *Id.* at 34. When asked what his recommendation would be in terms of a future job search to meet his vocational goal, he indicated that the vocational counselor

would have to really advocate for him and assist him with identifying quality job leads, quality job interviews, and perform more specialty work than Petitioner was capable of doing on his own. *Id.* at 35-36.

On cross-examination, Mr. Minnich confirmed that 100% of his work was done for employers, and no injured workers' attorney had every contacted him in the 23 years since he'd been doing vocational work. *Id.* at 40-41. He didn't think it was strange that no injured worker or an attorney had contacted him since 1992 for job search assistance. *Id.*

Mr. Minnich believed that Petitioner was working full time, but he was unaware if he worked overtime, and testified he simply reviewed Mr. Kaver's report. Although he prepared a report, he was unaware of any attempt by Respondent to offer his services to Petitioner. When asked about the specific jobs in the labor market survey and their availability, he indicated that he had not verified it as of the time of his deposition, but they were available when contacted directly. Unfortunately, none of this was ever communicated to Petitioner. The last time he checked to determine if these jobs were available was in March, and he testified by way of deposition in November. He testified that in order for Petitioner to obtain a job earning more money, a vocational expert would have to cultivate existing opportunities at Ace Hardware, and/or develop real and unique opportunities with high-level employers that would be willing to call and schedule interviews at a time convenient for Petitioner. Since Mr. Minnich is based in Oak Forest, his education and training would be performed on remote basis with an occasional meeting in person, and then "because he's as capable as he is, he would be able to do a self-directed job search with just the training that we'd provide him." Respondent never offered to assist in Petitioner's vocational efforts although it knew as early as December 2018 that Petitioner was performing a self-directed job search and shortly thereafter began receiving vocational rehabilitation assistance.

CONCLUSIONS OF LAW

Issue (L): What is the nature and extent of the injury?
Issue (O): Is Petitioner's current § 8(d)1 employment suitable; and are the vocational expenses following May 5, 2019 reasonable?

Respondent does not dispute that Petitioner is disabled from pursuing his usual and customary occupation. Respondent disputes the suitability of the outcome Petitioner's vocational rehabilitation plan and the resulting wage differential benefits.

Pursuant to the Act, when an employee sustains a compensable work-related injury, the employer "shall also pay for treatment, instruction and training necessary for the physical, mental and vocational rehabilitation of the employee, including all maintenance costs and expenses incidental thereto." 820 ILCS 305/8(a). When vocational rehabilitation is required, it is the Petitioner who "retains the right to choose their vocational counselor." *Scoville v. D.C. Elec.*

of Benton, 11 I.W.C.C. 0331 citing *Passas v. Kirby School Dist. # 140,* 94 WC 5553; 01 IIC 0178; *Hollins v. Aurora East School Dist. 131,* 07 IWCC 0382; *Hir v. City of Joliet,* 04 IIC 0614.

Petitioner's chosen vocational counselor, Timothy Kaver, testified that Petitioner's past relevant work experience in heavy labor provided no transferrable skills that would allow him to transition to another field above "entry level" work. He tested Petitioner's abilities in reading, arithmetic, spelling, and reading comprehension. Petitioner scored at grade school level at all categories, which Mr. Kaver testified was not unusual for a person who did not engage in recreational reading and had been out of school for as long as Petitioner had. The Arbitrator finds his opinion credible in light of Petitioner's work history and permanent restrictions of no overhead work and no lifting greater than 25 pounds.

The Arbitrator is not persuaded by the opinion of Dan Minnich, who believed that Petitioner could simply transition to a managerial level position despite his test results, lack of transferrable skills or past relevant/recent work experience, or his physical limitations in a competitive job market. Mr. Minnich sought to diminish the weight of the testing performed by Mr. Kaver and supplant it with anecdotal and superfluous testimony regarding Petitioner's potential. However, the Arbitrator cannot make findings based on such speculative data. Mr. Minnich also acknowledged: "I could easily see him being a general manager of an Ace Hardware store. So that's something you always want to keep as an option or as a possibility." (RX3, p.32-33) Based upon the evidence above, the Arbitrator finds that Petitioner has obtained suitable employment within his restrictions and vocational abilities and entitled to a wage differential award pursuant to § 8(d)1 of the Act. With respect to Respondent's dispute of Mr. Kaver's charges after obtained employment, the billing statements reflect that these were charges incurred during follow-up contacts and consultations. The Arbitrator finds it reasonable for Mr. Kaver as Petitioner's vocational counselor to follow up with Petitioner and ensure that his employment is suitable for Petitioner and consistent with his permanent restrictions.

The parties also disagree as to the amount of wage differential benefits Petitioner is entitled to. The Act states that Petitioner is entitled to "66 2/3% of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged in at the time of the accident and the average amount which he is earning or is able to earn in some suitable employment or business after the accident." 820 ILCS 305/8(d)1. Although Respondent argues that Petitioner is able to earn $40,000.00 per year based on the testimony of Mr. Minnich, based on the above findings as to the credibility of Mr. Minnich's vocational assessment, the Arbitrator finds that the appropriate method of determining Petitioner's wage differential award is to calculate two thirds (2/3) of the difference between Petitioner's current average weekly wage and his former average weekly wage working for Respondent.

Petitioner currently earns $8.25 an hour, yielding an average weekly wage of $330.00 and a weekly difference of $1,112.07 from his prior average weekly wage of $1,442.07. Two thirds of $1,112.07 yields a wage differential of $741.40.

Respondent shall therefore pay the expenses of Mr. Kaver pursuant to § 8(a) of the Act, pay Petitioner's mileage expenses, and continue to pay wage differential benefits pursuant to 8(d)(1) of the Act in the amount of $741.40 per week until Petitioner reaches the age of 67. Respondent shall have credit for the vocational, mileage, and maintenance expenses already paid.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC008650
Case Name	ADAMS,EULA v. CITY OF CHICAGO DEPT OF
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0267
Number of Pages of Decision	14
Decision Issued By	Maria Portela, Commissioner,

Petitioner Attorney	John Powers
Respondent Attorney	Donald Chittick

DATE FILED: 6/7/2021

/s/ Maria Portela, Commissioner
Signature

DISSENT

/s/ Thomas Tyrrell, Commissioner
Signature

21IWCC0267

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

EULA ADAMS,

Petitioner,

vs. NO: 15 WC 8650

CITY OF CHICAGO, DEPT. OF WATER MGT.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, temporary total disability benefits, and permanent partial disability 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 Commission affirms the Arbitrator's decision as to accident, causation, medical expenses and total temporary disability benefits. However, the Commission modifies the award for the lumbar spine from 4% person as a whole to a loss of 2% person as a whole.

The Commission modifies the Arbitrator's analysis under section 8.1b(b) as follows:

i) As no AMA rating report was admitted into evidence, the Commission also gives no weight to this factor.
ii) Petitioner was employed as a data entry operator prior to the accident and was able to return to the same position in a full capacity post-accident, so the Commission also gives some weight to this factor.
iii) Petitioner was 65 at the time of the accident. The Commission also gives some weight to this factor.
iv) There was no evidence regarding a loss of earnings as a result of the February 26, 2015 work accident. The Commission also gives no weight to this factor.
v) As a result of the February 26, 2015 work accident, Petitioner was seen at MercyWorks on February 27, 2015 and was diagnosed with a low back contusion and bilateral hip sprains. (Px2) On March 12, 2015, Petitioner followed up with

Dr. Goldvekht who diagnosed lumbar discogenic pain and prescribed physical therapy. (Px3) By April 9, 2015, Petitioner reported that the physical therapy was helping, though her diagnosis remained unchanged and guarded. (Px3) By May 14, 2015, Petitioner reported that "she is no longer experiencing pain or discomfort in her lower back. She reports that bending, lifting, carrying, pushing and pulling no longer aggravates her pain or discomfort. She stated that her pain is 0/10." (Px3). Petitioner underwent conservative treatment and per the note of Dr. Goldvekht, was released with no pain. The Commission gives this factor greater weight.

Based on the above, and specifically, the documented complete resolution of Petitioner's symptoms from her injuries due to her work-related accident, the Commission modifies the award of permanency from 4% loss of a person as a whole to a 2% loss of use of a person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $616.59 per week for a period of 2 5/7 weeks, from February 26, 2015, through March 17, 2015, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $554.93 per week for a period of 10 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 2% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $7,476.00 for medical expenses under §8(a) of the Act, subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that 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 $14,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

June 7, 2021 /s/ *Maria E. Portela*

MEP/dmm
O: 042021
49

/s/ *Kathryn A. Doerries*

DISSENT

I respectfully dissent from the opinion of the majority and would affirm and adopt the Decision of the Arbitrator. After carefully considering the totality of the evidence, I believe Petitioner met her burden of proving the February 26, 2015, work incident caused her to sustain a 4% loss of use of the whole person.

Petitioner worked as a data entry operator for Respondent for 22 years. On the date of accident, she sustained an injury when she fell to the floor after her chair rolled away as she tried to sit down. Petitioner was diagnosed with a low back contusion and bilateral hip sprains. Petitioner's complaints were treated conservatively with medication, physical therapy, and work restrictions. Petitioner participated in almost two months of physical therapy and was placed at MMI by her treating physician on May 14, 2015. While Petitioner was able to return to her normal job without any restrictions, Petitioner credibly testified that she still experiences chronic pain due to the February 26, 2015, work incident. Petitioner also testified that while she has good days and bad days, she often wakes up sore and stiff.

After considering the totality of the evidence, I believe Petitioner met her burden of proving she sustained a 4% loss of use of the whole person. While she was able to return to work full duty and her injury required only conservative treatment, I believe the majority's conclusion that Petitioner sustained only a 2% loss of use of the whole person disregards the extent of Petitioner's residual complaints. Petitioner continues to frequently deal with chronic symptoms relating to the work injury. The Arbitrator correctly analyzed the evidence pursuant to Section 8.1b(b) and appropriately considered the medical evidence as well as Petitioner's credible testimony regarding her chronic residual symptoms.

For the forgoing reasons, I would affirm and adopt the Decision of the Arbitrator in its entirety. Petitioner met her burden of proving she sustained a 4% loss of use of the whole person due to the February 26, 2015, work incident.

/s/ *Thomas J. Tyrrell*
Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ADAMS, EULA
Employee/Petitioner

Case# **15WC008650**

CITY OF CHICAGO DEPT WATER MANAGEMENT
Employer/Respondent

On 4 22 2019, 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 2.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1067 ANKIN LAW OFFICE LLC
JILL WAGNER
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60602

0010 CITY OF CHICAGO LAW DEPT
D TAYLOR CHITTICK
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

21IWCC0267

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

EULA ADAMS
Employee/Petitioner

v.

CITY OF CHICAGO, DEPT. WATER MANAGEMENT
Employer/Respondent

Case # **15** WC **8650**

Consolidated cases: **n/a**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **MARCH 5, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **FEBRUARY 26, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$48,226.39**; the average weekly wage was **$924.89**.

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

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

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

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

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

ORDER

As detailed in the attached memorandum discussing the *Findings of Fact and Conclusions of Law:*

- The Arbitrator finds the Respondent shall pay the Petitioner TTD benefits at a rate of **$616.59** per week for a period of **2 5/7 weeks**, as provided in **Section 8(b)** of the Act.; and,

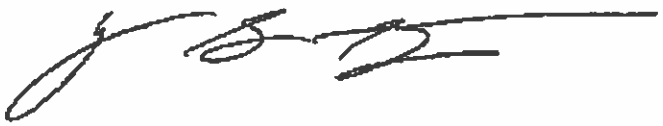
- The Arbitrator finds the Respondent shall pay Petitioner the sum of **$554.93** per week for a further period of **20 weeks**, as provided in **Section 8(d)2** of the Act, because the injury to the Petitioner caused a **4% loss of use of the person-as-a-whole.**; and,

- The Arbitrator finds the Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $4,932.12 to Advanced Physical Medicine, $1,749.89 to EQMD, Inc., and $793.99 to MercyWorks, as provided in Sections 8(a) and 8/2 of the Act. (AX 1 and PX 1); and,

- The Respondent shall pay those benefits that have accrued in a lump sum, and shall pay the remainder, 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

APRIL 18, 2019
Date

APR 2 2 2019

EULA ADAMS v. CITY OF CHICAGO DEPT. OF WATER MANAGEMENT

15 WC 8650

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried before Arbitrator Steffenson on March 5, 2019. The issues in dispute were accident, causal connection, medical bills, TTD, and the nature and extent of the injury. (Arbitrator's Exhibit 1). The parties agreed to receipt of this Arbitration Decision via e-mail and requested a written decision, including findings of fact and conclusions of law, per Section 19(b) of the Act. (Arbitrator's Exhibit (*hereinafter*, AX) 1).

FINDINGS OF FACT

The Petitioner, Eula Adams, (*hereinafter*, "Petitioner"), was a 65-year-old[1] woman who worked for Respondent, City of Chicago Department of Water Management (*hereinafter*, "Respondent"), as a data entry operator for 22 years. In that capacity, she entered the data collected from the field workers into the Respondent's database.

She testified that in that position, she normally was worked in a cubicle with a desk, a standard wheeled computer chair, and carpeting underneath. However, on February 26, 2015, due to renovations at her assigned workstation, she was assigned to a new, temporary cubicle. This cubicle also had a desk and a wheeled computer chair but had a tile surface underneath.

On February 26, 2015, she had just finished lunch and was coming back to her work station to return to work. She went to sit down in the chair at her temporary work station and the chair rolled out from underneath her. She tried to catch the chair but failed to do so and fell to the ground, landing on her buttocks. She testified that the tile floors in her temporary cubicle made it much easier for the chair to roll. She never had any problems in her normal cubicle with carpet. She immediately reported the injury to her supervisor, Brian Konkoleski,

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[1] A *Request for Hearing* form, prepared by the parties, was admitted into evidence. (AX 1). However, it fails to list the Petitioner's age "(a)t the time of injury, ...". (AX 1). However, this can be calculated as her birthday appears on those medical records admitted into evidence and her accident report. (*See* Petitioner's Exhibits 2 and 3, *and* Respondent's Exhibit 1).

who filled out an accident report. (Respondent's Exhibit (*hereinafter*, RX) 1). During cross examination, the Petitioner testified that there were no defects in the chair.

The next day she presented to Mercy Works and saw Dr. Homer Diadula. (Petitioner's Exhibit (*hereinafter*, PX) 2). She gave a consistent mechanism of injury and was diagnosed with a lower back contusion and bilateral hip sprains, status post fall. (PX 2). An x-ray was done, and she was given pain medications and taken off work. (Id.). She followed up on March 5, 2015 with continued low back pain complaints. (Id.). Dr. Diadula continued to recommend pain medications, physical therapy, and off work restrictions. (Id.).

The Petitioner then presented to Dr. Aleksandr Goldvekht at Advanced Physical Medicine on March 12, 2015 for a second opinion. (PX 3). Dr. Goldvekht diagnosed her with lumbar discogenic pain and recommended pain medications, physical therapy, and off work restrictions through March 17, 2015. (PX 3). The Petitioner underwent a course of physical therapy from March 21, 2015 through May 13, 2015 at Advanced Physical Medicine. (Id.). On April 9, 2015, Dr. Goldvekht continued to recommended pain medications and to continue her course of physical therapy. (Id.). On May 14, 2015, Dr. Goldvekht noted that physical therapy had helped her back pain and she was placed at maximum medical improvement (MMI). (Id.).

The Petitioner testified that she returned to work with the Respondent as a data entry operator, earning the same amount of money. The Petitioner testified that she still has pain as of the date of trial. She testified that she has good days and bad days, but that she will often wake up stiff and sore as a result of the injury. She testified that she never received temporary total disability benefits for the time she was off and that her medical bills have not been paid as of the date of trial.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

Issue C: *Accident*

The Arbitrator finds that the accident arose out of and in the course and scope of the Petitioner's employment with the Respondent. To obtain compensation under the Act, a claimant must show by a preponderance of the evidence that she has suffered a disabling injury arising out of and in the course of her employment. Both elements must be present at the time

of the claimant's injury to justify compensation. *IL Bell Telephone Co. v. Indust. Comm'n.*, 131 Ill.2d 478, 483 (1989). 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, are generally deemed to have been received "in the course" of the employment. *Caterpillar Tractor Co. v. Indust. Comm'n.*, 129 Ill.2d 52, 57 (1989). The "arising out of" component refers to the origin of cause of the claimant's injury and requires that the risk be connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. *Id.* at 58.

The Illinois Workers' Compensation Commission has consistently held that in "wheeled chair" cases where the Petitioner's work environment creates an increased risk of harm, the "arising out of and in the course of" requirement of the Act is met and the injury compensable. *See Gossett v. Hoopeston Mem. Hosp.*, 01 WC 32621, 2005 Ill. Wrk. Comp. LEXIS 3006 (2005); *Diaz v. IL State Police*, 93 WC 47795, 1998 Ill. Wrk. Comp. LEXIS 101 (1998); and, *Lanahan v. Alexian Brothers Medical Center*, 6 IWCC 305, 2005 Ill. Wrk. Comp. LEXIS 297 (2006).

In *Gossett*, the Petitioner was attempting to sit down on a wheeled chair that was located on a tiled floor when she grabbed the chair and it shot out from under her, causing her to fall. *Gossett v. Hoopeston Mem. Hosp.*, 01 WC 32621, 2005 Ill. Wrk. Comp. LEXIS 3006 (2005). In that case, the Commission found that the Petitioner sustained an accident that arose out of and in the course of her employment by the Respondent. *Id.* In finding accident, they held that the risk of injury in that case was enhanced due to the tile flooring, which made the chair more likely to roll out from a person. *Id.*

Similarly, the Petitioner was placed in an environment where she had an enhanced risk of injury. The Petitioner's unrebutted and credible testimony establishes that she was moved to a temporary work station with a wheeled chair from one that had carpet to one that had tile flooring. She testified that the tile flooring made the chair move more easily and resulted in her accident on February 26, 2015. She did not have any problems with the wheeled chair at her station that had carpet. On that date, she was coming back from lunch and attempted to sit down at her desk to her resume her work. When she went to sit down, the chair rolled from under her causing her to fall and injure herself. As such, the Arbitrator finds her temporary work station created an increased risk of harm peculiar to the Petitioner's work environment and she was therefore injured in an accident that arose out of and in the course of her employment by Respondent.

Issue F: *Causal connection*

The Arbitrator finds that the Petitioner's current condition of ill-being is causally related to her work accident. A causal connection between work duties and a condition of ill-being may be established by a chain of events including Petitioner's ability to perform the duties before the date of the accident, and inability to perform the same duties following that date. *Pulliam Masonry v. Industrial Comm'n.*, 77 Ill.2d 469, 471 (1979).

The Petitioner injured herself on February 26, 2015 when she attempted to sit down at her desk and the chair rolled away from under her causing her to fall and land on the ground. She immediately told her supervisor, who filled out an accident report. She presented to Dr. Homer Diadula at Mercy Works the following day, gave a consistent history of her accident, and was diagnosed with a low back contusion and bilateral hip strains, status post fall. (PX 2). Dr. Diadula recommended pain medications and off work restrictions "due to her work related condition." (PX 2). She followed up on March 5, 2015 with continued pain complaints and was again recommended pain medications, off work restrictions, and a course of physical therapy. (Id.).

The Petitioner presented for a second opinion with Dr. Aleksandr Goldvekht at Advanced Physical Medicine on March 12, 2015. (PX 3). Dr. Goldvekht noted a consistent history and diagnosed her with lumbar discogenic pain and continued her pain medications, physical therapy, and off work restrictions through March 17, 2015. (PX 3). She again followed up with him on April 9, 2015, and May 14, 2015, at which point he released her at MMI. (Id.).

The Arbitrator finds the Petitioner has proven that her current condition of ill being is causally related to her work accident on February 26, 2015. The Petitioner sought medical treatment immediately after the work accident and received consistent care through May 14, 2015. There is no evidence to suggest that any other mechanism of injury in this case is responsible for her current condition of ill-being and the Respondent produced no evidence that the Petitioner became symptomatic by anything other than her work injury. Thus, the Arbitrator finds that the Petitioner's current condition of ill being is causally related other February 26, 2015 work injury.

Issue J: *Medical bills*

The Arbitrator finds the medical services provided to the Petitioner have been reasonable and necessary. Due to her work-related injury, the Petitioner required treatment in the form of doctor's visits, diagnostic testing, medication, and physical therapy. Following her

course of treatment, the Petitioner was released at MMI as of May 14, 2015. These services are both reasonable and necessary in light of the Petitioner's injuries and there is no evidence in the record refuting the reasonableness and necessity of the treatment. Further, as of her release date, her pain had diminished, further evidencing the necessity of her treatment.

Accordingly, the preponderance of credible evidence establishes that the Petitioner sustained a low back contusion and bilateral hip sprains because of her work injury. The Arbitrator therefore finds the Petitioner's medical care has been reasonable and necessary and the Respondent has not paid all appropriate charges. (AX 1). At trial, the Petitioner produced an itemization of all medical bills that remained unpaid. (PX 1). As the treatment she received is deemed reasonable and necessary, the Arbitrator hereby awards the Petitioner those medical bills incurred as a result of this work-related injury. (AX 1 and PX 1).

Issue K: *TTD*

The Arbitrator finds that the Petitioner is entitled to TTD benefits from February 26, 2015 through March 17, 2015, a period of 2 5/7 weeks. The Petitioner has shown by a preponderance of credible evidence that her current condition of ill-being is causally related to her work injury. The Petitioner initially was taken off work by Dr. Diadula on February 27, 2015. (PX 2). She was continued off work by Dr. Aleksandr Goldvekht through March 17, 2015. (PX 3). The Petitioner testified she never received TTD benefits from the Respondent for the time that she was off work. (Transcript at 21). The Petitioner's medical records also establish that she was off work from February 27, 2015 through March 17, 2015 and is entitled to TTD benefits for a period of 2 5/7 weeks.

Issue L: *Nature and extent of injury*

Pursuant to Section 8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability ("PPD"), for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all 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 from (a) above;
(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.

(See 820 ILCS 305/8.1b)

With regards to factor (i) of Section 8.1b of the Act:

i. The Arbitrator notes that no AMA rating report was admitted into evidence by either party. As such, the Arbitrator gives ***no weight*** to this factor.

With regards to factor (ii) of Section 8.1b of the Act:

ii. The Arbitrator finds the Petitioner was employed as a data entry operator and was able to return to work at that position in a full duty capacity as of March 17, 2015. As such, the Arbitrator gives ***some weight*** to this factor.

With regards to factor (iii) of Section 8.1b of the Act:

iii. The Arbitrator notes that the Petitioner was 65 years old at the time of the accident. (*Compare* AX 1 *and* Transcript (*hereinafter*, T.) at 12 *and* PX 2 *and* PX 3). The Arbitrator therefore gives ***some weight*** to this factor.

With regards to factor (iv) of Section 8.1b of the Act:

iv. The Arbitrator notes that the Petitioner returned to employment in her pre-injury position as a data entry operator without loss of income. Furthermore, the record is devoid of any evidence of an impairment of earnings because of this February 26, 2015 work accident. As such, the Arbitrator therefore gives ***no weight*** to this factor.

With regards to factor (v) of Section 8.1b of the Act:

v. Evidence of disability corroborated by the treating medical records finds that the Petitioner was diagnosed with a low back contusion and bilateral hip sprains. (PX 2). However, Dr. Goldvekht only diagnosed her with lumbar discogenic pain and made no mention of any positive bilateral hip findings. (PX 3). Furthermore, the Petitioner informed Dr. Goldvekht on May 14, 2015 she "is no longer experiencing pain or discomfort in her lower back." (PX 3). She also only testified

to lower back pain complaints at trial. (T. at 22-23). Due to the Petitioner's medically documented injuries and other physical complaints, the Arbitrator therefore gives ***moderate weight*** to this factor.

Based on the above factors, and the entire record, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of a **4% loss of use of the person-as-a-whole** pursuant to **Section 8(d)2** and Section 8.1b of the Act.

Signature of Arbitrator

APRIL 18, 2019
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC019228
Case Name	VALENTINE, NATALIE v. COUNTRY CLUB HILLS POLICE DEPT
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0268
Number of Pages of Decision	25
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Chris Cooper
Respondent Attorney	Emilio Campos

DATE FILED: 6/7/2021

/s/Deborah Baker, Commissioner

Signature

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 Causation, Medical Expenses, Temporary Disability	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NATALIE VALENTINE,

Petitioner,

vs. NO: 18 WC 19228

COUNTRY CLUB HILLS POLICE DEPT.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed under section 19(b) of the Act by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, the reasonableness and necessity of medical treatment, prospective medical care, temporary disability, and penalties pursuant to sections 19(k) and 19(l) and being advised of the facts and law, modifies the Decision of the Arbitrator as set forth below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

At the outset, the Commission notes that at the Arbitration hearing, the parties stipulated that Petitioner sustained an accident that arose out of and in the course of his employment with Respondent on April 13, 2018, and as such, the Commission did not address this issue.

The Arbitrator found that "Petitioner's current condition is not causally connected to this [April 13, 2018] work accident" and in the Order section of the Decision of the Arbitrator ("Decision"), denied Petitioner's claim for unpaid medical bills, prospective medical care, temporary total disability ("TTD"), and penalties. In the Conclusions of Law section of the Decision, the Arbitrator found that "[a]ll medical treatment regarding Petitioner's pre-existing lumbar spine degenerative disc disease and right knee degenerative joint disease [was] not reasonable, necessary and causally connected to work." Further, the Arbitrator found that Petitioner reached maximum medical improvement ("MMI") relative to the lumbar spine condition

by January 16, 2019, per Dr. Singh's section 12 addendum report, and "[a]ny lost time subsequent to 1/16/19, including any alleged TTD benefits, is not causally connected to any compensable injury…" The Arbitrator denied Petitioner's claim for penalties (Petitioner's counsel did not seek attorneys' fees) as Respondent paid Petitioner TTD benefits from April 13, 2018, the date of accident, to January 16, 2019. The Commission views the evidence differently and modifies the Decision with respect to the issues of causal connection, medical expenses, and TTD. The Commission affirms the Decision with respect to the issues of prospective medical care and penalties.

The Commission finds that Petitioner testified to sustaining injuries to her lumbar spine (lower back), right leg (associated with her lumbar spine complaints), and right hip at the time of the undisputed April 13, 2018 work accident. The Commission finds that at the arbitration hearing, Petitioner did not testify to sustaining injuries to her right knee as a result of the undisputed accident. Based on the medical records, it is clear that Petitioner had preexisting lumbar spine and right hip conditions. Pre-accident medical records in evidence show Petitioner had treatment to her right hip and lumbar spine on numerous occasions prior to the undisputed work accident. (Pet.'s Ex. 3.) Additionally, Petitioner testified she did not dispute that she had a preexisting lower back condition. (Tr. 29-30, 33, 43-52) Thus, the issue before the Commission is whether Petitioner's current condition of ill-being to her right hip and lumbar spine (and need for lumbar spine surgery) was caused by the undisputed work-related accident on April 13, 2018, or in the alternative, caused by Petitioner's pre-existing conditions. The Commission agrees with the Arbitrator in finding that Petitioner's current condition of ill-being to the lumbar spine is not causally related to the undisputed work accident (the Decision did not address the right hip condition). However, the Commission finds the evidence demonstrates that the April 13, 2018 work accident temporarily aggravated Petitioner's preexisting lumbar spine (including right leg radicular symptoms as associated with her lumbar spine condition) and right hip conditions.

Petitioner's lumbar spine and right hip conditions were documented in the Country Club Hills Police Department's incident reports from April 13, 2018. (Resp.'s Ex. 8.) Additionally, Petitioner treated for both lumbar spine and right hip complaints at South Suburban Hospital Emergency Room immediately following the accident. (Resp.'s Ex. 6 at 42, 51)

With respect to Petitioner's right hip condition, Petitioner continuously complained of right hip pain while primarily treating for her lumbar spine condition at Ingalls Hospital and the Veterans Administration Medical Center ("VAMC") between April 2018 and October 2018. (Pet.'s Ex. 3; Resp.'s Ex. 5.) On October 1, 2018, Petitioner returned to the VAMC and reported complaints of right hip and groin pain as well as lower back pain. (Pet.'s Ex. 3.) The progress note states that Petitioner was scheduled for an orthopedic consult at an outside facility. *Id*. On October 15, 2018, Petitioner sought treatment with Dr. Christos Giannoulias with complaints of severe right hip pain. (Pet.'s Ex. 1.) Dr. Giannoulias recommended that Petitioner undergo MRIs to both hips to see if Petitioner had osteonecrosis or another type of pathology. *Id*. On November 26, 2018, Petitioner underwent bilateral hip MRIs and both MRIs showed no significant abnormality. *Id.* On December 3, 2018, Petitioner returned to Dr. Giannoulias who reviewed the November 26, 2018 MRIs of both the right and left hips. *Id.* Dr. Giannoulias opined that the MRI showed no evidence of pathology and no labral tear or fracture in the right hip. *Id.* Dr. Giannoulias opined that "more likely than not the symptoms that she explains, in the right leg in particular, is from her L5-S1 disc

herniation…" *Id.* Dr. Giannoulias recommended that Petitioner follow up with pain management and released Petitioner from care. *Id.* The Commission finds that based on a chain of events analysis, Petitioner's preexisting right hip condition was temporarily aggravated by the April 13, 2018 work accident and resolved as of December 3, 2018. Accordingly, the Commission finds that Petitioner is entitled to medical expenses for treatment to the right hip from April 13, 2018 through December 3, 2018.

With respect to Petitioner's lumbar spine condition, Petitioner had objective spinal pathology before the April 13, 2018 accident. (Pet.'s Ex. 3.) Specifically, on April 10, 2018, Petitioner underwent a lumbar spine MRI, which showed a disc protrusion at L5-S1 causing mild spinal canal stenosis and underwent an EMG that suggested bilateral S1 radiculopathy. *Id.* Following the April 13, 2018 accident, Petitioner treated for complaints of lower back pain that radiated into her bilateral lower extremities. On November 12, 2018, Dr. Kern Singh, Respondent's section 12 examiner, diagnosed Petitioner with lumbar strains, released Petitioner to work with a 20-pound lifting restriction, and requested a copy of the lumbar spine MRI that Petitioner underwent on July 23, 2018. (Pet.'s Ex. 1., Resp.'s Ex. 1.) On January 16, 2019, Dr. Singh issued an addendum report stating that he had reviewed the July 23, 2018 lumbar spine MRI, which showed an L5-S1 central disk protrusion without evidence of any central or foraminal stenosis. *Id.* Dr. Singh diagnosed Petitioner with a lumbar muscular strain, which had resolved, and an L5-S1 central disc protrusion which he opined to be preexisting in nature. *Id.* Dr. Singh opined that Petitioner had reached MMI and could work full duty without restrictions. *Id.*

The Commission agrees with the Arbitrator that Petitioner suffered a soft tissue strain and the spinal pathology for which she was referred to a surgeon prior to the April 13, 2018 work accident is not causally related to the accident. Further, the Commission concurs with the Arbitrator's finding that with respect to her lumbar spine condition, Petitioner reached MMI on January 16, 2019, the date of Dr. Singh's section 12 examination addendum report. However, the Commission finds that this conclusion requires that benefits be awarded for treatment obtained on the date of accident through the date of MMI. Accordingly, the Commission finds that Petitioner is entitled to medical expenses for treatment to her lumbar spine (lower back) from April 13, 2018 through January 16, 2019. Additionally, the Commission finds that Petitioner is entitled to temporary total disability benefits from April 14, 2018 through January 16, 2019. The Commission notes that the record shows Respondent paid Petitioner TTD benefits from April 14, 2018 through January 16, 2019 and is owed a credit. (Resp.'s Ex. 3.)

Finally, the Commission strikes the following sentence on page fifteen (15) of the Arbitrator's decision: "Accordingly, any claim by the Petitioner for benefits under the Act is denied."

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 19, 2020, as modified above, is hereby affirmed.

IT IS FURTHER ORDERED BY THE COMMISSION that as a result of the undisputed April 13, 2018 work accident, Petitioner sustained a temporary aggravation to her preexisting right

hip condition that resolved on December 3, 2018, and a temporary aggravation to her preexisting lumbar spine (lower back) condition, which included right leg radicular symptoms, that resolved on January 16, 2019.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the reasonable and necessary medical expenses for treatment of Petitioner's right hip condition from April 13, 2018 through December 3, 2018 as provided in §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the reasonable and necessary medical expenses for treatment of Petitioner's lumbar spine (lower back) condition from April 13, 2018 through January 16, 2019 as provided in §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $170.89 per week for a period of 39 and 5/7 weeks, representing April 14, 2018 through January 16, 2019, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b), 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 Petitioner's claim for penalties under sections 19(k) and 19(l) of the Act is denied.

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 including a credit of $6,762.35 for temporary total disability and $2,000.00 for other benefits already paid.

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.

JUNE 7, 2021

/s/ *Deborah J. Baker*
Deborah J. Baker

DJB/cak

O:4/7/21

/s/ *Stephen J. Mathis*
Stephen J. Mathis

43

/s/ *Deborah L. Simpson*
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0268
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

VALENTINE, NATALIE Case# **18WC019228**
Employee/Petitioner

COUNTRY CLUB HILLS POLICE DEPT
Employer/Respondent

On 2/19/2020, 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 1.51% 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 GUMBINER INJURY LAW GROUP
CHRIS COOPER
180 N MICHIGAN AVE SUITE 2100
CHICAGO, IL 60601

2542 BRYCE DOWNEY & LENKOV LLC
KEVIN KAUFMAN
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF **COOK**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

NATALIE VALENTINE
Employee/Petitioner

v.

COUNTRY CLUB HILLS POLICE DEPARTMENT
Employer/Respondent

Case # **18** WC **19228**

Consolidated cases: **n/a**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **AUGUST 20, 2019 and AUGUST 27, 2019**. 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. [ ] Is Respondent due any credit?

O. [ ] Other _____

FINDINGS

On the date of accident, **APRIL 13, 2018**, 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 $**8,886.20**; the average weekly wage was $**170.89**.

On the date of accident, Petitioner was **56** 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 $**6,762.35** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**2,000.00** for other benefits, for a total credit of $**8,762.35**.

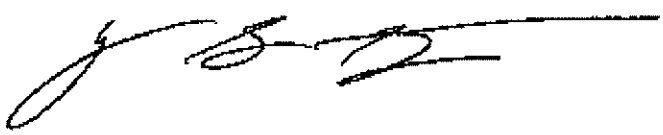
ORDER

As detailed in the attached memorandum discussing the *Findings of Fact and Conclusions of Law:*

- The Arbitrator finds Petitioner's current condition is not causally connected to this work accident. Accordingly, any claim by the Petitioner for benefits under the Act is denied.; and,
- Petitioner's claim that Respondent is liable for unpaid medical bills is denied.; and,
- Petitioner's claim for Prospective medical care is denied.; and,
- Petitioner's claim for TTD benefits is denied.; and,
- Petitioner's claim for penalties and attorneys' fees is denied.

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

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



Signature of Arbitrator

FEBRUARY 18, 2020
Date

ICArbDec19(b)

FEB 19 2020

NATALIE VALENTINE v. COUNTRY CLUB HILLS POLICE DEPARTMENT

18 WC 19228

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried on the Petitioner's Section 19(b)/8(a) Petition before Arbitrator Steffenson on August 20 and August 27, 2019. The issues in dispute were causal connection, medical bills, prospective medical care, Temporary Total Disability (TTD) benefits, and penalties and attorneys' fees. (Arbitrator's Exhibit 1). The parties requested a written decision, including findings of fact and conclusions of law, pursuant to Section 19(b) of the Act. They also agreed to receipt of this Arbitration Decision via e-mail. (Arbitrator's Exhibit (*hereinafter*, AX) 1).

FINDINGS OF FACT

A. Accident

Petitioner testified that she is employed by Respondent, Country Club Hills Police Department, and performs traffic and crowd control duties as well as duties as a booking officer. (Transcript at 15-16). Petitioner was working for Respondent on April 13, 2018. (Transcript (*hereinafter*, TR at 17). Petitioner was clearing the parking lot of Club 183 when she pulled in front of a car with her overhead lights on. (TR at 17). Petitioner's vehicle was parked approximately ten feet away from the other vehicle. (Respondent's Exhibit 8). Petitioner took off her seatbelt to get out of the car when the other vehicle moved forward and hit her car head-on. (TR at 17). Petitioner felt immediate lower back, right hip and right leg pain. (TR at 18). She reported the pain was sharp and became throbbing. (TR at 18). Petitioner went to South Suburban Hospital via ambulance. (TR at 19).

B. Treatment

1. Advocate South Suburban Hospital

On 4/13/18, Petitioner was treated on the scene of a motor vehicle accident by paramedics. (Respondent's Exhibit (*hereinafter*, RX) 6). Petitioner reported being rear-ended by another vehicle at close range. (RX 6). Petitioner reported that airbags were not deployed. (RX

6). Petitioner denied loss of consciousness and reported no head or neck pain. (*Id.*). Petitioner complained of lower back pain which she described as pre-existing. (*Id.*). Petitioner was ambulatory at the scene and requested to be taken to the hospital for evaluation. (*Id.*). Dr. Kimberly Booker diagnosed back strain and noted that Petitioner had a prescription for Norco previously written on 3/29/18. (*Id.*). Dr. Booker noted that spine x-rays showed no acute findings. (*Id.*). Dr. Booker ordered Petitioner to continue taking Norco for pain and prescribed Flexeril. (*Id.*). Dr. Booker discharged Petitioner from care and referred her to her primary care physician, Dr. Mehta. (*Id.*).

2. Ingalls Memorial Hospital

On 4/17/18, Petitioner saw Dr. Fred Richardson and reported that she was hit from behind while on duty. (RX 5). Petitioner complained of 8/10 lower back pain and 7/10 right rib cage pain with motion or deep breathing. (*Id.*). Petitioner described her pain as aching and reported she considered it to be moderate. (*Id.*). Dr. Richardson observed the Petitioner ambulated with a walker. (*Id.*). Dr. Richardson diagnosed:

1. Lower back muscle, fascia and tendon strain;
2. Rib sprain. (*Id.*).

Petitioner reported working full duty before the accident and that she did not feel she could return to full duty. (*Id.*). Dr. Richardson prescribed physical therapy three times per week for three weeks and returned Petitioner to work with restrictions of no lifting, pulling, pushing or carrying more than five pounds and no repetitive motions. (*Id.*).

3. Ingalls Care Center

On 4/18/18, Petitioner saw Ms. Latoya Duncan, APN and reported lower back, right hip and neck pain. (RX 7). Petitioner reported that her back pain was interfering with her work and her mobility, but that she had limitations from chronic back pain with a long history of conservative management including physical therapy and epidural injections. (RX 7). Petitioner reported using a walker for community ambulation for approximately six months before the April 13, 2018 accident. (*Id.*). Petitioner was approved for treatment but opted to transition her care to the Veterans Administration (VA) health services after just this initial evaluation and was discharged from care at Ingalls on 5/30/18. (*Id.*).

4. Illinois Orthopedic Network

On 7/11/18, Petitioner saw Dr. Sajjad Murtaza and complained of lower back pain, cervical neck pain, bilateral knee pain and left ankle pain. (Petitioner's Exhibit 3). Petitioner reported a history of lower back pain and right knee pain but reported that her pain was well controlled before the April 13, 2018 motor vehicle accident. (Petitioner's Exhibit (*hereinafter*, PX) 3). Petitioner reported that her right knee pain was severely exacerbated after the accident. (PX 3). Petitioner reported that it had been over a year since her last MRI. (*Id.*). Dr. Murtaza ordered a spinal MRI and a right knee MRI. (*Id.*). Dr. Murtaza prescribed Diclofenac and recommended physical therapy two to three times per week for four weeks. (*Id.*). Dr. Murtaza also authorized Petitioner off work. (*Id.*).

On 8/8/18, Petitioner saw Dr. Murtaza and reported continued cervical neck pain and bilateral knee pain. (PX 3). Dr. Murtaza reviewed Petitioner's cervical spine MRI and right knee MRI and diagnosed:

1. L5-S1 2 mm circumferential disk bulge with superimposed 3.4 mm broad based posterior central protrusion;
2. Impinging of the ventral thecal sac causing mild bilateral neural foraminal stenosis, facet arthropathy and ligamentum flavum hypertrophy;
3. Right knee lateral meniscal tear with equivocal extension into the posterior horn;
4. Right knee minimal degenerative fraying along the free edge margin of the posterior horn of the medial meniscus near the posterior root attachment;
5. Right knee tricompartment osteoarthritis;
6. Right knee irregularity of the ACL consistent with previous trauma, joint effusion and a partially ruptured Baker's cyst;
7. Right knee grade 1 fraying of the medial collateral ligament. (PX 3).

Dr. Murtaza prescribed Diclofenac, continued Petitioner's physical therapy and continued her off work status. (PX 3).

On 8/27/18, Petitioner saw Dr. Christos Giannoulias and reported lower back pain and right knee pain. (PX 3). Dr. Giannoulias diagnosed:

1. Right knee arthrosis;
2. Right knee meniscus degeneration;
3. Low back pain. (PX 3).

Dr. Giannoulias did not recommend surgical intervention for Petitioner's right knee but provided injections of both Depo-Medrol and lidocaine. (*Id.*).

On 10/23/18, Petitioner returned to Dr. Murtaza and reported worsening back pain from a preexisting condition and new onset of right leg pain. (PX 1). Petitioner reported that her right leg pain has gotten progressively worse and that it went down to her foot, causing numbness. (PX 1). Dr. Murtaza reviewed a previous MRI and noted a preexisting disk bulge and a superimposed disk herniation at L5-S1 causing central and neural foraminal stenosis. (*Id.*). Petitioner reported that her prior physical therapy had been beneficial. (*Id.*). Dr. Murtaza recommended a left paramedian transforaminal steroid injection and continued physical therapy. (*Id.*).

On 12/3/18, Petitioner returned to Dr. Giannoulias. (PX 1). Dr. Giannoulias reviewed the results of Petitioner's bilateral hip MRIs and noted that he did not find any evidence of hip pathology. (PX 1). Dr. Giannoulias opined that Petitioner's complaints were due to her L5-S1 disc herniation. (*Id.*). Dr. Giannoulias recommended Petitioner follow up with pain management to discuss the possibility of additional injections and a discectomy. (*Id.*).

On 12/6/18, Petitioner again returned to Dr. Murtaza and reported ongoing lower back pain. (PX 1). Petitioner reported a pending L5-S1 transforaminal epidural injection and requested a signed surgical consult due to her limited relief from the previous injections at the VA. (PX 1). Petitioner reported daily low back pain and associated right leg pain exacerbated by prolonged laying, sitting or walking. (*Id.*). Petitioner reported that she used a cane to ambulate due to her pain level. (*Id.*). Dr. Murtaza recommended a consultation with a spinal surgeon and ordered Petitioner to continue physical therapy. (*Id.*).

On 1/25/19, Petitioner saw Dr. Kevin Koutsky and reported lower back pain that radiated down both lower extremities. (PX 1). Petitioner reported that her symptoms began after the April 13, 2018 motor vehicle accident. (PX 1). Petitioner reported that her symptoms continued to be disabling and interfered with her function. (*Id.*). Dr. Koutsky reviewed Petitioner's 7/23/18 lumbar spine MRI and 11/26/18 bilateral hip MRIs.[1] (*Id.*). Dr. Koutsky diagnosed L5-S1 disk herniation and right lower extremity radiculopathy and recommended lumbar decompression surgery. (*Id.*).

On 2/8/19, Petitioner returned Dr. Koutsky and reported limited improvement of her symptoms. (PX 1). Dr. Koutsky again recommended lumbar decompression surgery based on his

[1] Despite the voluminous records discussed below in "D. Previous Treatment," Dr. Koutsky only noted the Petitioner's past medical history as being: "(s)ignificant for hypertension." (PX 1).

review of Petitioner's 7/23/18 lumbar spine MRI and history of failed conservative treatment. (PX 1).

On 3/18/19, Petitioner saw Dr. Shoeb Mohiuddin and reported lower back pain with radiation down the bilateral lower extremities. (PX 2). Petitioner reported experiencing symptoms following the April 13, 2018 motor vehicle accident but did not provide any information regarding her prior treatment. (PX 2). Petitioner reported 9/10 pain that was worse with activity. (*Id.*). Dr. Mohuiddin referred Petitioner to a spinal surgeon. (*Id.*).

On 3/3/19, Petitioner saw Dr. Koutsky and underwent an electrodiagnostic evaluation. (PX 2). Dr. Koutsky found evidence of right S1 radiculopathy, but no evidence of distal right leg peripheralneuropathy. (PX 2). On 3/29/19, Petitioner returned to Dr. Koutsky and reported continued 8/10 lower back pain with radiation into the right leg. (*Id.*). Dr. Koutsky recommended an L5-S1 laminectomy/discectomy, a home exercise program and authorized Petitioner off work. (*Id.*).

5. South Suburban Physical Therapy

On 8/17/18, Petitioner saw Dr. Tyra Horner for an initial physical therapy evaluation. (PX 3). Petitioner reported 8/10 lower back pain and 7/10 right knee pain. (PX 3). Dr. Horner noted that Petitioner's prior history of back pain and degenerative arthritis would complicate her recovery and extend her required treatment. (*Id.*). Dr. Horner prescribed physical therapy three times per week for four weeks. (*Id.*). Thereafter, between 8/17/18 and 1/28/19, Petitioner presented for six physical therapy appointments. (*Id.*).

6. Edward Hines VA

On 4/19/18, Petitioner saw Dr. Annu Mehta and reported acute back pain after being involved in a motor vehicle accident on April 13, 2018. (PX 3). Petitioner reported that she previously treated at South Suburban Hospital and Ingalls Care Center and was diagnosed with a neck strain and back strain. (PX 3). Petitioner reported that she attended physical therapy the day before and it helped. (*Id.*). Dr. Mehta diagnosed possible back strain and ordered Petitioner to maintain her current prescriptions. (*Id.*). Petitioner requested a work status note and Dr. Mehta authorized Petitioner off work. (*Id.*).

On 4/21/18, Petitioner saw Dr. Shruti Singh and reported cervical neck pain. (PX 3). Petitioner reported that she went to the OSH ED earlier in the day and drove to the VA ED after that visit. (PX 3). Petitioner reported that cervical spine x-rays taken at OSH ED were normal.

(*Id.*). Dr. Singh reviewed Petitioner's cervical spine x-rays and found no abnormality. (*Id.*). Dr. Singh diagnosed muscle spasms and prescribed Cyclobenzaprine. (*Id.*).

On 4/23/18, Petitioner saw Mr. Richard Lawley, PT, and reported increased neck pain and that she did not take Norco that morning due to her driving to her physical therapy appointment. (PX 3). Mr. Lawley found Petitioner to be hypotensive and sent her to the ED where she was admitted for intractable pain and low blood pressure. (PX 3). Petitioner underwent cervical spine x-rays that were unremarkable. (*Id.*). Dr. Jonathan Sachs diagnosed hypotension related to Petitioner's poor nutrition combined with her medication intake. (*Id.*). Dr. Sachs also diagnosed neck strain, continued Petitioner's medications and ordered a home stretching exercise program. (*Id.*). On 4/25/18, Petitioner reported that her pain was manageable and was discharged. (*Id.*).

On 5/4/18, Petitioner saw Ms. Deidre Rickelman and reported that her Hydrocodone prescription was not due to be refilled until 5/10/18 and she had already run out. (PX 3). Dr. Mehta prescribed a lower dose of Hydrocodone until Petitioner's regular prescription was ready on 5/10/18. (PX 3).

On 5/10/18, Petitioner saw Dr. David Alfieri and reported that her neck soreness had almost completely resolved but that she had worsened lower back pain. (PX 3). Petitioner reported that she had been experiencing improvement with physical therapy but that she had not returned to physical therapy since the April 13, 2018 motor vehicle accident. (PX 3). Dr. Alfieri opined that operative intervention would not be beneficial for Petitioner's symptoms and recommended continued conservative treatment. (*Id.*).

On 6/6/18, Petitioner saw Ms. Sally Stelsel, PT, and reported increased lower back and right hip pain. (PX 3). Ms. Stelsel noted Petitioner's cervical mobility and pain were mild/moderately worsened since her 12/17 evaluation. (PX 3). Ms. Stelsel recommended skilled therapy once a week for eight weeks. (*Id.*). On 6/11/18, Petitioner requested refills of all of her medications. (*Id.*). Petitioner's request was denied as Petitioner previously broke her narcotic contract by receiving prescriptions from other facilities according to an investigation by Illinois State Prescription Monitoring. (*Id.*). On 8/13/18, Petitioner underwent a bilateral lumbar epidural steroid injection by Dr. James Huang. (*Id.*).

7. MRI studies

On 11/26/18, Petitioner underwent a right hip and left hip MRIs (PX 1). Dr. Amjad Safvi found no significant abnormalities. (PX 1).

8. Dr. Kern Singh

On 11/12/18, Dr. Singh, a board-certified orthopedic surgeon, performed a Section 12 examination. (RX 1). Dr. Singh reviewed records and images from both before and after Petitioner's April 13, 2018 motor vehicle accident. (RX 1). Petitioner reported 5/10 mid back pain, 8/10 lower back pain and right leg parathesias. (*Id.*). Petitioner reported previous lower back issues that had resolved. (*Id.*). Petitioner reported that her pain was constant and increased with walking. (*Id.*). Petitioner reported that her pain kept her from walking distances, bending forward, lying on her back, sleeping at night, riding in a car and putting on socks. (*Id.*). Dr. Singh diagnosed both a lumbar muscle strain and a L5-S1 central disk protrusion. (*Id.*). Dr. Singh noted that Petitioner also was positive for symptom magnification. (*Id.*). Dr. Singh found no causal connection between Petitioner's subjective complaints or current state of ill-being and the April 13, 2018 motor vehicle accident, concluded Petitioner was at maximum medical improvement (MMI), and found no objective basis for Petitioner needing ongoing work restrictions. (*Id.*).

C. Current Condition

Petitioner testified that her current symptoms are:

1. Lower back pain (6/10);
2. Right hip pain (6/10);
3. Right leg numbing and tingling;
4. Right foot intermittent numbing (daily);
5. Left foot intermittent numbing (daily).

Petitioner is limited in her ability to:

1. Play catch with her grandchildren;
2. Bowl;
3. Take long walks;
4. Stand for long periods of time;
5. Go dancing.

D. Previous Treatment

On 7/17/15, Petitioner saw Ms. Latha Panicker, NP, at Edward Hines VA and reported chronic lower back pain. (PX 3). Petitioner reported previous injection for lower back pain and requested a "pain shot". (PX 3). Petitioner reported working three jobs and that she drove a squad car for one of these jobs. Petitioner reported her pain was exacerbated by sitting while driving. (*Id.*).

On 9/2/15, Petitioner saw Dr. Kunal Shah at Edward Hines VA Women's Health Clinic and reported lower back pain. (PX 3). Dr. Shah diagnosed likely partial disc herniation or nerve root impingement despite minor MRI findings. (PX 3). Dr. Shah prescribed aggressive PT and core strengthening. (*Id.*).

On 9/16/15, Petitioner saw Dr. Adam Kapler at Edward Hines VA for neurology consult. (PX 3). Dr. Kapler performed a lumbar spine MRI and found:

1. Tarlov cyst S2-S3;
2. L4-5 mild-to-moderate facet hypertrophy without significant foraminal narrowing;
3. L5-S1 mild-to-moderate facet hypertrophy without significant foraminal narrowing;
4. No cord compression or significant stenosis (PX 3).

On 10/23/15, Petitioner saw Ms. Sally Stelsel, PT, at Edward Hines VA and complained of right lower back pain and buttock pain. (PX 3). Petitioner reported that the pain started in December of 2014 when she started a second job. (PX 3). Petitioner reported functional limitations including difficulty tolerating job duties and occasional significant pain with average daily activities. (*Id.*). Petitioner reported a change in her work schedule and did not appear for her prescribed physical therapy sessions. (*Id.*).

On 12/11/15, Petitioner saw Mr. Aaron Brown at Edward Hines VA for a kinesiotherapy consult and reported having right shoulder, right hip and right knee pain for several years. (PX 3). Petitioner reported that she thought that she had a torn meniscus and that she had arthritis in her right hip and right knee. (PX 3).

On 1/15/16, Petitioner saw Dr. Angel Gierut-Speyer at Edward Hines VA and reported continued chronic lower back pain that she related to her job. (PX 3). Dr. Gierut-Speyer prescribed Hydrocodone. (PX 3).

On 4/6/16, Petitioner saw Dr. Fatima Ahmed at Edward Hines VA Emergency Department and reported having 7/10 bilateral hip pain for the prior two weeks. (PX 3). Petitioner reported a prior rheumatoid arthritis diagnosis and Dr. Ahmed prescribed Norco for Petitioner's pain. (PX 3).

On 4/10/16, Petitioner saw Dr. Mai Hanh Edward Hines VA ED and reported exacerbated left hip pain due to being on her feet all day at her new job as a security officer. (PX 3). Dr. Hanh performed an examination, diagnosed possible trochanteric bursitis, and prescribed Medrol dose pack. (PX 3).

On 11/29/16, Petitioner saw Dr. John Leuthner at the Edward Hines VA Pain Clinic and complained of lower back pain with radiation down the right hip and right lower extremity. (PX 3). Petitioner described her lower back pain as nagging, constant and tight. (PX 3). Petitioner reported an electric, taser-like sensation in the right leg. (*Id.*). Dr. Leuthner reviewed a 10/16 spinal MRI that showed:

1. L5-S1 large, central protrusion, 8.5 mm AP diameter, with indentation of the dural sac and mild central stenosis with no foraminal stenosis;
2. L4-5 diffuse disc bulge with mild central stenosis, hypertrophic facets and ligamentum flavum. Diffuse disc bulge extended into the bilateral foramina with bilateral mild foraminal stenosis. (*Id.*).

On 12/16/16, Petitioner saw Dr. James Huang at Edward Hines VA and underwent a lumbar epidural steroid injection for her chronic lower back pain. (PX 3). Petitioner reported 7/10 to 10/10 stabbing, aching bilateral hip pain. (PX 3). Petitioner reported that her pain was worse with walking and standing for a long time. (*Id.*).

On 2/13/17, Petitioner contacted the Edward Hines VA Telephone Triage and reported 12/10 lower back pain that she characterized as a "tearing and ripping". (PX 3).

On 2/14/17, Petitioner saw Mr. Kamaal Jones at Edward Hines VA and reported acute worsening of her chronic lower back pain. (PX 3). Petitioner reported that she was not interested in surgical intervention. (PX 3). Petitioner reported having a mechanical fall in 12/16 that she treated with epidural injections. (*Id.*). Petitioner reported that the injections wore off, causing 10/10 pain. (*Id.*). Mr. Jones noted extensive atherosclerotic calcifications in Petitioner's aorta leading to increased risk for lumbar spine degenerative disc disease and the development of atherosclerosis in other areas. (*Id.*).

On 3/2/17, Petitioner saw Dr. Annu Mehta at Edward Hines VA and reported 8/10 lower back pain that was always present. (PX 3). Dr. Mehta diagnosed lumbar radiculopathy and ordered Petitioner to restart taking Gabapentin and increased her Hydrocodone dosage. (PX 3).

On 3/22/17, Petitioner saw Dr. Nermeen Aziz at Edward Hines VA Pain Clinic and reported increased pain with standing and walking. (PX 3). Petitioner underwent a L5-S1 right paramedian interlaminar epidural steroid injection. (PX 3).

On 6/3/17, Petitioner was hospitalized at Edward Hines VA for acute chronic abdominal pain. (PX 3). Petitioner's Admission Assessment noted abnormal musculoskeletal findings and that Petitioner reported that she needed a walker to walk longer distances. (PX 3).

On 6/21/17, Petitioner saw Dr. Melanie Querubin at Edward Hines VA and reported 8/10 lower back pain. (PX 3). Petitioner reported that her pain was worse with sudden movement, lying supine, walking and prolonged standing. (PX 3). Petitioner reported that in March of 2017 her pain worsened significantly. (*Id.*). Petitioner denied any trauma and reported that the pain started when she started foot patrol. (*Id.*). Dr. Querubin diagnosed chronic lower back pain due to spondylosis with radiculopathy on the right L5/S1. (*Id.*). Dr. Querubin noted that Petitioner ambulated with a walker and prescribed physical therapy twice a week for four weeks. (*Id.*).

On 7/21/17, Petitioner saw Dr. David Kelton at Edward Hines VA ED and reported worsened lower back pain that radiated down her right leg. (PX 3). Dr. Kelton gave Petitioner a Toradal injection and prescribed Tramadol. (PX 3).

On 8/9/17, Petitioner saw Dr. Lindsay Wilkinson at Edward Hines VA and underwent bilateral sacroiliac joint steroid injection under fluoroscopy. (PX 3).

On 8/17/17, Petitioner saw Dr. Ryan Hofler at Edward Hines VA and reported bilateral leg pain and leg fatigue with walking and that she had to sit after about one block, but she was able to walk farther with a walker. (PX 3). Dr. Hofler did not recommend neurosurgical intervention as Petitioner exhibited symptoms that would preclude neurosurgical intervention prior to further work up and treatment. (PX 3).

On 10/23/17, Petitioner saw Dr. Srira Muthukrishnan at Edward Hines VA and reported 5% relief from the 8/9/17 bilateral sacroiliac joint steroid injection. (PX 3). Petitioner reported that she used a walker to ambulate long distances and had to modify activities of daily living. (PX 3). Dr. Muthukrishnan prescribed physical therapy twice a week for six weeks. (PX 3).

On 11/9/17, Petitioner saw Dr. James Huang at Edward Hines VA and underwent a lumbar epidural steroid injection. (PX 3).

On 11/22/17, Petitioner saw Ms. Stelsel at Edward Hines VA for a physical therapy consult and reported continued lower back pain. (PX 3). Petitioner reported that her pain was worse with standing and walking more than a couple minutes. (PX 3). Petitioner reported being limited with her job duties, sleep, activities of daily living and community mobility. (*Id.*). Petitioner reported her physical therapy goals as gaining strength and eliminating the use of her walker. (*Id.*).

On 1/3/18, Petitioner saw Ms. Joanne Latko, PA, at Edward Hines VA and reported left ankle and right knee pain. (PX 3). Petitioner reported that a 2012 right knee MRI showed meniscal tears. (PX 3). Ms. Latko diagnosed mild right knee degenerative joint disease with meniscal tears and performed a right knee corticosteroid injection. (*Id.*).

On 1/25/18, Petitioner saw Dr. Kaitlin Wanta at Edward Hines VA ED and complained of diffuse lower back and right hip pain. (PX 3). Petitioner reported that she recently treated at OSH for similar pain and was prescribed Diclonfenac and a Lidocaine patch. (PX 3). Petitioner reported increase pain with walking, especially while at work. (*Id.*). Petitioner reported that she ran out of Norco the night before and requested a refill of her prescription and a requested a lumbar epidural. (*Id.*). Dr. Wanta referred Petitioner to Dr. Mehta and discharged her from care. (*Id.*).

On 2/1/18, Petitioner saw Dr. Mehta and reported that she was not satisfied with her pain management. (PX 3). Petitioner reported that her pain affected her mobility, mood, personal care, physical activity, relationships with others, sexual functioning, sleep, social activities and work. (PX 3). Dr. Mehta increased Petitioner's Hydrocodone dosage and prescribed physical therapy. (*Id.*).

On 4/4/18, Petitioner saw Dr. Elyse Brinkman at Edward Hines VA and reported chronic right knee pain. (PX 3). Petitioner reported clicking and popping in the right knee and that the right knee occasionally gave way. (PX 3). Petitioner requested a corticosteroid injection in the right knee and Dr. Brinkman performed the procedure. (*Id.*).

On 4/10/18, Petitioner saw Dr. Jasvinder Chawla at Edward Hines VA and discussed the results of lumbar spine MRI and EMG (PX 3). Dr. Chawla found:

1. L5-S1 broad-based central/bi-paracentral disc protrusion causing mild spinal canal stenosis, deformation of the ventral thecal sac, narrowing of the bilateral lateral recesses and mild bilateral foraminal stenosis;
2. L4-5 broad-based disc bulge with mild flattening of the ventral thecal sac and moderate bilateral neural foraminal narrowing;
3. Bilateral S1 radiculopathy that could not be fully evaluated as Petitioner declined the needle portion of the exam. (PX 3).

At the conclusion of this appointment, and three days prior to her April 13, 2018, work accident, Petitioner agreed to seek a consult from a neurosurgeon (PX 3).

Petitioner testified that she had lower back pain prior to the April 13, 2018 accident and described her pain as "lower back pain coming not so much on the right, some spurs, you know, bone spurs." (TR at 30)." Petitioner testified that a few days before the April 13, 2018 accident, through physical therapy, her lower back pain had resolved, and she was released to work full duty. (TR at 32). Petitioner used a wheeled walker to ambulate for approximately six months before the 4/13/18 accident (TR at 39). Petitioner testified that she would have been able to play catch with her grandchildren, take long walks and go dancing the day before the April 13, 2018 accident (TR at 48).

E. Surveillance

Erik Duncan, a licensed private investigator and custodian of records with PhotoFax, Inc., played video clips of Petitioner obtained between 6/28/19 and 7/1/19.

1. On 6/28/19, Petitioner removes a wheeled walker from the trunk of her car and carries it to her residence. (RX 9). Petitioner carries a roll of paper towels, a purse, a cane, and a lunch bag from her residence to her vehicle and drives away in the vehicle. (RX 9). Petitioner again carries a large object from her vehicle into her residence and pushes her walker to her residence without using it for support. (*Id.*). Petitioner carries shopping bags from her vehicle to her residence. (*Id.*). Petitioner shows no signs of difficulty.
2. On 6/29/19, Petitioner drives her vehicle and carries a purse and a bag into her residence. (*Id.*). Petitioner show no signs of difficulty.
3. On 6/30/19, Petitioner drives her vehicle. (*Id.*). Petitioner shows no signs of difficulty.
4. On 7/1/19, Petitioner drives her vehicle and bends down to pick up a package. (*Id.*). Petitioner shows no signs of difficulty.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

Issue F: *Causal connection*

The Arbitrator finds that Petitioner's current condition **is not causally related** to the 4/13/18 work accident. The Arbitrator further finds that Dr. Singh's opinions, as expressed in his Section 12 report, are more credible than those of Dr. Koutsky.

Dr. Singh is a board-certified orthopedic surgeon. He reported that Petitioner had normal spinal examination and that her 7/23/18 spinal MRI revealed an L5-S1 disk protrusion without evidence of neural compression. Dr. Singh could not objectify Petitioner's subjective pain complaints. Dr. Singh diagnosed a soft tissue lumbar strain and concluded that Petitioner reached MMI and could work full duty without restrictions. Dr. Singh completed his Section 12 examination on 11/12/18 and had more information regarding Petitioner's pre-existing conditions than Dr. Koutsky.

In addition, Petitioner's treating doctors support Dr. Singh's opinions:

1. On 4/13/18, Dr. Booker diagnosed back strain;
2. On 4/17/19, Dr. Richardson diagnosed back strain and rib strain;
3. On 4/19/18, Dr. Mehta diagnosed back strain and neck strain;
4. On 4/21/18, Dr. Singh diagnosed muscle spasms;
5. On 4/23/18, Dr. Sachs diagnosed neck strain;
6. On 6/6/18, Ms. Stelsel noted that Petitioner's cervical mobility and pain were mild/moderately worse than they were in December of 2017.

Dr. Koutsky's opinions lack credibility because he did not review Petitioner's medical records or diagnostic imaging that preceded her April 13, 2018 accident. Dr. Koutsky's 1/25/19 visit notes indicate that Petitioner's symptoms **began** after a work-related motor vehicle accident on 4/13/18. Dr. Koutsky reviewed Petitioner's 7/23/18 lumbar spine MRI and 11/26/18 bilateral hip MRI but did not review images from before the accident. In his 2/8/19 visit notes, Dr. Koutsky notes that Petitioner presented with symptoms related to her L5-S1 disk protrusion and right lower extremity radiculopathy but fails to acknowledge Petitioner's condition predated her April 13, 2018 accident. In explaining the basis for his surgical recommendation, Dr. Koutsky relies on Petitioner's multiple rounds of physical therapy and

multiple injections with little long-term improvement but ignores that many of those treatments occurred well before her April 13, 2018 accident.

It is essential to highlight that Petitioner underwent a lumbar spine MRI and EMG with Dr. Chawla on 4/10/18, three (3) days before her accident. Dr. Chawla found:

1. L5-S1 broad-based central/bi-paracentral disc protrusion causing mild spinal canal stenosis, deformation of the ventral thecal sac, narrowing of the bilateral lateral recesses and mild bilateral foraminal stenosis;
2. L4-5 broad-based disc bulge with mild flattening of the ventral thecal sac and moderate bilateral neural foraminal narrowing;
3. Bilateral S1 radiculopathy that could not be fully evaluated as Petitioner declined the needle portion of the exam.

Additionally, after that examination, and just three (3) days prior to her April 13, 2018 accident, Petitioner agreed to consult a neurosurgeon to discuss surgical intervention for her lower back symptoms.

Furthermore, Petitioner herself also lacks credibility before the Arbitrator for multiple reasons:

1. Petitioner testified that her pain was well managed before the Apri 13, 2018 accident, but reported to Dr. Mehta on 2/1/18 that she was not satisfied with her pain management. She specifically reported her pain affected her mobility, mood, personal care, physical activity, relationships with others, sexual functioning, sleep, social activities, and work;
2. Petitioner testified that a few weeks before the April 13, 2018 accident her lower back pain had resolved, but she underwent a lumbar spine MRI and EMG on 4/10/18, **and** agreed to seek a neurosurgical consult;
3. On 7/11/18, Petitioner reported to Dr. Murtaza that it had been over a year since her last MRI, but Petitioner had a lumbar spine MRI on 4/10/18, again just three days before the accident;
4. Petitioner reported to Dr. Singh that her pain kept her from bending forward and riding in a car, but surveillance video shows Petitioner driving a vehicle on multiple occasions and bending forward to pick up packages;
5. Petitioner testified that she would have been able to go dancing and take long walks the day before the April 13, 2018 accident, but reported to Ms. Duncan on 7/11/18 that she had used a walker for community ambulation for approximately six months before the accident;

6. Dr. Singh also noted that Petitioner was positive for symptom magnification and was unable to objectify her subjective pain complaints.

For these reasons, the Arbitrator finds that Dr. Singh is more credible than Dr. Koutsky as it relates to Petitioner's alleged lower back injuries. The Arbitrator also finds the Petitioner not to be a credible witness for her claim. As such, the Arbitrator finds that Petitioner's current condition is not causally connected to this work accident. Accordingly, any claim by the Petitioner for benefits under the Act is denied.

Issue J: *Medical bills*

Based on the conclusions of **Issue F** above:

1. Petitioner's medical treatments for all alleged injuries after reaching MMI on 1/16/19 were not reasonable, necessary and causally connected to work;
2. Respondent has paid all reasonable, necessary and causally related treatment from 4/13/18 through 1/16/19;
3. All medical treatment regarding Petitioner's pre-existing lumbar spine degenerative disc disease and right knee degenerative joint disease is not reasonable, necessary and causally connected to work;
4. Petitioner failed to provide the necessary supporting evidence to prove Petitioner's medical treatments were causally related to work.

As such, the Petitioner's claim that Respondent is liable for unpaid medical bills is denied.

Issue K: *Prospective medical care*

Based on the conclusions of **Issues F & J** above, the Arbitrator denies the Petitioner's claim for Prospective medical care due to the credible findings and opinions of the Section 12 report of Dr. Singh.

Issue L: *TTD*

Based on the conclusions of **Issue F** above:

1. Petitioner reached MMI relative to the lumbar muscular strain by 1/16/19, per Dr. Singh;
2. Petitioner was capable of full duty work without restrictions as of 1/16/19, per Dr. Singh;
3. Petitioner's current subjective complaints are not causally related to the April 13, 2018 accident, per Dr. Singh;
4. Any lost time subsequent to 1/16/19, including any alleged TTD benefits, is not causally connected to any compensable injury which is related to any work accident.

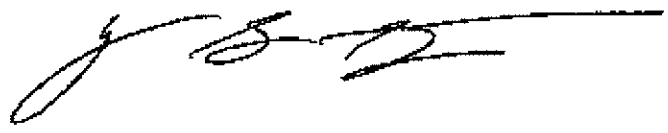
For these reasons, the Petitioner's claim for TTD benefits is denied.

Issue M: *Penalties and/or attorneys' fees*

Based on the conclusions of **Issue F & J** above:

1. Dr. Singh noted in his 1/16/19 Section 12 report that he could not objectify Petitioner's pain complaints, and placed her at MMI;
2. Respondent paid Petitioner TTD benefits through 1/16/19;
3. Petitioner was released to return to work without restrictions by Dr. Singh on 1/16/19.

Respondent paid Petitioner TTD benefits until 1/16/19, when Dr. Singh released Petitioner to return to work without restrictions. At that point, Respondent based its decision to deny benefits and challenge liability on the **qualified and credible medical opinion of Dr. Singh**, a board-certified orthopedic surgeon. Respondent's decision was objectively reasonable and based in good faith. For these reasons, Petitioner's claim for penalties and attorneys' fees is denied.



Signature of Arbitrator

FEBRUARY 18, 2020
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC019751
Case Name	SALLEY, LACHISHA M v. ST OF ILLINOIS-CHOATE
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0269
Number of Pages of Decision	18
Decision Issued By	Barbara Flores, Commissioner

Petitioner Attorney	Casey VanWinkle
Respondent Attorney	Natalie Shasteen

DATE FILED: 6/7/2021

/s/ Barbara Flores, Commissioner

Signature

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

LACHISHA M. SALLEY,

Petitioner,

vs. NO: 17 WC 19751

STATE OF ILLINOIS –
CHOATE MENTAL HEALTH,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective care, and temporary total disability benefits, being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill. 2d 327 (1980).

The Commission modifies the Decision of the Arbitrator with respect to the issue of medical expenses. Respondent takes exception to the award for MRI spectroscopy performed by Dr. Matthew Gornet, arguing that the test was not reasonable or necessary, and not generally used or accepted by the orthopedic community. In past cases where the issue was specifically raised, the Commission has generally disallowed charges for MRI spectroscopy. See, *e.g.*, *Cruse v. Choate Mental Health Center*, Ill. Workers' Comp. Comm'n, No. 17 WC 30738, 19 IWCC 419; *Streater v. Bi-State Development Agency*, Ill. Workers' Comp. Comm'n, No. 16 WC 15535, 20 IWCC 0034; *Jones v. American Steel Foun*dries, Ill. Workers' Comp. Comm'n, No. 14 WC 06878, 19 IWCC 259.

In this case, Dr. Michael Chabot, Respondent's Section 12 examiner, testified that MRI spectroscopy was not an approved test or procedure in the United States for determining disc pathology. He also noted that all of the forms he had seen regarding such test results contained disclaimers stating that federal law prohibited use of the study except for experimental purposes.

Dr. Gornet testified that MRI spectroscopy was used in the FDA clinical trials in which he was involved, but the fact that the FDA might approve of the procedure in this context does not establish that the procedure is generally accepted, reasonable or necessary in ordinary practice. Accordingly, given the testimony in this case, the Commission does not award the medical expenses incurred for the MRI spectroscopy performed by Dr. Gornet.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated October 19, 2020 is modified as stated herein. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS FURTHER FOUND BY THE COMMISSION that Petitioner proved that her current condition of ill-being is causally connected to the accident in this case.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $526.46 per week for the periods from June 3, 2017 through February 20, 2018, March 21, 2018 through April 25, 2018, and October 21, 2018 through August 13, 2020, for a period of 137 and 3/7ths weeks, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent shall receive a credit of $19,630.16 in temporary total disability benefits already paid, and $41,289.03 in extended benefits already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner's reasonable and necessary outstanding medical bills for treatment outlined in Petitioner's Group Exhibit 9, pursuant to the fee schedule and §§8(a) and 8.2 of the Act, excepting the medical bills for the MRI spectroscopy performed by Dr. Gornet. Respondent shall receive a credit for medical benefits that have already been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Petitioner is receiving this credit, as provided by §8(j) of the Act. All medical bills awarded shall be paid directly to the medical providers per the fee schedule or PPO agreement, whichever is less, per the stipulation of the parties.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the treatment recommended by Dr. Gornet, including but not limited to a single level disc replacement at L5-S1.

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.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

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.

JUNE 7, 2021

/s/ *Barbara N. Flores*
Barbara N. Flores

o: 6/3/21
BNF/kcb
045

/s/ *Christopher A. Harris*
Christopher A. Harris

/s/ *Marc Parker*
Marc Parker

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

21IWCC0269

SALLEY, LACHISHA M
Employee/Petitioner

Case# **17WC019751**

ST OF IL/CHOATE MEANTAL HEALTH
Employer/Respondent

On 10/19/2020, 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 0.11% 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:

6384 THE LAW OFFICE OF TIM DENNY
PO BOX 399
ANNA, IL 62906

0558 ILLINOIS ATTORNEY GENERAL
NATALIE N SHASTEEN
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
801 S 7TH ST
SPRINGFIELD, IL 62794

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
SPRINGFIELD, IL 62704

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

OCT 19 2020

Brendan O'Rourke, Assistant 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)

Lachisha M. Salley
Employee/Petitioner

v.

State of Illinois/Choate Mental Health
Employer/Respondent

Case # **17** WC **19751**

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 **Linda J. Cantrell**, Arbitrator of the Commission, in the city of **Herrin, IL**, on **August 13, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **May 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 $**17,373.30**; the average weekly wage was $**789.69**.

On the date of accident, Petitioner was **33** 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 $**19,630.16** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**41,289.03** for other benefits, for a total credit of $**60,919.19**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**526.46**/week for **137-3/7th** weeks, as provided in Section 8(b) of the Act, as Petitioner was temporarily and totally disabled for periods 6/3/17 through 2/20/18, 3/21/18 through 4/25/18, and 10/21/18 through the date of arbitration.

Respondent shall pay the reasonable and necessary medical services outlined in Petitioner's group exhibit 9, as provided in §8(a) and §8.2 of the Act. Respondent shall receive credit for any amounts previously paid and shall indemnify and hold Petitioner harmless from claims made by any health providers arising from the expenses for which it claims credit. All medical bills awarded shall be paid directly to the medical providers per the Illinois Medical Fee Schedule or PPO Agreement, whichever is less, per the stipulation of the parties.

Respondent shall authorize and pay for the treatment recommended by Dr. Gornet, including, but not limited to, a single level disc replacement at L5-S1.

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

10/13/20
Date

ICArbDec19(b)

OCT 19 2020

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

LACHISHA M. SALLEY,	)	
	)	
Employee/Petitioner,	)	
	)	
v.	)	Case No.: 17-WC-19751
	)	
STATE OF ILLINOIS/	)	
CHOATE MENTAL HEALTH,	)	
	)	
Employer/Respondent.	)	

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Herrin on August 13, 2020, pursuant to Section 19(b) of the Act. The issues in dispute are causal connection (lumbar spine only), medical expenses, temporary total disability benefits, and prospective medical treatment (lumbar spine only). All other issues have been stipulated.

TESTIMONY

Petitioner was 35 years old, single, with two dependent children at the time of arbitration. Petitioner has been employed by Choate Mental Health for fourteen years and is currently a Mental Health Technician II. Her job duties include assisting mentally disabled patients with daily living activities such as bathing, feeding, transportation to doctor appointments, and monitoring their behavior.

Petitioner testified that on May 12, 2017 she was sitting in a chair doing paperwork when a mentally disabled patient snatched her out of the chair by her left hand, pulled her hair, and then shoved her back into the chair. The patient was approximately 6'1" tall and weighed approximately 230 pounds. Petitioner wrestled with the patient before a co-worker intervened. Petitioner reported the incident and sought medical treatment with the facility physician. The supervisor's report of injury confirmed the accident and co-worker, Bethany Miles, provided a witness statement consistent with Petitioner's testimony.

Petitioner followed up with her primary care physician, Dr. Lucas at Rural Health, who took her off work and referred her to Dr. King. Petitioner testified she previously treated with Dr. King for a hip injury. Dr. King confirmed no new injury to Petitioner's hip. Dr. Lucas referred Petitioner to Dr. Gornet for neck and back pain. Dr. Gornet referred Petitioner to Dr. Paletta for a

shoulder evaluation. Dr. Paletta did not recommend treatment for Petitioner's shoulder. Dr. Gornet prescribed medication for Petitioner's low back symptoms which were denied by Tri-Star. Petitioner underwent a lumbar injection that provided temporary relief. Dr. Gornet has recommended a disc replacement surgery that Petitioner desires to undergo. She is currently off work as Respondent cannot accommodate her light duty restrictions. She is currently receiving non-occupational benefits.

Petitioner testified she has deep pain in her low back that feels like her upper back is crushing onto her lower back. On a scale from one to ten her current pain is seven. She is not taking any prescription medication because she cannot get them and takes Ibuprofen.

Petitioner testified she has a history of low back pain with lumbar diagnosis dating back to 2013. She did not recall the exact symptoms she suffered in 2013 and it was not a result of trauma. Her lumbar condition increased extensively in 2015 when she underwent physical therapy, injections, and radiofrequency ablations. In 2016, Petitioner began receiving treatment with Dr. King for left hip pain. She described her left hip pain as aching and stabbing, with numbness, radiating to her low back, left hip, and both knees. She underwent left hip surgery followed by physical therapy. Petitioner did not recall if the physical therapy included her low back at that time. Petitioner was off work for non-occupational disability from August 2016 through March 2017 related to her left hip. Petitioner denied any back pain from 2015 through the date of the subject accident on 5/12/17.

Petitioner testified that after the 5/12/17 incident, she experienced stabbing and deep aching pain in her low back, left hip, neck, shoulder, and pelvic area. Petitioner testified she did not see her primary care physician until 5/24/17 because it was the first appointment she could get. She did not seek emergency room treatment between 5/12/17 and 5/24/17. Petitioner underwent an MRI arthrogram for her left shoulder and Dr. Paletta opined her source of pain was her cervical spine.

Petitioner testified she still has stinging, stabbing, and aching pain in her neck that radiates to her left shoulder and fingers. Petitioner stated she is not currently seeking treatment for these symptoms. She testified she still has left hip pain. Petitioner testified she received extended benefits after the 5/12/17 accident and returned to light duty work performing computer tasks from 8:00 to 4:30.

MEDICAL HISTORY

Medical records from Southeast Health were admitted into evidence containing a lumbar MRI performed on 3/10/15 that revealed minor disc bulges at L4-5 and L5-S1, unchanged from a previous MRI. A lumbar MRI performed on 8/13/13 revealed a minor disc bulge at L5-S1, mild bilateral neural stenosis, greater on the left with mild encroachment on the left L4 nerve.

Medical records from Regional Brain and Spine were admitted into evidence. Petitioner was examined by Dr. Colle on 7/16/13 for low back pain, back and hip spasms, and knee pain, aching, numbness, stiffness, and popping. Dr. Colle provided a diagnosis of radiculitis, thoracic/lumbar and lumbago. An MRI revealed a broad-based disc bulge at L4-5 for which Dr.

Colle recommended a transforaminal steroid injection that was performed on 8/28/13. Petitioner's symptoms improved with the injection and Dr. Colle recommended a follow up injection on 10/11/13. Treatment continued through 7/2/15, including medial branch blocks and radiofrequency rhizotomies at L3, L4 and L5. Petitioner's last treatment with this facility was on 7/1/15 at which time she was discharged from care.

Immediately following the 5/12/17 incident, Petitioner reported to the facility physician for examination where she was ordered to follow up with her primary care physician. She was examined by Dr. Christine Lucas at Rural Health on 5/24/17 where she reported a consistent history of accident. Petitioner complained of constant pain in her low back radiating to her left buttock. She rated her back pain 6 out of 10. She stated her left leg felt weak and she reported difficulty walking. She reported a long history of neck and low back pain and has a history of scoliosis. She was under the care of a neurosurgeon with The Brain and Spine Institute until her insurance no longer covered her treatment. Petitioner reported pain in her neck radiating to her left shoulder. Dr. Lucas took Petitioner off work and referred her to Dr. King who performed her hip surgery. Dr. Lucas recommended Ibuprofen and Gabapetin and to follow up in two weeks. Petitioner also requested a referral to neurosurgeon Dr. Joel Ray.

Petitioner was examined by Dr. King on 5/25/17 who noted the history of work accident and recommended an MRI of Petitioner's left hip. Dr. King ordered physical therapy and ordered Petitioner off work.

On 6/1/17, Petitioner underwent a cervical x-ray that revealed possible myofascial spasms or strain.

Petitioner was re-evaluated on 6/15/17 by Dr. King who did not appreciate acute trauma to her left hip as a result of the 5/12/17 incident. Dr. King opined Petitioner reached MMI as it pertained to her hip injury and she could return to work without restrictions.

On 6/16/17, Petitioner returned to Dr. Lucas reporting Dr. King diagnosed her with a hip strain and released her to return to full duty work. Petitioner stated she did not feel ready and her left hip, low back, neck, and left shoulder were "still killing me". She reported her pain was interrupting her sleep, she had difficulty sitting for longer than ten minutes and walking more than 50 feet. Petitioner reported constant left hip pain, tingling in the left anterior thigh, and radiating pain from her left SI joint posteriorly down the back of her leg to just above the left knee. Her back pain was across her low back at the waistline. Dr. Lucas ordered Petitioner off work until a lumbar MRI was performed and Petitioner was evaluated by a neurosurgeon.

On 7/3/17, Petitioner underwent a lumbar MRI that revealed a minimal disc bulge at L3-4, a diffuse disc bulge at L4-5 eccentric left, and an L5-S1 diffuse disc bulge eccentric left, with a small left paracentral disc protrusion indenting the thecal sac. The radiologist noted, "When compared to the 3/10/15 exam, the small L5-S1 disc protrusion is new". Dr. Lucas referred Petitioner to an orthopedic surgeon.

On 9/18/17, Petitioner was examined by Dr. Matthew Gornet for neck and low back pain. Her complaints were neck pain on both sides with headaches to the right trapezius, right

shoulder, shoulder blade and upper arm. Her left side is all the way down her arm to her forearm and hand. She presents with low back pain on both sides, both buttocks and hips, with the left being worse than the right. Dr. Gornet reviewed the 7/3/17 MRI and noted it revealed obvious disc injury with annular tear at L5-S1. No additional radiographs were taken as Petitioner was pregnant at the time. Dr. Gornet opined Petitioner's current symptoms were causally connected to her work injury and placed her off work.

Petitioner was re-evaluated by Dr. Gornet on 3/19/18 at which time he reviewed prior medical records from the Regional Brain and Spine Clinic with Dr. Colle and noted her medical history through her last appointment after her MRI in 2015. Dr. Gornet noted that Dr. Colle felt there was no indication for further treatment and released her to pain management. Petitioner subsequently underwent RFA's on the right at L3, L4, and L5 as well as medial branch blocks and epidural steroid injections at L4-5 and a transforaminal steroid injection at L4-5. Dr. Gornet opined Petitioner has a disc injury at L5-S1 and recommended physical therapy and placed her on light duty. Dr. Gornet recommended new MRIs of her cervical and lumbar spine.

Petitioner returned to Dr. Gornet on 4/21/18 to review the cervical and lumbar MRIs. The cervical MRI revealed no significant disc abnormalities, with subtle protrusions from C-3 through C-7. The lumbar MRI revealed a central herniation/annular tear at L5-S1 with all other levels being fairly clean. Dr. Gornet recommended injections at C6-7 centrally and on the left side at L5-S1. He continued her light duty restrictions.

A phone note dated 5/3/18 indicated Petitioner continued to have increasing pain in her neck with headaches associated with the computer work she was doing on light duty. The P.A. prescribed Indomethacin and Tizanidine.

Petitioner followed up with Dr. Gornet on 6/25/18 and advised the lumbar injection did not help significantly. Dr. Gornet recommended a CT discogram at L4-5 and L5-S1, and MRI spectroscopy from L-3 to S1. On 8/20/18, Dr. Gornet noted the CT discogram was cancelled because Petitioner was breastfeeding, but the MRI spectroscopy revealed painful chemicals at L5-S1 and L4-5. He continued her light duty status. The 10/15/18 review of the CT discography revealed annular tear centrally and slightly to the left at L5-S1. In review of the discogram, MRI and MRI spectroscopy, Dr. Gornet opined L4-5 was completely normal and the structural back pain emanated from L5-S1 and not from L4-5. Dr. Gornet indicated the next option would be a lumbar disc replacement at L5-S1. On 12/17/18, Dr. Gornet continued to recommend disc replacement at L4-5. The recommendation remained unchanged on 4/15/2019. Dr. Gornet reviewed the IME report from Dr. Chabot and outlined his disagreement with the analysis. Dr. Gornet continues to seek approval for the single level disc replacement at L5-S1 and continues Petitioner on light duty work.

On 11/8/18, Petitioner underwent a Section 12 examination with Dr. Michael Chabot. Dr. Chabot requested additional medical records prior to rendering an opinion. On 1/9/19, Section 12 examiner Dr. Joseph Ritchie stated he was not requested to evaluate Petitioner's neck or back conditions, but her conditions are pre-existing and her work injury probably caused an exacerbation. Dr. Ritchie's report primarily focused on Petitioner's shoulder for which he recommended an MR arthrogram to rule out labral pathology. Dr. Ritchie opined there is a

causal relationship between the objective findings in Petitioner's left shoulder and the reported accident. Dr. Ritchie opined that Petitioner's medical treatment was reasonable and necessary.

On 3/1/19, Section 12 examiner Dr. Chabot produced a report indicating he reviewed additional medical records as requested and opined Petitioner has reached MMI regarding her neck and back strain injuries. Dr. Chabot opined Petitioner could return to full duty work and is in no need of further medical treatment.

Dr. Gornet recommended Petitioner follow up with Dr. George Paletta to evaluate her shoulder. On 8/28/19, Dr. Paletta recommended an MR arthrogram to evaluate the labrum and rotator cuff as her symptoms were suggestive of possible labral pathology. He opined that if the arthrogram was normal then her treatment should be directed to her neck. He recommended light duty work for her shoulder. On 9/18/19, Dr. Paletta noted no significant structural abnormalities on the MR arthrogram. He recommended Petitioner undergo a cervical MRI and indicated there was no need for additional shoulder treatment at this time.

Dr. Matthew Gornet testified by way of evidence deposition. Dr. Gornet's working diagnosis is an aggravation of an underlying disc condition at L5-S1. Dr. Gornet reviewed Petitioner's prior lumbar MRIs and noted no significant pathology at L5-S1 and believed these findings were new. He also noted the cervical MRI revealed no significant disc abnormalities and did not believe the cervical spine was a major issue. Dr. Gornet performed an MRI spectroscopy and discography which revealed a provocative disc at L5-S1 and an annular tear central and slightly to the left, with negative findings at L4-5. Dr. Gornet opined Petitioner's current lumbar condition is causally connected to her work accident and recommends a single level disc replacement at L5-S1. Dr. Gornet noted that an annular tear is significant as it is similar to a cartilage tear in your knee or a labrum or rotator cuff in your shoulder. He opined that while Petitioner may have a low-level disc herniation, she has mostly structural back pain and to remove part of the structure only weakens the structure. Since she is not complaining of significant neurologic impingement, it would be an operation done inappropriately so a better way to treat it is to fix the structural problem. Dr. Gornet opined that surgery is the best chance of returning Petitioner to full duty work with no restrictions. Based upon FDA measures for substantial clinical improvement, Petitioner has an 85 to 97 percent chance of reaching substantial clinical improvement while her current prognosis is that she is not able to work in any significant capacity. Dr. Gornet reiterated that the accident of May 12, 2017 caused a disc injury at L5-S1 and aggravated her underlined disc degeneration that she had in the past.

On cross-examination, Dr. Gornet clarified his disagreement with Dr. Chabot's Section 12 report. Dr. Gornet opined there is a clear mechanism of injury which is consistent with one that is attacked. Second, there is clear objective pathology at L5-S1 and a change in the pathology present at L5-S1 that is consistent with the radiologist's opinion from an outside facility. Petitioner had further objective testing that clearly identifies there is a structural problem. Dr. Gornet clarified that Petitioner has continual structural problems and he, as well as the radiologist, believes it is new, objective, and measurable.

Dr. Gornet clarified that the benefit of an MRI spectroscopy and a CT discogram is that the standard MRI scans would not give you any information regarding a patient's pain. These

tests allow a correlation with a patient's individual complaints. The CT discogram is one method of that testing. The MRI spectroscopy gives you an understanding of the physiology inside the back that a standard MRI or CT does not give you because it allows you to better predict the outcome by assessment of people's pain.

With regard to Petitioner's prior low back complaints, Dr. Gornet noted she responded to care and there is no indication that her alleged complaints in the back were limiting her activity. Upon review of the 2013 and 2015 MRI's, Dr. Gornet did not see any major disc pathology present. The 2017 MRI showed a disc herniation and annular tear at L5-S1 which had changed from the previous MRI. He clarified the MRI of 2017 is substantially different and there is no question it is a new finding. The radiologist reading the 7/3/17 MRI stated, "When compared to the 3/10/15 exam, this small L5-S1 disc protrusion is new." This reading is independent but consistent with Dr. Gornet's interpretation. Dr. Gornet's treatment was delayed until March 2018 due to Petitioner being pregnant and an MRI was ordered in April 2018.

Dr. Michael Chabot testified by way of evidence deposition. Dr. Chabot noted that at the time of his examination of Petitioner on 11/8/18, Petitioner complained of back and neck pain with severe sharp, aching, and generalized burning with numbness in the legs and weakness in the arms and legs. Petitioner reported her pain was 9 out of 10, but did not believe she appeared to be in any level of physical distress. Dr. Chabot reviewed medical records which indicated Petitioner suffered from disc bulging at L4-5 and L5-S1 in 2015. Dr. Chabot reviewed the lumbar MRI dated 4/21/18 that revealed a well-preserved disc space height throughout the lumbar spine with evidence of disc desiccation at L5-S1. He also noted evidence of a small central disc protrusion at L5-S1 with effacement of thecal sac. He also confirmed that the CT discogram dated 9/21/18 revealed contrast material within the disc space at L4-5 and L5-S1 with the disc height at L4-5 being normal. Dr. Chabot noted there was extravasation of the dye at L5-S1 toward the left neural foramina. The lumbar MRI dated 7/3/17 revealed a left side disc protrusion at L5-S1. He also indicated a small high intensity zone within the herniated disc material. Dr. Chabot stated there appears to be more desiccation present involving the L5-S1 compared to the study of 2013. Dr. Chabot opined that the changes suggest gradual advancement of the degeneration predominantly at L5-S1 level based upon review of the three diagnostic studies. Dr. Chabot did not appreciate objective evidence to support subjective complaints of the lumbar spine. He noted the history already documented chronic back pain complaints dating back to 2012 or early 2013 and a failure to respond to treatment. Although he did not believe there was an objective basis for her subjective complaints, he also noted there did not appear to be anything done previously which resolved those complaints.

Dr. Chabot diagnosed Petitioner with a neck strain, back strain, left shoulder strain, and history of chronic neck, back and left hip pain. He did not attribute any of those findings to the 2017 work accident. Dr. Chabot opined Petitioner was at maximum medical improvement at the time of his examination and could return to work without restrictions. He agreed Petitioner's treatment through the date of his examination [11/8/18] was reasonable and necessary.

With regard to the recommendation of a single level disc replacement at L5-S1, Dr. Chabot believes Petitioner is a poor candidate for surgical intervention because her complaint levels are escalated. Dr. Chabot also noted at the time of his examination, the only medication

Petitioner listed as using was Meloxicam once a day which does not warrant surgical intervention. Dr. Chabot clarified that surgery is a decision that is made between the physician and the patient and there is documentation of chronic back pain complaints dating back to 2012, but any intervention at the L5-S1 level is to address chronic changes that predate the injury of 2017. Dr. Chabot believes there was an annular tear in the MRI from 2013 and 2018 studies. While there was evidence of increased signal on the 2018 study, it was not as clear. It is Dr. Chabot's opinion that Petitioner has degenerated changes at L5-S1 that are unrelated to the work incident of 5/12/17. Dr. Chabot does not believe the disc replacement at L5-S1 will alleviate the multitude of subjective complaints.

Dr. Chabot was not provided the radiologist report from the July 2017 MRI that indicated the L5-S1 protrusion is new when compared to the 3/10/15 exam. Dr. Chabot indicated he does not discount the radiologist's opinion but did not believe the protrusion was evident on subsequent studies. Dr. Chabot does not dispute Dr. Gornet's findings with discography.

CONCLUSIONS OF LAW

Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?
Issue (K): Is Petitioner entitled to any prospective medical care?

The parties stipulated that this hearing was limited to the issue of whether Petitioner's condition of ill-being in her lumbar spine is causally related to her work injury. When a preexisting condition is present, a claimant must show that "a work-related accidental injury aggravated or accelerated the preexisting [condition] such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition." *St. Elizabeth's Hospital v. Workers' Comp. Comm'n*, 371 Ill. App. 3d 882, 864 N.E.2d 266, 272-273 (2007). Accidental injury need only be a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill.2d 193, 797 N.E.2d 665, 672 (2003) (emphasis added). Even when a preexisting condition exists, recovery may be had if a claimant's employment is a causative factor in his or her current condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill.2d 193, 797 N.E.2d 665 (2003). Allowing a claimant to recover under such circumstances is a corollary of the principle that employment need not be the sole or primary cause of a claimant's condition. *Land & Lakes Co. v. Indus. Comm'n*, 359 Ill.App.3d 582, 834 N.E.2d 583 (2005).

Employers are to take their employees as they find them. *A.C.& S. v. Indus. Comm'n*, 304 Ill.App.3d 875, 710 N.E.2d 837 (1999) citing *General Electric Co. v. Indus. Comm'n*, 89 Ill.2d 432, 433 N.E.2d 671, 672 (1982). The law is clear that if a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Rock Road Constr. v. Indus. Comm'n*, 37 Ill.2d 123, 227 N.E.2d 65, 67-68 (1967); see also *Illinois Valley Irrigation, Inc. v. Indus. Comm'n*, 66 Ill.2d 234, 362 N.E.2d 339 (1977). A compensable aggravation occurs when a claimant's need for surgery is accelerated. *Judith Wheaton v. State of Illinois/Choate Mental Health Center*, 13 I.W.C.C. 0467; *Bowman v. Gateway Reg'l Med. Ctr.*, 14 I.W.C.C. 1022; *Clutterbuck v. UPS*, 15 I.W.C.C. 0046; *Howard v. St. Clair Hwy. Dept.*, 16 I.W.C.C. 0187, *modified* 16 MR 106.

Respondent disputes liability for Petitioner's low back condition based on Petitioner's preexisting low back condition and treatment. While it is uncontested that Petitioner suffered from preexisting injury in her lumbar spine, the evidence demonstrates that Petitioner's preexisting condition was aggravated by the work injury on 5/12/17, as well as causing new pathology as identified in a lumbar MRI dated 7/3/17, prompting Dr. Gornet's recommendation for a single level disc replacement at L5-S1.

There is no dispute that Petitioner had a witnessed traumatic accident where a 6'1" mentally disabled patient, weighing approximately 230 pounds, pulled her out of her chair by her left hand, attempted to grab her by her hair and threw her back into her chair. Petitioner wrestled with the patient until a co-worker intervened. Petitioner sought immediate medical attention with the facility doctor and followed up with her primary care physician for numerous complaints, including back pain.

Diagnostic studies performed in 2013 and 2015 confirm minor disc bulges at L4-5 and L5-S1, with mild encroachment on the left L4 nerve. Prior to 5/12/17, Petitioner underwent significant conservative treatment for her lumbar spine, including injections, medial branch blocks, radiofrequency rhizotomies at L3, L4 and L5, and physical therapy. In July 2013, Dr. Colle noted Petitioner experienced low back pain, back spasms, hip spasms, knee pain aching and numbing, stiffness, and popping. Dr. Colle provided a diagnosis of radiculitis, thoracic/lumbar and lumbago. Petitioner was discharged from Dr. Colle's care in July 2015.

Following the 5/12/17 accident, Petitioner reported to her primary care physician, Dr. Christine Lucas, with constant pain in her low back radiating to her left buttock. She was taken off work and ordered to follow up with her hip surgeon due to left hip pain. Dr. King recommended an MRI of Petitioner's left hip, ordered physical therapy, and placed Petitioner off work. Approximately one month following Petitioner's accident, Dr. King opined she did not suffer acute trauma to her left hip as a result of the 5/12/17 incident and released her at MMI.

Petitioner continued to report low back pain that interrupted her sleep. She had difficulty sitting for more than ten minutes and walking more than 50 feet. She experienced constant left hip pain, tingling in the left anterior thigh, and radiating pain from her left SI joint posteriorly down the back of her leg to just above the left knee. Her back pain was across her low back at the waistline.

On 7/3/17, Petitioner underwent a lumbar MRI that revealed a minimal disc bulge at L3-L4, a diffuse disc bulge at L4-5 eccentric left, and a L5-S1 diffuse disc bulge eccentric left, with a small left paracentral disc protrusion indenting the thecal sac. The radiologist noted, "When compared to the 3/10/15 exam, the small L5-S1 disc protrusion is new". Dr. Gornet reviewed the 7/3/17 MRI and agreed it revealed obvious disc injury with annular tear at L5-S1, which was new pathology. Dr. Gornet reviewed Petitioner's prior medical records and noted her medical history through her last appointment after her MRI in 2015. Dr. Gornet noted that Dr. Colle felt there was no indication for further treatment and released her to pain management and at MMI in July 2015. Dr. Gornet ordered a new lumbar MRI that revealed a central herniation/annular tear at L5-S1 with all other levels being fairly clean. A CT discography revealed annular tear

centrally and slightly to the left at L5-S1. Dr. Gornet opined that L4-5 was completely normal and Petitioner's structural back pain emanated from L5-S1 and not from L4-5.

The Arbitrator gives greater weight to the opinions of Dr. Gornet, who noted an objective change on Petitioner's MRI studies. Petitioner did not require lumbar spine surgery and was not treating for her lumbar spine at the time of her 5/12/17 accident. Petitioner was able to work full duty prior to her 5/12/17 accident and has been off work since the incident, with the exception of some light duty computer work. Respondent's Section 12 examiner, Dr. Michael Chabot, reviewed Petitioner's prior medical records and opined she sustained a lumbar strain as a result of the 5/12/17 incident. It is difficult to reconcile Dr. Chabot's opinions regarding lack of pathology at L5-S1 when he discusses the findings showing pathology at L5-S1, including what he calls suggestive evidence of increase signal on the MRI, but does not concede an injury. Dr. Chabot placed a significant amount of his rational on his disbelief of Petitioner's subjective complaints because she was not taking medications. However, the Utilization Review offered into evidence by Petitioner demonstrates that Respondent denied authorization for the recommended pain medication.

Dr. Gornet used a multitude of diagnostic tools to identify and confirm Petitioner's current pathology at the L5-S1 level. Dr. Gornet eliminated level L4-5 as the source of Petitioner's symptoms which was more problematic prior to the 5/12/17 accident. Most significant is the MRI performed on 7/3/17, showing the L5-S1 disc protrusion is new pathology when compared to Petitioner's MRI performed on 3/10/15. This is a clear indication of a new objective finding in the Petitioner's lumber spine that Dr. Gornet associates with this accident. Dr. Gornet was clear that all of his studies indicate that there is an increase in the Petitioner's subjective complaints based upon the time of her last spine treatment as well as the clear objective evidence of a new injury.

An employee is entitled to medical care that is reasonably required to relieve the injured employee from the effects of the injury. 820 ILCS 305/8(a) (2011). Upon establishing causal connection and the reasonableness and the necessity of recommended medical treatment, employers are responsible for necessary prospective medical care required by their employees. *Plantation Mfg. Co. v. Indus. Comm'n*, 294 Ill.App.3d 705, 691 N.E.2d. 13, 229 Ill.Dec. 77 (Ill. 2000). This includes treatment required to diagnose, relieve, or cure the effects of claimant's injury. *F & B Mfg. Co. v. Indus. Comm'n*, 758 N.E.2d 18 (1st Dist. 2001).

Based on the above findings, the Arbitrator concludes the Petitioner's current condition of ill-being in her lumber spine is causally connected to her work injury of May 12, 2017. The Arbitrator orders Respondent to authorize and pay for the treatment recommended by Dr. Gornet, including, but not limited to, a single level disc replacement surgery at L5-S1.

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?

Upon establishing causal connection and the reasonableness and the necessity of recommended medical treatment, employers are responsible for necessary prospective medical care required by their employees. *Plantation Mfg. Co. v. Indus. Comm'n*, 294 Ill.App.3d 705, 691

N.E.2d. 13 (2000). This includes treatment required to diagnose, relieve, or cure the effects of claimant's injury. *F & B Mfg. Co. v. Indus. Comm'n*, 325 Ill.App.3d 527, 758 N.E.2d 18 (2001).

Based upon the above findings regarding causal connection, the Arbitrator finds that Petitioner is entitled to medical benefits related to her lumbar spine. Dr. Chabot testified that all of Petitioner's care was reasonable and necessary as of the date of his examination on 11/8/18. Petitioner offered into evidence three bills related to office visits with Dr. Gornet after 11/8/18. These bills correlate with office visit notes that were entered into evidence. Petitioner also offered into evidence two bills related to office visits with Dr. Paletta after 11/8/18. On 1/9/19, Dr. Ritchie opined there is a causal relationship between the objective findings in Petitioner's left shoulder and the reported accident and that Petitioner's medical treatment was reasonable and necessary.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, contained in Petitioner's Group Exhibit 9, as provided in Section 8(a) and Section 8.2 of the Act. Respondent shall be given a credit for any amounts previously paid under Section 8(a) of the Act for medical benefits and Respondent shall hold Petitioner harmless from claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

"A claimant is temporarily and totally disabled from the time an injury incapacitates him from work until such time as he is as far recovered or restored as the permanent character of [the] injury will permit." *Shafer v. Illinois Workers' Comp. Comm'n*, 2011 IL App (4th) 100505WC, ¶ 45, 976 N.E.2d 1. "It is a well-settled principle that when a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's condition has stabilized, i.e., whether the claimant has reached maximum medical improvement. *Interstate Scaffolding, Inc. v. Illinois Workers' Comp. Comm'n*, 236 Ill.2d 132, 142, 923 N.E.2d 266, 271 (2010).

Petitioner testified she received extended benefits following her 5/12/17 accident. The parties stipulate Respondent paid $41,289.03 in extended benefits to Petitioner for which Respondent shall receive a credit pursuant to Section 8(j) of the Act. The parties stipulate that Respondent has paid Petitioner $19,630.16 in temporary total disability benefits, for which Respondent shall receive a credit pursuant to Section 8(j) of the Act. Petitioner testified she is currently off work as Respondent cannot accommodate her light duty restrictions. She is currently receiving non-occupational disability benefits.

Petitioner claims to be temporarily totally disabled for a period of 137-3/7 weeks from 6/3/17 through 2/20/18, 3/21/18 through 4/25/18, and 10/21/18 through the date of arbitration. Dr. Lucas took Petitioner off work on 5/24/17 and Dr. King took Petitioner off work on 5/25/17. Petitioner was released by Dr. King on 6/15/17 related to her left hip and Dr. Lucas took Petitioner off work on 6/16/17 pending diagnostic testing for Petitioner's neck and back. Dr. Gornet took Petitioner off work on 9/18/17. Dr. Gornet returned Petitioner to light duty work effective 3/19/18 through the date of arbitration pending surgical approval.

Petitioner testified she returned to light duty work performing computer tasks for a period of time; however, it is unclear from the record what dates Petitioner worked light duty. Although the Arbitrator finds Petitioner was consistently taken off work from 5/24/17 through 3/19/18 when Dr. Gornet released Petitioner to work light duty through the date of arbitration, representing 168-2/7 weeks, Petitioner requests temporary total disability benefits for a period of 137-3/7 weeks for the periods indicated above.

Based upon the findings above with regard to causation, the Arbitrator finds the Petitioner is entitled to 137-3/7 weeks of temporary total disability benefits at the Petitioner's temporary total disability rate of $526.46.

This award shall in no instance be a bar to further hearing and determination of any additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

Linda J. Cantrell

Arbitrator Linda J. Cantrell

10/13/20

DATE

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC008846
Case Name	FLORES, ENRIQUE ROBERTO v. LABOR SOLUTIONS, INC.
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0270
Number of Pages of Decision	19
Decision Issued By	Barbara Flores, Commissioner

Petitioner Attorney	Peter Lekas
Respondent Attorney	Edward Jordan

DATE FILED: 6/7/2021

/s/ Barbara Flores, Commissioner

Signature

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ENRIQUE ROBERTO FLORES,

Petitioner,

vs. NO: 16 WC 8846

LABOR SOLUTIONS, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective care, and temporary total disability benefits, being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill. 2d 327 (1980).

The Commission modifies the Decision of the Arbitrator with respect to the issue of medical expenses, prospective care, and temporary total disability benefits.

I. Medical Expenses

The Arbitrator ordered that Respondent pay the $6,297.47 in medical expenses charged by the Chicago Pain & Orthopedic Institute, as listed in Petitioner's Exhibit 8. Respondent argues that its payment log indicates that it paid a number of the bills from Chicago Pain & Orthopedic Institute. Respondent maintains that it should not be liable for any medical expenses after December 4, 2018, the date on which Respondent's Section 12 examiner, Dr. Edward Goldberg, opined that Petitioner reached maximum medical improvement (MMI). Respondent further asserts that some of the awarded charges should be rejected because they were for non-emergency travel.

Under the provisions of section 8(a) of the Act, an employer is required to pay for all necessary medical, surgical, and hospital services that are reasonably required to cure or relieve the effects of an accidental injury sustained by an employee and arising out of and in the course of her employment. 820 ILCS 305/8(a) (West 2006). An employer's liability under this section of the Act is continuous so long as the medical services are required to relieve the injured employee from the effects of the injury. *Second Judicial District Elmhurst Memorial Hospital v. Industrial Comm'n*, 323 Ill. App. 3d 758, 764 (2001) (citing *Efengee Electrical Supply Co. v. Industrial Comm'n*, 36 Ill. 2d 450, 453 (1967)). However, the employee is only entitled to recover for those medical expenses which are reasonable and causally related to her industrial accident. *Second Judicial District Elmhurst Memorial Hospital*, 323 Ill. App. 3d at 764 (citing *Zarley v. Industrial Comm'n*, 84 Ill. 2d 380, 389 (1981)). The claimant has the burden of proving that the medical services were necessary, and the expenses incurred were reasonable. *City of Chicago v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 258, 267 (2011). The question of whether medical treatment is causally related to a compensable injury is one of fact to be determined by the Commission. *Second Judicial District Elmhurst Memorial Hospital*, 323 Ill. App. 3d at 764 (citing *Zarley*, 84 Ill. 2d at 389-90).

Respondent's argument based on Dr. Goldberg's asserted December 4, 2018 MMI date fails as a general proposition. A determination that a Petitioner has reached MMI does not necessarily mean the end of a causal relationship between the Petitioner's work accident and his condition of ill-being. MMI does not necessarily mean full recovery from an injury. Rather, an MMI finding indicates the point at which the employee's condition stabilizes or the employee has recovered as far as the character of the injury will permit. See, e.g., *Nascote Industries v. Industrial Comm'n*, 353 Ill. App. 3d 1067, 1072 (2004); *Freeman United Coal v. Industrial Comm'n*, 318 Ill. App. 3d 170, 177 (2000). An employer has an ongoing, continuous duty to pay reasonable medical expenses for services necessary to cure or relieve the injured employee from the effects of the injury.

Moreover, the Commission determines that Petitioner did not reach MMI on December 4, 2018. The Arbitrator's determination regarding MMI relies upon the opinions of Dr. Julian Bailes, Dr. Thomas Hudgins, and Dr. Goldberg. Dr. Bailes assessed Petitioner with lumbar pain syndrome, with no current surgical indication, and referred Petitioner to physiatry for discussion of a lumbar spine ESI in November 2015. Dr. Bailes did not render any opinion regarding whether Petitioner was at MMI. Dr. Hudgins diagnosed Petitioner with mechanical back pain and found Petitioner at MMI on March 10, 2016. This opinion was not shared by any of the other physicians involved in this case including Dr. Goldberg, whose initial Section 12 report opined that Petitioner was a candidate for a laminectomy and fusion at L5-S1, adding that Petitioner was not at MMI and would likely reach MMI nine months after surgery. Indeed, Dr. Goldberg's initial opinion was consistent with those of: Dr. Geoffrey Dixon, who recommended an L5-S1 decompressive laminectomy with interbody fusion and pedicle screw instrumentation, and placed Petitioner on work restrictions; Dr. Cary Templin, who recommended an L5-S1 transforaminal lumbar interbody fusion and placed Petitioner on work restrictions; and Dr. Kevin Koutsky, who agreed with Dr. Dixon's surgical recommendation, not only for decompression but also stabilization with instrumentation.

Dr. Goldberg's opinion changed after he reviewed 49 minutes of surveillance video. Dr. Goldberg opined that the video indicated that Petitioner was capable of working beyond a 10-pound restriction, walking with a normal gait and bending over without difficulty. The doctor recommended that Petitioner undergo a functional capacity evaluation (FCE) to determine the validity of Petitioner's complaints and a determination of work restrictions. Dr. Goldberg no longer believed fusion surgery was required.

Dr. Goldberg's change in opinion is not well-founded. The surveillance video depicts Petitioner driving, walking with a normal gait, occasionally bending over without obvious difficulty, and handling grocery items including detergent, diapers, toilet paper, and paper towels. There is no evidence, however, that any of these activities were beyond the restrictions imposed by Petitioner's treating physicians at the time. To the contrary, Petitioner testified without rebuttal that he had not been restricted from driving or grocery shopping. Petitioner also testified without rebuttal that he had not lifted heavy items while shopping. Dr. Goldberg acknowledged that he did not how much the diapers and detergent Petitioner was seen lifting weighed. Dr. Goldberg also acknowledged that he had not instructed his own patients with spondylolisthesis against driving a van or grocery shopping. Dr. Dixon testified that he did not know how much a box of diapers would weigh, but he had purchased paper towels and did not believe they would weigh more than 10 pounds.

The Commission also views Dr. Goldberg's change in light of the fact that he rejected the results of the FCE obtained at his own recommendation. He reviewed a job description from Respondent for a warehouse worker which indicated that Petitioner would be required to stand and continuously lift up to 25 pounds and carry 25 pounds. The FCE, which Dr. Goldberg testified was found valid by the therapist, reportedly indicated that Petitioner could lift only 23 pounds overhead occasionally, and only 12 pounds frequently. Petitioner reportedly could lift 28 pounds from desk to chair occasionally, but never frequently. The FCE indicated that Petitioner should not be lifting from floor to waist. Petitioner reportedly could push and pull 34 pounds occasionally, and 14 pounds frequently. He should "minimally balance bends to claim [sic] stairs" and not crawl or crouch. The FCE reportedly recommended that Petitioner work only six hours per day. Yet Dr. Goldberg opined that Petitioner could return to work full duty if the job description was accurate, despite the numerous findings suggesting that Petitioner's condition did not meet the stated requirements. Dr. Goldberg also did not believe the FCE correlated with the surveillance video, though he offered no basis on which it could be concluded that occasionally lifting detergent, diapers, toilet paper and paper towels contradicted the findings of the FCE.

In sum, the preponderance of the evidence indicates that Petitioner had not reached MMI as of December 4, 2018, even if he could engage in some activities of daily living within the restrictions imposed by his treating physicians.

The remaining issue is Respondent's objection to travel expenses. Respondent asserts that the billing code "A0120" appearing in Petitioner's Exhibit 8 represents non-emergency travel. There are 10 such charges in Petitioner's Exhibit 8, at the rate of $350.00 apiece. Contrary to the suggestion in Respondent's Statement of Exceptions, travel expenses to cover the cost of transportation to and from treatment can be awarded under the same standard of

reasonableness and necessity as medical expenses. *General Tire & Rubber Co. v. Industrial Comm'n,* 221 Ill. App. 3d 641, 651 (1991). However, while certified medical bills are presumed reasonable under section 16 of the Act, Petitioner's Exhibit 8 is a non-certified itemized summary of charges and the underlying bills are not included in Petitioner's Exhibits 6 and 7. There is no other evidence indicating that the challenged charges were reasonable. Accordingly, the Commission concludes that Petitioner failed to establish that the travel expenses listed in Petitioner's Exhibit 8 were reasonable and necessary and modifies the Decision of the Arbitrator to exclude those travel expenses from the award of medical expenses in this case.

II. Prospective Medical Care

The Arbitrator did not award the surgery recommended by Dr. Dixon or any prospective medical treatment, again relying on the opinions of Dr. Bailes, Dr. Hudgins, and Dr. Goldberg. As noted above, the Commission prefers the opinions of Dr. Dixon, Dr. Koutsky, and Dr. Templin, as well as the initial opinion of Dr. Goldberg regarding Petitioner's need for surgery. Accordingly, the Commission modifies the Decision of the Arbitrator to award the L5-S1 decompressive laminectomy with interbody fusion and pedicle screw instrumentation recommended by Dr. Dixon, along with the cost of reasonable and necessary pre-operative and post-operative care related to the surgery.

III. Temporary Total Disability

The Arbitrator did not award the temporary total disability (TTD) benefits Petitioner claimed for the period from December 11, 2018 through September 16, 2020. A claimant is temporarily totally disabled from the time an injury incapacitates him from work until such time as he is as far recovered or restored as the permanent character of his injury will permit. *Archer Daniels Midland Co. v. Industrial Comm'n*, 138 Ill. 2d 107, 118 (1990). The dispositive test is whether the claimant's condition has stabilized, *i.e.*, whether he has reached MMI. *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 759 (2003). Once an injured claimant has reached MMI, the disabling condition has become permanent and he is no longer eligible for TTD benefits. *Archer Daniels Midland Co.*, 138 Ill. 2d at 118.

For the reasons stated above regarding medical expenses and prospective care, the Commission determines that Petitioner's condition was not stabilized and therefore modifies the Decision of the Arbitrator to award TTD benefits for the period from December 11, 2018 through the September 16, 2020 hearing date.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated November 24, 2020 is modified as stated herein. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS FURTHER FOUND BY THE COMMISSION that Petitioner proved that his current condition of ill-being is causally connected to the accident in this case.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $253.00 per week for the period from December 11, 2018 through September 16, 2020, for a period of 92 and 2/7ths weeks, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent shall receive a credit of $3,057.32 in temporary total disability benefits already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner's reasonable and necessary outstanding medical bills of $6,297.27, pursuant to the fee schedule and §§8(a) and 8.2 of the Act, excepting the travel expenses listed in Petitioner's Exhibit 8. Respondent shall receive a credit for medical benefits that have already been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Petitioner is receiving this credit, as provided by §8(j) of the Act. All medical bills awarded shall be paid directly to the medical providers.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the L5-S1 decompressive laminectomy with interbody fusion and pedicle screw instrumentation recommended by Dr. Dixon, along with the cost of reasonable and necessary pre-operative and post-operative care related to the surgery.

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.

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 is hereby fixed at the sum of $23,200.00. 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.

JUNE 7, 2021

/s/ *Barbara N. Flores*
Barbara N. Flores

o: 6/3/21
BNF/kcb
045

/s/ *Christopher A. Harris*
Christopher A. Harris

/s/ *Marc Parker*
Marc Parker

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

21IWCC0270

FLORES, ENRIQUE ROBERTO Case# **16WC008846**

Employee/Petitioner

LABOR SOLUTIONS INC

Employer/Respondent

On 11/24/2020, 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 0.09% 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 LEKES
5357 W DEVON AVE
CHICAGO, IL 60646

2623 McANDREWS & NORGLE LLC
EDWARD JORDAN
53 W JACKSON BLVD SUITE 315
CHICAGO, IL 60604

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Enrique Roberto Flores
Employee/Petitioner

v.

Labor Solutions, Inc.
Employer/Respondent

Case # **16** WC **008846**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Glaub**, Arbitrator of the Commission, in the city of **Rockford**, on **September 16, 2020**. 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 6, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$16,157.96**; the average weekly wage was **$310.73**.

On the date of accident, Petitioner was **46** 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 **$0.00** for TTD, **$3,057.32** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$3,057.32**.

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 $6,297.47, as provided in Sections 8(a) and 8.2 of the Act

Petitioner's claim for TTD benefits is denied. No TTD benefits are awarded to Petitioner.

Petitioner is not entitled to any prospective medical treatment and all claims for prospective medical treatment are denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Signature of Arbitrator

November 18, 2020
Date

ICArbDec19(b)

NOV 24 2020

STATEMENT OF FACTS

Petitioner was employed by Respondent on July 6, 2015 as a temporary worker and began working for Respondent in November 2014. (Tx. 12-13). Petitioner was assigned to a job unloading products and making frames and glasses. (Tx. 12) Petitioner testified that he was working on July 6, 2015 and was unloading trucks of merchandise. (Tx. 13-14) He testified that another worker was pulling a pallet with a forklift and drove towards Petitioner and he fell backwards into a metal bar. (Tx. 13-14)

Petitioner testified that he felt back pain after the accident. (Tx. 15) Petitioner testified that he reported the accident to Jesus and he was sent to Human Resources at Labor Solutions on July 7th. (Tx. 15-16) An accident report was entered into evidence. (Rx. 11) The report states that the date of injury is June 8, 2015. (Rx. 11) Petitioner claimed that he did not draft the report, but admitted that he reviewed the report before signing the report. (Tx. 48-50)

Petitioner returned to work on July 7, 2015 and finished his work day. (Tx. 16) Petitioner's first medical treatment was on July 8, 2015. (Tx. 18) Petitioner testified that he was sent to PromptMed by Respondent. (Tx. 17-18) Petitioner presented to PromptMed on July 8, 2015 and reported that he had lower back pain since July 6, 2015. (Px. 1) The records state that Petitioner said that he fell backward into a trailer when a forklift came towards him at work. (Px. 1) The diagnosis was a lumbar strain. (Px. 1) Petitioner was prescribed meloxicam, flexeril and was given work restrictions. (Px. 1)

X-rays were taken at PromptMed on July 14, 2015 which showed degenerative changes with no fractures and no soft tissue swelling. (Px. 1) Petitioner's work restrictions were continued and his prescription medications were refilled. (Px. 1) Petitioner returned to PromptMed on August 27, 2015 and stated that he had increased back pain after carrying a box at work on August 10, 2015. (Px. 1) The diagnosis was lumbar strain and spondylolisthesis with myelopathy. (Px. 1) Petitioner was recommended to begin physical therapy. (Px. 1)

Petitioner started therapy at Athletico. (Px. 2) Petitioner underwent 12 visits of therapy from August 31, 2015 through October 7, 2015. (Px. 2) Petitioner testified that therapy did not help and he was fatigued after physical therapy sessions. (Tx. 20 and Tx. 60)

Petitioner was last seen at PromptMed on October 17, 2015. (Px. 1) Petitioner was referred for a lumbar MRI. (Px. 1) The records state that Petitioner was referred to a neurosurgeon, recommended to undergo a MRI and was diagnosed with spondylolisthesis and a lumbar strain. (Px. 1)

Petitioner underwent the lumbar MRI on October 26, 2015. (Px. 1) The impression was disc herniation, disc bulge at L4-5 and stenosis at L5-S1. (Px. 1) Petitioner was referred to Dr. Julian Bailes. (Tx. 20-21)

Petitioner saw Dr. Julian Bailes, a Neurosurgeon, at Northshore University HealthSystem on November 5, 2015. (Rx. 15) The records state that Petitioner reported back pain since an

accident when he tripped and fell into a metal band as a forklift was driving towards him. (Rx. 15) The examination noted normal range of motion and a negative straight leg raise test. (Rx. 15) The diagnosis was lumbar pain syndrome and Dr. Bailes opined that there was no current surgical indication. (Rx. 15) Petitioner was referred to a physiatrist for discussion of lumbar epidural injections. (Rx. 15) Dr. Bailes advised Petitioner to return as needed. (Rx. 15)

Petitioner underwent an injection on December 9, 2015 with Dr. John Palin at Kenosha Radiology. (Px. 4) Petitioner testified that he had no improvement after the injection. (Tx. 21-22) Petitioner then saw Dr. Thomas Hudgins at Northshore University Health Systems on January 15, 2016. (Rx. 19)

Dr. Hudgins records state that Petitioner was complaining of bilateral back pain after he was hit by a conveyor belt while unloading a truck. (Rx. 19) Petitioner stated that he was working light duty. (Rx. 19) The diagnosis was left lower extremity S1 radiculopathy with mechanical back pain. (Rx. 19) Dr. Hudgins recommended a trial of one left S1 epidural injection/selective nerve root block. (Rx. 19) Petitioner underwent a left S1 transforaminal epidural injection on February 19, 2016. (Rx. 19)

Petitioner returned to Dr. Hudgins on March 10, 2016. (Rx. 19) The records state that Petitioner alleged that he had no relief from the second injection. (Rx. 19 The diagnosis was mechanical back pain, non-organic pain complaints and no relief with two injections. (Rx. 19) Dr. Hudgins opined that Petitioner had non-organic pain complaints, was at maximum medical improvement, had exhausted non-surgical care and should continue to complete a home exercise program. (Rx. 19)

Petitioner testified that a friend then referred him to Chicago Pain and Orthopedic Institute. (Tx. 54) Petitioner saw Dr. Samir Sharma on March 23, 2016 for an alleged work injury on June 6, 2015. (Px. 6) The records state that Petitioner was operating a forklift and went in reverse and Petitioner was pinned against a steel plate. (Px. 6) Petitioner denied any numbness or weakness in his lower extremity. (Px. 6) Petitioner was working without any issues. (Px. 6) Dr. Sharma stated that the MRI showed a L5-S1 central disc protrusion with facet changes at L5-S1. (Px. 6) The diagnosis was low back pain with left lower extremity radiculopathy secondary to a work injury. (Px. 6) Dr. Sharma recommended an EMG, work restrictions, Lidoderm and Terocin patches. (Px. 6)

Petitioner underwent an EMG on April 9, 2016 and the impression was lumbar radiculopathy at L4-5. (Px. 6) Petitioner also started therapy at Metro Functional Rehabilitation on April 13, 2016. (Px. 5)

Petitioner saw Dr. Geoffrey Dixon at Chicago Pain and Orthopedic Institute on April 20, 2016. (Px. 6) The records state that Petitioner was unloading a truck when a sudden movement to secure a falling pallet resulted in significant back pain. (Px. 6) Dr. Dixon stated that the MRI showed Grade 1 spondylolisthesis at L5-S1 with a disc protrusion. (Px. 6) Dr. Dixon recommended a L5-S1decompressive laminectomy and fusion and work restrictions. (Px. 6)

On May 24, 2017, Dr. Dixon saw Petitioner and stated that there was confusion whether Petitioner had an IME, but Dr. Dixon learned that no IME had taken place. (Px. 6) Dr. Dixon again opined that Petitioner required lumbar spine surgery. (Px. 6) Petitioner saw Dr. Dixon on

December 13, 2017 and he opined that Petitioner was to return as needed until he can proceed with surgery. (Px. 6)

Petitioner saw Dr. Kevin Koutsky on January 26, 2018. (Px. 7) Dr. Koutsky's records state that Petitioner's accident occurred on July 26, 2015 and Petitioner slipped backwards while carrying an 80lb. box and hit a metal table. (Px. 7) The diagnosis was left L5-S1 radiculopathy, stenosis and spondyliolisthesis. (Px. 7) Dr. Koutsky recommended muscle relaxants, tramadol and a lumbar fusion. (Px. 7) Petitioner was allowed to return to work with restrictions of no lifting over 10lbs. (Px. 7)

Petitioner worked light duty for Respondent through April 26, 2018 and worked 40 hours per week. (Tx. 30-31) Petitioner testified that he started working for Respondent in their office 20 hours per week starting on April 26, 2018. (Tx. 31-32) Petitioner was paid TPD benefits by Respondent. (Tx. 31-32)

Petitioner testified that he saw Dr. Cary Templin on May 25, 2018. (Px. 7) The records state that Petitioner stated was injured after he lifted a heavy box and fell onto a metal conveyor. (Px. 7) The diagnosis was degenerative changes with S1-S2 disc and impingement of the S1 nerve. (Px. 7) Dr. Templin recommended a new MRI and lumbar spine surgery. (Px. 7)

Petitioner underwent a MRI on July 19, 2018. (Px. 7) The impression was diffuse protrusion at L4-5, mild diffuse bulge at L1-L4 and facet arthropathy. (Px. 7) Petitioner returned to Dr. Templin on September 21, 2018. (Px. 7) Dr. Templin stated that the new MRI showed grade 1 anterolisthesis with stenosis. (Px. 7)

Petitioner continued working for Respondent through December 10, 2018. (Tx. 61-62) Petitioner testified that he was offered a full duty job by Respondent on December 10, 2018, but did not return to work for Respondent. (Tx. 61-62)

Dr. Dixon saw Petitioner throughout 2019, restricted Petitioner from work and recommended lumbar spine surgery. (Px. 6) Petitioner's last visit with Dr. Dixon was September 9, 2020. (Px. 6) Petitioner complained that his symptoms have worsened and he had radicular back pain. (Px. 6) Dr. Dixon recommended lumbar decompression and fusion surgery and restricted Petitioner from work. (Px. 6)

Petitioner testified that he wants to undergo lumbar spine surgery. (Tx. 49) Petitioner testified that his left leg becomes numb and the bottom of his left foot feels like "fire". (Tx. 36) Petitioner testified that he has not returned to work since December 10, 2018 and has not earned any wages or received any workers' compensation benefits. (Tx. 37) Petitioner testified that his back pain has not improved since he stopped working. (Tx. 38)

Surveillance films were admitted into evidence by Respondent. Petitioner's counsel stipulated that Petitioner is the individual shown in the videos entered as Respondent's Exhibits 18 and 21. (Tx. 7-8) Respondent's Exhibit 18 is surveillance film taken of Petitioner on March 29, 2018 and April 3, 2018 and Exhibit 21 is surveillance on September 11, 2019 and September 12, 2019. The films show the following activities:

March 29, 2018 (Rx. 18):

- 7:55-Petitioner drives and walks into Target
- 8:01-Petitioner is seen pushing a shopping cart and walking normally
- 8:08-Petitioner is seen bending to pick up items, putting the items into the cart and picks up multiple items from the group, including a big box and puts it in the cart
- 8:19-Petitioner is seen putting the items from Target into his van and reaches to close the truck door
- 8:25-Petitioner is seen driving to Walgreens and leaving the store with a shopping bag in his hand
- 9:13-Petitioner is seen driving to CVS, then carrying toilet paper into his car and placing it in the trunk

April 3, 2018 (Rx. 18):

- 7:25-Petitioner is shown working on his car
- 9:44-Petitioner is shown driving his cars around his home and into his driveway
- 10:24 and 10:31-Petitioner is shown returning to Target and reaching for toilet paper
- 10:33-Petitioner is seen pushing a shopping cart and walking without a limp
- 10:43-Petitioner is seen unloading the cart and placing the items into his van
- 11:37-Petitioner is seen going to a supermarket or convenience store

September 11, 2019 (Rx. 21):

- 6:54-Petitioner is seen leaving a gas station and walking to his car
- 8:06-8:40-Petitioner is seen driving someone around and walking from a store with a plastic bag
- 8:49-Petitioner is seen walking into another store and leaves with a small plastic bag
- 9:30-Petitioner is seen outside and behind a fence at his house. Petitioner is seen lifting items out of his car and bringing them into his house, including toilet paper or paper towels.
- 9:36-Petitioner is seen walking out of his house and pulling his garbage cans from the street to his house.
- 10:43-Petitioner is shown bending over and tending to a garden

Petitioner testified that no doctor told him that he should not drive a vehicle or go shopping. (Tx. 38) Petitioner was asked questions regarding the weights of objects that he was shown lifting in the surveillance videos and he testified that the diapers weighed 6 pounds, paper towels weighed 5 pounds, and the laundry detergent weighed 6 pounds. (Tx. 41-43)

Dr. Edward Goldberg testified via evidence deposition. (Rx. 2) Dr. Goldberg is a board-certified orthopedic surgeon who practices at Midwest Orthopedics at Rush. (Rx. 2) Dr. Goldberg examined Petitioner on April 25, 2018 on behalf of Respondent. (Rx. 2)

He testified that he reviewed medical records of Dr. John Jurica, occupational health records, ATI Physical Therapy records, and medical records from Dr. Geoffrey Dixon and Dr.

Kevin Koutsky. (Rx. 2) Dr. Goldberg personally reviewed a lumbar MRI of October 26, 2015, which he read to show L5-S1 degenerative spondylolisthesis. (Rx. 2)

Dr. Goldberg's physical examination showed Petitioner was able to forward flex to only 60 degrees and extend backwards to 20 degrees with pain. (Rx. 2) Dr. Goldberg opined that these findings were abnormal because Petitioner reported significant pain while forward flexing and extending his lumbar spine. (Rx. 2) After his April 25, 2018 IME, Dr. Goldberg opined that Petitioner's diagnosis was low back pain and spondylolisthesis. (Rx. 2) He opined that Petitioner aggravated a degenerative condition in his lumbar spine after the July 6, 2015 incident. (Rx. 2) Dr. Goldberg testified that based on his examination findings, Petitioner's subjective complaints, and the medical records, Petitioner required a lumbar fusion and decompression. (Rx. 2) He opined that Petitioner could return to work with a 10-pound lifting restriction based, in part, on Petitioner's subjective complaints. (Rx. 2)

However, Dr. Goldberg testified that he then reviewed 49 minutes of video surveillance of Petitioner on March 29, 2018 and April 2, 2018. (Rx. 2) Dr. Goldberg testified that the video surveillance on March 29, 2018 showed Petitioner walking without an altered gait, walking normally and in no distress. (Rx. 2) He also testified Petitioner was able to bend and reach, and crouch without any evidence of pain. (Rx. 2) He opined that the videos showed Petitioner having no limitations of his activities and was pushing a large cart, grabbing products from a store, and was not limping or walking with an altered gait. (Rx. 2)

Dr. Goldberg testified that, after his review of the video surveillance, Petitioner was able to return to work with a 25-pound lifting restriction and he did not need a fusion surgery. (Rx. 2) Dr. Goldberg testified that Petitioner only needed a functional capacity evaluation to address his work ability and the validity of his complaints. (Rx. 2)

Dr. Goldberg also reviewed a functional capacity evaluation dated October 4, 2018 from ATI Physical Therapy. (Rx. 2) The FCE stated that Petitioner was able to lift 23 pounds, 12 pounds frequently, no floor-to-waist lift, and with no crouching or squatting. (Rx. 2) Dr. Goldberg disagreed with the findings of the functional capacity evaluation. (Rx. 2) He stated there was no evidence that Petitioner could not return to work full duty based on the job description of a warehouse worker and the video surveillance. (Rx. 2) Dr. Goldberg testified that the functional capacity evaluation did not correlate with the video surveillance and he opined that Petitioner could return to work full duty as of December 4, 2018. (Rx. 2)

Dr. Goldberg drafted an addendum IME report on July 22, 2019 after his review of additional records. (Rx. 3) Dr. Goldberg opined that Petitioner had an aggravation of spondylolisthesis at L5-S1 that pre-dated the work accident. (Rx. 3) However, based upon the inconsistent examination and video surveillance, Petitioner did not require a lumbar fusion surgery and could return to full duty work. (Rx. 3)

Dr. Geoffrey Dixon testified via evidence deposition. (Px. 9) Dr. Dixon is a board-certified neurosurgeon and is a solo practitioner at Elmhurst Memorial Hospital with an independent contract and relationship with Chicago Pain and Orthopedic Surgery and Illinois Orthopedic Network. (Px. 9)

Petitioner was first seen by Dr. Dixon on April 20, 2016. (Px. 9) Dr. Dixon took a history from Petitioner and Petitioner stated that he was injured on July 6, 2015 when he was securing a falling pallet. (Px. 9) Dr. Dixon reviewed an MRI of October 26, 2015, which showed a disc protrusion with spondylolisthesis with stenosis. (Px. 9) He also reviewed an EMG report which showed a left L5 radiculopathy. (Px. 9) Dr. Dixon recommended an L5-S1 fusion and decompression surgery. (Px. 9) He opined that Petitioner's work accident was a causative factor in Petitioner's lumbar spine condition. (Px. 9) Dr. Dixon opined that Petitioner was able to work with a 10-pound weight restriction. (Px. 9)

Dr. Dixon reviewed Dr. Goldberg's IME reports on February 27, 2019. (Px. 9) Dr. Dixon opined that Petitioner's surgical recommendation was based on Petitioner's objective records and the MRI and EMG findings. (Px. 9) Dr. Dixon testified that he disagreed with Dr. Goldberg's opinions that the surveillance films indicated that Petitioner did not require surgery, because Petitioner was able to complete activities of daily living, however, he did not review the surveillance videos. (Px. 9) Dr. Dixon opined that surveillance video would not change his opinions that Petitioner requires surgery. (Px. 9) Dr. Dixon opined that Petitioner's surgery and medical treatment has been related to Petitioner's accident. (Px. 9)

Dr. Dixon was asked to review Dr. Sharma's report dated March 23, 2016 and testified that the record stated that Petitioner reported an accident that he operating a forklift, went in reverse, and was pinned against a steel plate. (Px. 9) Dr. Dixon admitted that Petitioner's history to Dr. Sharma is different than the history provided to Dr. Dixon. (Px. 9) Dr. Dixon also admitted that Petitioner's history to Dr. Koutsky was different than the history provided to Dr. Dixon on his first visit with Petitioner. (Px. 9) Dr. Dixon opined that Petitioner was restricted from all work, however he confirmed that the FCE report indicated Petitioner could return to work with restrictions. (Px. 9) Dr. Dixon testified he did not have the findings of the FCE at the time of the deposition. (Px. 9)

ARBITRATOR'S FINDINGS ON DISPUTED ISSUES:

As to Issue (C), Did Petitioner Sustain an Accident Arising Out Of and In The Course Of Petitioner's Employment With Respondent, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner proved that he sustained an accidental injury that arose out of and in the course of his employment with Respondent. Petitioner testified that he was injured on July 6, 2015 when he fell backwards into a metal railing while lifting a box over his head. The Arbitrator notes that the initial medical records from PromptMed state that Petitioner fell backward as a forklift was driving towards him at work. This history is similar to Petitioner's trial testimony.

However, in finding that the Petitioner met his burden of proof on accident, the Arbitrator must note that Petitioner's medical records contain different accident histories and inconsistent accident reporting. The accident report entered by Respondent lists an accident date of June 8, 2015, one month before Petitioner alleged that he was injured. Although Petitioner testified that he did not write this report, he admitted to reviewing and signing the document.

The accident histories provided to his doctors at Chicago Pain and Orthopedic Institute are inconsistent and different from Petitioner's testimony. Dr. Sharma, per his records, states that Petitioner was operating a forklift that went in reverse and pinned Petitioner against a steel plate. Dr. Geoffrey Dixon's records state that Petitioner was unloading a truck when a sudden movement to secure a falling pallet resulted in significant low back pain. Dr. Templin's records state that Petitioner was injured when he lifted a heavy box and fell onto a metal conveyor.

While finding that the Petitioner met his burden of proof on the issue of accident, the Arbitrator finds that Petitioner's testimony and accident reporting is inconsistent and that Petitioner's testimony is not entirely credible. However, Petitioner proved by a preponderance of the evidence that he sustained accidental injuries arising out of and in the course of his employment with Respondent on July 6, 2015.

As to Issue (F), Is Petitioner's Current Condition of Ill-Being Causally Related to the Injury, the Arbitrator finds as follows:

In support of the Arbitrator's Decision with respect to issue (F); Is Petitioner's current condition of ill-being causally related to the injury; the Arbitrator finds as follows:

The Arbitrator concludes that petitioner's current condition of ill-being in his low back is causally related to his July 6, 2015 work accident.

The Arbitrator relies upon the causation opinions of Dr. Samir Sharma, Dr. Geoffrey Dixon, Dr. Kevin Koutsky, Dr. Cary Templin and Dr. Edward Goldberg. Dr. Sharma examined the petitioner on March 23, 2016. Her assessment was that petitioner is a 38-year-old gentleman with ongoing low back left lower extremity radiculopathy secondary to a work-related injury in June 2015. {Petitioner Exhibit No. 6} Dr. Dixon examined the Petitioner on April 20, 2016. Dr. Dixon's diagnosis was L5-S1 grade 1 spondylolisthesis with radiculopathy. Dr. Dixon noted his belief that this is a work – related injury emanating from the events of July 6, 2015. {Petitioner Exhibit No. 7} Dr. Dixon further testified at his Deposition that petitioner's current condition of ill-being in his low back is causally related to his July 6, 2015 work accident. {Petitioner's Exhibit No. 10} Dr. Koutsky examined the petitioner on January 28, 2018, and noted that petitioner has spondylolisthesis with stenosis and presents today with the above condition after a work related injury. {Petitioner Exhibit No. 6} Dr. Cary Templin examined the petitioner on May 25, 2018 and assessed him as a 50 year old gentleman with lumbar degenerative changes, possible spondylolisthesis, facet arthropathy, and Left S1 radiculopathy, aggravated as a result of his work injury. {Petitioner Exhibit No. 6} Dr. Edward Goldberg examined the petitioner on April 25, 2018. Dr. Goldberg opined that the petitioner aggravated his pre existing asymptomatic spondylolisthesis with stenosis from the accident of July 6, 2015. Dr. Goldberg further testified at his evidence deposition that the petitioner aggravated his spondylolisthesis on July 6, 2015. {Petitioner Exhibit No. 10} {Respondent Exhibit No. 2}

The Arbitrator concludes that petitioner's current condition of ill-being in his low back is causally related to is July 6, 2015 work accident.

The Arbitrator relies upon the causation opinions of Dr. Samir Sharma, Dr. Geoffrey Dixon, Dr. Kevin Koutsky, Dr. Cary Templin and Dr. Edward Goldberg.

As 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:

Respondent shall pay reasonable and necessary medical services of $6,297.47, as provided in Sections 8(a) and 8.2 of the Act.

The Arbitrator finds the unpaid medical bills from Chicago Pain and Orthopaedic Institute to be incurred within the normal course of treatment and the responsibility of the Respondent. {Petitioner Exhibit No. 8} Dr. Goldberg examined the petitioner on April 25, 2018 and opined that the treatment he has received has been appropriate. {Petitioner Exhibit No. 10}

As to Issue (K), Is Petitioner Entitled to Any Prospective Medical Care, the Arbitrator finds as follows:

The Arbitrator denies Petitioner's claim for prospective medical treatment, including surgery prescribed by Dr. Dixon based largely upon the testimony and opinions of Dr. Goldberg, Dr. Bailes and Dr. Hudgins. The Arbitrator finds that these doctors are more credible than Dr. Dixon regarding the need for prospective medical treatment.

The Arbitrator gives weight to the fact that Petitioner testified that the injections, therapy, and medications have not significantly improved his alleged pain. The Arbitrator declines to award surgery as an additional course of treatment based upon the medical opinions that Petitioner did not require surgery, has inconsistent non-organic pain complaints and is shown on surveillance being active without any evidence of disability. Petitioner was able to return to work and worked light duty for over three years, which supports the denial of surgery since Petitioner was able to return to work despite claiming he required lumbar spine surgery.

Based on the above, the Arbitrator does not award surgery recommended by Dr. Dixon or any prospective medical treatment.

As to Issue (L), Is Petitioner Entitled to TTD Benefits, the Arbitrator finds as follows:

The Arbitrator does not award Petitioner any TTD benefits claimed from December 11, 2018 to the date of the trial. The Arbitrator adopts the findings and opinions of Dr. Bailes, Dr. Hudgins and Dr. Goldberg that Petitioner was at maximum medical improvement on, or before, December 4, 2018.

Dr. Goldberg opined that Petitioner was at MMI and could return to full duty work as of December 4, 2018. Petitioner admitted that Respondent offered him a full duty job on December 10, 2018 and he declined to return to work full duty. Based on the above, the Arbitrator finds that Petitioner failed to prove that he is entitled to any TTD benefits claimed from December 11, 2018 to present.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	14WC039574
Case Name	MCLAURIN, ZARAK v. CITY OF CHICAGO DEPT OF WATER MANAGEMENT
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0271
Number of Pages of Decision	30
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Patrick Shifley
Respondent Attorney	Donald Chittick

DATE FILED: 6/7/2021

/s/Kathryn Doerries, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ZARAK McLAURIN,

Petitioner,

vs. NO: 14 WC 39574

CITY OF CHICAGO, DEPARTMENT OF WATER MANAGEMENT,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 17, 2019, 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.

JUNE 7, 2021

/s/*Kathryn A. Doerries*
Kathryn A. Doerries

KAD/bsd
O040621
42

/s/*Thomas J. Tyrrell*
Thomas J. Tyrrell

/s/*Maria E. Portela*
Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0271

McLAURIN, ZARAK
Employee/Petitioner

Case# **14WC039574**
16WC011548

CITY OF CHICAGO WATER MANAGEMENT
Employer/Respondent

On 4/17/2019, 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 2.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1315 DWORKIN AND MACIARIELLO
PATRICK SHIFLEY
134 N LASALLE ST SUITE 650
CHICAGO, IL 60602

0010 CITY OF CHICAGO LAW DEPT
D TAYLOR CHITTICK
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

21IWCC0271

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

ZARAK McLAURIN
Employee/Petitioner

v.

CITY OF CHICAGO WATER MANAGEMENT
Employer/Respondent

Case # **14** WC **39574**

Consolidated cases: **16 WC 11548**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **JUNE 25, 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. [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 **AUGUST 21, 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 **$77,222.14**; the average weekly wage was **$1,485.04**.

On the date of accident, Petitioner was **42** years of age.

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 **$71,140.73** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$71,140.73**.

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

ORDER

As detailed in the attached memorandum discussing the *Findings of Fact and Conclusions of Law:*

- The Arbitrator finds the Respondent shall pay the Petitioner TTD benefits at a rate of **$990.03** per week for a period of **71 6/7 weeks**, as provided in **Section 8(b)** of the Act. The Respondent shall be given a credit of **$71,140.73** for previously paid TTD benefits.; and,

- The Arbitrator finds the Respondent shall pay Petitioner the sum of **$735.37** per week for a further period of **80.63 weeks**, as provided in **Section 8(e)12** of the Act, because the injury to the Petitioner caused a **37.5% loss of use of the right leg.**; and,

- The Arbitrator finds the Respondent shall resolve with and pay directly to those providers, *pursuant to the parties' agreed stipulation on the record,* the reasonable, necessary, and related medical bills of Premium Healthcare Solutions, Chicago Orthopaedic & Sports Medicine, and Illinois Orthopedic Network as itemized in Petitioner's Exhibit 7, and as provided in Sections 8(a) and 8.2 of the Act. (*See* Petitioner's Exhibit 7, and Transcript at 9-10 and 65-66); and,

- The Respondent shall pay those benefits that have accrued in a lump sum, and shall pay the remainder, 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

APRIL 17, 2019
Date

APR 17 2019

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McLAURIN, ZARAK
Employee/Petitioner

Case# **16WC011548**
14WC039574

CITY OF CHICAGO WATER MANAGEMENT
Employer/Respondent

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

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21IWCC0271

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

ZARAK McLAURIN
Employee/Petitioner

v.

CITY OF CHICAGO WATER MANAGEMENT
Employer/Respondent

Case # **16** WC **11548**

Consolidated cases: **14 WC 39574**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **JUNE 25, 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?
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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 29, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* 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 **$80,806.30**; the average weekly wage was **$1,553.97**.

On the date of accident, Petitioner was *at least* **43** years of age. (*Compare* Arbitrator's Exhibits 1A and 1B).

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 **$43,947.41** for TTD, **$0.00** for TPD, **$43,227.11** for maintenance, and **$0.00** for other benefits, for a total credit of **$87,174.52**.

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

ORDER

As detailed in the attached memorandum discussing the *Findings of Fact and Conclusions of Law:*

- The Arbitrator finds the Respondent shall pay the Petitioner TTD benefits at a rate of **$1,035.98** per week for a period of **34 5/7 weeks** (4/1/16 through 11/29/16) as provided in **Section 8(b)** of the Act. The Respondent shall be given a credit of **$43,947.41** for previously paid TTD benefits. Additionally, the Respondent shall pay the Petitioner maintenance benefits at a rate of **$1,035.98** per week for a period of **82 weeks** (11/29/16 through 6/25/18) as provided in **Section 8(a)** of the Act. The Respondent shall be given a credit of **$43,227.11** for previously paid maintenance benefits.; and,

- The Arbitrator finds the Respondent shall pay the Petitioner wage loss differential benefits, commencing on 6/26/18, of **$875.98/week** until the Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injury sustained caused a loss of earnings **as provided in Section 8(d)1 of the Act.**; and,

- The Arbitrator finds the Respondent shall resolve with and pay directly to those providers, *pursuant to the parties' agreed stipulation on the record,* the reasonable, necessary, and related medical bills of Premium Healthcare Solutions, Illinois Orthopedic Network, Rx Development Associates, Nova Pharmacy LP, and Metro Health Solutions, as itemized in Petitioner's Exhibit 7, and as provided in Sections 8(a) and 8.2 of the Act. (*See* Petitioner's Exhibit 7, and Transcript at 9-10 and 65-66); and,

- The Respondent shall pay those benefits that have accrued in a lump sum, and shall pay the remainder, 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

APRIL 17, 2019
Date

APR 17 2019

ZARAK McLAURIN v. CITY OF CHICAGO WATER MANAGEMENT

14 WC 39574 & 16 WC 11548

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

These matters were tried before Arbitrator Steffenson on June 25, 2018. The issues in dispute for both claims were causal connection, medical bills, lost time benefits (TTD and maintenance), and the nature and extent of the injuries. (Arbitrator's Exhibits 1A and 1B). The parties agreed to receipt of this Arbitration Decision via e-mail and requested a written decision, including findings of fact and conclusions of law, per Section 19(b) of the Act. (Arbitrator's Exhibits (*hereinafter*, Ax) 1A and 1B).

FINDINGS OF FACT

The Petitioner, a 46-year-old male, testified that he had been employed with the Respondent for 17 years, under the title Construction Laborer.[1] He described his duties as assisting carpenters in their trade by drilling, digging, and plowing. (Tx at 14).

14 WC 39574[2]

Petitioner testified that on August 21, 2014 he reported to work at 6:00 a.m. and was working on level minus 51 of the Jardine Water purification plant. (Tx at 16, 18). Petitioner was setting up for a job assignment of shoring up a ceiling when a battery powered vehicle used to move equipment (a Cushman cart) crushed his right leg against a stationary machine. (Tx at 16). The Petitioner described the Cushman cart as a steel vehicle, and the stationary machine as a large concrete steel machine. (Tx at 17). Petitioner experienced a pain of 10 out of 10 after his

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[1] Petitioner admitted a history of a work-related rotator cuff tear which he believed had occurred in 2013. (Transcript at 15). Illinois Workers' Compensation Commission (IWCC) records do not show any claim filed for that period or that body part. Petitioner testified that he had returned to work full duty after that injury and that he was able to complete the tasks he was assigned. (Transcript (*hereinafter*, Tx) at 16).

[2] (Ax 1A)

leg was crushed. Petitioner has no further recollection of the accident until he was taken by an ambulance to Northwestern Hospital. (Tx at 18).

On August 21, 2014 at 10:45 am the Petitioner was seen in the Northwestern Hospital Emergency Department. At the time a history was provided of a heavy cart tipping and crushing his right leg against a wall at the water infiltration system [sic]. (Petitioner's Exhibit 1). He was diagnosed with an open fracture of the right mid-shaft tibia and referred for surgery.

A surgical report dated August 22, 2014 shows that the Petitioner had a grade I right tibia fracture, and that he was treated with an intramedullary nailing of the right tibia fracture. (Petitioner's Exhibit (*hereinafter*, Px) 1).

On September 2, 2014, the Petitioner was seen at Northwestern by Dr. Merk for follow up on his surgical repair. He noted some drainage from the surgical wound. He was deemed to be doing well and asked to return in one week. (Px 1). On September 9, 2014 the Petitioner was seen at Northwestern by Dr. Merk and referred to Dr. Dumanian for examination of the drainage in his wound. He was to return in two days. (Px 1). On September 12, 2014 the Petitioner was seen for debridement of his surgical wound. The right anterior third of his surgical wound was noted to be an open draining wound. His wound was surgically debrided, and he was placed on bedrest for 5 days. The Petitioner was discharged after 5 days on September 17, 2014 and was prescribed antibiotics to be provided at home via IV. (Px 1).

On October 7, 2014 the Petitioner was seen by Dr. Merk for follow up at Northwestern. He was noted to be healing well and was advised to begin home exercise. At this time, he was noted to be eligible for sedentary duty. (Px 1). On October 22, 2014 the Petitioner was seen by Dr. Dumanian for follow up on his wound. He was released "prn", or to return "when necessary" for wound care purposes. (Px 1).

On November 25, 2014 the Petitioner was seen for follow up on his right leg surgery at Northwestern Memorial. (Px 1). He was noted to be participating in physical therapy, and to be reporting mild residual discomfort. (Px 1).

On January 6, 2015 the Petitioner was seen for follow up on his right leg surgery by Dr. Merk. He was noted to be attending physical therapy at NovaCare three times per week and was making progress. He was noted to have a limp and to ambulate with a cane when outdoors. However, Petitioner was still experiencing sharp pain in his injured shin. Treatment options were discussed, and he was to follow up in 6 weeks. (Px 1).

On February 17, 2015 the Petitioner was seen for follow up on his right leg surgery by Dr. Merk. He was noted to be attending physical therapy at NovaCare and reported that while pain was present, it was improving. He reported difficulty with stairs and being unable to kneel. (Px 1).

On March 17, 2015 the Petitioner was seen for follow up on his right leg by Dr. Merk. He was noted to be walking with an overall improved gait pattern without significant limp. He was to initiate work conditioning, and it was noted that his nail would have to be surgically removed when the bones had healed satisfactorily. (Px 1).

On April 15, 2015 the Petitioner was seen for follow up on his right leg by Dr. Merk. He was noted to have been attending work conditioning but noted continuing discomfort in his leg and knee. His fracture was x-rayed and deemed well healed, and he was to complete two and half more weeks of work conditioning. (Px 1).

On May 8, 2015 the Petitioner was seen for follow up on his right leg by Dr. Merk. He was noted to have been attending work conditioning but noted continuing discomfort in his leg and knee. He complained of giving way of the right knee which was noted to be related to quadriceps strength. A plan for removal of the surgical nail was scheduled. (Px 1). On May 18, 2015 the Petitioner underwent a surgical procedure at Northwestern Memorial to remove the intramedullary nail and interlocking bolt which had been retained after the repair of his fracture on August 22, 2014. (Px 1).

On June 2, 2015 the Petitioner returned to Dr. Merk for a post-operative visit. He was noted to have not yet returned to work, and to be weightbearing as tolerated. He noted discomfort and stiffness which had increased after his second surgery. The plan was to release Petitioner to return to work on June 22, 2015 without restrictions. (Px 1).

Petitioner concluded treatment with Dr. Merk and returned to work. However, he testified that he had been dissatisfied with the condition of his leg and sought a second opinion. (Tx at 23).

On September 1, 2015 the Petitioner returned to Dr. Merk for follow up on his right leg injury. The Petitioner reported that after three days at work he had been sent home due to inability to function due to pain. He reported that he had been directed to return to Dr. Merck after requests by the Petitioner's PCP for an MRI were denied by the insurance provider. He complained of persistent occasional pain radiating down the medial aspect of his lower leg, as well as soreness in his knee and feelings of weakness and instability. The Petitioner was

returned to work with light duty restrictions, and a Functional Capacity Evaluation (FCE) was ordered in addition to a follow-up MRI. (Px 1).

On February 17, 2016 the Petitioner returned to Dr. Merk for follow up on his right leg injury. The Petitioner reported aching discomfort in his knee and his leg with activity. Dr. Merk found the Petitioner to be at maximum medical improvement (MMI) and he was released to follow up as needed. (Px 1).

On March 17, 2016 the Petitioner was seen Chicago Orthopaedics & Sports Medicine for examination of his right tibia and knee. He complained of ongoing weakness and pain after a work injury in August of 2014. He was examined by Dr. Ellis Nam and given a referral to an orthopedic trauma surgeon. (Px 3). A copy of this referral note is duplicated in the files of Dr. Poepping, discussed below. On March 18, 2016 the Petitioner returned to Dr. Merk for follow up for names of a second opinion for his knee injury. He reported being back to work full duty, but feeling unable to continue his job duties, and using vacation days. (Px 1).

16 WC 11548[3]

Petitioner testified that in March of 2016 he had returned to his original position as a construction laborer while receiving ongoing care for his right leg. (Tx at 26). On March 29, 2016 he was unloading lumber off a pick-up track at 52nd and Western when he felt a tear in his left shoulder. (Tx at 33). He was immediately unable to lift his left arm and was unable to complete his work that day. (Tx at 33). Petitioner left the job under his own power. (Tx at 33).

On April 5, 2016 the Petitioner was seen by Dr. Poepping for his right tibia injury. He was complaining of right knee pain and giving way in his knee. (Px 2). MRI of the right knee was ordered to determine if the complaints were related to a tear in the knee. (Px 2). A copy of the evaluation and referral of Dr. Ellis Nam was included in the record. (Px 2).

On April 14, 2016, the Petitioner underwent an MRI of the right knee at Molecular Imaging. (Px 2). The MRI report showed a Grade II sprain of the ACL, and a Grade I mucoid degeneration without evidence of tear. (Px 2). On April 14, 2016 the Petitioner also underwent an MRI of the left shoulder at Molecular Imaging. (Px 2). The MRI report showed glenohumeral joint effusion, AC joint arthropathy, and a near complete re-tear at the insertion of the supraspinatus. (Px 2).

[3] (Ax 1B)

On April 19, 2016 the Petitioner was seen for follow up on the MRI of his right knee by Dr. Thomas Poepping. (Px 2). He gave a history of a March 29, 2016 injury to his shoulder due to lifting a 12-foot 4 x 4 into a truck. (Px 2). An MRI of the left shoulder was reviewed along with the MRI of the right knee. The diagnoses on examination were a left shoulder recurrent rotator cuff tear, left shoulder AC arthrosis, left shoulder biceps tendonitis, and right knee bone bruise. Surgical repair of the left shoulder was planned, and further physical therapy for the right knee was recommended. (Px 2). Petitioner was given work restrictions and instructed to follow up in 4 weeks. (Px 2).

On April 30, 2016, the Petitioner began physical therapy with Advanced Spine and Rehab Center/Midwest Pain and Rehab. (Px 4). A treatment plan was created to treat his left knee and his right knee. (Px 4). He received therapy through September 1, 2016. (Px 4).

On May 17, 2016 the Petitioner was seen for follow up on the right leg injury. He reported tenderness over his surgical flap, and the diagnosis was right knee bone bruise and right knee pain. The plan for long term care for the right leg injury was deferred due to the plan for shoulder surgery to take place the same date. He was kept off work. (Px 2).

On May 17, 2016 the Petitioner underwent a surgical repair of his left shoulder. (Px 2). The procedure performed was a left shoulder arthroscopic revision rotator cuff repair, subacromial decompression, distal clavicle excision, and subpectoral biceps tenodesis. The surgery found a complete full thickness retracted tear to the glenoid margin, with 50% biceps tenodesis. (Px 2). On May 31, 2016 the Petitioner was seen for surgical follow up. A that time he was doing well, kept off work, and to follow up in four weeks. (Px 2).

On June 28, 2016 the Petitioner was seen for surgical follow up for his left shoulder. He was participating in therapy and doing well. He was to remain off work and follow up in 4 weeks. He was also seen for his right knee pain. He was offered an injection to treat his ongoing pain but deferred in favor of further physical therapy. (Px 2).

On July 19, 2016 Petitioner was seen for left shoulder. There was noted crepitus of concern to Dr. Poepping, the Petitioner was to continue therapy, remain off work, and to return in 5 weeks. He also followed up for his right knee pain. He reported ongoing knee pain and underwent a right knee Kenalog injection. (Px 2).

On September 6, 2016, Petitioner was seen for follow up on his left shoulder surgery. He was noted to be improving and to require 2 additional months of therapy. He was kept off work and was to follow up in 4 weeks. Petitioner followed up on ongoing right knee pain. He

reported increasing pan and no benefit from the injection. He was to continue physical therapy. (Px 2).

On October 4, 2016, Petitioner was seen for follow up on his left shoulder. He was expected to need one more month of physical therapy. He was also seen for his right leg and continued to report pain in the anterior knee and the area of his previous fracture. (Px 2).

On November 1, 2016, Petitioner was seen for follow up on his left shoulder. He was noted to have full active and passive range of motion, but positive Neer's and Hawkin's tests, indicative of impingement. He reported ongoing symptoms in his knee, subject to changes in the weather. He was referred again for an FCE and was to follow up in 4 weeks. (Px 2).

On November 15, 2016, Petitioner underwent an FCE at ATI. Petitioner was deemed to have made a valid effort. His physical restrictions included lifting restrictions, and a 4-hour overall work day tolerance. He was noted to have sitting restrictions of 3-4 hours, in 35-minute durations. He was noted to have standing restrictions of 3-4 hours, in 14-minute durations. He was noted to have walking restrictions of 1 to 2 hours with only occasional short distances.

On November 29, 2016, Petitioner was seen by Dr. Poepping, following up on his FCE. The FCE was deemed valid, and he was given permanent restrictions based on the findings. (Px 2). He was found to be at MMI. (Px 2).

On August 15, 2017, Petitioner was seen by Dr. Poepping for follow up on ongoing pain and numbness in his right leg. He was reporting numbness in his right foot that fluctuated without pattern. On examination decreased sensation in the right foot was noted. Based upon his symptoms he was referred for an MRI of the lumbar spine and an EMG of the right lower extremity. (Px 2). On August 18, 2017, Petitioner underwent a lumbar MRI. The findings of the report showed no evidence of herniation or stenosis. (Px 2).

On September 5, 2017, Petitioner was seen by Dr. Poepping for follow up care. He was noted to have low back pain, and right lower extremity numbness. (Px 2). The EMG was pending, and he was referred for follow up after the EMG. (Px 2). On September 19, 2017, Petitioner was seen by Dr. Poepping for further follow up care for the right leg pain and numbness. The EMG report was still pending, and the visit was continued. (Px 2).

On October 3, 2017, Petitioner was seen by Dr. Poepping to review his EMG. He was referred to physical therapy for pain which apparently was radiating from his low back. (Px 2).

On October 31, 2017, Petitioner was seen by Dr, Poepping for his lumbar radiculopathy. Dr. Poepping opined the right leg was not generating the pain, and he was referred for pain management. (Px 2).

On January 9, 2018, Petitioner was seen for follow up on his low back, right leg, and left shoulder pain. On examination, he reported tenderness over the bicep tendon, but had a full range of motion. He was referred for physical therapy, and his permanent restrictions were continued. (Px 2).

On March 6, 2018, Petitioner was seen for follow up on his low back, right leg, and left shoulder pain. He was pending the results of a Section 12 examination. (Px 2). He was continued at his permanent restrictions, and he was referred to therapy. (Px 2). On March 7, 2018 he was seen for re-examination at Advanced Spine and Rehab. He continued therapy with Advanced Spine and Rehab Center through March 30, 2018. (Px 4). Dr. Poepping's records contain the Section 12 report, but no medical record reviewing the Section 12 report is contained in the file. (Px 2).

After being released by Dr. Poepping to return to work with restrictions he sought to return to work with the Respondent. Petitioner completed a Request for Reasonable Accommodation with the Respondent. (Px 5E and Tx at 40). Petitioner sought employment with the Respondent in his original position, and in other positions. (Tx at 40).

After being unable to return to work with the Respondent, the Petitioner began a vocational rehabilitation program with Vocamotive in Hinsdale on or about June 28, 2017. (Tx at 40, 56). Petitioner worked with them at their office in Hinsdale three days per week, requiring an hour drive from his home. (Tx at 41, 42). Petitioner testified that because of the lengthy commute, he would experience pain from his injuries during his commute. (Tx at 41). The remaining two days a week the Petitioner would work from home on his job search and computer work. (Tx at 43).

During the period around July 24, 2017, the Petitioner applied to return to work with the Respondent. (Tx at 50). The jobs he applied for included "Chief Assistant Corporation Counsel". (Tx at 50). Petitioner testified that he was unaware that the position was for an attorney position in the Respondent's Law Department, at the time he applied. (Tx at 51). He admitted to having no background in law. The jobs also included "financial planning analyst". (Tx at 51). Petitioner testified that he had a background assisting with financial grant applications for hospitalized people. (Tx at 51).

Petitioner testified that prior to July 24th he had only undergone two workshops explaining what kind of jobs he should be applying for. (Tx at 55). He also testified that he believed his experience qualified him for the "financial planning analyst" position. (Tx at 56). Petitioner claimed that while his job title states that he is a laborer, he has never done laborer job duties. Similarly, he believed that other positions with the Respondent might have descriptions which did not match their duties. (Tx at 57).

Petitioner testified he received computer training in Microsoft Word and Excel as well as training in job searching. (Tx at 41). Petitioner was able to identify an Excel 2013 Basic Certificate, a Word Basic Certificate, and an Internet Basic Certificate he had received from Vocamotive from his efforts. (Tx at 42).

Petitioner admitted he missed appointments with Vocamotive due to a family death and medical emergencies. (Tx at 54). He also described the end of his work with Vocamotive as not on a good note. (Tx at 45). He had been harassed due to his dress and his appearance, claiming to have been sent home for working Harley Davidson branded polo shirts with a logo on the back of the shirt. (Tx at 45).

Petitioner identified job application receipts he had received from applying for jobs with Indeed.com. (Tx at 46). He testified that he had applied for 1,388 positions without getting an interview since the termination of his program with Vocamotive. (Tx at 47).

Petitioner testified that he continues to experience pain in his right leg two to three times a day. Petitioner rated the pain as ranging from a 3 to an 8 out of ten. (Tx at 28). Petitioner described his leg as interfering with his abilities to walk, run, stand, and sit for long periods of time. (Tx at 29). He testified that he can walk on his leg for 30-40 minutes and sit for 30–40 minutes. He testified that he experiences cramping, tenderness and tingling because of sitting, and pain, tingling, and numbness because of standing. He also testified to problems with his knee which he relates to his hardware installation surgery. The Petitioner showed the Arbitrator an extremely large depressed scar on the inside of his right calf, a scar on the inside of his calf near his ankle which he relates to a surgical screw installation, and then a scar on his knee which he relates to installation of a rod. (Tx at 31).

Petitioner testified that he continues to experience pain in his left shoulder. (Tx at 36). He testified that he experiences pain once or twice a week as a 2 out of 10. (Tx at 37).

Vocational efforts

Both parties introduced job application logs, and the Respondent introduced reports of the vocational rehabilitation provider, Vocamotive. Those records show that the Petitioner began his program on June 28, 2017. During June he was required to attend only one date onsite with Vocamotive and had two call-in dates. The records show he was to be studying Windows 7 Tutorials. (Px 5D).

In July, the Petitioner was to attend two onsite classes per week, and to call in three days per week. The Petitioner was to study Windows 7, to complete Internet Basics Workbooks, to Study Office 2013 and Word 2013, and to be engaged in job search workshops. The Arbitrator notes that the job search workshops ran one per week at Vocamotive's office and lasted from 8:45 am – 3:30pm. The Petitioner noted typing speeds for each of the days in July, except for July 12, which is blank on both July log sheets. Petitioner noted a doctor appointment on July 25, and that he called in on July 26 rather than attend the scheduled Vocational Testing. (Px 5D).

In August, the Petitioner was to attend two on-site classes per week, and to call in three days per week. The Petitioner was to study Word 2013 and Office 2013. The Petitioner noted typing speeds for all days except August 17, 18, 22 and 24th, which are blank on both August log sheets. The Petitioner noted that he had a doctor appointment on August 15th, and that he had to reschedule a class. He noted that the attended an extra class in place of a call in on August 17th, two days later. (Px 5D).

On August 4, 2017 the Petitioner was awarded a certificate of achievement for completion of the Windows 7/Internet Basics course at Vocamotive. (Px 5D).

In September the Petitioner was to attend two onsite classes per week, and to call in three days per week. The Petitioner was to study Excel 2013 and Word 2013. The Petitioner noted typing speeds for all days except for the period from September 8 through September 15, which is noted as "funeral miss". The Petitioner also noted that he had to call off two dates, September 5 and 6 for a doctor appointment.

Petitioner submitted a job search log to the Respondent which shows vocational applications with the Respondent for various positions between July 3 – September 10, 2017. The Petitioner applied for positions with the Respondent in positions including: Accounting Technician II, Auditor II, Supervising Timekeeper – Laborer, Supervising Ventilation and Furnace Inspector, Customer Account Representative, , Architect III, Pool Motor Truck Driver, Painter,

Chief Assistant Corporation Counsel, Civil Engineer III – Sewer, Zoning Plan Examiner, Custodian Worker – Full-Time, Laborer – Apprentice, Chief Airport Operations Supvsr, Clerk IV, Library Division Chief, Glazier. (Respondent's Exhibit 3).

In October the Petitioner was to attend two onsite classes for the first three weeks, and no activity shows as planned for the final week. The Petitioner crossed off September 3, an Attend day, and noted the name of Dr. Poepping. On October 6 he noted that he was sent home. Petitioner noted that he reported Friday October 13 for a makeup date. Finally, on October 17 he noted the name Dr. Hajat.

On October 18, 2017 the Petitioner was awarded a certificate of achievement for completion of the Word 2013 Basic course at Vocamotive. On October 19, 2017 the Petitioner was awarded a certificate of achievement for completion of the Excel 2013 Basic course at Vocamotive. (Px 5D).

Petitioner submitted Mileage Logs into evidence. Those logs show that the Petitioner drove from his home to the Vocamotive offices in Hinsdale on September 7, 21, 22, and 26th, as well as October 4, 5, 6, 10, 12, and 13th. (Px 5D).

Petitioner provided records of job application receipts provided by the job seeking service, Indeed. (Px 5B). The Petitioner was noted to have applied to 1388 jobs over a 221-day period and would indicate a rate of 6.28 jobs per day, including holidays and weekends. (Px 5B).

Reports of Vocamotive

The April 6, 2017 Initial Evaluation Report of Vocamotive identified the Petitioner as a 45-year-old candidate for vocational rehabilitation. Both the August 2014 leg injury and the March 2016 shoulder injury were noted. His FCE from ATI physical therapy was noted, and his restrictions were noted to be a 4-hour work day, no lifting of over 17 lbs. overhead, and no sitting or standing for more than 1 hour. His medical records were reviewed, as was his educational history, vocational history, and socioeconomic status. (Respondent's Exhibit (*hereinafter*, Rx) 4)

The report is specifically noted to exclude consideration of his prior leg injury and that "restrictions pertaining to the leg will not be taken into consideration." (Rx 4).

It was the opinion of the Report that the Petitioner had lost access to his usual and customary line of occupation. The Petitioner was concluded to have an earning potential between $9.00 per hour and $12.00 per hour. (Rx 4).

The October 23, 2017 Final Report of Vocamotive indicates that Petitioner missed an appointment on October 24, 2017 due to medical issues. That appointment was rescheduled for October 26, 2017, and Petitioner was noted to be in attendance. The Reports notes that Petitioner was required to be available for vocational efforts from 8 am to 5pm. The Report specifically notes that Petitioner was required to be available more than his work restrictions. (Rx 4).

The Reports show that Petitioner frequently missed or rescheduled appointments due to medical issues and last-minute visits to his physicians. According to the report, these efforts were not limited to his work-related injuries. As of November 17, 2017, the Petitioner terminated his Vocational efforts with Vocamotive and returned his equipment to their office. (Rx 4).

January 8, 2018 Section 12 Report of Dr. Brian Cole

The Petitioner was seen by Dr. Brian Cole on January 8, 2018 for a Respondent's Section 12 examination. Dr. Cole reviewed medical records, examined the Petitioner, and took a history of the injury. Dr. Cole's diagnosis was a left shoulder rotator cuff injury which had reached MMI with residual pain and biceps tendinitis, as well as related restrictions. (Rx 2).

Dr. Cole gave the Petitioner restrictions "roughly in accordance with the FCE". He set the push/pull up to 20 pounds regularly, with no overhead work with the left upper extremity. Dr. Cole's only point of dispute with the FCE was with the 4-hour work restriction. Dr. Cole found that Mr. McLaurin could return to work without restrictions on his hours. (Rx 2).

January 26, 2018 Addendum Report of Dr. Brian Cole

An Addendum report was produced by Dr. Cole on January 26, 2018. Dr. Cole was provided additional materials for his review, in the form of surveillance footage. Dr. Cole, personally reviewing the footage, noted that the Petitioner was seen working outside with family members hanging Christmas lights. Dr. Cole noted the Petitioner was not seen lifting anything of significant weight during the 17 minutes recorded on the video.

Dr. Cole opined the activities performed were within the restrictions previously provided, and that the video surveillance did not reveal the Petitioner exceeding the performance he had shown during the original examination, or during the FCE.

Dr. Cole continued to opine that the FCE represented a valid representation of the Petitioner's capabilities.

Medical Bills

Petitioner introduced the medical bills of Chicago Orthopaedics & Sports Medicine. The bill shows an unpaid balance of $254 for services on March 17, 2016. The Arbitrator takes judicial notice that the CPT code 99204, the code billed, represents a new patient visit. (Px 7).

Petitioner introduced the medical bills of Premium Healthcare Solutions. The bill shows an unpaid balance of $4,662 for services on April 14, 2016. Treatment is identified as an upper extremity joint MRI and a lower extremity joint MRI. (Px 7).

Petitioner introduced the medical bills of Illinois Orthopedic Network. The bills show unpaid therapy for date of injury March 29, 2016, from April 30, 2016 through September 1, 2016 and March 7, 2018 through March 30, 2018. For those treatments the unpaid amount is listed as $10,763.63. Unpaid office visits are noted for the right knee from April 5, 2016 through March 6, 2018. Bills for the shoulder surgery on May 17, 2016 and post-operative care for the shoulder show as partially paid, with $1,742.00 showing as unpaid. (Px 7).

Petitioner introduced the medical bills of Suburban Pain Care Center. The bill shows a balance of $0. (Px 7).

Petitioner introduced the medical bills of ATI. The bill shows a balance of $0. (Px 7).

Petitioner introduced the Health Insurance claims forms of Specialty Pharmaceutical Inc. The referring provider is listed as doctor Neeraj Jain and is for pharmaceuticals provided on October 3, 2016. (Px 7).

Petitioner introduced the medical bills of Rx Development Associates. Inc. The bill shows a balance due for $2,198.90 for Terocin Lotion and Terocin patch on September 29, 2016. The facility is Midwest Pain Specialists, Inc, the Petitioner's physical therapy provider. (Px 7).

Petitioner introduced the medical bills of Nova Pharmacy LP. The bill shows a balance due for $68.01 for Hydrocodone prescribed by Dr. Thomas Poepping on May 18, 2016. (Px 7).

Petitioner introduced the medical bills of Metro Health Solutions. The bill shows a balance due for $1,440.54 for Zofran, Duricef, and Narcosoft prescribed at Illinois Orthopedic Network on May 18, 2016, and a $0 balance for Urine test strips. (Px 7).

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

14 WC 39574

Issue F: *Causal connection*

The Arbitrator finds that the Petitioner has met his burden of proof by the preponderance of the evidence that the current condition of his right leg is causally connected to the accident of August 21, 2014.

"A causal connection between work duties and a condition may be established by a chain of events including petitioner's ability to perform duties before the date of the accident and inability to perform the same duties following that date." Darling v. Indus. Comm'n., 176 Ill App. 3d 186, 193 (1988). A causal connection may be established by evidence of prior good health, a work injury, resulting disability and inability to work. (Id.).

The Petitioner's unrebutted testimony was that he was able to perform his full duties in the time prior to his accident. The Petitioner testified to a 17-year history with the Respondent and testified that he had returned to full duty after a prior injury to his left rotator cuff. (Tx at 16). The Petitioner testified, consistent with the medical records, that while he had returned to work he was not satisfied with the condition of his leg, and that he continues to experience symptoms to this day. (Tx at 26).

The Petitioner's testimony was credible and unrebutted, as well as consistent with the medical records. The Arbitrator finds that the current condition of the Petitioner's right leg is causally connected to the accident of August 21, 2014.

Issue J: *Medical bills*

The Arbitrator finds that the Petitioner has proven by the preponderance of the evidence that the bills of Premium Healthcare Solutions for the lower extremity joint MRI is reasonable and related to the injury to the right leg. (Px 7).

The Arbitrator finds that the Petitioner has proven by the preponderance of the evidence that the medical bills of Chicago Orthopaedics & Sports Medicine for evaluation by Dr. Nam was reasonable and related to the injury to the right leg.

The Arbitrator finds that the Petitioner has proven by the preponderance of the evidence that the bills of Illinois Orthopedic Network for unpaid office visits are noted for the right knee from April 5, 2016 through March 6, 2018 are reasonable and related to the injury to the right leg. (Px 7).

The Respondent is ordered to make payment of the above bills directly to the medical providers noted, pursuant to the terms of the Act, and pursuant to the stipulation of the parties. (Tx at 9-10 and 65-66).

Issue K: *TTD*

The Petitioner has met his burden of proof by the preponderance of the evidence that he was temporarily totally disabled beginning August 22, 2014 through and including June 21, 2015. This is consistent with the Petitioner's testimony as well as the medical records of Dr. Merk at Northwestern Memorial Hospital. This represents a period of 43 and 3/7 weeks. The parties also stipulated that the Petitioner was owed TTD from August 5, 2015 through February 19, 2016, a period of 28 and 3/7 weeks. The Petitioner was therefore owed a total of 71 and 6/7 weeks of TTD. Pursuant to the stipulation of the parties, the Respondent is given a credit of $71,140.73 for TTD paid. (Ax 1A).

Issue L: *Nature and extent of injury*

Pursuant to Section 8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability ("PPD"), for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all 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 from (a) above;
(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.

(See 820 ILCS 305/8.1b)

With regards to factor (i) of Section 8.1b of the Act:

i. The Arbitrator notes that no AMA rating report was admitted into evidence by either party. As such, the Arbitrator gives **no weight** to this factor.

With regards to factor (ii) of Section 8.1b of the Act:

ii. The Arbitrator finds the Petitioner was required to work in a heavy physical demand position as a laborer for the Respondent. As the injury involved relates to his right leg, and as the job cannot be satisfied from a sedentary position, or without the use of right leg, the Arbitrator gives **moderate weight** to this factor.

With regards to factor (iii) of Section 8.1b of the Act:

iii. The Arbitrator notes that the Petitioner was 42 years old at the time of the accident. (Ax 1A). The Arbitrator therefore gives ***some weight*** to this factor.

With regards to factor (iv) of Section 8.1b of the Act:

iv. The Arbitrator notes that the Petitioner returned to employment in his pre-injury position without loss of income prior to his subsequent accident on March 29, 2016. Furthermore, the record is devoid of any evidence of an impairment of earnings because of this August 21, 2014 work accident. As such, the Arbitrator therefore gives ***no weight*** to this factor.

With regards to factor (v) of Section 8.1b of the Act:

v. Evidence of disability corroborated by the treating medical records finds that the Petitioner's injury to his right leg was a comminuted fracture of his tibia which required three (3) surgical interventions for treatment, including a five (5) day inpatient stay at Northwestern Hospital. His open reduction and internal fixation required hardware placement, surgical care for an infected wound, and subsequent hardware removal. Dr. Poepping has prescribed continuing physical therapy through March 6, 2018, and the Petitioner testified he continues to have pain in his right leg. Scarring also is present across the Petitioner's right leg. (Tx at 30-32). Due to the Petitioner's medically documented injuries and other physical complaints, the Arbitrator therefore gives ***significant weight*** to this factor.

Based on the above factors, and the entire record, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of an **37.5% loss of use of the right leg** pursuant to Section 8(e)12 and Section 8.1b of the Act.

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Issue F: *Causal connection*

The Arbitrator finds that the Petitioner has met his burden of proof by the preponderance of the evidence that the current condition of his left shoulder is causally connected to the accident of March 29, 2016.

"A causal connection between work duties and a condition may be established by a chain of events including petitioner's ability to perform duties before the date of the accident and inability to perform the same duties following that date." Darling v. Indus. Comm'n., 176 Ill App. 3d 186, 193 (1988). A causal connection may be established by evidence of prior good health, a work injury, resulting disability and inability to work. Id.

The Petitioner's unrebutted testimony was that he had returned to work after his injury to his right leg and was in the performance of his duties in the time prior to his March 29, 2016 accident. (Tx at 33). The Petitioner testified, consistent with the medical records, that he continues to experience symptoms in his left shoulder. (Tx at 36). Finally, the Respondent's Section 12 examiner, Dr. Cole, found that the Petitioner's current condition and the residual impairment are related to the injury of March 29, 2016. (Rx 2).

The Petitioner's testimony was credible and unrebutted, as well as consistent with the medical records. The Arbitrator finds that the current condition of the Petitioner's left shoulder is causally connected to the accident of March 29, 2016.

Issue J: *Medical bills*

The Arbitrator finds that the Petitioner has proven by the preponderance of the evidence that the bills of Premium Healthcare Solutions for the upper extremity joint MRI is reasonable and related to the injury to the left shoulder. (Px 7).

The Arbitrator finds that the Petitioner has proven by the preponderance of the evidence that the bills of Illinois Orthopedic Network for therapy for the shoulder surgery on May 17, 2016 and post-operative care are reasonable and related to the injury to the left shoulder. (Px 7).

The Arbitrator finds that the Petitioner has proven by the preponderance of the evidence that the bills of Rx Development Associates, Inc., are reasonable and related to the injury to his left shoulder and the treatment he received at Advanced Spine and Rehab/Midwest Pain Specialists, Inc. (Px 7).

The Arbitrator finds that the Petitioner has proven by the preponderance of the evidence that the bills of Nova Pharmacy LP are reasonable and related to the injury to the left shoulder. (Px 7).

The Arbitrator finds that the Petitioner has proven by the preponderance of the evidence that the bills of Metro Health Solutions are reasonable and related to the injury to the left shoulder. (Px 7).

The Respondent is ordered to make payment of the above bills directly to the medical providers noted, pursuant to the terms of the Act, and pursuant to the stipulation of the parties. (Tx at 9-10 and 65-66).

Issue K: *TTD and Maintenance*

The Petitioner has met his burden of proof by the preponderance of the evidence that he was temporarily totally disabled beginning April 1, 2016 through and November 29, 2016, when he was found to be at MMI by Dr. Poepping.

Regarding Maintenance, the Petitioner was placed at MMI on November 29, 2016. Maintenance therefore begins the date the Petitioner reached MMI.

The Petitioner's Permanent Restrictions

A difference of opinion between the Petitioner's treating physician's MMI restrictions and the Section 12 Report restrictions regarding permanency exists in this case and is relevant to the issue of Maintenance and Permanency. The Arbitrator finds the opinion of Dr. Poepping, the Petitioner's treating physician, most credible.

Dr. Poepping treated the Petitioner beginning from his interview on April 5, 2016. Dr. Poepping was the Petitioner's surgeon, and his treating physicians for both his ongoing right knee complaints, and his left shoulder injury. Dr. Poepping set the Petitioner's restrictions after ordering an FCE by ATI, and after reviewing what was deemed to be a valid FCE. Considering the length of the care provided by Dr. Poepping, the Arbitrator finds the opinion of Dr. Poepping very credible.

Dr. Cole, the Respondent's Section 12 physician, agreed with Dr. Poepping on all respects regarding the permanent restrictions, with the sole exception of the 4 hour per day work restriction. While the Arbitrator finds the Dr. Cole to be credible, the Arbitrator notes that a single examination does not provide the Section 12 examiner the same depth of understanding of the Petitioner's abilities as over 19 months of treatment. Neither does an Section 12 examination last as long as an FCE.

Weighing the differing medical opinions regarding the Petitioner's restrictions, the Arbitrator finds the opinion of Dr. Poepping most credible and finds that the preponderance of the evidence is that the Petitioner is only able to work 4 hours per day due to his injury.

The Arbitrator therefore awards the Petitioner 4 hours per day of maintenance pay from the date he reached MMI, November 29, 2016, through the date of the trial, June 25, 2018, a period of exactly 82 weeks.

The Petitioner's vocational efforts

Petitioner introduced evidence that he applied for accommodation with the Respondent, via the Request for Reasonable Accommodation. The Respondent was unable to provide the Petitioner with a position. The Respondent offered vocational services pursuant to

Rule 9110.10, and the Petitioner began a coordinated vocational program on or about the time of the March 23, 2017 interview with Vocamotive staff. (Rx 4).

The Petitioner is therefore awarded Maintenance pay for the remaining 4 hours per day from November 29, 2016 through March 23, 2017, a period of 16 and 4/7 weeks.

The Petitioner was involved in a coordinated vocational rehabilitation program with Vocamotive through November 17, 2017, when he returned the equipment of Vocamotive to their offices. The Arbitrator therefore awards 4 hours of maintenance from March 23, 2017 through November 17, 2017, a period of 34 and 2/7 weeks.

The Arbitrator is forced to consider the cause of Petitioner's termination from Vocamotive's program on November 17, 2017 and the sufficiency of his efforts after that date. It is evident from the reports of Vocamotive that the Petitioner was struggling to cooperate with Vocamotive due to personal issues, medical issues, and personality conflicts with Vocamotive staff. The Arbitrator also notes that Vocamotive explicitly stated in their reports that they would be expecting the Petitioner to work beyond the 4 hour per day restrictions the Arbitrator has deemed credible. The Petitioner was also required to drive to Vocamotive a distance which required him to exceed the amount set forth in his restrictions. Neither party can be deemed to have fully cooperated with the other.

Considering the behavior of both the Petitioner and Vocamotive, the Arbitrator must ponder the vocational efforts of the Petitioner after he terminated his efforts with Vocamotive. The Petitioner was able to demonstrate that he continued job applications through the date of the trial, applying to 1,388 jobs through Indeed. The Arbitrator finds that this was enough effort to merit maintenance. The Arbitrator therefore awards the remaining 4 hours of maintenance per day from November 17, 2017 through June 25, 2018, a period of 31 and 4/7 weeks. The Arbitrator thereby awards full payment of maintenance from November 29, 2016 through June 25, 2018.

Issue L: *Nature and extent of injury*

The Petitioner has met his burden of proof that he is owed a wage differential under §8(d)1 of the Act. The Petitioner has sustained an accidental injury, which has resulted in partial incapacity which prevents him from pursuing his usual and customary line of employment. The parties to this matter agreed that on March 29, 2016, the Petitioner was involved in a work-related accidental injury. (Ax 1B).

Regarding the element that partial incapacity prevents the Petitioner from pursuit of his usual and customary employment, the Arbitrator finds that the Petitioner is so restricted. The Petitioner testified that he had worked for the Respondent for 17 years prior to his injuries, and that he was employed as a construction laborer. The Arbitrator finds that the usual and customary employment was in the construction trade.

The Respondent's Section 12 examiner, Dr. Cole, on review of the surveillance footage, and after examination of the Petitioner and his medical records, found that the Petitioner would not be able to return to work to his original job or in a construction basis. In this matter Dr Cole's opinion was in accord with the Petitioner's treating physician Dr. Poepping. There being no dispute that the Petitioner cannot return to work in the construction trade, the Arbitrator finds that he has lost access to his usual and customary employment.

Furthermore, as evidenced by the "request for accommodation" completed by the Petitioner to the Respondent, and the job applications by the Petitioner for positions with the Respondent, the Respondent is unable to accommodate the Petitioner in his current condition.

As stated above regarding **Issue K:** *TTD and Maintenance*, the Arbitrator finds that the restrictions of the Dr. Poepping and the FCE to be most credible and finds that the Petitioner is restricted as per the FCE report. Pursuant to the terms of that report, the Petitioner is restricted to a 4-hour work day, and to no more than the physical capabilities listed in that report.

The labor market survey provided by Respondent's vocational provider, Vocamotive, sets forth the Petitioner's potential earning capacity as between $9 per hour and $12 per hour. The Arbitrator takes judicial notice that the minimum wage in the City of Chicago as of the date of this Decision is $12 per hour. The Arbitrator therefore finds that the Petitioner, per his Application a resident of the City of Chicago, can earn $12 per hour, 4 hours per day, per his FCE.

The Arbitrator therefore awards a wage differential between the Petitioner's Average Weekly Wage ($1,553.97), representing the amount which he would be able to earn in the full

performance of the duties he was engaged in at the time of the accident, and a weekly wage of $240 ($12/per hour x 4 hours/per day x 5 days/week). The differential is therefore $1,313.97, and the Respondent is ordered to pay $875.98 per week until the Petitioner reaches age 67, pursuant to the Act. ($1,553.97 - $240 = $1,313.97 and $1,313.97 x 66.6% = $875.98)

Signature of Arbitrator

APRIL 17, 2019
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC011548
Case Name	MCLAURIN, ZARAK v. CITY OF CHICAGO DEPT. OF WATER MANAGEMENT
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0272
Number of Pages of Decision	35
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Patrick Shifley
Respondent Attorney	Donald Chittick

DATE FILED: 6/7/2021

DISSENT

/s/Kathryn Doerries, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ZARAK McLAUREN,

Petitioner,

vs. NO: 16 WC 11548

CITY OF CHICAGO, DEPARTMENT OF WATER MANAGEMENT,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 17, 2019, 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:

JUNE 7, 2021

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/s/ Thomas J. Tyrrell
Thomas J. Tyrrell

/s/ Maria E. Portela
Maria E. Portela

DISSENT

I respectfully disagree with the Majority's Decision affirming and adopting the Arbitrator's Decision finding Petitioner is entitled to a wage-differential under §8(d)1 because the Petitioner was non-compliant with vocational rehabilitation that was provided by Respondent, did not reasonably cooperate with vocational rehabilitation or embark on a good faith effort to cooperate in the rehabilitation effort as required under *Archer Daniels Midland Co. v. Industrial Comm'n*, 138 Ill.2d 107, 561, N.E. 2d 623, 149 Ill.Dec 253 (1990). I would, therefore, vacate the wage differential award in favor of an award under §8(d)2 for the reasons that follow.

> The law on reasonable cooperation is scant. Three reported decisions have addressed the issue. In *Archer Daniels Midland Co. v. Industrial Comm'n,* 138 Ill. 2d 107, 149 Ill. Dec. 253, 561 N.E.2d 623 (1990), the Illinois [****376] [**283] Supreme Court set forth the duty: "in attempting rehabilitation of the injured employee there are 'boundaries which reasonably confine the employer's [*178] responsibility,' including a requirement that the claimant make good-faith efforts to cooperate in the rehabilitation effort." *Archer Daniels Midland Co.,* 138 Ill. 2d at 115-16, quoting *National Tea Co. v. Industrial Comm'n,* 97 Ill. 2d 424, 433, 73 Ill. Dec. 575, 454 N.E.2d 672 (1983).

Stone v. Industrial Comm'n (R. Olson Constr. Co.), 286 Ill. App. 3d 174, 177-178, 675 N.E.2d 280, 282-283, 1997 Ill. App. LEXIS 5, *6, 221 Ill. Dec. 373, 375-376.

In *Stone*, the Appellate Court agreed that the Commission's Decision to terminate claimant's TTD benefits because he failed to cooperate reasonably with rehabilitation, was not against the manifest weight of the evidence. Over the three-month period claimant received rehabilitative counseling, he failed to take any steps to obtain his GED, and he failed to visit the library to research vocational interests, despite directions to do both. According to the vocational rehabilitation counselor, Boyd, claimant failed to "give any indication whatsoever that he was interested in vocational rehabilitation services." Claimant also forced an interview to be rescheduled because [***11] he was not given 48 hours' notice. When claimant did appear for the interview, he was unshaven and dirty and had failed to dress properly. Boyd had specifically told claimant how to dress and appear; nonetheless, claimant ignored this advice. In rendering its decision, the Commission relied on all of these reasons to terminate TTD benefits.

Stone v. Industrial Comm'n (R. Olson Constr. Co.), 286 Ill. App. 3d 174, 179, 675 N.E.2d 280, 284, 1997 Ill. App. LEXIS 5, *10-11, 221 Ill. Dec. 373, 377

In *Archer Daniels Midland*, the Court held that Petitioner was entitled to vocational rehabilitation benefits although Petitioner failed to complete his locksmithing correspondence course by the deadline imposed by Respondent. However, there Petitioner failed to meet the deadline because he was limited to working a 20-25 hour work week by his treating physician. In order to complete the course by the imposed deadline, he would have had to work a 40 hour week. Petitioner's vocational rehabilitation counselor also testified that the claimant cooperated with him and the rehabilitation program. Those facts are starkly different than the vocational counselor's reports in the case at bar.

The Rehabilitation Plan for Petitioner, dated April 6, 2017, included a timeframe implementing "immediate and ongoing" vocational counseling "to facilitate career education, appropriate job target identification, understanding of labor market/wage data related to occupational alternatives, etc., to assist with appropriate identification of, and commitment to, specific job targets." (RX4) The vocational counselor's obligations are further enunciated under various other subsections including "Job Search-Supervised and Independent" where Vocamotive's responsibility is "to supervise job search activity as per the Illinois Workers' Compensation Act. It is the responsibility of the rehabilitation client to implement a reasonable and diligent job search effort in accordance with the Act." Under "General Service Delivery Guidelines/Time Requirements" vocational rehabilitation is identified as a full-time effort, with services implemented five days weekly at eight hours per day and, further, Petitioner was explicitly expected to conform to the Vocamotive protocol for dress, timeliness and attendance. (RX4, 4/16/17, p. 3) The last paragraph is explicit regarding the Petitioner's obligations, to wit, "Mr. McLaurin must, of course, manifest meaningful behavioral commitment to implementation of this agenda and participation in the crafting of future rehabilitation activities. Otherwise, extended unemployment or underemployment is likely to result." (RX4, 4/16/17 p. 6)

The Vocamotive Progress Report issued on July 25, 2017, documents that Petitioner did not check in on July 12, 2017. On July 13, 2017, he explained he was getting his car repaired. On July 13, 2017, he was wearing a polo shirt and grooming requirements were reviewed with him. On July 17, 2017, Petitioner did not return a voice message requesting his keyboarding scores and curriculum progress. On July 20, 2017, he was again wearing a polo shirt and was reminded that grooming had been discussed with him previously. At this time, a four hour workday tolerance was to be clarified by his physician. (RX4, 7/25/17)

The Vocamotive Progress Report issued on August 30, 2017, notes that Petitioner failed to show up for Vocational Testing scheduled for July 26, 2017. He later reported in a phone call that he had forgotten about the appointment. He confirmed that he had received a letter regarding the testing two weeks prior. The testing date was also on his calendar. On July 27, 2017, he was 4 days behind schedule in the computer lab class. Two voice messages were placed requesting a return phone call and no return phone call was received. On August 1, 2017, Petitioner failed to have the references required for his Job Search Workshop despite having an extra week to complete that exercise as he did not attend the Workshop on July 25, 2017. (RX4, 8/30/17, p. 2) On August 7, 2017, Petitioner did not call back to record his progress, and a call was placed to him

and a voice message was left requesting a call back. Petitioner did not return the call. As of August 16, 2017, Petitioner had not completed Overview tutorials and had not scheduled a Skype call for the Concept exam second attempt. (RX4, 8/30/17, p. 3)

A call was placed to Petitioner informing him to call Vocamotive back to schedule a Skype call and to complete the tutorials as review for the Concept exam. A voice message was left requesting a return phone call, however, no return phone call was received. (RX4, 8/301/7, p. 4) At the in-person meeting with Ms. Helma from Vocamotive on August 17, 2017, Petitioner's progress was reviewed, and he was reminded of the grooming policy as it was noted that he was wearing a Harley Davidson shirt. The next day, Vocamotive called and requested scores and progress and he reported he did not complete his typing tests or work on any curriculum due to him thinking he "was off for the day." Petitioner was noted to have had a calendar and had always known that he had to work on a daily basis. (RX4, 8/30/17, p. 5) Thereafter, on August 22, 2017, Petitioner began to complain of pain and reported that he would call back when he got his pain "under control." When he was called on August 25, 2017, he did not answer and did not return the call. (RX4, 8/30/17, p. 7) On August 29, 2017, Petitioner was asked why he did not respond to the request for information, he reported that he "got busy." When he did not record his curriculum progress, a call was placed to him for his progress, but he did not return the call. (RX4, 8/30/17, p. 8) In the Analysis of that reporting period, the case manager Sharon Zajac noted that Petitioner had missed numerous appointments due to reported pain, he did not consistently return phone calls, and it was unclear if Petitioner understood his responsibilities in vocational rehabilitation despite having received a thorough orientation to the program and receiving consistent reminders as to what is necessary. It was noted that Petitioner was not following through. (RX4, 8/30/17, p. 9)

The Vocamotive Progress Report issued on September 27, 2017, documented more flagrant failures to return calls. (RX4, 9/27/17, pp. 2, 4, 5) Petitioner also failed to inform Vocamotive of the day or days he intended to miss his Vocamotive obligations for a relative's funeral. On September 21, 2017, when Petitioner arrived at Vocamotive, his computer was charged but he did not have his power cords for his computer. He left an appointment early without notifying anyone at Vocamotive. He was again reminded of the Vocamotive grooming policy after wearing red dress pants, black leather boots, a black leather vest and a red polo shirt. (RX4, 9/27/17, p. 6) The Analysis noted that Petitioner was two days behind schedule and that he had only a part-time schedule based upon his four-hour workday restriction. Again, it was noted that Petitioner failed to comply with Vocamotive's daily communication policy and again, he did not return phone calls. He was not keeping appointments or complying with dress/grooming policies. Finally, it was noted that Petitioner needed to immerse himself in the process and complete computer training, and in the next 30 days, improve his attendance, his grooming and communication with the Vocamotive office, and become vested in the program regarding training and job search. (RX4, 9/27/17, pp. 7-8)

The Vocamotive Progress Report issued on October 22, 2017, documented continued lack of cooperation, reporting that he was not sure if he would be able to attend computer lab on October 2, 2017, because "Mondays are hard for" him. It further documented he missed appointments and his failure to return calls. (RX4, 10/22/17, pp. 1, 2, 4, 5, 6)

The final Vocamotive Progress Report issued on November 21, 2017, documents that at the initiation of the job search aspect of the vocational rehabilitation program, Petitioner was not cooperating by failing to report his keyboarding accuracy, failing to complete his interviewing questions as requested, and missing a Vocamotive meeting without the courtesy of reporting a medical appointment. Further, Petitioner failed to complete cover letters for applications, he failed to return phone calls, he hung up on a phone call with Vocamotive, and he missed appointments on November 2, 2017 and November 3, 2017. Vocamotive then provided field preparation for Petitioner. On November 15, 2017, field visits were completed on behalf of Petitioner to various employers. When a phone call was placed to Petitioner later in the day, Petitioner answered the phone and stated, "I take it you haven't spoken with my lawyer?" Petitioner informed Vocamotive that his attorney informed him that he could begin job searching independently and should return his computer equipment, which was returned on November 17, 2017. (RX4, 11/21/17)

Based on the foregoing, I disagree with the majority's agreement with the Arbitrator that "Neither party can be deemed to have fully cooperated with the other." The record does not support that there were "personality conflicts" with the staff at Vocamotive. Further, the Arbitrator's notation that Vocamotive explicitly stated in their reports that they would be expecting the Petitioner to work beyond the four hour per day restrictions is patently false. The September 27, 2017, Vocamotive report documents that Vocamotive adjusted the eight hour per day expectation to four hours per day specifically in the Analysis section, "It is noted that he has a part time schedule based upon his four-hour workday restriction." Further, in the November 21, 2017, report he was advised that his appointments at Vocamotive would be Tuesdays and Thursdays between 8:00 and 12:00 p.m. (RX4) It is plainly evident that Petitioner did not follow the rules set out by the Vocamotive staff.

Further, the Petitioner's job logs contained in Respondent's Exhibit 3 document that the Petitioner pointlessly applied for jobs that he was not qualified for with the Respondent and further show Petitioner's lack of diligence. Petitioner testified that he filled out the Reasonable Accommodation Request that was submitted to the City. (T, p.39, PX5-E) There are four columns on the form. The first column is a checklist of a potential work restriction. The second column requires a "yes" or "no" response to whether the employee has the work restriction and the last two columns ask to describe the limitation or specify time/weight/degrees if the answer is "yes" to a specific restriction. Petitioner answered "yes" to every restriction except to one restriction when in reality, none of those work restrictions are listed on the FCE or assigned by his physician. He has the ability to use his hands and keyboard yet he answered "yes," that he had a restriction to use his hands and keyboard. There is no restriction on Petitioner's ability to use or operate radio equipment yet he answered "yes" he had that restriction. He answered "yes" he had a restriction on mental/emotional functions and "yes" he had restrictions on vision and hearing and other restrictions that he did not have. Therefore, Petitioner misrepresented to Respondent that he had restrictions that he did not have and Respondent was not given fair opportunity to evaluate Petitioner's case or to give him a reasonable accommodation within the restrictions that he did have. I find that Petitioner is simply not credible and did not demonstrate the desire to return to work.

As further evidence of this lack of commitment, Petitioner submitted a grand total of approximately 55 job applications to the Respondent over a course of nine non-consecutive days

between June and August 2017. On the first day, he submitted one application. On the days that he submitted multiple applications, the time entries confirm that all nine, or, at most, ten applications were submitted within a ten or eleven minute time frame. That effort does not qualify for a meaningful job search. (RX 3)

Further, none of the Respondent job applications coincide with the work that Petitioner is qualified for as identified by the certified Vocational Counselor as likely or possible nor was any evidence of qualification for these positions in the record and are evidence of Petitioner's lack of sincerity in his quest to return to gainful employment. Instead, Petitioner, a Construction Laborer, applied for jobs that he was either not qualified for or were outside of his restrictions including: Engineering Technician although Petitioner does not have an engineering degree; Auditor II (6//3017 & 7/10/17) although Petitioner does not have an accounting degree; Medical Director-Chronic Disease, although Petitioner does not have a medical license or background; Carpenter, Operating Engineer; Librarian IV; Accounting Technician II; Project Manager; Projects Administrator; Accountant IV; Supervising Timekeeper-Laborer; Supervising Ventilation and Furnace Inspector; Customer Account Representative; Supervising Clerk-Woodson Regional; Architect III; Civil Engineer III-Sewer; Staff Assistant-Contracts; Chief assistant Corporation Counsel (FCRL Division); Central Voucher Coordinator; Programmer Analyst; Painter; Project Coordinator; Principal Operations Analyst; Financial Planning Analyst; Benefit Claims Supervisor; Contracts Coordination; Clinical Therapist III; Traffic Engineer IV; Occupational Health Nurse; Paralegal II; Financial Analyst-Payments; Electrical Mechanic (Automotive); Chief Airport Operations Supervisor; Freedom of Information Act Officer; Traffic Signal Repairman; Laborer-Apprentice; Custodial Worker-Full-Time; Civil Engineer IV, etc. (RX3)

I further disagree with the majority's decision to adopt the Arbitrator's conclusion that Petitioner is entitled to a maintenance after he terminated his efforts with Vocamotive because "he was able to demonstrate that he continued to submit job applications through the date of trial, applying to 1,388 jobs through Indeed." The Arbitrator found this online application process over a period of 221 days, at "a rate of 6.28 jobs per day, including holidays and weekends" "was enough of an effort to merit maintenance." I would find that the Petitioner does not get the proverbial "second bite of the apple" given the opportunity Petitioner had to participate in a valid rehabilitation program with job seeking assistance as evidenced by the counselor's in person contacts with potential employeers. While in some instances a self-directed job search is appropriate, in this case, it was agreed by the parties that Petitioner would undergo vocational rehabilitation and that program was abandoned by Petitioner, not in favor of an alternative plan, but simply because he clearly had no intention of cooperating. Filling out online "Indeed" applications, in any number, thereafter, does not prove anything except that Petitioner tried to mitigate his non-compliance and lack of cooperation with the vocational counselors. Further, Petitioner offered no evidence of follow-up to any of these positions. I would find that Petitioner is not entitled to maintenance after November 17, 2017.

None of the City of Chicago applications submitted over a course of approximately nine days between June 2017 and September 2017 provide meaningful intent to return to work and Petitioner was obviously non-compliant with the Vocamotive efforts for vocational rehabilitation and job placement. This Petitioner has essentially mirrored the Petitioner in *Stone v. Industrial Comm'n (R. Olson Constr. Co.), (citations omitted)* by failing to comply with vocational

rehabilitation in any meaningful way by defying dress codes, failing to communicate and return calls and out and out refusal to act upon the field search jobs identified as potential employers. Petitioner failed to cooperate as required under the criteria enunciated in *Archer Daniels Midland* and *National Tea*. (Citations omitted) Therefore, I dissent from the majority opinion and would find Petitioner has not sustained his burden of proving entitlement to a wage-differential under §8(d)1 and instead, would find that he is entitled to an award under §8(d)2.

/s/*Kathryn A. Doerries*
Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0272
NOTICE OF ARBITRATOR DECISION

McLAURIN, ZARAK
Employee/Petitioner

Case# **14WC039574**
16WC011548

CITY OF CHICAGO WATER MANAGEMENT
Employer/Respondent

On 4/17/2019, 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 2.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1315 DWORKIN AND MACIARIELLO
PATRICK SHIFLEY
134 N LASALLE ST SUITE 650
CHICAGO, IL 60602

0010 CITY OF CHICAGO LAW DEPT
D TAYLOR CHITTICK
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

21IWCC0272

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

ZARAK McLAURIN
Employee/Petitioner

v.

CITY OF CHICAGO WATER MANAGEMENT
Employer/Respondent

Case # **14** WC **39574**

Consolidated cases: **16 WC 11548**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **JUNE 25, 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 **AUGUST 21, 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 **$77,222.14**; the average weekly wage was **$1,485.04**.

On the date of accident, Petitioner was **42** years of age.

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 **$71,140.73** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$71,140.73**.

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

ORDER

As detailed in the attached memorandum discussing the *Findings of Fact and Conclusions of Law:*

- The Arbitrator finds the Respondent shall pay the Petitioner TTD benefits at a rate of **$990.03** per week for a period of **71 6/7 weeks**, as provided in **Section 8(b)** of the Act. The Respondent shall be given a credit of **$71,140.73** for previously paid TTD benefits.; and,

- The Arbitrator finds the Respondent shall pay Petitioner the sum of **$735.37** per week for a further period of **80.63 weeks**, as provided in **Section 8(e)12** of the Act, because the injury to the Petitioner caused a **37.5% loss of use of the right leg.**; and,

- The Arbitrator finds the Respondent shall resolve with and pay directly to those providers, *pursuant to the parties' agreed stipulation on the record,* the reasonable, necessary, and related medical bills of Premium Healthcare Solutions, Chicago Orthopaedic & Sports Medicine, and Illinois Orthopedic Network as itemized in Petitioner's Exhibit 7, and as provided in Sections 8(a) and 8.2 of the Act. (*See* Petitioner's Exhibit 7, and Transcript at 9-10 and 65-66); and,

- The Respondent shall pay those benefits that have accrued in a lump sum, and shall pay the remainder, 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

APRIL 17, 2019
Date

APR 17 2019

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McLAURIN, ZARAK
Employee/Petitioner

Case# **16WC011548**
14WC039574

CITY OF CHICAGO WATER MANAGEMENT
Employer/Respondent

On 4/17/2019, 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 2.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1315 DWORKIN AND MACIARIELLO
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0010 CITY OF CHICAGO LAW DEPT
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21IWCC0272

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

ZARAK McLAURIN
Employee/Petitioner

v.

CITY OF CHICAGO WATER MANAGEMENT
Employer/Respondent

Case # **16** WC **11548**

Consolidated cases: **14 WC 39574**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **JUNE 25, 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 **MARCH 29, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 **$80,806.30**; the average weekly wage was **$1,553.97.**

On the date of accident, Petitioner was *at least* **43** years of age. (*Compare* Arbitrator's Exhibits 1A and 1B).

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 **$43,947.41** for TTD, **$0.00** for TPD, **$43,227.11** for maintenance, and **$0.00** for other benefits, for a total credit of **$87,174.52**.

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

ORDER

As detailed in the attached memorandum discussing the *Findings of Fact and Conclusions of Law:*

- The Arbitrator finds the Respondent shall pay the Petitioner TTD benefits at a rate of **$1,035.98** per week for a period of **34 5/7 weeks** (4/1/16 through 11/29/16) as provided in **Section 8(b)** of the Act. The Respondent shall be given a credit of **$43,947.41** for previously paid TTD benefits. Additionally, the Respondent shall pay the Petitioner maintenance benefits at a rate of **$1,035.98** per week for a period of **82 weeks** (11/29/16 through 6/25/18) as provided in **Section 8(a)** of the Act. The Respondent shall be given a credit of **$43,227.11** for previously paid maintenance benefits.; and,

- The Arbitrator finds the Respondent shall pay the Petitioner wage loss differential benefits, commencing on 6/26/18, of **$875.98/week** until the Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injury sustained caused a loss of earnings **as provided in Section 8(d)1 of the Act.**; and,

- The Arbitrator finds the Respondent shall resolve with and pay directly to those providers, *pursuant to the parties' agreed stipulation on the record,* the reasonable, necessary, and related medical bills of Premium Healthcare Solutions, Illinois Orthopedic Network, Rx Development Associates, Nova Pharmacy LP, and Metro Health Solutions, as itemized in Petitioner's Exhibit 7, and as provided in Sections 8(a) and 8.2 of the Act. (*See* Petitioner's Exhibit 7, and Transcript at 9-10 and 65-66); and,

- The Respondent shall pay those benefits that have accrued in a lump sum, and shall pay the remainder, 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

APRIL 17, 2019
Date

APR 17 2019

ZARAK McLAURIN v. CITY OF CHICAGO WATER MANAGEMENT

14 WC 39574 & 16 WC 11548

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

These matters were tried before Arbitrator Steffenson on June 25, 2018. The issues in dispute for both claims were causal connection, medical bills, lost time benefits (TTD and maintenance), and the nature and extent of the injuries. (Arbitrator's Exhibits 1A and 1B). The parties agreed to receipt of this Arbitration Decision via e-mail and requested a written decision, including findings of fact and conclusions of law, per Section 19(b) of the Act. (Arbitrator's Exhibits (*hereinafter*, Ax) 1A and 1B).

FINDINGS OF FACT

The Petitioner, a 46-year-old male, testified that he had been employed with the Respondent for 17 years, under the title Construction Laborer.[1] He described his duties as assisting carpenters in their trade by drilling, digging, and plowing. (Tx at 14).

14 WC 39574[2]

Petitioner testified that on August 21, 2014 he reported to work at 6:00 a.m. and was working on level minus 51 of the Jardine Water purification plant. (Tx at 16, 18). Petitioner was setting up for a job assignment of shoring up a ceiling when a battery powered vehicle used to move equipment (a Cushman cart) crushed his right leg against a stationary machine. (Tx at 16). The Petitioner described the Cushman cart as a steel vehicle, and the stationary machine as a large concrete steel machine. (Tx at 17). Petitioner experienced a pain of 10 out of 10 after his

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[1] Petitioner admitted a history of a work-related rotator cuff tear which he believed had occurred in 2013. (Transcript at 15). Illinois Workers' Compensation Commission (IWCC) records do not show any claim filed for that period or that body part. Petitioner testified that he had returned to work full duty after that injury and that he was able to complete the tasks he was assigned. (Transcript (*hereinafter*, Tx) at 16).

[2] (Ax 1A)

leg was crushed. Petitioner has no further recollection of the accident until he was taken by an ambulance to Northwestern Hospital. (Tx at 18).

On August 21, 2014 at 10:45 am the Petitioner was seen in the Northwestern Hospital Emergency Department. At the time a history was provided of a heavy cart tipping and crushing his right leg against a wall at the water infiltration system [sic]. (Petitioner's Exhibit 1). He was diagnosed with an open fracture of the right mid-shaft tibia and referred for surgery.

A surgical report dated August 22, 2014 shows that the Petitioner had a grade I right tibia fracture, and that he was treated with an intramedullary nailing of the right tibia fracture. (Petitioner's Exhibit (*hereinafter*, Px) 1).

On September 2, 2014, the Petitioner was seen at Northwestern by Dr. Merk for follow up on his surgical repair. He noted some drainage from the surgical wound. He was deemed to be doing well and asked to return in one week. (Px 1). On September 9, 2014 the Petitioner was seen at Northwestern by Dr. Merk and referred to Dr. Dumanian for examination of the drainage in his wound. He was to return in two days. (Px 1). On September 12, 2014 the Petitioner was seen for debridement of his surgical wound. The right anterior third of his surgical wound was noted to be an open draining wound. His wound was surgically debrided, and he was placed on bedrest for 5 days. The Petitioner was discharged after 5 days on September 17, 2014 and was prescribed antibiotics to be provided at home via IV. (Px 1).

On October 7, 2014 the Petitioner was seen by Dr. Merk for follow up at Northwestern. He was noted to be healing well and was advised to begin home exercise. At this time, he was noted to be eligible for sedentary duty. (Px 1). On October 22, 2014 the Petitioner was seen by Dr. Dumanian for follow up on his wound. He was released "prn", or to return "when necessary" for wound care purposes. (Px 1).

On November 25, 2014 the Petitioner was seen for follow up on his right leg surgery at Northwestern Memorial. (Px 1). He was noted to be participating in physical therapy, and to be reporting mild residual discomfort. (Px 1).

On January 6, 2015 the Petitioner was seen for follow up on his right leg surgery by Dr. Merk. He was noted to be attending physical therapy at NovaCare three times per week and was making progress. He was noted to have a limp and to ambulate with a cane when outdoors. However, Petitioner was still experiencing sharp pain in his injured shin. Treatment options were discussed, and he was to follow up in 6 weeks. (Px 1).

On February 17, 2015 the Petitioner was seen for follow up on his right leg surgery by Dr. Merk. He was noted to be attending physical therapy at NovaCare and reported that while pain was present, it was improving. He reported difficulty with stairs and being unable to kneel. (Px 1).

On March 17, 2015 the Petitioner was seen for follow up on his right leg by Dr. Merk. He was noted to be walking with an overall improved gait pattern without significant limp. He was to initiate work conditioning, and it was noted that his nail would have to be surgically removed when the bones had healed satisfactorily. (Px 1).

On April 15, 2015 the Petitioner was seen for follow up on his right leg by Dr. Merk. He was noted to have been attending work conditioning but noted continuing discomfort in his leg and knee. His fracture was x-rayed and deemed well healed, and he was to complete two and half more weeks of work conditioning. (Px 1).

On May 8, 2015 the Petitioner was seen for follow up on his right leg by Dr. Merk. He was noted to have been attending work conditioning but noted continuing discomfort in his leg and knee. He complained of giving way of the right knee which was noted to be related to quadriceps strength. A plan for removal of the surgical nail was scheduled. (Px 1). On May 18, 2015 the Petitioner underwent a surgical procedure at Northwestern Memorial to remove the intramedullary nail and interlocking bolt which had been retained after the repair of his fracture on August 22, 2014. (Px 1).

On June 2, 2015 the Petitioner returned to Dr. Merk for a post-operative visit. He was noted to have not yet returned to work, and to be weightbearing as tolerated. He noted discomfort and stiffness which had increased after his second surgery. The plan was to release Petitioner to return to work on June 22, 2015 without restrictions. (Px 1).

Petitioner concluded treatment with Dr. Merk and returned to work. However, he testified that he had been dissatisfied with the condition of his leg and sought a second opinion. (Tx at 23).

On September 1, 2015 the Petitioner returned to Dr. Merk for follow up on his right leg injury. The Petitioner reported that after three days at work he had been sent home due to inability to function due to pain. He reported that he had been directed to return to Dr. Merck after requests by the Petitioner's PCP for an MRI were denied by the insurance provider. He complained of persistent occasional pain radiating down the medial aspect of his lower leg, as well as soreness in his knee and feelings of weakness and instability. The Petitioner was

returned to work with light duty restrictions, and a Functional Capacity Evaluation (FCE) was ordered in addition to a follow-up MRI. (Px 1).

On February 17, 2016 the Petitioner returned to Dr. Merk for follow up on his right leg injury. The Petitioner reported aching discomfort in his knee and his leg with activity. Dr. Merk found the Petitioner to be at maximum medical improvement (MMI) and he was released to follow up as needed. (Px 1).

On March 17, 2016 the Petitioner was seen Chicago Orthopaedics & Sports Medicine for examination of his right tibia and knee. He complained of ongoing weakness and pain after a work injury in August of 2014. He was examined by Dr. Ellis Nam and given a referral to an orthopedic trauma surgeon. (Px 3). A copy of this referral note is duplicated in the files of Dr. Poepping, discussed below. On March 18, 2016 the Petitioner returned to Dr. Merk for follow up for names of a second opinion for his knee injury. He reported being back to work full duty, but feeling unable to continue his job duties, and using vacation days. (Px 1).

16 WC 11548[3]

Petitioner testified that in March of 2016 he had returned to his original position as a construction laborer while receiving ongoing care for his right leg. (Tx at 26). On March 29, 2016 he was unloading lumber off a pick-up track at 52nd and Western when he felt a tear in his left shoulder. (Tx at 33). He was immediately unable to lift his left arm and was unable to complete his work that day. (Tx at 33). Petitioner left the job under his own power. (Tx at 33).

On April 5, 2016 the Petitioner was seen by Dr. Poepping for his right tibia injury. He was complaining of right knee pain and giving way in his knee. (Px 2). MRI of the right knee was ordered to determine if the complaints were related to a tear in the knee. (Px 2). A copy of the evaluation and referral of Dr. Ellis Nam was included in the record. (Px 2).

On April 14, 2016, the Petitioner underwent an MRI of the right knee at Molecular Imaging. (Px 2). The MRI report showed a Grade II sprain of the ACL, and a Grade I mucoid degeneration without evidence of tear. (Px 2). On April 14, 2016 the Petitioner also underwent an MRI of the left shoulder at Molecular Imaging. (Px 2). The MRI report showed glenohumeral joint effusion, AC joint arthropathy, and a near complete re-tear at the insertion of the supraspinatus. (Px 2).

[3] (Ax 1B)

On April 19, 2016 the Petitioner was seen for follow up on the MRI of his right knee by Dr. Thomas Poepping. (Px 2). He gave a history of a March 29, 2016 injury to his shoulder due to lifting a 12-foot 4 x 4 into a truck. (Px 2). An MRI of the left shoulder was reviewed along with the MRI of the right knee. The diagnoses on examination were a left shoulder recurrent rotator cuff tear, left shoulder AC arthrosis, left shoulder biceps tendonitis, and right knee bone bruise. Surgical repair of the left shoulder was planned, and further physical therapy for the right knee was recommended. (Px 2). Petitioner was given work restrictions and instructed to follow up in 4 weeks. (Px 2).

On April 30, 2016, the Petitioner began physical therapy with Advanced Spine and Rehab Center/Midwest Pain and Rehab. (Px 4). A treatment plan was created to treat his left knee and his right knee. (Px 4). He received therapy through September 1, 2016. (Px 4).

On May 17, 2016 the Petitioner was seen for follow up on the right leg injury. He reported tenderness over his surgical flap, and the diagnosis was right knee bone bruise and right knee pain. The plan for long term care for the right leg injury was deferred due to the plan for shoulder surgery to take place the same date. He was kept off work. (Px 2).

On May 17, 2016 the Petitioner underwent a surgical repair of his left shoulder. (Px 2). The procedure performed was a left shoulder arthroscopic revision rotator cuff repair, subacromial decompression, distal clavicle excision, and subpectoral biceps tenodesis. The surgery found a complete full thickness retracted tear to the glenoid margin, with 50% biceps tenodesis. (Px 2). On May 31, 2016 the Petitioner was seen for surgical follow up. A that time he was doing well, kept off work, and to follow up in four weeks. (Px 2).

On June 28, 2016 the Petitioner was seen for surgical follow up for his left shoulder. He was participating in therapy and doing well. He was to remain off work and follow up in 4 weeks. He was also seen for his right knee pain. He was offered an injection to treat his ongoing pain but deferred in favor of further physical therapy. (Px 2).

On July 19, 2016 Petitioner was seen for left shoulder. There was noted crepitus of concern to Dr. Poepping, the Petitioner was to continue therapy, remain off work, and to return in 5 weeks. He also followed up for his right knee pain. He reported ongoing knee pain and underwent a right knee Kenalog injection. (Px 2).

On September 6, 2016, Petitioner was seen for follow up on his left shoulder surgery. He was noted to be improving and to require 2 additional months of therapy. He was kept off work and was to follow up in 4 weeks. Petitioner followed up on ongoing right knee pain. He

reported increasing pan and no benefit from the injection. He was to continue physical therapy. (Px 2).

On October 4, 2016, Petitioner was seen for follow up on his left shoulder. He was expected to need one more month of physical therapy. He was also seen for his right leg and continued to report pain in the anterior knee and the area of his previous fracture. (Px 2).

On November 1, 2016, Petitioner was seen for follow up on his left shoulder. He was noted to have full active and passive range of motion, but positive Neer's and Hawkin's tests, indicative of impingement. He reported ongoing symptoms in his knee, subject to changes in the weather. He was referred again for an FCE and was to follow up in 4 weeks. (Px 2).

On November 15, 2016, Petitioner underwent an FCE at ATI. Petitioner was deemed to have made a valid effort. His physical restrictions included lifting restrictions, and a 4-hour overall work day tolerance. He was noted to have sitting restrictions of 3-4 hours, in 35-minute durations. He was noted to have standing restrictions of 3-4 hours, in 14-minute durations. He was noted to have walking restrictions of 1 to 2 hours with only occasional short distances.

On November 29, 2016, Petitioner was seen by Dr. Poepping, following up on his FCE. The FCE was deemed valid, and he was given permanent restrictions based on the findings. (Px 2). He was found to be at MMI. (Px 2).

On August 15, 2017, Petitioner was seen by Dr. Poepping for follow up on ongoing pain and numbness in his right leg. He was reporting numbness in his right foot that fluctuated without pattern. On examination decreased sensation in the right foot was noted. Based upon his symptoms he was referred for an MRI of the lumbar spine and an EMG of the right lower extremity. (Px 2). On August 18, 2017, Petitioner underwent a lumbar MRI. The findings of the report showed no evidence of herniation or stenosis. (Px 2).

On September 5, 2017, Petitioner was seen by Dr. Poepping for follow up care. He was noted to have low back pain, and right lower extremity numbness. (Px 2). The EMG was pending, and he was referred for follow up after the EMG. (Px 2). On September 19, 2017, Petitioner was seen by Dr. Poepping for further follow up care for the right leg pain and numbness. The EMG report was still pending, and the visit was continued. (Px 2).

On October 3, 2017, Petitioner was seen by Dr. Poepping to review his EMG. He was referred to physical therapy for pain which apparently was radiating from his low back. (Px 2).

On October 31, 2017, Petitioner was seen by Dr, Poepping for his lumbar radiculopathy. Dr. Poepping opined the right leg was not generating the pain, and he was referred for pain management. (Px 2).

On January 9, 2018, Petitioner was seen for follow up on his low back, right leg, and left shoulder pain. On examination, he reported tenderness over the bicep tendon, but had a full range of motion. He was referred for physical therapy, and his permanent restrictions were continued. (Px 2).

On March 6, 2018, Petitioner was seen for follow up on his low back, right leg, and left shoulder pain. He was pending the results of a Section 12 examination. (Px 2). He was continued at his permanent restrictions, and he was referred to therapy. (Px 2). On March 7, 2018 he was seen for re-examination at Advanced Spine and Rehab. He continued therapy with Advanced Spine and Rehab Center through March 30, 2018. (Px 4). Dr. Poepping's records contain the Section 12 report, but no medical record reviewing the Section 12 report is contained in the file. (Px 2).

After being released by Dr. Poepping to return to work with restrictions he sought to return to work with the Respondent. Petitioner completed a Request for Reasonable Accommodation with the Respondent. (Px 5E and Tx at 40). Petitioner sought employment with the Respondent in his original position, and in other positions. (Tx at 40).

After being unable to return to work with the Respondent, the Petitioner began a vocational rehabilitation program with Vocamotive in Hinsdale on or about June 28, 2017. (Tx at 40, 56). Petitioner worked with them at their office in Hinsdale three days per week, requiring an hour drive from his home. (Tx at 41, 42). Petitioner testified that because of the lengthy commute, he would experience pain from his injuries during his commute. (Tx at 41). The remaining two days a week the Petitioner would work from home on his job search and computer work. (Tx at 43).

During the period around July 24, 2017, the Petitioner applied to return to work with the Respondent. (Tx at 50). The jobs he applied for included "Chief Assistant Corporation Counsel". (Tx at 50). Petitioner testified that he was unaware that the position was for an attorney position in the Respondent's Law Department, at the time he applied. (Tx at 51). He admitted to having no background in law. The jobs also included "financial planning analyst". (Tx at 51). Petitioner testified that he had a background assisting with financial grant applications for hospitalized people. (Tx at 51).

Petitioner testified that prior to July 24th he had only undergone two workshops explaining what kind of jobs he should be applying for. (Tx at 55). He also testified that he believed his experience qualified him for the "financial planning analyst" position. (Tx at 56). Petitioner claimed that while his job title states that he is a laborer, he has never done laborer job duties. Similarly, he believed that other positions with the Respondent might have descriptions which did not match their duties. (Tx at 57).

Petitioner testified he received computer training in Microsoft Word and Excel as well as training in job searching. (Tx at 41). Petitioner was able to identify an Excel 2013 Basic Certificate, a Word Basic Certificate, and an Internet Basic Certificate he had received from Vocamotive from his efforts. (Tx at 42).

Petitioner admitted he missed appointments with Vocamotive due to a family death and medical emergencies. (Tx at 54). He also described the end of his work with Vocamotive as not on a good note. (Tx at 45). He had been harassed due to his dress and his appearance, claiming to have been sent home for working Harley Davidson branded polo shirts with a logo on the back of the shirt. (Tx at 45).

Petitioner identified job application receipts he had received from applying for jobs with Indeed.com. (Tx at 46). He testified that he had applied for 1,388 positions without getting an interview since the termination of his program with Vocamotive. (Tx at 47).

Petitioner testified that he continues to experience pain in his right leg two to three times a day. Petitioner rated the pain as ranging from a 3 to an 8 out of ten. (Tx at 28). Petitioner described his leg as interfering with his abilities to walk, run, stand, and sit for long periods of time. (Tx at 29). He testified that he can walk on his leg for 30-40 minutes and sit for 30–40 minutes. He testified that he experiences cramping, tenderness and tingling because of sitting, and pain, tingling, and numbness because of standing. He also testified to problems with his knee which he relates to his hardware installation surgery. The Petitioner showed the Arbitrator an extremely large depressed scar on the inside of his right calf, a scar on the inside of his calf near his ankle which he relates to a surgical screw installation, and then a scar on his knee which he relates to installation of a rod. (Tx at 31).

Petitioner testified that he continues to experience pain in his left shoulder. (Tx at 36). He testified that he experiences pain once or twice a week as a 2 out of 10. (Tx at 37).

Vocational efforts

Both parties introduced job application logs, and the Respondent introduced reports of the vocational rehabilitation provider, Vocamotive. Those records show that the Petitioner began his program on June 28, 2017. During June he was required to attend only one date onsite with Vocamotive and had two call-in dates. The records show he was to be studying Windows 7 Tutorials. (Px 5D).

In July, the Petitioner was to attend two onsite classes per week, and to call in three days per week. The Petitioner was to study Windows 7, to complete Internet Basics Workbooks, to Study Office 2013 and Word 2013, and to be engaged in job search workshops. The Arbitrator notes that the job search workshops ran one per week at Vocamotive's office and lasted from 8:45 am – 3:30pm. The Petitioner noted typing speeds for each of the days in July, except for July 12, which is blank on both July log sheets. Petitioner noted a doctor appointment on July 25, and that he called in on July 26 rather than attend the scheduled Vocational Testing. (Px 5D).

In August, the Petitioner was to attend two on-site classes per week, and to call in three days per week. The Petitioner was to study Word 2013 and Office 2013. The Petitioner noted typing speeds for all days except August 17, 18, 22 and 24th, which are blank on both August log sheets. The Petitioner noted that he had a doctor appointment on August 15th, and that he had to reschedule a class. He noted that the attended an extra class in place of a call in on August 17th, two days later. (Px 5D).

On August 4, 2017 the Petitioner was awarded a certificate of achievement for completion of the Windows 7/Internet Basics course at Vocamotive. (Px 5D).

In September the Petitioner was to attend two onsite classes per week, and to call in three days per week. The Petitioner was to study Excel 2013 and Word 2013. The Petitioner noted typing speeds for all days except for the period from September 8 through September 15, which is noted as "funeral miss". The Petitioner also noted that he had to call off two dates, September 5 and 6 for a doctor appointment.

Petitioner submitted a job search log to the Respondent which shows vocational applications with the Respondent for various positions between July 3 – September 10, 2017. The Petitioner applied for positions with the Respondent in positions including: Accounting Technician II, Auditor II, Supervising Timekeeper – Laborer, Supervising Ventilation and Furnace Inspector, Customer Account Representative, , Architect III, Pool Motor Truck Driver, Painter,

Chief Assistant Corporation Counsel, Civil Engineer III – Sewer, Zoning Plan Examiner, Custodian Worker – Full-Time, Laborer – Apprentice, Chief Airport Operations Supvsr, Clerk IV, Library Division Chief, Glazier. (Respondent's Exhibit 3).

In October the Petitioner was to attend two onsite classes for the first three weeks, and no activity shows as planned for the final week. The Petitioner crossed off September 3, an Attend day, and noted the name of Dr. Poepping. On October 6 he noted that he was sent home. Petitioner noted that he reported Friday October 13 for a makeup date. Finally, on October 17 he noted the name Dr. Hajat.

On October 18, 2017 the Petitioner was awarded a certificate of achievement for completion of the Word 2013 Basic course at Vocamotive. On October 19, 2017 the Petitioner was awarded a certificate of achievement for completion of the Excel 2013 Basic course at Vocamotive. (Px 5D).

Petitioner submitted Mileage Logs into evidence. Those logs show that the Petitioner drove from his home to the Vocamotive offices in Hinsdale on September 7, 21, 22, and 26th, as well as October 4, 5, 6, 10, 12, and 13th. (Px 5D).

Petitioner provided records of job application receipts provided by the job seeking service, Indeed. (Px 5B). The Petitioner was noted to have applied to 1388 jobs over a 221-day period and would indicate a rate of 6.28 jobs per day, including holidays and weekends. (Px 5B).

Reports of Vocamotive

The April 6, 2017 Initial Evaluation Report of Vocamotive identified the Petitioner as a 45-year-old candidate for vocational rehabilitation. Both the August 2014 leg injury and the March 2016 shoulder injury were noted. His FCE from ATI physical therapy was noted, and his restrictions were noted to be a 4-hour work day, no lifting of over 17 lbs. overhead, and no sitting or standing for more than 1 hour. His medical records were reviewed, as was his educational history, vocational history, and socioeconomic status. (Respondent's Exhibit (*hereinafter*, Rx) 4)

The report is specifically noted to exclude consideration of his prior leg injury and that "restrictions pertaining to the leg will not be taken into consideration." (Rx 4).

It was the opinion of the Report that the Petitioner had lost access to his usual and customary line of occupation. The Petitioner was concluded to have an earning potential between $9.00 per hour and $12.00 per hour. (Rx 4).

The October 23, 2017 Final Report of Vocamotive indicates that Petitioner missed an appointment on October 24, 2017 due to medical issues. That appointment was rescheduled for October 26, 2017, and Petitioner was noted to be in attendance. The Reports notes that Petitioner was required to be available for vocational efforts from 8 am to 5pm. The Report specifically notes that Petitioner was required to be available more than his work restrictions. (Rx 4).

The Reports show that Petitioner frequently missed or rescheduled appointments due to medical issues and last-minute visits to his physicians. According to the report, these efforts were not limited to his work-related injuries. As of November 17, 2017, the Petitioner terminated his Vocational efforts with Vocamotive and returned his equipment to their office. (Rx 4).

January 8, 2018 Section 12 Report of Dr. Brian Cole

The Petitioner was seen by Dr. Brian Cole on January 8, 2018 for a Respondent's Section 12 examination. Dr. Cole reviewed medical records, examined the Petitioner, and took a history of the injury. Dr. Cole's diagnosis was a left shoulder rotator cuff injury which had reached MMI with residual pain and biceps tendinitis, as well as related restrictions. (Rx 2).

Dr. Cole gave the Petitioner restrictions "roughly in accordance with the FCE". He set the push/pull up to 20 pounds regularly, with no overhead work with the left upper extremity. Dr. Cole's only point of dispute with the FCE was with the 4-hour work restriction. Dr. Cole found that Mr. McLaurin could return to work without restrictions on his hours. (Rx 2).

January 26, 2018 Addendum Report of Dr. Brian Cole

An Addendum report was produced by Dr. Cole on January 26, 2018. Dr. Cole was provided additional materials for his review, in the form of surveillance footage. Dr. Cole, personally reviewing the footage, noted that the Petitioner was seen working outside with family members hanging Christmas lights. Dr. Cole noted the Petitioner was not seen lifting anything of significant weight during the 17 minutes recorded on the video.

Dr. Cole opined the activities performed were within the restrictions previously provided, and that the video surveillance did not reveal the Petitioner exceeding the performance he had shown during the original examination, or during the FCE.

Dr. Cole continued to opine that the FCE represented a valid representation of the Petitioner's capabilities.

Medical Bills

Petitioner introduced the medical bills of Chicago Orthopaedics & Sports Medicine. The bill shows an unpaid balance of $254 for services on March 17, 2016. The Arbitrator takes judicial notice that the CPT code 99204, the code billed, represents a new patient visit. (Px 7).

Petitioner introduced the medical bills of Premium Healthcare Solutions. The bill shows an unpaid balance of $4,662 for services on April 14, 2016. Treatment is identified as an upper extremity joint MRI and a lower extremity joint MRI. (Px 7).

Petitioner introduced the medical bills of Illinois Orthopedic Network. The bills show unpaid therapy for date of injury March 29, 2016, from April 30, 2016 through September 1, 2016 and March 7, 2018 through March 30, 2018. For those treatments the unpaid amount is listed as $10,763.63. Unpaid office visits are noted for the right knee from April 5, 2016 through March 6, 2018. Bills for the shoulder surgery on May 17, 2016 and post-operative care for the shoulder show as partially paid, with $1,742.00 showing as unpaid. (Px 7).

Petitioner introduced the medical bills of Suburban Pain Care Center. The bill shows a balance of $0. (Px 7).

Petitioner introduced the medical bills of ATI. The bill shows a balance of $0. (Px 7).

Petitioner introduced the Health Insurance claims forms of Specialty Pharmaceutical Inc. The referring provider is listed as doctor Neeraj Jain and is for pharmaceuticals provided on October 3, 2016. (Px 7).

Petitioner introduced the medical bills of Rx Development Associates. Inc. The bill shows a balance due for $2,198.90 for Terocin Lotion and Terocin patch on September 29, 2016. The facility is Midwest Pain Specialists, Inc, the Petitioner's physical therapy provider. (Px 7).

Petitioner introduced the medical bills of Nova Pharmacy LP. The bill shows a balance due for $68.01 for Hydrocodone prescribed by Dr. Thomas Poepping on May 18, 2016. (Px 7).

Petitioner introduced the medical bills of Metro Health Solutions. The bill shows a balance due for $1,440.54 for Zofran, Duricef, and Narcosoft prescribed at Illinois Orthopedic Network on May 18, 2016, and a $0 balance for Urine test strips. (Px 7).

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

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Issue F: *Causal connection*

The Arbitrator finds that the Petitioner has met his burden of proof by the preponderance of the evidence that the current condition of his right leg is causally connected to the accident of August 21, 2014.

"A causal connection between work duties and a condition may be established by a chain of events including petitioner's ability to perform duties before the date of the accident and inability to perform the same duties following that date." Darling v. Indus. Comm'n., 176 Ill App. 3d 186, 193 (1988). A causal connection may be established by evidence of prior good health, a work injury, resulting disability and inability to work. (Id.).

The Petitioner's unrebutted testimony was that he was able to perform his full duties in the time prior to his accident. The Petitioner testified to a 17-year history with the Respondent and testified that he had returned to full duty after a prior injury to his left rotator cuff. (Tx at 16). The Petitioner testified, consistent with the medical records, that while he had returned to work he was not satisfied with the condition of his leg, and that he continues to experience symptoms to this day. (Tx at 26).

The Petitioner's testimony was credible and unrebutted, as well as consistent with the medical records. The Arbitrator finds that the current condition of the Petitioner's right leg is causally connected to the accident of August 21, 2014.

Issue J: *Medical bills*

The Arbitrator finds that the Petitioner has proven by the preponderance of the evidence that the bills of Premium Healthcare Solutions for the lower extremity joint MRI is reasonable and related to the injury to the right leg. (Px 7).

The Arbitrator finds that the Petitioner has proven by the preponderance of the evidence that the medical bills of Chicago Orthopaedics & Sports Medicine for evaluation by Dr. Nam was reasonable and related to the injury to the right leg.

The Arbitrator finds that the Petitioner has proven by the preponderance of the evidence that the bills of Illinois Orthopedic Network for unpaid office visits are noted for the right knee from April 5, 2016 through March 6, 2018 are reasonable and related to the injury to the right leg. (Px 7).

The Respondent is ordered to make payment of the above bills directly to the medical providers noted, pursuant to the terms of the Act, and pursuant to the stipulation of the parties. (Tx at 9-10 and 65-66).

Issue K: *TTD*

The Petitioner has met his burden of proof by the preponderance of the evidence that he was temporarily totally disabled beginning August 22, 2014 through and including June 21, 2015. This is consistent with the Petitioner's testimony as well as the medical records of Dr. Merk at Northwestern Memorial Hospital. This represents a period of 43 and 3/7 weeks. The parties also stipulated that the Petitioner was owed TTD from August 5, 2015 through February 19, 2016, a period of 28 and 3/7 weeks. The Petitioner was therefore owed a total of 71 and 6/7 weeks of TTD. Pursuant to the stipulation of the parties, the Respondent is given a credit of $71,140.73 for TTD paid. (Ax 1A).

Issue L: *Nature and extent of injury*

Pursuant to Section 8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability ("PPD"), for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all 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 from (a) above;
(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.

(See 820 ILCS 305/8.1b)

With regards to factor (i) of Section 8.1b of the Act:

i. The Arbitrator notes that no AMA rating report was admitted into evidence by either party. As such, the Arbitrator gives **no weight** to this factor.

With regards to factor (ii) of Section 8.1b of the Act:

ii. The Arbitrator finds the Petitioner was required to work in a heavy physical demand position as a laborer for the Respondent. As the injury involved relates to his right leg, and as the job cannot be satisfied from a sedentary position, or without the use of right leg, the Arbitrator gives **moderate weight** to this factor.

With regards to factor (iii) of Section 8.1b of the Act:

iii. The Arbitrator notes that the Petitioner was 42 years old at the time of the accident. (Ax 1A). The Arbitrator therefore gives ***some weight*** to this factor.

With regards to factor (iv) of Section 8.1b of the Act:

iv. The Arbitrator notes that the Petitioner returned to employment in his pre-injury position without loss of income prior to his subsequent accident on March 29, 2016. Furthermore, the record is devoid of any evidence of an impairment of earnings because of this August 21, 2014 work accident. As such, the Arbitrator therefore gives ***no weight*** to this factor.

With regards to factor (v) of Section 8.1b of the Act:

v. Evidence of disability corroborated by the treating medical records finds that the Petitioner's injury to his right leg was a comminuted fracture of his tibia which required three (3) surgical interventions for treatment, including a five (5) day inpatient stay at Northwestern Hospital. His open reduction and internal fixation required hardware placement, surgical care for an infected wound, and subsequent hardware removal. Dr. Poepping has prescribed continuing physical therapy through March 6, 2018, and the Petitioner testified he continues to have pain in his right leg. Scarring also is present across the Petitioner's right leg. (Tx at 30-32). Due to the Petitioner's medically documented injuries and other physical complaints, the Arbitrator therefore gives ***significant weight*** to this factor.

Based on the above factors, and the entire record, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of an **37.5% loss of use of the right leg** pursuant to Section 8(e)12 and Section 8.1b of the Act.

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Issue F: *Causal connection*

The Arbitrator finds that the Petitioner has met his burden of proof by the preponderance of the evidence that the current condition of his left shoulder is causally connected to the accident of March 29, 2016.

"A causal connection between work duties and a condition may be established by a chain of events including petitioner's ability to perform duties before the date of the accident and inability to perform the same duties following that date." Darling v. Indus. Comm'n., 176 Ill App. 3d 186, 193 (1988). A causal connection may be established by evidence of prior good health, a work injury, resulting disability and inability to work. Id.

The Petitioner's unrebutted testimony was that he had returned to work after his injury to his right leg and was in the performance of his duties in the time prior to his March 29, 2016 accident. (Tx at 33). The Petitioner testified, consistent with the medical records, that he continues to experience symptoms in his left shoulder. (Tx at 36). Finally, the Respondent's Section 12 examiner, Dr. Cole, found that the Petitioner's current condition and the residual impairment are related to the injury of March 29, 2016. (Rx 2).

The Petitioner's testimony was credible and unrebutted, as well as consistent with the medical records. The Arbitrator finds that the current condition of the Petitioner's left shoulder is causally connected to the accident of March 29, 2016.

Issue J: *Medical bills*

The Arbitrator finds that the Petitioner has proven by the preponderance of the evidence that the bills of Premium Healthcare Solutions for the upper extremity joint MRI is reasonable and related to the injury to the left shoulder. (Px 7).

The Arbitrator finds that the Petitioner has proven by the preponderance of the evidence that the bills of Illinois Orthopedic Network for therapy for the shoulder surgery on May 17, 2016 and post-operative care are reasonable and related to the injury to the left shoulder. (Px 7).

The Arbitrator finds that the Petitioner has proven by the preponderance of the evidence that the bills of Rx Development Associates, Inc., are reasonable and related to the injury to his left shoulder and the treatment he received at Advanced Spine and Rehab/Midwest Pain Specialists, Inc. (Px 7).

The Arbitrator finds that the Petitioner has proven by the preponderance of the evidence that the bills of Nova Pharmacy LP are reasonable and related to the injury to the left shoulder. (Px 7).

The Arbitrator finds that the Petitioner has proven by the preponderance of the evidence that the bills of Metro Health Solutions are reasonable and related to the injury to the left shoulder. (Px 7).

The Respondent is ordered to make payment of the above bills directly to the medical providers noted, pursuant to the terms of the Act, and pursuant to the stipulation of the parties. (Tx at 9-10 and 65-66).

Issue K: *TTD and Maintenance*

The Petitioner has met his burden of proof by the preponderance of the evidence that he was temporarily totally disabled beginning April 1, 2016 through and November 29, 2016, when he was found to be at MMI by Dr. Poepping.

Regarding Maintenance, the Petitioner was placed at MMI on November 29, 2016. Maintenance therefore begins the date the Petitioner reached MMI.

The Petitioner's Permanent Restrictions

A difference of opinion between the Petitioner's treating physician's MMI restrictions and the Section 12 Report restrictions regarding permanency exists in this case and is relevant to the issue of Maintenance and Permanency. The Arbitrator finds the opinion of Dr. Poepping, the Petitioner's treating physician, most credible.

Dr. Poepping treated the Petitioner beginning from his interview on April 5, 2016. Dr. Poepping was the Petitioner's surgeon, and his treating physicians for both his ongoing right knee complaints, and his left shoulder injury. Dr. Poepping set the Petitioner's restrictions after ordering an FCE by ATI, and after reviewing what was deemed to be a valid FCE. Considering the length of the care provided by Dr. Poepping, the Arbitrator finds the opinion of Dr. Poepping very credible.

Dr. Cole, the Respondent's Section 12 physician, agreed with Dr. Poepping on all respects regarding the permanent restrictions, with the sole exception of the 4 hour per day work restriction. While the Arbitrator finds the Dr. Cole to be credible, the Arbitrator notes that a single examination does not provide the Section 12 examiner the same depth of understanding of the Petitioner's abilities as over 19 months of treatment. Neither does an Section 12 examination last as long as an FCE.

Weighing the differing medical opinions regarding the Petitioner's restrictions, the Arbitrator finds the opinion of Dr. Poepping most credible and finds that the preponderance of the evidence is that the Petitioner is only able to work 4 hours per day due to his injury.

The Arbitrator therefore awards the Petitioner 4 hours per day of maintenance pay from the date he reached MMI, November 29, 2016, through the date of the trial, June 25, 2018, a period of exactly 82 weeks.

The Petitioner's vocational efforts

Petitioner introduced evidence that he applied for accommodation with the Respondent, via the Request for Reasonable Accommodation. The Respondent was unable to provide the Petitioner with a position. The Respondent offered vocational services pursuant to

Rule 9110.10, and the Petitioner began a coordinated vocational program on or about the time of the March 23, 2017 interview with Vocamotive staff. (Rx 4).

The Petitioner is therefore awarded Maintenance pay for the remaining 4 hours per day from November 29, 2016 through March 23, 2017, a period of 16 and 4/7 weeks.

The Petitioner was involved in a coordinated vocational rehabilitation program with Vocamotive through November 17, 2017, when he returned the equipment of Vocamotive to their offices. The Arbitrator therefore awards 4 hours of maintenance from March 23, 2017 through November 17, 2017, a period of 34 and 2/7 weeks.

The Arbitrator is forced to consider the cause of Petitioner's termination from Vocamotive's program on November 17, 2017 and the sufficiency of his efforts after that date. It is evident from the reports of Vocamotive that the Petitioner was struggling to cooperate with Vocamotive due to personal issues, medical issues, and personality conflicts with Vocamotive staff. The Arbitrator also notes that Vocamotive explicitly stated in their reports that they would be expecting the Petitioner to work beyond the 4 hour per day restrictions the Arbitrator has deemed credible. The Petitioner was also required to drive to Vocamotive a distance which required him to exceed the amount set forth in his restrictions. Neither party can be deemed to have fully cooperated with the other.

Considering the behavior of both the Petitioner and Vocamotive, the Arbitrator must ponder the vocational efforts of the Petitioner after he terminated his efforts with Vocamotive. The Petitioner was able to demonstrate that he continued job applications through the date of the trial, applying to 1,388 jobs through Indeed. The Arbitrator finds that this was enough effort to merit maintenance. The Arbitrator therefore awards the remaining 4 hours of maintenance per day from November 17, 2017 through June 25, 2018, a period of 31 and 4/7 weeks. The Arbitrator thereby awards full payment of maintenance from November 29, 2016 through June 25, 2018.

Issue L: *Nature and extent of injury*

The Petitioner has met his burden of proof that he is owed a wage differential under §8(d)1 of the Act. The Petitioner has sustained an accidental injury, which has resulted in partial incapacity which prevents him from pursuing his usual and customary line of employment. The parties to this matter agreed that on March 29, 2016, the Petitioner was involved in a work-related accidental injury. (Ax 1B).

Regarding the element that partial incapacity prevents the Petitioner from pursuit of his usual and customary employment, the Arbitrator finds that the Petitioner is so restricted. The Petitioner testified that he had worked for the Respondent for 17 years prior to his injuries, and that he was employed as a construction laborer. The Arbitrator finds that the usual and customary employment was in the construction trade.

The Respondent's Section 12 examiner, Dr. Cole, on review of the surveillance footage, and after examination of the Petitioner and his medical records, found that the Petitioner would not be able to return to work to his original job or in a construction basis. In this matter Dr Cole's opinion was in accord with the Petitioner's treating physician Dr. Poepping. There being no dispute that the Petitioner cannot return to work in the construction trade, the Arbitrator finds that he has lost access to his usual and customary employment.

Furthermore, as evidenced by the "request for accommodation" completed by the Petitioner to the Respondent, and the job applications by the Petitioner for positions with the Respondent, the Respondent is unable to accommodate the Petitioner in his current condition.

As stated above regarding **Issue K:** *TTD and Maintenance*, the Arbitrator finds that the restrictions of the Dr. Poepping and the FCE to be most credible and finds that the Petitioner is restricted as per the FCE report. Pursuant to the terms of that report, the Petitioner is restricted to a 4-hour work day, and to no more than the physical capabilities listed in that report.

The labor market survey provided by Respondent's vocational provider, Vocamotive, sets forth the Petitioner's potential earning capacity as between $9 per hour and $12 per hour. The Arbitrator takes judicial notice that the minimum wage in the City of Chicago as of the date of this Decision is $12 per hour. The Arbitrator therefore finds that the Petitioner, per his Application a resident of the City of Chicago, can earn $12 per hour, 4 hours per day, per his FCE.

The Arbitrator therefore awards a wage differential between the Petitioner's Average Weekly Wage ($1,553.97), representing the amount which he would be able to earn in the full

performance of the duties he was engaged in at the time of the accident, and a weekly wage of $240 ($12/per hour x 4 hours/per day x 5 days/week). The differential is therefore $1,313.97, and the Respondent is ordered to pay $875.98 per week until the Petitioner reaches age 67, pursuant to the Act. ($1,553.97 - $240 = $1,313.97 and $1,313.97 x 66.6% = $875.98)

Signature of Arbitrator

APRIL 17, 2019
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC037076
Case Name	BRINCKS,TROY v. MASCHHOFFS
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0273
Number of Pages of Decision	14
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	Mary Massa
Respondent Attorney	Austin Moore

DATE FILED: 6/8/2021

/s/ Christopher Harris, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TROY BRINCKS,

Petitioner,

vs. NO: 19 WC 37076

MASCHHOFFS,

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, causal connection, and temporary total disability (TTD) 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 modifies the Decision of the Arbitrator and finds that the Petitioner established that his current condition if ill-being is causally related to his December 3, 2019 work-related accident. As Petitioner established causal connection, the Commission awards Petitioner all reasonable and necessary medical expenses, TTD benefits from April 25, 2020 through July 2, 2020, and prospective medical treatment as recommended by Dr. Ma. All else is affirmed and adopted.

It has long been recognized that, in pre-existing condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the

pre-existing disease such that the employee's current condition of ill-being can be said to have been causally-connected to the work-related injury and not simply the result of a normal degenerative process of the pre-existing condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d 30, 36-37, 65 Ill. Dec. 6, 440 N.E.2d 861 (1982); *Caradco Window & Door v. Industrial Comm'n*, 86 Ill. 2d 92, 99, 56 Ill. Dec. 1, 427 N.E.2d 81 (1981); *Azzarelli Construction Co. v. Industrial Comm'n*, 84 Ill. 2d 262, 266, 49 Ill. Dec. 702, 418 N.E.2d 722 (1981); *Fitrro v. Industrial Comm'n*, 377 Ill. 532, 537, 37 N.E.2d 161 (1941).

It is axiomatic that employers take their employees as they find them. *Baggett*, 201 Ill. 2d at 199. "When workers' physical structures, diseased or not, give way under the stress of their usual tasks, the law views it as an accident arising out of and in the course of employment." *General Electric Co. v. Industrial Comm'n*, 89 Ill. 2d 432, 434, 60 Ill. Dec. 629, 433 N.E.2d 671 (1982). Thus, even though an employee has a pre-existing condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d at 36. Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was *a* causative factor in the resulting condition of ill-being. *Rock Road Construction Co. v. Industrial Comm'n*, 37 Ill. 2d 123, 127, 227 N.E.2d 65 (1967).

Furthermore, a chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury." *International Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63-64, 442 N.E.2d 908, 66 Ill. Dec. 347 (1982). In *Price v. Industrial Comm'n*, 278 Ill. App. 3d 848, 853-54, 663 N.E.2d 1057, 215 Ill. Dec. 543 (1996), this court considered the applicability of this principle to a case involving a preexisting condition and reasoned as follows:

> The employer also contends that the facts of the present case do not support the Commission's 'chain of events' analysis because [the claimant] had a preexisting condition. The employer cites no authority for the proposition that a 'chain of events' analysis cannot be used to demonstrate the aggravation of a preexisting injury, nor do we see any logical reason why it should not. *The rationale justifying the use of the 'chain of events' analysis to demonstrate the existence of an injury would also support its use to demonstrate an aggravation of a preexisting injury*. (Emphasis added.)

The Commission finds the Petitioner's testimony relative to his prior accident and resulting condition of his left hand, along with his testimony regarding the work accident and subsequent disability, credible. The Petitioner sustained a prior fracture in 2009 or 2010 resulting in a deformity of his left hand. However, Petitioner returned to work following the 2009/2010 injury and continued to work in various positions without any left-handed issues until his December 3, 2019 work-related accident. The Petitioner credibly testified that he was splinted for 6 weeks

following the 2009/2010 injury and did not have any treatment thereafter. T.15. While the injury resulted in a visible bump on the back of his left hand, the size of the bump remained the same between the old fracture and new fracture. T.14-15. Other than this bump, Petitioner did not have any issues with his left-hand including pain or weakness. T.15-16. Petitioner also did not have any issues with his left hand that precluded him from performing his full job duties when he began working for the Respondent in April 2019. *Id*. According to the Petitioner, it was only after the work-related accident that he noticed that the bump was visibly larger, was more uncomfortable, and he had weakness in his left hand. T.15.

Based upon the above, the Commission finds that the Arbitrator's finding that the Petitioner's weakness has been present since the prior injury and that the work-related accident "neither aggravated, exacerbated, or accelerated this prior injury" is not supported by the evidence.

The Commission is not persuaded by Dr. Rotman's opinion and finds the opinion of Dr. Ma more persuasive. Dr. Rotman opined that the old fracture healed horribly and nothing about the new fracture had anything to do with Petitioner's current issue. RX.1. pg.18. He stated that Petitioner would have needed the osteotomy regardless of the work accident as the deformity was so significant and he should have had the osteotomy prior to the work accident. RX.1. pg.21-22. Dr. Rotman, however, testified that he did not review any medical records from prior to the work accident and acknowledged there was no medical treatment between 2009 and 2019. RX.1. pg.32. While he stated that he would have fixed the deformity closer to the original accident, he conceded that he would not have performed the surgery if Petitioner had no complaints. RX.1. pg.36.

The Commission finds the evidence contradicts Dr. Rotman's opinion. As stated above, there is no evidence that Petitioner had any ongoing issues with his left hand leading up to the work accident or that his deformity hindered his ability to perform his full job duties. It was not until the work-related injury that Petitioner noticed a change in the deformity and began to experience weakness and had difficulty performing his job duties. While the new fracture was at a different location, that fracture brought about his current pain and weakness and the need for the proposed osteotomy. In that respect, the Commission finds the opinion of Dr. Ma persuasive. While the proposed osteotomy would be performed at the location of the old injury, Dr. Ma stated that the osteotomy was necessary to fix the deformity in hopes of regaining Petitioner's loss of strength due to the work injury and was now necessary due to the new fracture. Dr. Ma's opinion is supported by Petitioner's testimony that he had no ongoing pain or weakness following the original injury, the absence of any medical records between 2009 and the work accident documenting ongoing treatment or difficulties, and his testimony that he was able to perform his job duties without issue prior to the work accident.

As the credible evidence demonstrates that Petitioner did not have any ongoing issues with his left hand prior to the work accident, the Commission finds that Petitioner established causal connection between the work accident and his current condition of ill-being. The Commission, therefore, awards Petitioner the proposed osteotomy as recommended by Dr. Ma.

The Commission further finds that Petitioner is entitled to TTD benefits from April 25, 2020 through July 2, 2020. A claimant is temporarily totally disabled from the time an injury incapacitates him from work until such time as he is as far recovered or restored as the permanent character of his injury will permit. *Archer Daniels Midland Co. v. Industrial Comm'n*, 138 Ill. 2d 107, 118 (1990). The dispositive test is whether the claimant's condition has stabilized, *i.e.*, whether he has reached MMI. *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 759 (2003). Once an injured claimant has reached MMI, the disabling condition has become permanent and he is no longer eligible for TTD benefits. *Archer Daniels Midland Co.*, 138 Ill. 2d at 118.

On March 25, 2020, Dr. Ma placed work restrictions of limited lifting of less than 10 pounds with the left hand on the Petitioner. Petitioner was allowed to work light duty until Dr. Rotman returned him to work full duty on April 14, 2020. T.17-18. Petitioner stated that he could not perform his full duty tasks without pain in his left hand and he does not have the strength to perform his full duty work. T.18. Petitioner has not worked since April 24, 2020. For reasons stated above, the Commission does not find the testimony of Dr. Rotman persuasive. Therefore, the Commission finds that the Petitioner is entitled to TTD benefits from April 25, 2020 through July 2, 2020, representing 9 and 6/7 weeks.

The Commission further finds that Petitioner is entitled to all reasonable and necessary medical expenses as contained in Petitioner's exhibit 6.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 10, 2020, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $371.70 per week for a period of 9-6/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $2,823.38 for medical expenses under §8(a) of the Act and subject to the medical fee schedule.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

June 8, 2021

CAH/tdm
O: 6/3/21
052

/s/ *Christopher A. Harris*
Christopher A. Harris

/s/ *Barbara N. Flores*
Barbara N. Flores

/s/ *Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0273

BRINCKS, TROY
Employee/Petitioner

Case# **19WC037076**

MASCHHOFFS
Employer/Respondent

On 9/10/2020, 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 0.12% 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:

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

2904 HENNESSY & ROACH PC
AUSTIN T MOORE
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

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

TROY BRINCKS
Employee/Petitioner

v.

MASCHHOFFS
Employer/Respondent

Case # **19** WC **37076**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield, IL**, on **July 2, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of the accident, **December 3, 2019**, 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 **$28,992.60**; the average weekly wage was **$557.55**.

On the date of accident, Petitioner was **26** years of age, ***single*** with **zero** dependent children.

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

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

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

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

ORDER

Because Petitioner's current condition of ill-being is not causally related to the injury, Respondent is not liable for paying prospective medical services after April 14, 2020.

TTD benefits from April 25, 2020 to July 2, 2020 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.

Carl Lee
Signature of Arbitrator

9/6/20
Date

SEP 10 2020

Troy Brincks vs. Maschhoffs
19 WC 37076

FINDINGS OF FACT

Petitioner filed an Application for Adjustment of Claim alleging he sustained an accidental injury arising out of and in the course of his employment by Respondent on December 3, 2019. Petitioner alleges he smashed his left hand between a gate and a board while herding pigs into a pen. This case was tried pursuant to Petitioner's Request for Hearing under Section 19(b) of the Act. Respondent stipulated that Petitioner was an employee of Respondent and gave timely notice of his accident. The issues in dispute are whether Petitioner's current condition of ill-being is causally related to his work injury of December 3, 2019, TTD, and prospective medical care.

The only witness at the hearing was Petitioner. Petitioner testified on direct examination that he has worked for Respondent since early 2019. Petitioner testified that, on the date of accident, he was herding pigs into a pen. Petitioner testified that as the pigs were being herded in, one of them hit an open gate. Petitioner testified that at the time the pig hit the gate, his left hand, which he testified was his dominant hand, was situated between the gate and a board. Petitioner testified that as a result, the gate swung open, smashing his hand between the gate and the board.

Petitioner testified that prior to his injury on December 3, 2019, he sustained a left-hand fracture in about 2009 or early 2010 when he was about 16 years old. Petitioner testified that he used to participate in MMA (mixed martial arts) and fractured his left hand when he punched a floor while attempting to punch his opponent. Petitioner testified that because of his left-hand fracture in 2009/2010, his hand failed to hand properly causing a deformity. Petitioner testified that he did not experience any weakness in his left hand until after his new fracture on December 3, 2019.

On cross examination Petitioner testified he treated for his left-hand fracture in 2009/2010 for about six weeks. Petitioner testified that between the time of his old fracture and accident on December 3, 2019, he worked a variety of light duty jobs. Petitioner testified that one job required lifting of about 30 pounds.

After the date of accident, Petitioner sought treatment at the Passavant Area Hospital emergency room for evaluation of a left-hand injury. An x-ray of the left-hand revealed a comminuted minimally displaced distal left fourth metacarpal fracture. Petitioner was released and recommended to follow-up. (PX 1)

On December 13, 2019, Petitioner presented to Dr. Jianjun Ma at Springfield Clinic regarding his left-hand injury. An examination of the left hand demonstrated significant swelling and tenderness to palpation over the dorsal aspect of the left fourth metacarpal. Petitioner submitted for an x-ray which revealed a fracture of the neck of the left fourth metacarpal. Petitioner was recommended to proceed with immobilization over surgery, and his forearm was placed in a cast to the left hand. He was taken off work. (PX 2)

Petitioner followed-up with Dr. Ma on December 27, 2019. An x-ray showed no change in the alignment of the distal fourth metacarpal fracture. Petitioner was kept off work and then referred for occupational therapy. (PX 2)

Petitioner presented to Philip Jostes, an occupational therapist at Springfield Clinic, for occupational therapy. Petitioner was recommended to proceed with a home exercise program and then to begin occupational therapy at Passavant Rehabilitation Services. (PX 3)

On January 8, 2020, Petitioner presented to Todd Thorsen, an occupational therapist at Passavant Rehabilitation Services. Petitioner was recommended to continue occupational therapy two times a week for six weeks. (PX 3)

On January 15, 2020, Petitioner returned to Dr. Ma regarding his left-hand fracture. Petitioner's left hand appeared to be improving with therapy, and he reported that the pain was minimal. An x-ray demonstrated that the left hand was healing well. Petitioner was kept off work and he was recommended to continue his home exercise program. (PX 2)

Petitioner followed-up with occupational therapy with Kellie Steele on January 23, 2020. According to the report, Petitioner had decreased pain symptoms and increased function in his left hand. He was recommended to continue therapy. (PX 3)

Petitioner reported decreased symptoms and increased function at his occupational therapy session on January 28, 2020 with Todd Thorsen. He was recommended to continue therapy. (PX 3)

Petitioner followed-up with Dr. Ma on February 26, 2020 and reported increased strength in left hand. He continued to suffer from weakness in left wrist and struggled to make a fist. He submitted for an x-ray which revealed some dorsal angulation with malunion. Petitioner was given light duty restrictions of lifting no more than 20-30 pounds and no pushing or pulling over 20-30 pounds with the left arm. He was recommended to continue therapy and follow-up in a month. (PX 2)

On March 25, 2020, Petitioner followed-up with Dr. Ma and reported dull, intermittent pain in his left hand. Dr. Ma opined that the pain and weakness in his left hand was due to fourth metacarpal malunion and recommended that he undergo an osteotomy. An x-ray of the left hand did not reveal any new fracture, dislocation, or osseous defect. Petitioner was recommended to continue working but with 10-pound restrictions using the left hand. (PX 2)

Petitioner returned to Dr. Ma on April 8, 2020. Petitioner reported dull pain which he rated at a 3/10, as well as weakness in his left hand. Again, Dr. Ma recommended he proceed with an osteotomy. (PX 2)

Petitioner was seen for an IME at the request of Respondent by Dr. Mitchell Rotman on April 14, 2020. Dr. Rotman reported that Petitioner had reached MMI as of April 14, 2020 and could return to work full duty. (RX 1)

Dr. Rotman reported that Petitioner had sustained a prior fracture at the left fourth metacarpal. Upon physical examination, Dr. Rotman noted that Petitioner's new fracture resulting from his December 3, 2019 accident, which he identified as a fracture to the neck of the left fourth metacarpal, had healed. If surgery were required, as Dr. Ma recommended, the surgery would be to the old fracture site, which Dr. Rotman located as the midshaft of the left fourth metacarpal. Dr. Rotman reported that Petitioner's current symptoms of left-hand weakness was significantly magnified. (RX 1)

Dr. Ma testified via evidence deposition on June 9, 2020. Dr. Ma testified that he was a board-certified orthopedic hand surgeon. Dr. Ma testified that he treated Petitioner from December 13, 2019 through April 8, 2020. When asked if he had an opinion within a reasonable degree of medical certainty whether Petitioner's new fracture, which he sustained at the neck of the left fourth metacarpal in the course of his employment, had healed, Dr. Ma testified that it had. Dr. Ma then testified, however, that Petitioner sustained an aggravation of the pre-existing fracture located at the midshaft of the left fourth metacarpal that he sustained in 2009-2010. Dr. Ma testified that the basis for his opinion was Petitioner's left-hand weakness. Dr. Ma testified that he normally would not recommend an osteotomy but for the persistent weakness Petitioner alleged he suffered from. (PX 5)

On June 16, 2020, Dr. Rotman testified via evidence deposition. Dr. Rotman testified that he was a board-certified orthopedic hand surgeon with over 30 years of experience. Dr. Rotman testified that he went to the University of Illinois for medical school and did a fellowship in hand surgery at Washington University in St. Louis, Missouri. Dr. Rotman testified that all his opinions were to a reasonable degree of medical certainty. Dr. Rotman testified that Petitioner's new fracture had healed perfectly and that his ongoing complaints involved his old fracture at the midshaft of the left fourth metacarpal. Dr. Rotman testified that he did not believe Petitioner aggravated or exacerbated the midshaft of the left fourth metacarpal and that the injury sustained on December 3, 2019 was to the neck of the left fourth metacarpal. Dr. Rotman testified that the basis for his opinions were the x-ray films he reviewed following the work accident of December 3, 2019. Dr. Rotman testified that he agreed with Dr. Ma that Petitioner would need an osteotomy at the midshaft of the left fourth metacarpal due to his old injury in 2009/2010, but reported that due to the significance of the deformity, he would have required an osteotomy regardless of whether he was involved in the work accident of December 3, 2019. On cross-examination, Dr. Rotman testified that he did not review x-ray films of the old fracture at the midshaft of the left fourth metacarpal from 2009/2010 because he found sufficient the new x-ray following the accident on December 3, 2019. Dr. Rotman testified that based on his review of the x-ray, Petitioner's old fracture site was fine, except for the deformity caused in 2009/2010. Dr. Rotman testified that Petitioner's new fracture at the neck of the left fourth metacarpal

was not displaced, indicating that the force caused by the accident was not great. Dr. Rotman testified that Petitioner likely had weakness associated with the deformity from 2009/2010. Dr. Rotman testified that the deformity sustained in 2009/2010 likely caused Petitioner to have some weakness in his hand since his initial fracture of 2009/2010. (RX 1)

CONCLUSIONS

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

The Arbitrator finds that on December 3, 2019, Petitioner sustained a work-related fracture at the neck of the left fourth metacarpal which had healed as of the date of his IME, April 14, 2020. The left-hand weakness Petitioner alleges to suffer from is related to the midshaft of the left fourth metacarpal which was caused by an injury sustained in late 2009 or early 2010. Petitioner's weakness has been present since his injury of 2009/2010 and the non-displaced fracture sustained on the date of the accident was of little force to have impacted the old fracture site. It neither aggravated, exacerbated, or accelerated this prior injury. It is likely Petitioner would have needed an osteotomy in the future to repair the deformity that limited his strength regardless of his work accident to the neck of the left fourth metacarpal.

The Arbitrator finds that the opinions of Dr. Rotman carry more weight and are more persuasive than the opinions of Dr. Ma, and finds there is no causal connection between the weakness alleged by Petitioner and the work accident sustained on December 3, 2019.

ISSUES (J) AND (K): Has Respondent paid all appropriate charges for reasonable and necessary medical services?

Based on the preceding causal connection finding, Respondent is liable for all related and necessary medical expenses incurred prior to April 14, 2020 the date of MMI. Respondent is not liable for any medical expenses incurred on and after April 14, 2020. Likewise, Respondent is not liable for any prospective medical treatment that is presently being considered.

ISSUE (L): TTD

Based on the preceding causal connection finding, Respondent is not liable to pay TTD benefits for April 25, 2020 through July 2, 2020 as Petitioner was found to be at MMI as of April 14, 2020.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC030977
Case Name	CALVILLO, TIFFANY v. ANIXTER CENTER
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0274
Number of Pages of Decision	6
Decision Issued By	Barbara Flores, Commissioner

Petitioner Attorney	Christopher Bassmaji
Respondent Attorney	Brad Antonacci

DATE FILED: 6/8/2021

/s/ Barbara Flores, Commissioner

Signature

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

TIFFANY CALVILLO,

Petitioner,

vs. NO: 17 WC 30977

ANIXTER CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

Petitioner has timely filed a Petition for Review, wherein she requests review of Arbitrator Watts's order denying reinstatement of her case. Respondent has filed a Motion to Dismiss Petitioner's Review for want of prosecution. The Commission, after considering the filings of the parties and the record, and being advised of the facts and law, denies the Motion to Dismiss, vacates the Order of the Arbitrator, and remands the matter for a hearing on the merits for the reasons stated below.

I. STATEMENT OF FACTS

On October 20, 2017, Petitioner filed an Application for Adjustment of Claim, alleging that Petitioner suffered "[m]ultiple injuries while working" on September 19, 2017.

On July 18, 2018, Respondent filed a Motion to Dismiss or Bar Petitioner's Medical Evidence, with supporting exhibits, alleging that Petitioner failed to appear for Section 12 examinations scheduled for January 26, 2018, March 12, 2018, and July 16, 2018, causing Respondent to incur cancellation fees.

Respondent asserts that Arbitrator Soto initially set the motion for hearing on September 7, 2018, but continued the motion to October 12, 2018 and November 13, 2018, instructing Petitioner's counsel on both occasions that Petitioner was required to appear and explain why she failed to attend the Section 12 examinations.

On November 13, 2018, Arbitrator Soto granted Respondent's motion, with "DWP"

handwritten next to the description of Respondent's motion.

On January 3, 2019, Petitioner filed a Petition to Reinstate Case, stating:

> "This matter was set for hearing on November 13, 2018 before Arbitrator Soto. However, the claim appears to have been inadvertently dismissed. Petitioner has a compensable claim. Reinstating this claim will not prejudice Respondent in any way. Therefore, we respectfully request that this claim be reinstated and restored to call."

On February 14, 2019, Arbitrator Watts denied the Petition to Reinstate Case.

On March 14, 2019, Petitioner filed a Petition for Review before the Commission. The sole issue listed in the petition is the "Oral decision of the Arbitrator failing to reinstate the case or issue a written decision or conduct hearing." On the same date, Petitioner filed a motion to reinstate the case.[1]

On January 22, 2021, Respondent filed its Motion to Dismiss Petitioner's Review for want of prosecution, asserting that Petitioner had taken no action to advance her claim or her Petition for Review since filing it.

On March 24, 2021, Petitioner filed her Statement of Exceptions and a separate Petitioner's Response to Respondent's Motion to Dismiss Petitioner's Review. In her Statement of Exceptions, Petitioner asserts that she was unable to attend the Section 12 examination scheduled for January 26, 2018 because she was hospitalized for high blood pressure unrelated to her workers' compensation claim. Petitioner asserts that she was unable to attend the Section 12 examination scheduled for March 12, 2018 due to being diagnosed with tonsilitis. She further asserts that she was a "no call no show" for the Section 12 examination scheduled for July 16, 2018. She claims that she was unable to attend the hearing on Respondent's Motion to Dismiss or Bar Medical Evidence on October 12, 2018. She also claims that she was unable to attend the hearing on November 13, 2018 because she was closing on the sale of her house.

Petitioner's Statement of Exceptions acknowledges that none of her factual assertions regarding her failures to attend Section 12 examinations or hearings before the Arbitrator are of record. Petitioner states that there was no court reporter present for the proceedings on November 13, 2018, when Respondent's Motion to Dismiss was granted, or February 14, 2019, when Petitioner's Petition to Reinstate Case was denied. Petitioner argues that the Arbitrators erred in dismissing her case and denying reinstatement without making any record for review by the Commission. In the alternative, Petitioner argues that the Arbitrators erred in dismissing her case based on the facts she asserted in her Statement of Exceptions.

Petitioner's Response to Respondent's Motion to Dismiss Petitioner's Review argues that Petitioner properly perfected her review under the Act and the rules governing practice before the Commission, whereupon the parties are to wait for the Commission to issue a Notice of the

[1] On July 9, 2019, Commissioner Barbara N. Flores continued the motion, to be consolidated with Petitioner's Petition for Review of the Arbitrator's denial of the Petition to Reinstate Case.

Return Date on Review. Petitioner asserts that Respondent provided Petitioner with copies of emails sent to the Commission inquiring about the Return Date on Review. Petitioner also asserts that Petitioner's counsel telephoned the Commission regarding the Return Date on Review and was never given a concrete answer. Petitioner further asserts that there is no motion practice before the Commission and therefore no authority for the Commission to grant Respondent's motion to dismiss the review.

On April 9, 2021, Respondent filed its Response to Petitioner's Statement of Exceptions and a separate Reply in Support of Motion to Dismiss Petitioner's Review. The Response to Petitioner's Statement of Exceptions argues that Petitioner failed to present evidence to support her claim of missing two Section 12 examinations for medical reasons and provided no explanation for missing the third examination. Respondent also questions the propriety of Petitioner failing to appear before the Arbitrator in favor of closing on the sale of her house. Respondent further argues that Petitioner failed to explain why she failed to attend the October 12, 2018 hearing.

Respondent's Reply in Support of Motion to Dismiss Petitioner's Review argues that Petitioner is simply incorrect in asserting that there is no motion practice before the Commission. Respondent also argues that a Petition for Review can be considered abandoned if not prosecuted by the movant, in this case for nearly two years.

II. CONCLUSIONS OF LAW

As a threshold matter, the Commission addresses Respondent's Motion to Dismiss Petitioner's Review for want of prosecution. Petitioner argues that the motion is improper because there is no motion practice before the Commission. Petitioner's position is incorrect. The rules and regulations governing practice before the Commission contemplate certain motion practice before Arbitrators and Commissioners, up to and including motions made during a Review hearing. See 50 Ill. Adm. Code 9020.70 (eff. Nov. 9, 2016). Indeed, in this case, Respondent's motion to dismiss filed before Commissioner Flores was accompanied by the Commission's form Notice of Motion and Order, checking the box marked "Dismissal of review."

Petitioner also observes that she timely filed her Petition for Review following the denial of reinstatement. However, "[j]ust as a petitioner may lose [her] right to proceed before the Commission by failing to file a timely petition, resulting in a binding decision by the arbitrator [citations], so, too, may [she] lose [her] right to be heard by the Commission after a timely petition has been filed, by failing to proceed in accordance with the statutory requirements and the governing rules." *Bromberg v. Industrial Comm'n*, 97 Ill. 2d 395, 401 (1983). The timely filing of a Petition for Review, while necessary, is not sufficient. The determination of whether to dismiss a Petition for Review for want of prosecution rests within the sound discretion of the Commission. See *id*. at 400.

In considering how to exercise our discretion in this case, the Commission is persuaded by standards established in our own rules regarding reinstatement of cases dismissed from the arbitration call for want of prosecution. The Commission shall apply standards of fairness and

equity, considering the Petitioner's grounds, the Respondent's objections, and the precedents set forth in Commission decisions. See 50 Ill. Adm. Code 9020.90 (eff. Nov. 9, 2016).

In support of its motion, Respondent cites a single decision of the Commission, *Kelsey v. UPS*, Ill. Workers' Comp. Comm'n, No. 14 WC 30511, 14 IWCC 30511 (Feb. 15, 2018). In *Kelsey*, the Commission determined that a petitioner had abandoned his Petition for Review after he twice failed to appear in person or through counsel to contest the Respondent's motion to dismiss. *Id*. *Kelsey* is consistent with other Commission decisions dismissing petitions for want of prosecution where the petitioner fails to appear before the Commission, particularly where there are multiple failures to appear before the Commission or where a petitioner has an opportunity to refile. See, *e.g*., *Arnold v. State of Illinois/Fox Developmental Center*, Ill. Workers' Comp. Comm'n, No. 01 WC 13489 (Oct. 29, 2019); *Strong v. University of Illinois-Chicago*, Ill. Workers' Comp. Comm'n, No. 12 WC 01213 (Feb. 15, 2018).

In this case, Petitioner has contested the Motion to Dismiss Petitioner's Review, which distinguishes this case from the Commission's prior decisions. Petitioner argues that after timely filing her Petition for Review, counsel waited for the Commission to issue a Notice of Return Date on Review. Petitioner also asserts that counsel for both parties contacted "the Commission" regarding the Return Date on Review, though no evidence of such communications was submitted as exhibits in these proceedings and none appear in the Commission's file. The Commission does not conclude that there were no such communications, although their absence from the record limits the Commission's review of the facts in this case inasmuch as there is no record of whether the filing of the authenticated transcript was discussed.

The Return Date on Review is limited to the filing of an authenticated transcript in review proceedings before the Commission. See 50 Ill. Adm. Code 9040.10 (eff. Nov. 9, 2016). However, the timing of the appellant's filing of a Statement of Exceptions and Supporting Brief, and the appellee's filing of a response, are generally linked to the Return Date on Review. See 50 Ill. Adm. Code 9040.70 (eff. Nov. 9, 2016).

In this case, however, Petitioner's Petition for Review specifically objects that the Arbitrators erred in dismissing her case and denying reinstatement without making any record for review by the Commission. The absence of a transcript is not expressly contemplated by the rules governing practice before the Commission.[2] Even in cases involving petitions to reinstate, a record shall be made of a hearing on any contested petition. See 50 Ill. Adm. Code 9020.90 (eff. Nov. 9, 2016). Accordingly, it is understandable that it would not occur to counsel for either party or even to Commission staff that the absence of a transcript may result in the Commission not issuing a Notice of Return Date on Review. Given the unusual facts and circumstances presented in this matter, the Commission exercises its discretion to deny Respondent's Motion to Dismiss Petitioner's Review for want of prosecution.

[2] The current rules governing practice before the Commission differ from our prior regulations, which specifically contemplated cases in which no transcript was filed. See, *e.g*., *Guillermo v. Industrial Enclosure Corporation*, Ill. Workers' Comp. Comm'n, No. 03 WC 15746, 5 IWCC 0196 (Mar. 18, 2005) (quoting and discussing prior regulations).

Turning to the merits of the review, Petitioner argues that the Arbitrators erred in failing to make a record of the dismissal of her case for want of prosecution or the denial of her Petition to Reinstate Case. Petitioner's argument has merit regarding the denial of the petition to reinstate. As stated above, the rules governing practice before the Commission provide that a record shall be made of a hearing on any contested petition to reinstate a case dismissed for want of prosecution. See 50 Ill. Adm. Code 9020.90 (eff. Nov. 9, 2016). The Commission has previously vacated Arbitrators' orders in similar cases because it is impossible for the Commission to meaningfully review a denial of reinstatement absent a hearing on the motion and the Arbitrator's findings on the issue. *E.g.*, *Malik v. M.P. Trailer Repair Ltd.*, Ill. Workers' Comp. Comm'n, No. 09 WC 20637, 15 IWCC 290 (Apr. 23, 2015); *Yepez v. Juno Lighting, Inc.,* Ill. Workers' Comp. Comm'n, Nos. 99 WC 11284, 99 WC 11285, 99 WC 19716, 13 IWCC 995 (Nov. 21, 2013); *Huerta v. Vital*, Ill. Workers' Comp. Comm'n, No. 07 WC 09752, 12 IWCC 439 (May 1, 2012). Accordingly, the Commission vacates the Arbitrator's Order denying reinstatement of Petitioner's claim, and remands the case for a hearing on Petitioner's Petition to Reinstate Case. A record must be made with all necessary evidence and the Arbitrator shall make a determination with specific and express findings on the petition.

Lastly, the Commission notes that only final determinations of the Commission are appealable. "In determining whether a decision of the Commission is final, the question to be decided is whether administrative involvement in the case has been terminated or the Commission has ordered further administrative proceedings." *Supreme Catering v. Illinois Workers' Compensation Comm'n*, 2012 IL App (1st) 111220WC, ¶ 8 (citing *International Paper Co. v. Industrial Comm'n*, 99 Ill. 2d 458, 465-66 (1984)). In this case, the decision to remand to the Arbitrator for a hearing on Petitioner's Petition to Reinstate Case does not determine the rights of the parties on the merits and requires further administrative involvement, rendering our order interlocutory and not appealable.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Motion to Dismiss Petitioner's Review is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that the Order dated February 14, 2019, denying reinstatement of Petitioner's claim, is hereby vacated, that this matter is remanded to the Arbitrator for hearing and determination with a record and findings that would permit a meaningful review on Petitioner's Motion to Reinstate.

JUNE 8, 2021

o: 6/3/21
BNF/kcb
045

/s/ *Barbara N. Flores*
Barbara N. Flores

/s/ *Christopher A. Harris*
Christopher A. Harris

/s/ *Marc Parker*
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC017547
Case Name	RALLS,STEVEN E v. SOUTHERN ILLINOIS UNIVERSITY
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remanded Arbitration
Decision Type	Commission Decision
Commission Decision Number	21IWCC0275
Number of Pages of Decision	19
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	Casey VanWinkle
Respondent Attorney	Nicole Werner

DATE FILED: 6/8/2021

/s/ Christopher Harris, Commissioner

Signature

17wc017547STATE 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

STEVEN E. RALLS,

Petitioner,

vs. NO: 17 WC 17547

SOUTHERN ILLINOIS UNIVERSITY CARBONDALE,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical treatment, and intervening 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. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 23, 2020 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.

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

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

June 8, 2021

CAH/tdm
O: 6/3/21
052

/s/ *Christopher A. Harris*
Christopher A. Harris

/s/ *Barbara N. Flores*
Barbara N. Flores

/s/ *Marc Parker*
Marc Parker

21IWCC0275

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
8(A)

RALLS, STEVEN E Case# **17WC017547**
Employee/Petitioner

SIU-CARBONDALE
Employer/Respondent

On 6/23/2020, 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 0.17% 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:

0000 TIM DENNY LLC
PO BOX 399
ANNA, IL 62906

0499 CMS RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
801 S 7TH ST 8M
SPRINGFIELD, IL 62794

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

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

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

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

JUN 23 2020

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF JACKSON)

☐ 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)

Steven E. Ralls
Employee/Petitioner
v.
SIU - Carbondale
Employer/Respondent

Case # **17** WC **017547**

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 **Herrin**, on **December 19, 2019**. 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, **1/10/2017**, 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 $**73,342.35**; the average weekly wage was $**1,410.43**.

On the date of accident, Petitioner was **50** years of age, **married** with **2** dependent children.

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

Respondent shall be given a credit of $**76,972.72** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0,00** for other benefits, for a total credit of $**76,972**.72

Respondent is entitled to a credit of $**credit due for any bills paid by stipulation of the parties** under Section 8(j) of the Act.

ORDER

The Respondent shall authorize and pay for the left knee surgery recommended by Dr. Paletta as well as any ancillary reasonable, necessary, related medical care in accordance with sections 8(a) and 8.2 of the Act.

Parties stipulated that Petitioner was temporarily totally disabled from January 13, 2017, through April 2, 2017, and April 25, 2017, to September 30, 2018. Parties stipulated Respondent paid and shall receive credit for $76,972.72 of TTD paid, Respondent shall receive credit for TTD paid.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Signature of Arbitrator

5/11/2020
Date

ICArbDec 8 (a)

JUN 2 3 2020

The Arbitrator makes the following findings of facts:

This matter was heard by Arbitrator Michael Nowak December 19, 2019. The parties stipulated to another Arbitrator writing Decision from Transcript of Proceedings and exhibits.

The Petitioner, Steve Ralls, is 53 years old and has been married since 1993. (AT p. 10). He has 2 children that are 19 and 14, and he is employed at Southern Illinois University, Carbondale. (AT p. 11). The Petitioner has been employed at SIU for almost 18 years. He is a carpenter but more specifically, he installs flooring and does carpentry work when there is not flooring work. (AT p. 11). His job duties consist mainly of tearing out old flooring and installing new flooring crawling on his knees seven and a half hours per day. (AT p. 12). As of the time of Arbitration the Petitioner had taken a carpenter's foreman position. (AT p. 12).

On January 10, 2017, the Petitioner got up from where they meet at 7 in the morning and went out to get in the vehicle. (AT p. 12). He was ready to get off a loading dock in the same way he had for 15 years by putting one hand on the front of the van and one hand on a piece of steel in front of the dock then put his feet out to let himself down to get in the vehicles when his left foot slipped on the ice. (AT p. 13). He lost his balance and fell basically headfirst but somehow reached his hands back on the van enough to get his feet under him then both feet kind of did the splits the wrong way and straight out to the side. (AT p. 13). The Petitioner described the photograph in Petitioners exhibit 1, which is the physical plant building. The center door right beside the maroon hopper is where he came out of the building. (AT p. 14). The Petitioner then confirmed that Petitioner's exhibit 2 is the ground level view of the photograph off the ledge where he was going to the vehicles. (AT p. 15). He further confirmed that the maroon van in Petitioners exhibit 2 was not exactly where it is sitting in the photograph, but that was the van he put his hand on as it was the van he was driving at the time. (AT p. 15).

The Petitioner also confirmed that there was ice that had been treated with salt and the piece of steel along the front of the dock either had no salt on it or was just colder and still had ice on it. (AT p. 15). When the Petitioner's knees went out on him, he had asphalt and cinders on the inside of his left knee after he hit the ground. (AT p. 16). The Petitioner further described that all his weight, which pretty much went flat, and the other leg went out. Both legs went out, but the left knee is the one that started swelling up and hurting. (AT p. 16). The Petitioner did not hit his head at the time of the accident. (AT p. 16). The area of the loading dock where the Petitioner fell is not open to the public and is only for employees to get in and out of the vehicles. (AT p. 17).

The Petitioner reported the injury to his foreman Mark and completed some witness statements. (AT p. 17). On the 13th of January in 2017, he went to Southern Orthopedic Group walk-in clinic. (AT p. 17). He saw Dr. JT Davis who ordered an MRI to see how bad his knee was injured and ordered physical therapy. (AT p. 18). Dr. Davis advised the Petitioner that he would do physical therapy because he would rather it heal itself than to do surgery. (AT p. 18). The physical therapy assisted the Petitioner as they got him back where he could bend his leg all the way back with a lot of pain. (AT p. 18). Dr. Davis advised the Petitioner he would do physical therapy for up to 6 months and then if it wasn't healed, they would do something different. (AT p. 18). After about 3 months he tried to go back to work around the 1st of April in 2017, and made it about 3 days, but when he attempted to get down and do ceramic tile in the building, he would actually feel his knee pop like he really did not know what was happening and a knee cap was popping out of place and his knee would pop real loud after he walked 8 to 10 steps. (AT p. 19). The Petitioner had gone through work hardening with Rick Vicenzi, the physical therapist at Southern Orthopedic Group which included him using the knee pads he used at work. (AT p. 19). This consisted of him putting his knee pads on and crawling across approximately fifty feet down and back

and he would have to do it for a certain period. (AT p. 20). Dr. Davis had initially indicated that after 6 months of physical therapy he would do surgery but after 6 months of therapy he recommended 3 more months of therapy. (AT p. 20). At that time, the Petitioner elected to get a second opinion with Dr. Paletta, who secured a new MRI. Dr. Paletta continued physical therapy and did an injection with Dr. Blake. (AT p. 21). At that time, the Respondent sent him to see Dr. Nogalski after which the Petitioner underwent viscosupplementation injections.

Dr. Paletta recommended surgery that was performed in January of 2018, which was authorized by the Respondent. (AT p. 22). Dr. Nogalski had previously told the Petitioner he would require surgery to get back to his job. (AT p. 22). After surgery the Petitioner gained strength because he lost a lot of the pain. (AT p. 22). Before surgery he could not even step up on a 12-inch box or step with the left leg. (AT p. 22). However, where he hit the ground at the time of his fall he had cinders on his pants and something that felt like a raw nerve sticking out inside the leg where you almost have to pull your pants off to keep them off it and it never went away. (AT p. 23). His strength returned in his leg but whatever was hurting inside never went away. (AT p. 23). After that Dr. Paletta recommended a dynamic ultrasound. (AT p. 23). Dr. Paletta had also told him that after the first surgery his knee was tore really bad and for a lot of people, they would remove part of the (meniscus. B because of what the Petitioner does for a living he needed to be constructed back right and that he may not get it all the first time. (AT p. 23). Dr. Paletta believed there was a part he could not see with the scope and that is why he ordered the dynamic ultrasound with Dr. Crane at Blue Tail Medical Group. (AT p. 23).

The Petitioner underwent the dynamic ultrasound with Dr. Crane who told him that the bottom end of the meniscus still had a tear in it that was sticking out and that was causing the pain that could not be seen by Dr. Paletta. Dr. Crane described to the Petitioner that he and Dr. Paletta would do a surgery together through the screen to see what was going on. (AT p. 24). At the time of Arbitration, the Petitioner was designed to undergo the surgery recommended by Dr. Paletta. (AT p. 24). The Petitioner specified that if he could get the pain out of his knee, he would do anything. (AT p. 25). At the time of Arbitration, the Petitioner could do any kind of getting around, climbing a small number of steps with less pain but after a good day of work or riding home in his vehicle, he is miserable. (AT p. 25). At the time of Arbitration, the Petitioner was taking ibuprofen but did not like to take too many of them because they are not good for the body. (AT p. 26). None of the doctors had told him to refrain from his daily activities other than right after surgery and then he was told to do whatever he wanted to do and if it started to hurt, quit. (AT p. 26). The Petitioner did not have a second accident in September of 2018. (AT p.26).

The Petitioner did mention to Dr. Paletta that he had done some bush hogging at home which is driving a shuttle shift tractor that you put in gear and you don't have to use your leg. (AT p. 27). Dr. Paletta asked if it created pain he said, "Yes, if I use the clutch." (AT p. 27). The Petitioner specified it is not an old clutch that is hard to push and it is hydraulic and you can push it in with your hand but after pushing in three or four times he definitely could tell it in there so the Petitioner would bush hog for a couple of hours quit and then go back and bush hog for a couple more hours. (AT p. 28). When asked if the knee would return to baseline after bush hogging, the Petitioner stated it does. (AT p. 29). He also clarified that the longer he does any activity throughout the day and his knee becomes more fatigued from climbing stairs it happens quicker. (AT p. 29). The bush hogging was far enough back when he still had pain about everyday then after his first steroid shot it numbed it up enough that he could go on with zero pain for two days. (AT p. 29).

On cross examination the Petitioner confirmed that he has been back at work since October 1, 2018, and he was recently promoted to the foreman position. (AT p. 31). Prior to being promoted to foreman, he was doing his regular job duties but with help. (AT p. 31). Specifically, his foreman Mark had assigned

him to install ceramic walls on bathrooms which allowed him to stand up and work to keep him off his knees. Kevin Rudman, the boy he worked with, has had the Petitioner's back on a lot of tasks if his knees get sore and they would make it work. (AT p. 31). The Petitioner did not have any complaints of his job duties after his return to work. (AT p. 32).

As it pertains to the accident, the Petitioner landed on his knees, but he thinks he probably hit his feet and then slid and the best he could recall, he believes his feet hit first and split. (AT p. 32). When asked whether he believed he took the brunt of the fall on his knees, the Petitioner stated, "I feel like a took the brunt of it right there, because it never stopped hurting in that spot where I buried it in asphalt." Pointing to the inside of his left knee. (AT p. 32). The Petitioner did not dispute that he did well after the first surgery. (AT p. 34).

The Petitioner clarified on redirect examination, that when he did bush hogging at home there were not any new problems created from that. (AT p.36). He specified that Dr. Paletta told him to do it and if he had pain to quit, so he did it until he had pain and then quit. (AT p. 36).

Medical records show The Orthopedic Institute of Southern Illinois / Dr. J.T. Davis were offered into evidence as Petitioner's Exhibit 3. The Petitioner presented to Dr. Davis on January 13, 2017 describing the work-related accident as he did at Arbitration. He specifically noted that his left knee buckled with a valgus stress causing an immediate sharp pain. (PE 3 p. 2). Dr. Davis documented a report of intense pain medially based. (PE 3 p. 2). Dr. Davis further noted that the Petitioner reported it is unstable and could give away. (PE 3 p. 2). On exam Dr. Davis reviewed a mild effusion and stated that the patient was quite tender exquisitely through the medical aspect of the knee predominantly along the course of the MCL especially over the distal femur medially. (PE 3 p. 3). Dr. Davis' first impression was that of a 50-year old male with a MCL sprain. (PE 3 p. 4). Dr. Davis recommended an MRI scan and placed him in an immobilizer. (PE 3 p. 4). The MRI was taken on January 20, 2017 and provided the impression of a grade 2 MCL sprain with partial tear of the ligament anterior fibers. The MRI also showed at least a high grade partial and possibly complete tear of the medial patellofemoral ligament from the femoral attachment, mild marrow edema with anterior aspect of the tibia medially and posterior aspect of the lateral femoral condyle, moderate sized joint effusion. (PE 3 p. 8).

The Petitioner followed up with Dr. Davis on January 23, 2017, when Dr. Davis recommended, he continue with the knee brace for what he believed was a grade II MCL sprain. (PE 3 p. 10). The Petitioner followed up with Dr. Davis on February 20, 2017 and Dr. Davis noted that the Petitioner continued to need recommended physical therapy to improve. (PE 3 p. 17). On March 20, 2017 Dr. Davis noted that the Petitioner had finished physical therapy but still had some weakness and occasional soreness at the medial aspect of the knee. (PE 3 p. 23). Dr. Davis recommended work hardening for two weeks with the return to work full duty. (PE 3 p. 24). On April 24, 2017 the Petitioner returned to Dr. Davis who noted the return to work had some progressive pain predominantly anteromedially in the knee that was exacerbated with getting on his knees at work. (PE 3 p. 31). Dr. Davis recommended that the Petitioner to be put back in physical therapy. (PE 3 p. 31). On May 22, 2017 Dr. Davis noted persistent discomfort over the medial joint line with some improvement with some aches and pains and inability to bend and squat for long periods of time. (PE 3 p. 38). Dr. Davis again recommended four weeks of physical therapy and continued his modified work duties. (PE 3 p. 39). The Petitioner was examined by Dr. Davis on June 13, 2017 Dr. Davis noted that the Petitioner is not well, but he has made some improvements and is interested in trying to get back to work. (PE 3 p. 47). Dr. Davis gave him a full release for this Monday and recommended that he check back in a month. (PE 3 p. 47).

Physical therapy records from the Orthopedic Institute of Southern Illinois were offered into evidence as Petitioner's exhibit 4. A document showing that the Petitioner was in physical therapy from January 26, 2017 through May 11, 2017.

These records commend the efforts of the Petitioner was making and no attained document that he was noncompliant. However, the records do indicate that he continues to struggle as he progressed through physical therapy.

Petitioner's exhibit 4 documents more than thirty-five physical therapy appointments for the Petitioner between January 26, 2017 and August 30, 2017. Taken as a whole demonstrate significate effort on behalf of the Petitioner to return to work without surgical intervention and document multiple increases in pain after physical therapy or an attempt to increase in activity.

Medical records of the Orthopedic Center of St. Louis were offered into evidence as Petitioner's exhibit 5. The Petitioner was examined by Dr. Paletta at the Orthopedic Center of St. Louis on June 12, 2017. He presented with a history of being injured on January 10, 2017, an injury consistent with his testimony. (PE 5 p. 1). Dr. Paletta's initial impression was a medial collateral ligament sprain of the left knee with probable ACL injury of the left knee and possible medial patellofemoral ligament injury of the left knee. (PE 5 p. 2). Dr. Paletta recommended a repeat MRI and placed the Petitioner on restrictions. (PE 5 p. 3). On July 18, 2017, Dr. Paletta reviewed the prior MRI that had been performed at Diagnostic Imaging of Carterville. His review of the MRI indicated a lateral meniscus tear, patellofemoral chondroids without evidence of full thickness chondral loss, no evidence of patellofemoral ligament insufficiency and a ruptured baker cyst. (PE 5 p. 16). Based on the MRI options included arthroscopy with partial lateral meniscectomy verses intraarticular injection and a course of physical therapy. (PE 5 p. 16).

The Petitioner followed up with Dr. Paletta on October 11, 2017, at that time Dr. Paletta indicated that the first option would be to consider a visco supplementation injection. An arthroscopy would be an option but is potentially unpredictable. (PE 5 p. 22). Dr. Paletta re-evaluated the Petitioner on December 27, 2017 after two injections and physical therapy had been continued at home. He noted that the Petitioner continued to have medial joint line pain and had findings consistent with a meniscus tear. At this point Dr. Paletta indicated that additional injections and therapy would be a waste of time and they proceeded with the recommendation for surgery. (PE 5 p. 27).

On January 16, 2018, the Petitioner underwent left knee surgery consisting of exam under anesthesia diagnostic arthroscopy left knee arthroscopic debridement chondroplasty of the patellofemoral compartment and left knee arthroscopic medial meniscus repair. (PE 5 p. 29).

On February 5, 2018 the Petitioner followed up with Dr. Paletta reporting he was doing well and had been doing his home exercise program. (PE 5 p. 34). At that time the Petitioner was improving but remained on restrictions with a hope for a full duty release. (PE 5 p. 34). On March 19, 2018, the Petitioner returned to Dr. Paletta at eight weeks post arthroscopy in medial meniscus repair. (PE 5 p. 38). He was still having pain on the medial side and, "He notes one particular area of pain." (PE 5 p. 38). Dr. Paletta assured him that he was doing well and that he and was making good progress and recommend that he continue to participate in physical therapy with emphasis on restoring full range of motion and progressive strengthening. (PE 5 p. 38).

On May 2, 2018, the Petitioner followed up indicating that he is doing dramatically better than before surgery, but still complaining of pain of the interior medial aspect of the knee. (PE 5 p. 42). Since it was now fourteen weeks post op with residual symptoms, Dr. Paletta recommended an arthrogram of the left knee to evaluate the integrity of the meniscus repair. (PE 5 p. 42). Dr. Paletta issued a May 7, 2018, letter and follow up to his review of the IME report of Dr. Paletta. (PE 5 p. 45). Dr. Paletta indicated that the review of Dr. Nogalski's report did not alter any of his causation opinions regarding the Petitioner's left knee injury being related to the

work accident. (PE 5 p. 45). On June 18, 2018, Dr. Paletta had an opportunity to review the new MRI scan of June 13, 2018, which indicated a healed medial meniscus post meniscus repair with post-surgical changes of the lateral meniscus consistent with a partial lateral meniscectomy and patellofemoral chondrosis with a full thickness chondral, lateral facet patella. (PE 5 p. 47). Based upon the MRI, Dr. Paletta recommended an ultrasound and gave an injection with continued physical therapy. (PE 5 p. 47). On August 29, 2018, Dr. Paletta indicated the Petitioner returned for a follow up on his left knee and was doing better but continued to have discomfort in the front of the knee particularly with certain activities of prolonged standing and with stairs. (PE 5 p. 53). Dr. Paletta noted on exam that he is moderately tender directly over the pes on the medial tibial metaphysis. (PE 5 p. 54). Dr. Paletta recommended a prednisone taper to treat the pes bursitis and discuss additional therapy including visco supplementation versus a biological injection. Dr. Paletta also kept the Petitioner on restrictions of no squatting, kneeling, ladders, stairs or climbing. (PE 5 p. 54). On September 7, 2018, the Petitioner returned for re-evaluation indicating that he was making improvements but did not know if it was related to the dose pack. (PE 5 p. 60). He also noticed that he was doing activities such as bush hogging around the pond which really tore him up. (PE 5 p. 60). Dr. Paletta performed a Synvisc injection and kept him on the same restrictions. (PE 5 p. 60).

On November 7, 2018, the Petitioner returned with persistent left knee pain status post meniscus repair and Dr. Paletta recommended a dynamic ultrasound to evaluate the instability of the meniscus and the integrity of the repair. (PE 5 p. 63). Dr. Paletta indicated that if the test confirms the MRI findings and does not appear in any way to be related to meniscus, he would recommend consultation with Matt Bradley to discuss possible knee replacement. (PE 5 p. 63).

On December 3, 2018, Dr. Paletta reviewed the dynamic ultrasound results which demonstrated findings consistent with extrusion of the medial meniscus especially a horizontal cleavage tear. (PE 5 p. 66). The ultrasound confirmed that Dr. Paletta's clinical suspicion of instability of the medial meniscus and he recommended arthroscopy with revision of the meniscus repair versus partial meniscectomy as well as concomitant medial meniscotibial ligament repair. (PE 5 p. 66).

On February 25, 2019, Dr. Paletta again issued a letter summarizing the current treatment offer to the patient as well as its causal relationship to the work accident. Dr. Paletta specifically addresses Dr. Nogalski's IME at his strongest disagreement with Dr. Nogalski's opinion as the ultrasound clearly shows evidence of instability in the meniscus and insufficiency of the meniscotibial ligaments. (PE 5 p. 74). On April 15, 2019, Dr. Paletta issued another letter outlining his recommendations for the patient and summarizing the care and treatment offered to date. (PE 5 p. 75). In conclusion, Dr. Paletta noted that Dr. Nogalski's conclusions indicating that objective data does not support further intervention belies Dr. Nogalski's ignorance and lack of understanding of the evolving concept of meniscotibial extrusion on the complex clinical symptom exam findings and a diagnostic study typical of the condition. (PE 5 p. 86).

Medical records from MRI Partners of Chesterfield were offered into evidence as Petitioner's exhibit 6. These records contain the MRI images that have been reference and summarized by Dr. Paletta.

Medical records from Blue Tail Medical Group were offered into evidence as Petitioner's exhibit 7. These records consist of the diametrical ultrasound performed by Dr. Crane. The findings of the diametrical ultrasound indicate that there is a 2.4 mm extrusion on mid body medial meniscus. (PE 7 p. 6). Dr. Crane indicated that he feels that patient is a good candidate medial meniscal extrusion repair of the left knee with Dr. Paletta. (PE 7 p. 6).

The deposition of Dr. Paletta was offered into evidence as Petitioner's exhibit 8. Dr. Paletta is a board-certified orthopedic surgeon who primarily focus on problems of the shoulder elbow. and knee. (PE 8 pp. 5, 6). Since the issue of the accident, causation and reasonableness and necessity of the first surgery with Dr. Paletta was not in dispute at this 19(b) Hearing the Arbitrator moves forward as that treatment was sufficiently summarized above. On August 29, 2018 Dr. Paletta noted things were going better than they were before surgery but the patient was still having pain particularly in the front of the knee and region of the kneecap especially if he did prolong standing and with stairs. (PE 8 p. 20). The exam was consistent with tenderness around the kneecap and evidence of the tendinitis involving the hamstring tendons so Dr. Paletta recommended visco supplementation injections. (PE 8 p. 21). Dr. Paletta continued to note that he was concerned about combination of problems and whether they would resolve. (PE 8 p. 21). As of August 29, 2018, he continued to have the Petitioner under the same restrictions of no squatting, kneeling, or ladders. (PE 8 p. 21). The Petitioner came in on September 17, 2018 and underwent the viscosupplementation injection with the recommendation to wait a couple of weeks and attempt to return to work for duty. (PE 8 p. 22). In follow up in November of 2018 the Petitioner reported that he can do his job, but it was not very pleasant. (PE 8 p. 22). Dr. Paletta recommended the dynamic ultrasound of the knee with Dr. Crane which was done on November 20, 2018. (PE 8 p. 24). That study along with selective images of the ultrasound was reviewed by Dr. Paletta who indicated that showed the medical meniscus was somewhat unstable meaning with load on the knee the meniscus joint would squirt out or extrude out of the joint. (PE 8 p. 24). In addition, there appear to be a horizontal tear which is a particular pattern of tear in the meniscus and the remainder of the study was pretty unremarkable. (PE 8 p. 24). Dr. Paletta further explained that when the patient loads the knee if the meniscus is extruding or squirting out of the joint it is not going to do its job as a shock absorber or load sharing structure of the knee. (PE 8 p. 25). This is particularly true in a knee some early arthritis that can increase pain because of the joint that compartment part of the joint is now seeing an increase force because the meniscus is not in position to its job. (PE 8 p. 25). When asked whether this is something that had happened in the interim or whether it was back in place at the time of his earlier surgery in January Dr. Paletta offered opinion quote, "It is probably something that was in place and that, quite honestly, I failed to diagnose at the time." (PE 8 p. 26). The MRI scan is a static study and is done with the patient lying flat on a table with no load on the knee, so it is very difficult to pick up that instability of the meniscus without loading it. (PE 8 p. 26). His initial MRI did not show any obvious evidence of medial meniscus tear but MRI's can sometimes miss a meniscus tear as it did in this case and he did not consider or think that he had evidence of meniscus instability at the time that he did the Petitioner's meniscus repair but in my opinion he probably did and is not picked up at the beginning. (PE 8 p. 26).

The reason Dr. Paletta had requested dynamical ultrasound is that the Petitioner did not make a full recovery and he continued with complaints of pain and continued to follow up and treat to resolve that pain until it became clear that perhaps he was having symptoms related to meniscus instability. (PE 8 p. 27). At that time Dr. Paletta thought that the Petitioner had done everything he could non-surgically and since there was clear evidence of instability of the meniscus, he recommended he would consider another arthroscopy to stabilize the meniscus by doing what is called a meniscal tibial ligament repair. (PE 8 p. 27). That is a procedure where stiches are put on the outside of the meniscus so they can hold it in place and allow those ligaments to heal so they can maintain good stability of the meniscus so it can resume doing its function in a normal way. (PE 8 p. 28). Dr. Paletta confirmed that the reports he prepared dated February 25 and April 15 contained his opinions regarding his assessment of Dr. Nogalski's recommendations and his opinions on causation. It is Dr. Paletta's opinion that the injury that the January 10, 2017 work injury is the cause of the factor which regards to his meniscus injury and aggravated the patellofemoral arthritis with an increase of symptoms. (PE 8 p. 30). It is Dr. Paletta's opinion within reasonable degree of medical certainty that as a result of the January 10, 2017 work injury the patient should consider arthroscopy with repair of the meniscal tibial ligaments and stabilization of the meniscus. (PE 8 p. 30). Upon review of Dr. Nogalski's opinions Dr. Paletta agreed and disagreed with Dr. Nogalaski on sone issues. (PE 8 p. 31). The most significate disagreement is with respect to the diagnosis of

meniscal instability and extrusion and the treatment for that. (PE 8 p. 31). He specified that is clear but based upon diagnostic studies that were done by Dr. Crane this patient has meniscal instability he had insufficiency of the meniscal tibial ligaments and this results in the meniscus extrusion. (PE 8 p. 31). It is Dr. Paletta's opinion based upon his experience and understanding of the condition there is a way to effectively treat and it would have a reasonable chance of Mr. Ralls improving his knees symptoms and improving function. (PE 8 p. 31).

On cross-examination Dr. Paletta confirmed that the review of the June 22, 2017 MRI indicated a tear in the lateral meniscus he did not visualize a lateral meniscus tear and the Petitioner's symptoms were not consistent with a tear of the lateral meniscus. (PE 8 p. 37). However, at the time of surgery he found a full thickness longitudinal tear which is a tear that goes from the top to the bottom through the height of the meniscus. (PE 8 p. 38). When asked whether it was possible the bush hogging activities could have aggravated or worsened the Petitioner's condition Dr. Paletta conceded that it could have. (PE 8. P. 40).

Dr. Paletta further distinguished between the Petitioner being in a static laying down position on the MRI compared to the ultrasound where the physician is loading and unloading with knee and by putting different forces on it so the examiner is actually loading the knee even though the patient may not be weight bearing. (PE 8 p. 41). Therefore, they call it dynamic ultrasound because the knee is put through varies positions and various loads and stresses to establish how the meniscus stability is how the meniscus moves and works with those particular loads. (PE 8 p. 41). Dr. Paletta confirmed that he did not see the Petitioner after the ultrasound but simply reported his recommendations having reviewed the study. (PE 8 p. 42). Dr. Paletta confirmed that it is his opinion that the medial meniscus extrusion was likely present prior to his surgery but because Dr. Paletta did not recommend the appropriate test to demonstrate that it was not considered prior to surgery. (PE 8 p. 43). Dr. Paletta conceded that it was possible the injury occurred after the surgery. (PE 8 p. 43).

On redirect examination Dr. Paletta indicated that he does approximately 150 knee surgeries per year, so it is a significant component of his practice. (PE 8 p. 44). Dr. Paletta also confirmed that the Petitioner did not report any type of accident with regards to bush hogging just that the activities increased soreness and pain of the knee. (PE 8 p. 46). He confirmed that an increase in symptom is not necessarily a new injury. (PE 8 p. 46).

Dr. Paletta clarified that the extrusion of the meniscus is something that even when they know that it is there on ultrasound is very difficult to identify surgically. It is not something that is easily seen in surgery even when they know it is there. (PE 8 p. 47). When this type of repair is performed, an actual ultrasound will be done in the operating room before surgery and then after the meniscus is repaired a second ultrasound will be performed in the operating room to confirm adequate repair and stability of the meniscus. (PE 8 p. 47). He reiterated his opinion in that this surgery gives the patient a good chance of significantly improving his current knee condition. (PE 8 p. 48). The ongoing symptoms is what led to the dynamic ultrasound as the patient symptoms never fully resolved after the first surgery which is why Dr. Paletta was compelled to continue to follow him, treat him, and ultimately re-evaluate him to see if there was some other explanation for his symptoms. (PE 8 p. 48). In Dr. Paletta's opinion the explanation is that he has some underlying arthritis of the kneecap that maybe contributing in part to his symptoms but also that the meniscus extrusion explains significate component of his symptoms and can be addressed with additional surgery. (PE 8 p. 48). Dr. Paletta further clarified that no other treatment is going to resolve in stabilization of the meniscus and restoration of the meniscus function. (PE 8 p. 49).

Medical bills were offered into evidence as Petitioner's exhibit 9. Specific medical bills were not disputed at the time of Arbitration and the parties stipulated that if there are any cause related outstanding medical bills the Respondent will pay those bills directly to the provider in compliance with Sections 8(a) and 8.2 of the Medical Fee Schedule. The parties also agreed that the Respondent is entitled to credit for any bills that may have been paid through the Respondent's group health insurance plan pursuant to Section 8(j) of the Act.

The Workers' Compensation Employee Notice of Injury was offered into evidence as Respondent's Exhibit 1. It confirms the Petitioner completed the accident report on January 13, 2017 reporting that he got his right foot got under me and left landed at 45-degree angle, twisted knee.

The Illinois Form 45, Employer's First Report of Injury, was offered into evidence as Respondent's exhibit 2. It again confirms that the Petitioner reported the injury on January 13, 2017 and was injured while leaning forward placing hands on the hood of a truck to ease down to get off a loading dock when he feet slipped on a patch of ice employee started to fall forward and got feet under him and the left knee buckled.

The Supervisor's Report of Injury or Illness was offered into evidence as Respondent's exhibit 3. This document was also completed on January 13, 2017 illustrating; while climbing off dock slipped on ice and twisted knee.

The Workers' Compensation Witness Report was offered into evidence as Respondent's exhibit 4 and demonstrates that Kevin Rendleman saw Steve slip on the ice while getting off the loading dock but did not see him land as he was on the other side of the truck.

Dr. Nogalski's Independent Medical Examination Report dated September 6, 2017, was offered into evidence as Respondent's Exhibit 5. Dr. Nogalski sufficiently summarized the Petitioner's report of accident which has been repeatedly documented and not disputed. He also documented the Petitioner's report of pain which again repeatedly documented and does not need repeating. On physical examination Dr. Nogalski noted that fact there was some tenderness over the anterolateral joint line and direct tenderness over the lateral joint line itself. (RE 5 p. 3). Dr. Nogalski further noted that the meniscal sign testing generates some mild pain laterally and motor strengths 4 out of 5. The exam was otherwise unremarkable. (RE 5 p. 3). Dr. Nogalski provided the diagnosis of anterior knee pain with possible plica syndrome or occult lateral meniscal tear with probable rupture of the Baker's cyst. (RE 5 p. 5). Dr. Nogalski indicated that he believes there was a causal link between the claimed event of January 10, 2017 and a knee strain or contusion the mechanism and an early clinical course are not consistent with their recent diagnoses of a MPFL injury nor lateral meniscal tear. (RE 5 p. 5). Dr. Nogalski believed that the medical treatment assessment to date was reasonable and necessary. (RE 5 p. 5). Dr. Nogalski recommended some aggressive physical therapy and after four to six weeks a possible diagnostic and potentially therapeutic arthroscopy would reasonably entertained. Dr, Nogalski did not believe the Petitioner had reached maximum medical improvement. (RE 5 p. 5).

The November 26, 2018 Independent Medical Examination Report from Dr. Nogalski was offered into evidence as Respondent's exhibit 6. Dr. Nogalski reviewed the medical records which have been previously summarized above. Dr. Nogalski believed that the subjective complaints were predominantly pain with respect to position or activities in pain along femoral condyle but did not believe that the objective findings were studies support for the mechanical issues in the knee nor do they support a severe osteoarthritic condition. (RE 6 p. 5). He further opined that he can not say that the Petitioner was exhibiting any findings that would support malingering. (RE 6 p. 5). Dr. Nogalski opined that he believes that is a causal relationship between the claimed injury and diagnostic arthroscopy performed and documented ongoing which he does not have clear objective findings for. (RE 6 p. 5). He did not believe that it was appropriate for the Petitioner to see another physician for a knee replacement at this time. (RE 6 p. 5). He did not believe that further medical treatment was reasonable and necessary as a result of the January 10, 2017 work injury and indicated he believes the Petitioner could work at a level of full duty without restrictions, with some symptoms in his knee. (RE 6 p. 6).

The Independent Medical Examination addendum by Dr. Nogalski dated March 12, 2019 was offered into evidence as Respondent's Exhibit 7. Dr. Nogalski reviews the results of Dr. Crane's November 27, 2018

diagnostic ultrasound findings of a 2.4mm extrusion of the mid body of the medial meniscus. His opinion remains the same and the meniscal instability posited by Dr. Paletta is from his practice in a non-controlled study. (RE 7 p. 6). He noted that Dr. Paletta does not note any evidence of meniscus instability in direct arthroscopic evaluation and assessment of the knee viewed in the January 16, 2018 surgery. (RE 7 p. 6). Dr. Nogalski specifically stated, "There was no new injury or change reported at the direct observation and treatment of pathology that was identified by Dr. Paletta in the January 16, 2018 operation. (RE 7 p. 6). In short Dr. Nogalski did not have these similar findings as Dr. Paletta and relied more heavily on the MRI studies with which did not show any acute findings in the region. (RE 7 p. 7). Dr. Nogalski questions the Petitioner's mechanism of injury asking how he hit his head falling off of a loading dock and injured his knee. (RE 7 p. 7). Dr. Nogalski questions the collaborative efforts of Dr. Paletta and Dr. Crane indicating that they have not subjected their proposals to peer review or controlled study and are only self recorded findings. (RE 7 p. 8).

The deposition of Dr. Nogalski was offered into evidence as Respondent's Exhibit 8. Dr. Nogalski is a board-certified orthopedic surgeon focusing his practice in St. Louis County. (RE 8 pgs. 4, 5). Approximately 5% of his practice is related to Independent Medical Examinations and he sees approximately 60 to 80 patients per week. His charge for an Independent Medical Examination is $1,750.00 and depositions charges the same. (RE 8 p. 6). Dr. Nogalski reviewed the Petitioner's medical records and took a history from him. (RE 8 p. 8). The history included that he hurt his knee on January 10, 2017, when stepping off a loading dock and reported he slipped as he had his feet on the loading dock and trying to place his hands out to lower himself down. (RE 8 p. 8). He stated that his feet essentially kicked out in front of him and fell off the loading dock and he estimates he went headfirst about 3 feet downward and stated that his head hit first and then his left knee hit somehow but does not specifically recall how he could have hit his head and his left knee together. (RE 8 p. 8). He did document that the Petitioner reported to him that there were 3,000 cameras located on campus and if there was a question regarding how he fell the Respondent would have access to the fall if they so desired. (RE 8 p. 9). At the time of the injury the Petitioner bent his knee inward what it appears to be somewhat of a valgus mechanism. (RE 8 p. 9). The Petitioner reported that he hit his knee on the asphalt and got up and went on working the rest of the day and ignored the problem using ibuprofen, but he became sick the following morning because he had taken so much ibuprofen. (RE 8 p. 9).

Dr. Nogalski performed a physical examination indicating some tenderness over the anterior lateral joint line with direct tenderness over the lateral joint as well as tenderness over the suprapatellar pouch or the area of the above the kneecap. (RE 8 p. 11). In the superomedial region there was a palpable plica which is a folded tissue in the knee which appeared to be tender as well as tenderness over the medial femoral condyle. (RE 8 p. 11). There is no tenderness or pain with valgus or varus stress and he appeared to have an intact ligament exam with possibly mild anterior translation with solid endpoint consistent with a Grade 1-A Lachman. (RE 8 p. 11). The meniscal sign testing generated some mild pain laterally with minimal tenderness with the patellofemoral compartment pressure. (RE 8 p. 12). Dr. Nogalski's review of the MRI study showed some mild changes in the medial patellofemoral ligament without any correlating signal change in the patella or lateral trochlea to support acute patella instability nor medial patellofemoral ligament injury. (RE 8 p. 13). There were some signal changes in the medial collateral ligament there do not appear to be a finding consistent with anterior cruciate ligament injury. (RE 8 p. 13). Dr. Noglaski reviewed the June 22, 2017 MRI but did not find any major changes between the two MRI's. (RE 8 p. 14). Dr. Noglaski provided a diagnosis of anterior knee pain and possibly a plica syndrome or occult lateral meniscal tear and probably had rupture of Baker's cyst. (RE 8 p. 15). Dr. Noglaski struggled with he perceived as the unusual history but believed the Petitioner might or could have sustained a knee strain or contusion but did not find an injury or clinical findings consistent with a diagnosis medial patellofemoral ligament injury or lateral meniscus tear. (RE 8 p. 15). At that time, he recommended physical therapy. (RE 8 p. 16). Dr. Nogalski performed a physical examination as well as reviewed a additional medical records including the January 16, 2018 operative report and June 13, 2018 MRI arthrogram of Mr. Ralls left knee. At that time, it was Dr. Nogalski's diagnosis of solid mechanical findings in

the knee with generalized medial knee pain with mild to moderate chondromalacia over the left knee as documented in the January 16, 2018 operative report. (RE 8 p. 20). There are no correlating objective findings on MRI to support significant objective bone marrow signal changes below the joint surfaces. (RE 8 p. 20). Dr. Nogalski did not believe the Petitioner needed further treatment and opined at maximum medical improvement. (RE 8 p. 21). Dr. Nogalski stated that taking everything into consideration and even considering that Mr. Ralls may have required a diagnostic of potentially therapeutic arthroscopy it appeared reasonable that he would have reached maximum medical improvement as of his last office visit with Dr. Paletta prior to his November 26, 2018 evaluation. (RE 8 p. 21). Dr. Nogalski believed the Petitioner was capable of working full duty without restrictions. (RE 8 p. 21). Dr. Nogalski reviewed some additional records in generated March 12, 2019 report. (RE 8 p. 22). Dr. Nogalski's biggest issue was there would not been any findings to support that there was indeed a medial meniscal tear. (RE 8 p. 23). He specifically noted that finding that stable meniscal issue that Dr. Paletta noted in his operative report isn't supported by previous physical findings from several doctors in this matter. (RE 8 p. 23). He stated that Dr. Paletta did not note any extrusion or instability of the meniscus at the time and is it not reasonable that the condition would exist after time. (RE 8 p. 24). Dr. Nogalski indicated that it could exist with some changes of time, age, and laxity of the tissues along the knee that occur with time and age but there's not been a correlating finding of objective studies that supports the condition that was cause or created by the claimed injury nor validated by the physical exam findings. (RE 8 p. 24). He expressed skepticism regarding the relatively new and experimental concept provided by Dr. Crane which has not validated by peer reviewed studies. (RE 8 p. 25). It was Dr. Nogalski's belief that an MRI taken with the knee in full extension is going to typically show the maximum amount of extrusion of the meniscus because the bones are pushed together. (RE 8 p. 25). He reiterated that Dr. Paletta had ample opportunity to assess the meniscal tissues at the time of surgery and did not find any dynamic instability. (RE 8 p. 25). He further reiterated that this is a new concept that's being thrown out there and possible improvement but does not have any documented peer review support. (RE 8 p. 26). Dr. Nogalski agreed up until the point of his November 26, 2018 examination he did not have a serious with dispute with the treatment that had been provided to that point. He further agreed that in review of both notes of Dr. Davis and Dr. Paletta it did not seem that anyone had a really clear diagnosis. Dr. Nogalski did not have an opportunity to review the photographs from Dr. Crane's dynamic ultrasound but was relying on Dr. Crane's report. When asked to clarify whether he does not believe that there is a 2.4mm extrusion there or that he does not believe it is from the work injury Dr. Nogalski stated I'm saying that it was not from the injury and I'm also saying that 2.4mm is a pretty amount of translation of meniscal tissue. (RE 8 p. 32). When asked whether he disagreed with Dr. Paletta's opinion that a 2.4mm extrusion is in excess of an extrusion for a normal degenerative issue Dr. Nogalski stated that he believes that is Dr. Paletta's opinion who is collaborating with Dr. Crane, but he did not answer the question. Dr. Nogalski did not review any of the literature Dr. Paletta sited in his report regarding the peer review data on the issue. (RE 8 p. 33). (RE 8 p. 34). Dr. Nogalski recommended the Petitioner simply optimize his knee function with solid strength flexibility and avoid further procedures. (RE 8 p. 35).

The Arbitrator makes the following conclusions:

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

The Respondent did not dispute the Petitioner suffered an accident that arose out of and in the course of his employment with the respondent or that he injured his left knee as a result of that injury. The Respondent's position on causation is that the Petitioner suffered in intervening accident on or about October 1, 2018 when he was bush hogging at home as referenced in the September 7, 2018 note of Dr. Paletta. In review of the prior note, the Petitioner was still reporting pain and Dr. Paletta was recommending he continue with visco supplementation injections. His restrictions after the August 29th appointment were, "squatting, kneeling, ladders, or climbing." Had Dr. Paletta wanted the Petitioner to refrain from driving or operating equipment, he

could have checked that box 3 lines below the box he checked on the restrictions sheet. (PE 5, p. 59). The treatment plan was not altered after bush hogging. Dr. Paletta wanted to see how the petitioner responded to the injections. Further, Dr. Nogalski did not opine the petitioner suffered a new injury as a result of a new accident. Dr. Nogalski unequivocally states that, "There was no new injury or change reported after direct observation and treatment of pathology that was identified by Dr. Paletta in the 1/16/2018 operation. Dr. Paletta believes the extrusion of the meniscus was present at the time of the first surgery and candidly conceded he missed it."

Petitioner reported persistent pain throughout the course of his treatment. He never reached MMI or violated the restrictions from his physician. There was no change in the reported problems or the course of his symptoms around the time of the alleged intervening accident. Therefore, the Arbitrator concludes that the petitioner did not sustain an intervening incident sufficient to break the chain of causation. His current condition of ill-being is causally related to his work accident.

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

Respondent only disputed medical after October 1, 2018, due to the assertion of an intervening accident defense. Based on the Arbitrator's findings above, the Arbitrator concludes that the medical care rendered to date has been reasonable, necessary, and related, and the Respondent shall pay any and all outstanding medical bills directly to the providers in accordance with sections 8(a) and 8.2 of the Act. Respondent shall receive credit for any and all bills through their group health insurance carrier and/or the workers compensation third party administrator.

K. Is Petitioner entitled to any prospective medical care?

The main issue in this Section 8(a) hearing is whether the proposed left knee surgery by Dr. Paletta is reasonable and necessary. Dr. Nogalski is of the mind that the petitioner needs to live with his current problem and does not believe there is an identifiable problem to be addressed. Dr. Nogalski asserted that Dr. Paletta and Dr. Crane are performing experimental treatment that has not been validated. However, Dr. Nogalski refused to review the peer review data of the procedure that was offered to by Dr. Paletta.

The petitioner exhausted every known conservative and diagnostic measure available. The procedure was not immediately performed at the first sign of residual problems after surgery, but only after extensive attempts to resolve the petitioner's knee issue with physical therapy and multiple types of injections. Dr. Paletta and Dr. Crane both opine there is an extrusion of the meniscus that was likely present at the time of the first injury and just no observed. Further, they believe another surgery is likely to resolve the problem and is the petitioner's best chance to return to work full duty. Therefore, the Arbitrator concludes the prospective medical care recommended by Dr. Paletta is reasonable and necessary. The Respondent is ordered to authorize and pay for the left knee surgery recommended by Dr. Paletta and reasonable, necessary, related ancillary treatment.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC022979
Case Name	HARRELL, RICHARD v. KNIGHT HAWK COAL, LLC
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0276
Number of Pages of Decision	17
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Kirk Caponi
Respondent Attorney	Julie Webb

DATE FILED: 6/8/2021

/s/Deborah Baker, Commissioner

Signature

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

RICHARD HARRELL,

Petitioner,

vs. NO: 16 WC 22979

KNIGHT HAWK COAL,

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, causal connection, nature and extent of the injury, and "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 December 20, 2019 is hereby affirmed and adopted. Petitioner's claim for compensation is denied.

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." 820 ILCS 305/19(f)(2). Based upon the denial of compensation herein, no bond is set by the Commission. 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.

JUNE 8, 2021

/s/ *Deborah J. Baker*
Deborah J. Baker

DJB/cak

O:5/18/21

/s/ *Stephen Mathis*
Stephen Mathis

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/s/ *Deborah L. Simpson*
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HARRELL, RICHARD
Employee/Petitioner

Case# **16WC022979**

KNIGHT HAWK COAL
Employer/Respondent

On 12/20/2019, 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 1.55% 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

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

Richard Harrell
Employee/Petitioner

v.

Night Hawk Coal
Employer/Respondent

Case # 16 WC 22979

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 William R. Gallagher, Arbitrator of the Commission, in the city of Herrin, on October 18, 2019. 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 Sections 1(d)-(f) of the Occupational Diseases Act

FINDINGS

On June 18, 2016, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $65,452.40; the average weekly wage was $1,258.70.

On the date of accident, Petitioner was 61 years of age, single with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

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

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

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

William R. Gallagher, Arbitrator

December 15, 2019
Date

DEC 20 2019

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged that as a result of "Inhalation of coal mine dust including but not limited to coal dust, rock dust, fumes & vapors for a period of 31 years", Petitioner sustained an occupational disease to his "Lungs and/or heart, pulmonary system, respiratory tracts" (Arbitrator's Exhibit 2). Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

At the time of trial, Petitioner was 65 years of age. Petitioner has a Bachelor's Degree in Business Administration from Southern Illinois University at Carbondale, Illinois. Petitioner received an associate's degree from Rend Lake College in Industrial Maintenance in 1984. Petitioner also attended John A. Logan College in 1996 taking computer information systems classes. Petitioner worked in coal mining for 31 years with all of those years being underground. Petitioner testified that in addition to coal dust he was regularly exposed to and breathed silica dust, roof bolting glue fumes and diesel fumes.

Petitioner's last date of coal mine employment was June 18, 2016, with Respondent at the Prairie Eagle Mine. He was two months shy of his 62 birthday. His job classification at that time was mechanic repairman. He testified that he was exposed to coal dust on that day. He testified that he retired on that date for health reasons. He testified that he was getting to where he could not breathe very well and his back and legs were hurting with packing all the heavy equipment. Petitioner did not work anywhere after he left the mine.

Petitioner started working in the coal mines in March 1978 for Freeman United Coal Mining Company. He started as a trainee laborer. His job duties included shoveling the belts which required him to use a shovel to scoop up the coal and throw it on the conveyor belt. He testified that this work generated a lot of dust. He also helped rock dust and build stoppings for air ventilation. Petitioner testified that he sprayed rock dust on the roof and ribs of the coal mine with a hose. Rock dust is incombustible and mixes with the combustible coal dust so it makes it nonexplosive. After working as a laborer for approximately one year, Petitioner started running a shuttle car which transported the coal from the continuous miner to the belt. He testified that he was at the face of the mine where the coal was being cut.

Petitioner went to work at Kathleen Mine in 1984. He worked there as a roof bolter where he would drill into the roof of the mine and insert roof bolts to secure the roof. He testified that sometimes he used glue pins when securing the roof bolts. He testified that in that job he was exposed to silica dust and rock dust because when he emptied the dust tank and swept all of the silica dust out of the tank, he would breathe a lot of the dust. Petitioner testified that the glue pins had an odor when they would break open. Petitioner left the Kathleen Mine in 1986 and then went back to work there in 1989. He testified that in that three year gap the mine was shutdown, and he worked at a pharmacy. He was hired back at the Kathleen Mine as a mechanic. This job required checking equipment to make sure everything was okay. He also repaired the equipment in the mine as the coal was being cut and transported. He testified that he had the same exposures as the other miners as he was working on the equipment. Petitioner worked at Kathleen Mine until 1995.

He did some odd jobs between 1995 and 1997 when he started at Conant Mine where he was a mechanic repairman. He worked there until 2000 when he went to Arch Mine in Colorado where he worked for less than one year as a mechanic repairman. He worked for Freeman starting in 2001 as a mechanic. In 2007, he left Freeman and went to work as a mechanic for Respondent and stayed there until he retired. He testified that his job duties were about the same as in the other mines as a mechanic. He testified that his exposures and the dust were also about the same as the other mines. He testified that as a mechanic he had diesel fume exposure.

Petitioner testified that he first noticed breathing problems about two years before he retired. He noticed that his lungs were always congested and he had a little shortness of breath. He testified that from the time he first noticed breathing problems until he left the mine, it seemed like it started to get worse. He testified that he thought the congestion would go away after he got out of the dusty environment, but it never cleared up. He testified that since leaving the mine up until the time of arbitration, his breathing has pretty much stayed the same. He takes Symbicort, one puff in the morning and one puff at night. He testified that he has shortness of breath. He cannot do anything very strenuous without breathing real hard. He testified that he has discussed his breathing difficulties with his family doctor, Dr. Ralph Latta. Petitioner testified that he has never smoked. Petitioner does not have any other health concerns or take medications for any health problems other than his breathing. Petitioner testified that after he retired he received his UMWA pension. Petitioner never looked for work after he left Respondent. Petitioner testified that to stay active he rides a bicycle a little bit and likes to go bass fishing. He also works in his yard. Petitioner testified that when he mows his grass he wears a respirator which seems to help a lot. He testified that he just had a garage built and he was working on it. His house is on a one acre lot which he maintains himself.

While Petitioner was a coal miner from time to time he would undergo chest x-ray screening by NIOSH for black lung. After the x-ray was performed, they would write to him and tell him what the film revealed. He did not bring any of those letters with him to arbitration. Petitioner testified that he was honest with Dr. Istanbouly in sharing any breathing problems that he had. Petitioner testified that his asthma was not any better since he had moved out of Illinois.

Petitioner testified that he had back pain from lifting all the heavy stuff while working in the mine. He had to wear the safety belt which contained the self rescurer as well as other tools and a battery. He testified that at the end of his employment he was working nine hours a day five to six days per week. He would have to change tires on the coal haulers which were big and heavy. He would have to use a six foot pry bar or change a motor using a chain hoist. He testified that it was heavy work.

Dr. Suhail Istanbouly is a physician specializing in pulmonary medicine and critical care medicine. He is board certified in internal medicine, pulmonary medicine and critical care medicine. During the course of his practice, Dr. Istanbouly has had numerous occasions to work with and treat coal miners or former coal miners. He treats patients with emphysema, COPD, chronic bronchitis, asthma, coal workers' pneumoconiosis and lung cancer (Petitioner's Exhibit 1, pp 4-5).

Dr. Istanbouly examined Petitioner on September 20, 2016, at the request of his counsel. Petitioner provided a history of being a coal miner for 31 years. His primary care physician had

diagnosed him with COPD and he was on Symbicort, which is a bronchodilator. Dr. Istanbouly testified that based on all of his findings and the totality of his examination, he found this diagnosis and treatment to be appropriate. Petitioner reported to Dr. Istanbouly that he never smoked. Petitioner gave a history of coughing on a daily basis for the last six to eight years. The coughing was around the clock, mild to moderate in intensity and productive. Dr. Istanbouly testified that the cough qualified for a diagnosis of chronic bronchitis, which is included in COPD. Dr. Istanbouly testified that Petitioner's wheeze with exertion is a bronchospasm and in Petitioner's case the main culprit would be long term coal dust inhalation. Dr. Istanbouly testified that Petitioner's spirometry revealed a mild obstructive defect with no good response to bronchodilator. Dr. Istanbouly testified that overall this pulmonary function testing according to the GOLD standard was consistent with COPD GOLD stage II. Dr. Istanbouly testified that the wheeze and post bronchodilator change in the FEV1 of 10% would indicate reactive airways disease or bronchoreactivity to a certain extent although it was not that significant per ATS guidelines (Petitioner's Exhibit 1, pp 6-10).

Dr. Istanbouly testified that the chest x-ray which he reviewed was consistent with coal workers' pneumoconiosis. Dr. Istanbouly testified that on physical examination of Petitioner's chest, there were bilateral rhonchi and late expiratory wheezing. He described rhonchi as coarse breath sounds mainly with inhalation. He testified that the wheezing being late expiratory reflected bronchospasms involving the small airways (Petitioner's Exhibit 1, pp 10-11).

Dr. Istanbouly testified that based on the totality of his examination, in his opinion Petitioner had coal workers' pneumoconiosis caused by long term coal dust inhalation. Petitioner also has COPD, chronic bronchitis, abnormally reduced FEV1, and obstructive lung disease which were all caused by long term coal dust inhalation. Dr. Istanbouly testified that in light of these diagnoses, Petitioner could not have any further exposure to the environment of a coal mine without endangering his health. He testified that Petitioner has clinically significant pulmonary impairment caused by long term coal dust inhalation. Dr. Istanbouly testified that Petitioner had radiographically apparent pulmonary impairment as well as physiologically significant pulmonary impairment (Petitioner's Exhibit 1, pp 11-13).

Dr. Istanbouly testified that if he reads a chest x-ray as being positive for coal workers' pneumoconiosis and the patient has a sufficient exposure to coal mine dust to cause that disease, then those two things combined suffice for him to make a diagnosis of coal workers' pneumoconiosis. He testified that if a chest x-ray is read as being negative that does not necessarily rule out the existence of coal workers' pneumoconiosis. Dr. Istanbouly agreed that a recent study showed that 50% or more of long term coal miners are found to have coal workers' pneumoconiosis at autopsy even though during life it was not found radiographically (Petitioner's Exhibit 1, p 15).

Dr. Istanbouly saw Petitioner one time for the purpose for working him up for his state occupational disease claim. Dr. Istanbouly testified that for several years he had performed an average of five to seven such examinations a month and he was now performing three to five. He testified that these were always done at the request of the Petitioner's attorney. Petitioner did not relate to Dr. Istanbouly any specific triggers for his cough. Petitioner suffered no significant exertional dyspnea. Petitioner did not tell Dr. Istanbouly that he had any problems in completing

the duties of his last job at the coal mine which was a fairly physical job in nature. Petitioner did not tell Dr. Itanbouly that he left his job at the mine due to problems with respiratory disease or a diagnosis of respiratory disease. Dr. Istanbouly did not review any treatment records regarding Petitioner. Dr. Istanbouly testified that given the values obtained on Petitioner's forced vital capacity, there was no indication of restriction in him. He testified that the test was more consistent with obstructive defect (Petitioner's Exhibit 1, p 16-18).

Dr. Istanbouly is neither an A-reader nor a B-reader of films. When he interprets a chest x-ray for pneumoconiosis, he determines whether the film is positive or negative and if it is positive he classifies what he sees as early, moderate or severe. Dr. Istanbouly does not provide profusion ratings on the films he interprets. He testified that he could not say whether Petitioner's chest x-ray presented a 0/1 or a 1/0 profusion. He classified what he saw as early pneumoconiosis (Petitioner's Exhibit 1, p 19).

Dr. Henry K. Smith, a board certified radiologist and B-reader, reviewed chest x-ray of Petitioner dated June 24, 2016. Dr. Smith interpreted the chest x-ray as positive, profusion 1/0 with P/P opacities in the middle and lower lung zones bilaterally (Petitioner's Exhibit 2).

Dr. Cristopher Meyer reviewed a PA chest x-ray of Petitioner dated June 24, 2016, from Harrisburg Medical Center. Dr. Meyer found the film to be quality 1. Dr. Meyer testified that there were no small or large opacities on this chest x-ray and his impression was no radiographic findings of coal workers' pneumoconiosis (Respondent's Exhibit 1, p 40).

Dr. Meyer has been board certified in radiology since 1992. Dr. Meyer has been a B-reader since 1999. Dr. Meyer was asked to take the B-reading exam by Dr. Jerome Wiot who was part of the original committee that designed the training program which was called the B-reader program. Dr. Meyer was on the American College of Radiology Pneumoconiosis Task Force, which was engaged in redesigning the course, and the examination and submitting cases for the B-reader training module and exam. Dr. Meyer has recently been asked to have a more academic role in the B-reader program. He testified that the faculty for the B-reader program was typically experienced senior level B-readers. Dr. Meyer testified that radiologists have a 10% higher pass rate on the B-reading exam than other specialties. In Dr. Meyer's opinion, radiologists have a better sense of what the variation of normal is. One of the most important parts of the B-reader training and examination is making the distinction between a film with profusion of 0/1 versus a film with 1/0 profusion (Respondent's Exhibit 1, pp, 7, 19-21, 32-35).

Dr. Meyer testified that the B-reader looks at the lungs to decide whether there are any small nodular opacities or any linear opacities. Based on the size and appearance of those small opacities they are given a letter score. Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described as revealing small round opacities. Diseases that cause pulmonary fibrosis, such as asbestosis, are described by small linear or small irregular opacities. The distribution of the opacities is also described as different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper zone predominant process. The last component of the interpretation is the extent of the lung involvement or the so-called profusion.

Dr. Meyer testified that the profusion is essentially an attempt to define the density of the small opacities in the lung (Respondent's Exhibit 1, pp 22-23, 28-30).

At the request of Respondent's counsel, Dr. James R. Castle reviewed medical records and a chest x-ray regarding Petitioner. Dr. Castle is a pulmonologist and is board certified in internal medicine and the subspecialty of pulmonary disease. Dr. Castle practiced in Roanoke, Virginia for 30 years. His practice was limited to pulmonary disease and chest disease, which encompassed critical care medicine. Dr. Castle's practice included patients with occupational lung disease. He had some patients in his practice who had coal workers' pneumoconiosis. Dr. Castle was first certified as a B-reader in 1985 and was continuously certified as a B-reader through June 30, 2017 (Respondent's Exhibit 2, pp 2-3, 6-7, 11-18).

Dr. Castle reviewed a chest x-ray for Petitioner from Harrisburg Medical Center dated June 24, 2016. Dr. Castle testified that there were no parenchymal abnormalities indicating the presence of pneumoconiosis on the film. Dr. Castle testified that for a proper reading of a chest x-ray for pneumoconiosis, one has to compare the subject film to the standard ILO classification films in order to classify it in that system. Dr. Castle testified that the reader needs to identify the patient name, location where the film was taken, date and quality of the film. If there are opacities on the film, they are classified according to their size and shape. The reader also notes the lung zones in which they are located as well as the profusion. Dr. Castle testified that profusion is important because that is the determination of whether or not the x-ray is positive or negative. Dr. Castle testified that if the reader compares the chest x-ray he is interpreting to the ILO standard 1/1 film and thinks that it is actually closer to the 0/0 film, then he would classify it as 0/1 which is a negative film. If it is closer to a category 1, it would be classified as 1/0 film. Dr. Castle testified that the zero indicates the reader considered that it might be a negative film. Dr. Castle testified that 1/0 is the lowest positive film (Respondent's Exhibit 2, pp 25-27).

Dr. Castle testified that there is no such thing as radiographically apparent pulmonary impairment. Dr. Castle testified that he is familiar with the *Guides to the Evaluation of Permanent Impairment, Sixth Edition*. He testified that he agrees with Section 5.4b which states that the correlation of chest imaging with physiologic measures of impairment is poor. Dr. Castle testified that the *Guides* do not use imaging of the chest as a factor in the assessment of impairment. Dr. Castle testified that there is essentially no clinical significance to subradiographic pneumoconiosis. He testified that subradiographic means that one has evidence of pneumoconiosis pathologically that would not be present on a chest x-ray which means that the pneumoconiosis is of insufficient severity to be seen on an x-ray and is unlikely to cause any impairment. Dr. Castle testified that when impairment results due to scarring of the lungs from inhalation of dust, it involves the interstitium. Dr. Castle testified that diffusing capacity measures whether there has been any damage done to the interstitium. In Petitioner's case, his diffusing capacity was 129% of predicted. Dr. Castle testified that this means there has been no impairment to the interstitium of the lung that is clinically significant. Dr. Castle testified that the increased diffusing capacity is something frequently seen in the disease of asthma. Dr. Castle agrees with the position of the American Thoracic Society that an older worker with a mild pneumoconiosis may be at low risk from working in currently permissible dust exposure levels until he reaches retirement age. Dr. Castle testified that it is very unlikely for simple pneumoconiosis to progress once the exposure ceases (Respondent's Exhibit 2, pp 27-30).

Dr. Castle testified that Petitioner's total lung capacity measured on August 28, 2017, was 108% of predicted. He testified that same is a normal total lung capacity and rules out restriction in Petitioner. Dr. Castle testified that Petitioner suffers from reactive airways disease which is very common in the general public. He testified that it is one of the most common diseases in the world. He testified that there would not be any reason that Petitioner could not continue in his job as a coal miner with asthma. Dr. Castle testified that Petitioner's treating physician diagnosed him with reactive airways disease and treated him with a medication called Symbicort. Dr. Castle testified that Petitioner's treating physician never restricted him from work. Dr. Castle testified that he did not see a diagnosis of chronic bronchitis or COPD in the treatment records that he reviewed (Respondent's Exhibit 2, p 30-32).

Dr. Castle testified that for an individual who has asthma that is related to his employment, one looks to Table 5.5 of the *AMA Guides* to determine if there is any impairment associated with that asthma. If Table 5.5 is applied to the results from the pulmonary function testing performed on Petitioner, he would fall in Class 0 impairment. (Respondent's Exhibit 2, p 33).

Dr. Castle testified that based upon a thorough review of all the data, he concluded that Petitioner did not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure to coal mine dust. Petitioner worked in or around the underground mining industry for a sufficient enough time to have possibly developed coal workers' pneumoconiosis if he were a susceptible host. He worked for 31 years in the mining industry and last worked in June 2016 as a repairman. Dr. Castle testified that Petitioner was a lifelong non-smoker. Dr. Castle testified that a risk factor for the development of pulmonary disease is that of bronchial asthma and Petitioner had a history of diagnosis of reactive airways disease by his primary care physician. Petitioner had an episode of persistent wheezing, cough and chest congestion which totally cleared after a two week period of treatment with Formoterol/Budesonide HFA. Petitioner also demonstrated intermittent wheezing on pulmonary examinations. Petitioner had evidence of very significant bronchoreversibility on pulmonary function studies obtained by Dr. Istanbouly. Dr. Castle also testified that there was variability in the function between the two sets of studies that he reviewed. Dr. Castle testified that all of these findings are consistent with a diagnosis of bronchial asthma or reactive airways disease. Dr. Castle testified that coal mine dust exposure does not cause bronchial asthma. Dr. Castle testified that Petitioner had a history of rather severe gastroesophageal reflux disease with symptoms occurring four to five times per week. Dr. Castle testified that gastroesophageal reflux disease is a known cause for the development of bronchial asthma in adults (Respondent's Exhibit 2, pp 33-35).

Dr. Castle testified that there are other things besides coal dust that a person is exposed to in a coal mine including fumes from roof bolting glues. Each of those is known to be a potential cause or aggravator of asthma. Dr. Castle testified that it would be very unlikely for a person to have asthma solely because of his work in the coal mine (Respondent's Exhibit 2, p 41-42).

Dr. Castle testified that the pulmonary function test performed by Dr. Istanbouly was interpreted by him as showing mild obstructive defect. A year later the testing at Methodist Hospital showed a moderate obstruction. On the testing from Methodist Hospital there was an improvement after

bronchodilator administration of 27% in the FEV1. Dr. Castle testified that the reason for the variability between the two tests would be Petitioner's asthma (Respondent's Exhibit 2, p 44-45).

Dr. Castle testified that studies show that as many as 50% of long term coal miners have pathological coal workers' pneumoconiosis that was not appreciated radiographically during their lives. He believed that it is true that an individual can have the disease and have a negative chest x-ray. Dr. Castle testified that the abnormality of coal workers' pneumoconiosis is essentially trapped coal dust in a part of the lung that ends up wrapped in scar tissue and can be accompanied by emphysema around it. The affected tissue itself cannot perform the function of normal healthy lung tissue. He testified that by definition, if a person has coal workers' pneumoconiosis, he would have an impairment in the function of his lungs at the site of the scarring. Dr. Castle testified that to his knowledge there is no cure for coal workers' pneumoconiosis (Respondent's Exhibit 2, p 54, 58-59, 66).

Dr. Castle testified that in spirometry one looks to the FEV1/FVC ratio to determine whether an individual suffers from obstruction. The ratio of the prebronchodilator testing by Dr. Istanbouly was 57% and postbronchodilator it was 58%. The testing at Methodist Hospital was done about a year later and the ratio prebronchodilator was 57% and postbronchodilator it was 61%. Dr. Castle testified that there was no significant difference in those two studies (Respondent's Exhibit 2, pp 77-78).

Medical records of SSM Medical Group were entered into evidence. Petitioner was seen on September 14, 2009, for general physical and checkup. Diagnosis history showed that there was no asthma. He was not smoking at that time. His history was significant for heart disease. Physical examination of the lungs showed respiratory excursion was not diminished. There was no wheezing, rhonchi or rales/crackles heard. Petitioner was seen on July 25, 2012, for general checkup. He was complaining of left sided neck discomfort which had been present for a long time. He was recorded as being a never smoker. Physical examination of the lungs showed respiratory excursion not diminished. He had no wheezing, rhonchi or rales/crackles. Petitioner was seen on April 21, 2014, and complained of wheezing and cough for the past two months. These symptoms began gradually and included chest congestion, cough and wheezing. He had no history of asthma and had never used an inhaler. Physical examination of the lungs showed expiratory wheezes throughout all lung fields. The assessment was wheezing and shortness of breath. He was prescribed Symbicort. Petitioner returned on May 5, 2014. He reported that the shortness of breath and wheezing had all resolved and he felt much better. He still had a slight bit of sinus drainage that made him cough at times. This assessment was reactive airway disease. On examination his lungs had normal respiratory effort with no wheezes. The doctor advised him to reduce the Symbicort to one inhalation twice daily (Respondent's Exhibit 4, pp 49-53, 63-65, 70-72).

Petitioner was seen on May 4, 2015, for annual wellness exam. He denied shortness of breath. He reported that he had planned to retire that year. Physical examination of the lungs showed breath sounds were normal and symmetric with no rales or wheezes. The assessment included reactive airways disease. Petitioner was seen for his annual wellness exam on May 10, 2016. Physical examination of the lungs showed his breath sounds were normal and symmetric with no rales or wheezes. Petitioner was seen on May 12, 2017, for his annual wellness examination. He

was noted to have reactive airways disease and was using Symbicort which continued to work well for him. He reported he was retired from the mines and noticed that his breathing was better. He was continuing to fish and stay active. On physical examination his breath sounds were normal and symmetric with no rales or wheezes. Petitioner was seen on May 31, 2018, for annual wellness examination. He was noted to have reactive airways disease and was using one puff daily of Symbicort which was continuing to work well. On examination his breath sounds were normal and symmetric with no rales or wheezes (Respondent's Exhibit 4, pp. 3-5, 11-13, 18-19, 36-38).

Conclusion of Law

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

The Arbitrator concludes that Petitioner did not sustain an occupational disease arising out of and in the course of his employment with Respondent.

In support of this conclusion the Arbitrator notes the following:

Dr. Henry K. Smith, a B-reader and board certified radiologist, interpreted the chest x-ray of June 24, 2016, as positive for coal workers' pneumoconiosis. Dr. Smith found the film to be profusion 1/0 with P/P opacities in the middle and lower lung zones bilaterally. Dr. Istanbouly is not an A-reader or B-reader of films. Dr. Istanbouly does not have the special training for interpreting chest x-rays for occupational lung disease that was described by Dr. Meyer. Dr. Meyer, board certified radiologist and B-reader, and Dr. Castle, A-reader, reviewed Petitioner's chest x-ray of June 24, 2016. Dr. Meyer testified that there were no radiographic findings of coal workers' pneumoconiosis. Dr. Castle testified that there were no parenchymal abnormalities consistent with pneumoconiosis on the film. Dr. Castle described the protocol for proper reading of a chest x-ray for pneumoconiosis. He also testified that profusion is important because that is the determination whether or not the x-ray is positive or negative. Dr. Istanbouly did not follow this protocol and did not know the profusion of the film that he reviewed. Dr. Meyer testified that location of the opacities is important because different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper zone predominant process. Dr. Smith found opacities only in the middle and lower lung zones bilaterally.

Dr. Istanbouly noted that Petitioner was being treated with Symbicort, which is a bronchodilator. Petitioner gave a history of coughing on a daily basis for the last six to eight years. He reported the coughing was constant, mild to moderate in intensity and productive. Dr. Istanbouly testified that this history of cough qualified for diagnosis of chronic bronchitis. Dr. Istanbouly testified that Petitioner's spirometry revealed mild obstructive defect with no good response to bronchodilator treatment. Dr. Istanbouly testified that the wheeze noted on physical examination and post bronchodilator change in the FEV1 of 10% would indicate reactive airways disease or bronchoreactivity to a certain extent. Dr. Castle agreed that Petitioner suffers from reactive airways disease which is very common in the general public. Dr. Castle testified that Petitioner's treating physician diagnosed him with reactive airways disease and treated him with Symbicort. Dr. Castle testified that Petitioner's treating physician never restricted him from work. Dr. Castle

testified that he did not see a diagnosis of chronic bronchitis or COPD in the treatment records that he reviewed.

Dr. Castle testified that there was variability in the function between the two sets of pulmonary function studies that he reviewed. He testified that the findings on the studies were consistent with the diagnosis of bronchial asthma or reactive airways disease. Dr. Castle testified that coal mine dust exposure does not cause bronchial asthma. Dr. Castle testified that Petitioner had a history of rather severe gastroesophageal reflux disease with symptoms occurring four to five times per week. Dr. Castle testified that gastroesophageal reflux disease is a known cause for development of bronchial asthma in adults. Dr. Castle testified that for an individual who has asthma that is related to his employment, one looks to Table 5.5 of the *AMA Guides for Evaluation of Permanent Impairment Sixth Edition*, to determine if there is any impairment associated with asthma. Dr. Castle testified that if Table 5.5 is applied to results from the pulmonary function testing performed on Petitioner, he would fall in Class 0 impairment.

Based upon the preceding, the Arbitrator finds the opinions of Dr. Castle and Dr. Meyer to be more persuasive than those of Dr. Istanbouly and Dr. Smith.

Petitioner testified that he noticed breathing problems about two years before he retired, Dr. Castle testified that there would not be any reason that Petitioner could not continue in his job as a coal miner with asthma. At the time of his examination by Dr. Istanbouly, Petitioner did not relate any specific triggers for his cough. He was not suffering any significant exertional dyspnea. Petitioner did not tell Dr. Istanbouly that he had any problems in completing the duties of his last job at the coal mine which was a fairly physical job. Petitioner did not tell Dr. Istanbouly that he left his job at the mine due to problems with respiratory disease or a diagnosis of respiratory disease. As of the time of arbitration, Petitioner was staying active riding a bicycle, bass fishing and maintaining his yard.

In regard to disputed issues (L) and (O) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law on disputed issues (C) and (F).

William R. Gallagher, Arbitrator

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC020264
Case Name	HINES, WANOKA v. BUFFALO WILD WINGS
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0277
Number of Pages of Decision	17
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Martha Niles
Respondent Attorney	Edward Jordan

DATE FILED: 6/9/2021

/s/Marc Parker, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Wanoka Hines,

Petitioner,

vs. NO: 16 WC 20264

Buffalo Wild Wings, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical expenses, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 22, 2019, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

June 9, 2021

/s/ *Marc Parker*
Marc Parker

MP:yl
o 6/3/21
68

/s/ *Barbara N. Flores*
Barbara N. Flores

/s/ *Christopher A. Harris*
Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0277
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

HINES, WANOKA Case# **16WC020264**
Employee/Petitioner

BUFFALO WILD WINGS INC
Employer/Respondent

On 4/22/2019, 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 2.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(A)

WANOKA HINES
Employee/Petitioner

v.

BUFFALO WILD WINGS, INC.
Employer/Respondent

Case # 16 WC 20264

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 **Waukegan, IL**, on **February 21, 2019**. 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 TTD**

FINDINGS

On the date of accident, **4/21/16,** Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$19,689.80**; the average weekly wage was **$378.65**.

On the date of accident, Petitioner was **48** 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 **$0** under Section 8(j) of the Act.

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $4,780.62 to Illinois Bone and Joint Institute , $ 5,149.90 to Vista East Medical Center as provided in Sections 8(a) and 8.2 of the Act if these medical bills remain unpaid. If any or all of these medical bills are paid by any third party, respondent shall hold the petitioner harmless against any attempt by any third party payor seeking reimbursement from the petitioner.

Respondent shall further pay prospective medical treatment in the form of the proposed surgery and resasonable and necessary post operative care.

Temporary Total Disability

The parties stipulated that the petitioner has not lost any time from work as a result of her alleged injury. Petitioner has requested prospective temporary total disability benefits. The Arbitrator is unaware of any provision in the Act or any judicial interpretation in the Act that grants the Arbitrator authority to grant this request.

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

April 18, 2019
Date

ICArbDec19(b)

APR 22 2019

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Wanoka Hines,	)	
	)	
Petitioner,	)	
	)	Case No. 16 WC 20264
v.	)	
	)	
Buffalo Wild Wings,	)	
	)	
Respondent.	)	

STATEMENT OF FACTS

Petitioner was a 48 year old female who was single with 2 dependents under the age of 18 at the time of her alleged accident. (Tx. 13). Petitioner had worked for Respondent, Buffalo Wild Wings, since September, 2015 in various positions until April 21, 2016, the date of her alleged accident. (Tx. 13). Petitioner initially worked for Buffalo Wild Wings in the Outside Expo position. (Tx. 14). This position required Petitioner to assemble food orders on a tray. (Tx. 14). The physical demands of that job included reaching underneath counters, setting trays on a counter and physically assembling the object and the order on a tray. (Tx. 14). Petitioner worked in the Outside Expo job from September, 2015 until February, 2016. (Tx. 15).

Petitioner began working in the Chip Station at BWW in February, 2016. (Tx. 15-16). The Job Description for the Chip Station was entered into evidence as Respondent's Exhibit #5. (Rx. 5) Petitioner testified that the written Job Description was accurate. (Tx. 15-16). The Job Description states that Petitioner was responsible for the preparation and production of all food items including appetizers, potato wedges, French Fries, buffalo chips and fried items, including chicken. (Rx. 5). Petitioner was also required to clean and maintain her work area, around the fryers and the kitchen and was responsible for preparation of food and vegetables. (Tx. 17-19 and Rx. 5).

Petitioner also cooked chicken in the Chip Station job. Petitioner placed pieces of chicken into fry baskets that were approximately 18 inches wide and 12 inches high. (Tx. 18). The baskets of chicken would cook in the fryer for approximately 14 minutes. (Tx. 20). After the chicken cooked, Petitioner grabbed the basket of chicken to remove it from the fryer and would dump the chicken into a hot holding drawer. (Tx. 20-21). Petitioner always used both her right and left arms to dump the chicken out of the fry basket into the hot holding drawer. (Tx. 21).

Petitioner alleged that she was required to cook and dump chicken baskets approximately 30-40 times per hour and 60-70 times a day. (Tx. 21 and Tx. 49-50). Petitioner was also required to cook other fried items, including chicken tenders, potato wedges, buffalo chips, mozzarella sticks. (Tx. 21). Petitioner always used her right and left arms to grab and dump the other fried foods out of the fry baskets into holding drawers. (Tx. 21).

Petitioner testified that while she worked in the Chip Station, she was also asked to do other activities in the kitchen. (Tx. 26). Petitioner testified that she was also assist with the Shake Station. (Tx. 26). This job required Petitioner to put chicken into a sauce bucket and shake the container with both her right and left hands to place sauce on the chicken. (Tx. 26). When Petitioner opened the store, she would be responsible for preparation of food, including cutting vegetables and other food preparation. (Tx. 45-46). Petitioner was also asked to assist with preparing and cooking grilled food, including hamburgers, quesadillas on a grill. (Tx. 78-79). Petitioner testified that she never did one specific job when she worked in Chip Station. Overall, Petitioner cooked food on the grill, prepared vegetables and other food, cleaned her work station, cooked chicken and also assisted in the Shake Station. (Tx. 52-55).

On April 21, 2016, Petitioner alleged that she was lifting a chicken basket out of the fryer and felt right elbow pain that radiated into her right arm. (Tx. 28). Petitioner testified that she dropped the fry basket on the edge of the fryer and notified her Manager. (Tx. 29). Petitioner alleged that she notified her Manager, Eddie Nutter. (Tx. 30). Petitioner finished her work day on April 21, 2016 and went home and took Ibuprofen. (Tx. 33). Petitioner continued working full duty for Respondent until May 4, 2016. (Tx. 34). Petitioner did not seek medical treatment on April 21, 2016 and the first time that Petitioner sought treatment was on May 4, 2016.

Medical records from Vista East Medical Center were entered into evidence as Petitioner's Exhibit #3. Petitioner presented to Vista East Medical Center on May 4, 2016 complaining of right shoulder and arm pain after an injury at work a few weeks prior when she was working the fryer at work. (Px. 3). The history states that Petitioner was complaining of right elbow pain for a few days prior to her visit that was located to the outer aspect of the elbow. (Px. 3). The examination noted Petitioner was tender to her right lateral epicondylitis and Petitioner was diagnosed with tennis elbow. (Px. 3).

Petitioner returned to Vista East Medical Center on June 14, 2016. (Px. 3). Petitioner was complaining of right elbow pain and arm pain for approximately two months. (Px. 3). Petitioner reported that she was employed as a Cook at a restaurant and her work activities included repetitive use of her right elbow. (Px. 3). Petitioner was diagnosed with right elbow lateral epicondylitis and was prescribed Flexeril, Norco, and referred to see Dr. DeLeon at Illinois Bone & Joint Institute. (Px. 3).

Petitioner saw Dr. DeLeon in June, 2016. (Tx. 37). Dr. DeLeon's records were entered into evidence as Petitioner's Exhibit #1. Petitioner first saw Dr. DeLeon on June 20, 2016. (Px. 1). Petitioner reported that she was having right elbow pain from an injury in April, 2016 and complained of right forearm pain. (Px. 1). Petitioner stated that after a long day at work in April 2016, she returned home with an aching pain in her right elbow. (Px. 1). Petitioner complained of pain while lifting chicken baskets. (Px. 1). Dr. DeLeon diagnosed Petitioner with right lateral epicondylitis. (Px. 1). He prescribed a wrist brace and instructed Petitioner to return to work with restrictions of no lifting and carrying with the right arm. (Px. 1). The medical records indicate petitioner is right hand dominant. (Px 1).

Dr. DeLeon recommended Petitioner begin physical therapy, use a tennis elbow strap at work and return to work with no lifting over 5 lbs with the right hand on July 18, 2016 (Px. 1).

Petitioner began physical therapy at Illinois Bone & Joint Institute on July 22, 2016. (Px. 1). Petitioner was recommended to undergo 2 visits of physical therapy a week for 8 weeks, for a total of 16 visits of physical therapy. (Px. 1). Petitioner testified that she completed physical therapy at Illinois Bone & Joint Institute. (Tx. 66-67). The therapy records state that Petitioner "no showed" 2 appointments in a row and was removed from their schedule. (Px. 1). The records state that Petitioner did not return a call from physical therapy to reschedule therapy and was discharged with only one visit recorded. (Px. 1). Petitioner testified that she went to multiple physical therapy appointments and denied that she did not complete physical therapy.

Petitioner also "no showed" a visit with Dr. DeLeon on August 15, 2016. (Px. 1). Petitioner returned to Dr. DeLeon on November 21, 2016, four months after her last visit in July. (Px. 1). Petitioner continued to have right elbow pain since April, 2016. (Px. 1). Petitioner stated that she was unable to attend physical therapy due to transportation issues. (Px. 1). Dr. DeLeon recommended that Petitioner undergo a MRI of the right elbow and gave her work restrictions of no lifting over 5 lbs with her right hand. Dr. DeLeon performed a right elbow injection. (Px. 1).

Petitioner underwent an MRI of her right elbow at Progressive Radiology on January 16, 2017 which showed marked thickening and edema in the common extensor tendon consistent with the severe tendonopathy or partial tearing. (Px. 2).

Petitioner returned to Dr. DeLeon on January 23, 2017. He opined that the MRI demonstrated severe tendonopathy and/or partial thickness tearing of the common extensor tendon on the lateral epicondyle. (Px. 1). Dr. DeLeon recommended a lateral epicondyle release with denervation. (Px. 1). Dr. DeLeon continued Petitioner's work restrictions of no lifting over 5 lbs with the right hand. (Px. 1).

Petitioner testified that her last visit with Dr. DeLeon was on January 23, 2017, however the medical records show that Petitioner returned to Dr. DeLeon on April 16, 2018. (Px. 1). Petitioner complained that her elbow and arm pain had worsened. (Px. 1). Petitioner reported that she was employed as a Supervisor at the Lake Forest Cafeteria. (Px. 1). Dr. DeLeon recommended a lateral epicondyle release with denervation and continued Petitioner's work restrictions. (Px. 1).

Petitioner is presently working at Sodexo as a Cafeteria Supervisor at the Lake Forest Academy. (Tx. 70-71). Petitioner did not know when she began working at Lake Forest Academy, but admitted that she worked for Sodexo throughout 2017. (Tx. 70-71). Petitioner's job duties at Sodexo require some data entry that she completes with her right hand and is mostly supervisory job duties. (Tx. 70-71).

Dr. DeLeon testified via evidence deposition on August 22, 2018. (Px. 4). Dr. DeLeon is a Board Certified Orthopedic Surgeon who concentrates in hand surgery. Dr. DeLeon testified that Petitioner stated that she had an onset of pain in April, 2016 after a long day of work and returned home with aching of her right elbow. Dr. DeLeon testified that Petitioner had severe elbow pain that occurred more severely at work and specifically while lifting chicken baskets. Dr. DeLeon diagnosed Petitioner with lateral epicondylitis. Dr. DeLeon testified that Petitioner

provided a description of her work at Buffalo Wild Wings and that Petitioner cooked chicken. Dr. DeLeon testified he recommended Petitioner undergo physical therapy and gave her work restrictions in July 2016. Dr. DeLeon testified that the MRI of January 16, 2017 confirmed lateral epicondylitis. Dr. DeLeon testified that he is currently recommending surgery for Petitioner's right elbow. Dr. DeLeon testified that Petitioner's right elbow injuries were aggravated by her work at Buffalo Wild Wings and that her condition was accelerated and exacerbated by her job as a fry cook. Dr. DeLeon testified that Petitioner's medical treatment, including surgery and physical therapy, are related to her alleged work injuries.

On cross-examination, Dr. DeLeon admitted he did not review medical records from any of Petitioner's treatment other than at Illinois Bone & Joint Institute. Dr. DeLeon admitted that he did not review a Job Description. Dr. DeLeon admitted that the initial history and examination on June 20, 2016 was taken by his Physician's Assistant. Dr. DeLeon did not have any specific information whether Petitioner lifted chicken baskets with her right or left hands or both of her hands and did not know the specific amount of fry baskets that Petitioner lifted per day. Dr. DeLeon recommended physical therapy because therapy has been shown to accelerate the healing process of epicondylitis, although physical therapy would not affect the long term history or healing of the injury. Dr. DeLeon testified that he also recommends physical therapy before any surgery for epicondylitis. Dr. DeLeon testified that if Petitioner did not complete physical therapy, that could impact Petitioner's ability to return to light duty work. Dr. DeLeon had no information regarding Petitioner's job at Sodexo.

Petitioner saw Dr. Bryan Neal for a §12 Independent Medical Evaluation March 6, 2017. (Rx. 2). Dr. Bryan Neal testified via evidence deposition on September 27, 2018. (Rx. 2). Dr. Bryan Neal is an orthopedic surgeon who practices at Arlington Orthopedics & Hand Surgery and is a Board-Certified orthopedic surgeon specializing in treatment of hand and upper extremity. Dr. Neal examined Petitioner on March 6, 2017. Dr. Neal review the Chip Station Job Description that was entered into evidence as Respondent's Exhibit #5. Dr. Neal reviewed all medical records from Vista East Medical Center, Dr. DeLeon and a Form 45 Accident Report. Dr. Neal diagnosed Petitioner with right lateral epicondylitis Dr. Neal testified that Petitioner's current condition of ill-being regarding her right elbow is not causally related to a work accident, because the medical records did not support a specific injury and the Job Description and Petitioner's history did not support that Petitioner's work activities caused or aggravated her right elbow injuries. Dr. Neal testified that the cause of Petitioner's epicondylitis was unknown or idiopathic. Dr. Neal opined that Petitioner should undergo surgery, however surgery is not related to a work injury. Dr. Neal prepared a supplemental report on September 4, 2018 after reviewing medical records from Vista Medical Center and Dr. DeLeon. Dr. Neal testified that his causation opinion was validated based upon the review of the updated medical records from Dr. DeLeon because Petitioner was still complaining of significant right lateral epicondylitis in 2018, had not worked for Buffalo Wild Wings for approximately 2 years and her condition worsened. Dr. Neal testified that if Petitioner's work activities caused her injuries, since Petitioner was no longer working for BWW and was avoiding those work activities, Petitioner's right elbow pain should have resolved or improved.

Petitioner testified that she still has right elbow pain. Petitioner testified that she wants to pursue surgery, but she has not had the surgery because it has been denied. Petitioner was not

claiming any lost time benefits. Petitioner entered alleged unpaid medical bills, however Petitioner was unaware if any of her medical bills were paid by her insurance or Medicaid. Respondent introduced an exhibit showing that some medical bills were paid by Workers' Compensation.

CONCLUSIONS OF LAW

As to Issue (C), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent and as to issue (F), Is Petitioner's condition of ill-being causally related to the injury, the Arbitrator finds as follows:

The Arbitrator finds that petitioner sustained accidental injuries arising out of and in the course of her duties on April 21, 2016. The Arbitrator further finds that petitioner's current right elbow condition is causally related to the repetitive nature of her job duties for the respondent. In support of these findings, the Arbitrator states as follows:

Petitioner testified to a large number of tasks associated with her work while in the employment of Respondent. She stated that she initially start started in the "outside expo" position (Tx. 15). She also cooked and worked the "chip station," which was described as a frying station. She testified that as part of that preparation, she would chop vegetables and ensure that all of the necessary supplies for the food stations were made available to other workers. (Tx. 16-17)

She testified that she would work four fryers at a time using basket fryers for chicken wings and other items. She indicated that the baskets could be as much as 18 inches in size, approximately a foot deep and approximately 12 inches wide. (Tx. 18-19). She testified this would be filled to the top with chicken wings to be fried.

Petitioner testified that when the wings or other food finished cooking, it would be dumped into a holding drawer to keep warm. She testified that she would perform this specific activity approximately 60 to 70 baskets during her shift. (Tx. 21) Initially she stated the 60-70 was per hour, but she changed that on cross examination to per shift. (Tx. 50)

Petitioner further stated that the chip station included cleaning including sinks, baseboards, washing vent hoods and other parts of the kitchen; as well as sweeping scrubbing and polishing walls and sorting linens. (Tx. 25)

In addition to operating the chip station, she testified that she operated the "shake station" which she described as where the chicken is placed in a bucket and sauce is added in, then the bucket is shaken. She demonstrated this activity by moving her arms in an up-and-down manner.

(Tx. 26) Petitioner testified this one bucket would weigh 6 to 7 pounds and she had to do it approximately every 30 seconds.

Petitioner testified that on April 21, 2016 as she was lifting fried chicken out of the hot grease, she felt a pain shooting, radiating through her right arm. (Tx. 28) She testified pain was so severe she drop the chicken at the edge of the fry station. The pain was located in the top of the forearm towards the right elbow on the medial epicondyles area. (Tx. 29)

Petitioner testified that she continued working, went home and took ibuprofen. Petitioner testified that she continued working at Respondent's restaurant but suffered ongoing pain (Tx. 33) Petitioner first sought medical care on May 4, 2016 when she saw Dr. Al Sarog at Vista East. Petitioner testified that she was diagnosed with tennis elbow at that time. The medical records (Px. 3) also contain this diagnosis. Petitioner testified was that she told Dr. Sarog the accident happened lifting the basket of chicken using the fryer at work. (Tx. 35)

Petitioner was seen again at Vista on June 14 by Dr. Jeffrey Helwig. Dr. Helwig diagnosed petitioner with lateral epicondylitis (Tx. 36) and prescribed a tennis brace from Walgreens. Petitioner commenced treating with Dr. Serafin DeLeon at Illinois Bone and Joint Institute on July 18, 2016. (Px 1). Petitioner next treated with Dr. DeLeon on November 21, 2016 at which time he administered a steroid injection into her right elbow.

The petitioner returned on December 23, 2016 at which time Dr. DeLeon ordered an MRI and imposed a 5-pound work restriction. (Px. 1) Petitioner underwent the MRI on January 16, 2017. Petitioner subsequently met with Dr. DeLeon again on January 23, 2017 at which time he prescribed surgery. (Tx. 39) Petitioner testified the reason she did not yet undergone the prescribed surgery is that she could not afford it as the insurance company stopped paying for medical treatment. (Tx. 40)

Petitioner testified that on the day of trial she had throbbing pain in her right arm it an area that the arbitrator noted included the top third of the forearm outside going up into the elbow on the outside.

Petitioner testified that her employment with Buffalo wild wings was terminated, but that she has obtained alternate employment and is now receiving health insurance benefits again.

Petitioner testified she never had any problems with her right arm prior to the April 21, 2016 (Tx. 74).

Petitioner offered the records of the Illinois Bone and Joint Institute, and the testimony of Dr. DeLeon. The doctor testified that the condition of epicondylitis, also known as tendinosis, is the results of scar tissue buildup on the tendon, which may be completely asymptomatic (Px 4, p. 3-7) He further testified that there is no known timeline or study for when an asymptomatic

tendinosis would become symptomatic. (Id. 7) In his opinion, it could be as short a time as "a few days." (Id.7-8)

Dr. DeLeon testified as to the history petitioner provided him of an onset of elbow pain in April 2016 following a long day of work. (Id. 9-10) He then testified as to a course of treatment consistent with the petitioner's testimony noted above.

Dr. DeLeon identified that petitioner had objective findings as well as subjective findings (Id. 12-13) and that her condition has not improved with conservative care. As of the last date he saw her, April 16, 2018, petitioner was still having pain in the elbow which was progressively worsening. (Id. 18-19)

Dr. DeLeon testified that he had recommended surgery which the progress note of January 23, 2017 describes as a right lateral epicondyle release with denervation (Px 1). The prescribed surgery based in part on his belief that the MRI confirmed his diagnosis of lateral epicondylitis and the failure of conservative care and time to resolve the petitioner's condition. Specifically, Dr. DeLeon believed that the MRI revealed thickening and edema within the common extensor tendon where it attaches to the lateral epicondyle and that it was consistent with severe tendinopathy and partial thickness tearing of the tendon. (Px 4 p.16-17) Petitioner has yet not undergone the surgery as (Id.19), and it to the best of his knowledge she has not undergone the surgery.

When asked his opinion as to whether or not her work at Buffalo Wild Wings caused aggravation, acceleration or exacerbation of her condition, he testified that her work directly aggravated, accelerated and exacerbated her condition. (Id.21). He further testified that he felt that her treatment had been reasonable and necessary up to that point in time but that she needs the surgery. (Id. 22)

On cross-examination, Respondents counsel pointed out that Petitioner had not completed physical therapy and inquired whether this would have a negative impact on her recovery. (Id. 29-30) Dr. DeLeon testified that studies demonstrate physical therapy has no long-term impact on prognosis, only on short term recovery. (Id. 31)

Respondent offered the testimony of Dr. Bryan Neal, their expert witness. Dr. Neal testified that he had the opportunity to examine Petitioner and review medical records (Neal Dep 12 as well as a job description provided by Respondent. (Id. 45)

In reviewing the medical records, Dr. Neal noted the history of working with the deep fryers (Id.14) and that she had been suffering elbow pain for a few days when she was first seen at Vista on May 4, 2016. In response to his questions, Petitioner told Dr. Neal that she hurt herself in April 2016 lifting and flipping baskets of food while working for respondent. (Id. 21)

During the examination, Dr. Neal noted that provocative maneuvers with regard to the wrist extension were painful and positive and that the examination was consistent with lateral epicondylitis, tennis elbow. (Id. 24) That was also his diagnosis. (Id. 24-25)

Dr. Neal opinioned there was no causal relationship between her employment and her condition because of a lack of studies supporting work activities causing lateral epicondylitis. (Id. 27), stating that the most common mechanism of injury is a process over time. (Id.48)

Dr. Neal agreed that there was no evidence of any injury to her right elbow prior to her employment with Respondent (Id. 51) and that lifting weights overtime could cause the type of condition that she suffered. (Id. 49-50)

In reviewing the testimony of the two experts, the Arbitrator chooses to adopt the testimony of the treating physician, Dr. DeLeon. The Arbitrator notes that Dr. DeLeon is a board-certified hand surgeon who focuses his practice on the hand and upper extremity. (Px 4). The Arbitrator finds it believable that the repetitive job duties described by the petitioner could cause or aggravate lateral epicondylitis. The Arbitrator notes the lack of any history of complaints or treatment for this medical condition. The petitioner notified her employer of her of her right elbow pain and sought treatment shortly thereafter. The histories in the medical records are consistent regarding both the petitioner's subjective complaints and the nature of her job duties. The petitioner's treatment was relatively consistent until the proposed surgery was denied by the respondent. The Arbitrator notes that the petitioner's pain has progressively worsened according to the testimony of Dr. DeLeon between the date he originally prescribed surgery and when he next saw her approximately 15 months later.

Based on all of the above, the Arbitrator finds the petitioner proved she sustained accidental injuries arising out of and in the course of her employment on April 21, 2016 and that her current right elbow condition of ill being is causally related to her job duties with the respondent.

As to Issue (E), Was Timely Notice Of The Accident Given To Respondent, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner provided notice of the alleged accident to Edie Nutter, Petitioner's Supervisor, within the requirements of the Act. The Arbitrator's finding is based on the Petitioner's unrebutted testimony that she provided notice of the alleged accident to her Supervisor on April 21, 2016.

As to Issue (J), Were The Medical Services That Were Provided To Petitioner Reasonable And Necessary and Respondent Paid All Appropriate Charges For All Reasonable And Necessary Medical Services, the Arbitrator finds as follows:

The Arbitrator finds that the medical care Petitioner has received to date is both reasonable and necessary. The Arbitrator bases this finding on the fact that both the testifying doctors opined that the treatment was both reasonable and necessary.

Respondent submitted Respondent's Exhibit 3 which details medical payments it has made. The respondent is entitled to the appropriate credit for any medical bills it paid to these providers.

Based on the above, the Arbitrator awards the medical bills submitted by petitioner in (Px 5) pursuant to the Illinois Fee Schedule as set forth in Section 8.2 of the Act provided that the medical bills are in fact unpaid. If any of the medical bills in Petitioner's Exhibit 5 are paid by any third party, the respondent shall instead hold the petitioner harmless against any claims made by any third-party payor for reimbursement, subject to the appropriate limitations set forth in the Illinois Medical Fee Schedule.

As to Issue (K), Is Petitioner Entitled To Any Prospective Medical Care, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner is entitled to prospective medical care. Specifically. the Arbitrator finds the respondent shall pay for the proposed or prescribed surgery of Dr. Deleon involving a right lateral epicondyle release with denervation. The Arbitrator also finds

the respondent shall pay for the appropriate post-operative medical care associated with this surgery to promote a successful recovery.

As to Issue (O), Is Petitioner Entitled To Prospective TTD Benefits, the Arbitrator finds as follows:

The parties stipulated that the petitioner has not lost any time from work as a result of her workers' compensation injuries through the trial date. The petitioner testified that she is currently working. There is no medical evidence that petitioner is authorized to be off work. The petitioner requests an award of prospective temporary total disability benefits. The Arbitrator is unaware of any provision in the Workers' Compensation Act or any judicial ruling that enables an Arbitrator at the Illinois Workers' Compensation Commission to award prospective temporary total disability benefits based on these set of facts.

Based on the above, petitioner's request for prospective temporary total disability benefits is denied.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC001204
Case Name	TERVEN, RON v. ILLINOIS DEPARTMENT OF TRANSPORTATION DIST 5
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0278
Number of Pages of Decision	17
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Jean Swee
Respondent Attorney	Bradley Defreitas

DATE FILED: 6/9/2021

/s/Marc Parker, Commissioner

Signature

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

☒ 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

Ron Terven,

Petitioner,

vs. NO: 18 WC 1204

Illinois Department of
Transportation, Dist. 5

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issue of the nature and extent of Petitioner's disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 2, 2020, 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.

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.

June 9, 2021

/s/ *Marc Parker*
Marc Parker

MP:yl
o 6/3/21
68

/s/ *Barbara N. Flores*
Barbara N. Flores

/s/ *Christopher A. Harris*
Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0278

TERVEN, RON
Employee/Petitioner

Case# **18WC001204**

ILLINOIS DEPT OF TRANSPORTATION DIST 5
Employer/Respondent

On 12/2/2020, 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 0.09% 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
JEAN A SWEE
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
SPRINGFIELD, IL 62704

6079 ASSISTANT ATTORNEY GENERAL
BRADLEY DeFREITAS
500 S SECOND ST
SPRINGFIELD, IL 62706

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

1430 BUREAU OF RISK MANAGEMENT
801 S 7TH ST
6TH FL
SPRINGFIELD, IL 62794

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

DEC 2 - 2020

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Ron Terven
Employee/Petitioner

v.

Illinois Department of Transportation Dist. 5
Employer/Respondent

Case # **18** WC **1204**

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 **Bloomington**, on **October 16, 2020**. By stipulation, the parties agree:

On the date of accident, **September 18, 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, per the stipulation of the parties, Petitioner's earnings in the year preceding the injury were **$55,680.04**; the average weekly wage was **$1,070.77**.

At the time of injury, Petitioner was **54** years of age, ***married,*** with **0** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent, and Respondent has or will pay all reasonable and necessary medical bills as contained in Petitioner's Exhibit 19.

Respondent shall be given a credit of **$34,368.21** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$34,368.21.**

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

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

ORDER

Respondent shall pay Petitioner the sum of **$642.46/week** for a period of **134.375 weeks,** as provided in Section **8(e)** of the Act, because the injuries sustained caused **45% loss of use of the right leg and 17.5% loss of use of the left leg.**

Respondent shall pay Petitioner compensation that has accrued from **September 18, 2017** through **October 16, 2020,** and shall pay the remainder of the award, if any, in weekly payments.

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

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

Melinda M. Gore-Gillman

Signature of Arbitrator

11/18/2020

Date

ICArbDecN&E p.2

DEC 2 - 2020

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MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he was employed by Respondent as a highway maintainer on September 18, 2017. Petitioner testified that on that date, he was working on Interstate 74 weed eating near the Morris Avenue bridge. He testified that while he was weed eating he was standing on a hidden rotten culvert filled with rock when it gave out from underneath him causing him to drop down on his heels, bending both knees backwards and causing him to fall onto his back on the ground. He testified that testified that both knees hyperextended, and that both knees hurt with the right knee worse than the left. Petitioner further testified that he immediately reported the injury to his supervisor.

After outlining the medical treatment that he received for his injuries, Petitioner testified that prior to his September 18, 2017 accident he did not have any ongoing pain in his right or left knee, and that he had never treated medically for either knee before his work accident. Petitioner testified that since his accident on September 18, 2017, he has continued to have pain in both of his knees on a daily basis. He testified that he experiences increased bilateral knee pain while performing some of his work activities. He testified that the cab of the truck he drives for IDOT is high and that it has three steps to get in and out. He testified that his left leg is stronger than his right, and that he leads with his right foot coming down. He testified that he used to be able to climb foot over foot up and down stairs, but that he now climbs one leg at a time.

Petitioner testified that when he sits in his IDOT truck his knees stiffen and that he has trouble bending his knees if he sits for any length of time. He testified that some days were worse than others and that it depended upon what he did at work. He testified that if he is walking up and down hills with rough terrain at work, he experiences increased discomfort in both of his knees. He testified that after a day of weed eating at work, his right knee swells up and that he goes home to ice both knees. He testified that the right knee is far worse than the left, but that he experiences swelling in both knees.

Petitioner testified that he takes Tramadol daily for the pain and that he also takes Naproxen or Ibuprofen. He testified that weather affects his knees, but that it affects the pain in the right knee the most. He testified that his right knee pops when he walks and that his right knee is hotter to the touch than his left. He testified that he wears compression hoses on both legs for swelling on occasion.

The Narrative Report of Dr. Hanson dated January 6, 2020 was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The report reflects that Dr. Hanson outlined the treatment course for Petitioner for the injury to both knees which occurred on September 16, 2017. It was noted that Dr. Hanson was still seeing Petitioner post-operatively for continued pain in his right total knee, that he was

currently being worked up for infection, that it was possible that he could need an early revision if he did have an infection or early loosening, and that it was also a certainty that he would need a revision right total knee arthroplasty in the future due to his young age. It was further noted that, as to Petitioner's left knee, Dr. Hanson was concerned there was a very similar injury pattern to the right knee, that his chondromalacia could deteriorate and also require a total knee on this side, and that he thought it was highly likely, more likely than not, that this knee would also require a revision within 20 years due to his young age. (PX1).

The Narrative Report of Dr. Hanson dated October 3, 2018 was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The report reflects that Dr. Hanson performed right knee arthroscopy, partial medial meniscectomy with loose body removal and microfracture chondroplasty of the medial femoral condyle and that Petitioner's chondral defect appeared to be traumatic in nature. It was noted that Petitioner underwent left knee arthroscopy, partial medial and lateral meniscectomy with microfracture lateral femoral condyle, that the full-thickness chondral defect appeared acute and traumatic in the left knee as well, and that he had continued to follow him for knee pain. It was noted that Dr. Hanson was recommending total knee arthroplasty on the right and that he believed that Petitioner's arthritis was significantly aggravated and advanced more rapidly due to his initial injury, resulting in the need for a total knee arthroplasty in a much accelerated manner as well. (PX2).

The Employee Accident/Incident Report dated September 19, 2017 was entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The report reflects that Petitioner was weed eating, that he stepped on the ground, that it gave way, and that it bent his knees backwards. It was further noted that it was a washout that broke loose, and that Petitioner's foot went into the hole. (PX3).

The medical records of OSF Saint Joseph Medical Center/Dr. Chow were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on September 19, 2017, at which time it was noted that he was weed eating on September 16, 2017 and stepped on some ground that had been washed away, that he twisted both knees and fell down, and that he was having knee pain and some swelling. It was noted that Petitioner landed on his buttock and low back because he was holding a weed eater, that he bent both knees backwards with the right heel locked in the hole hyperextending both knees but that the right knee hurt more than the left, and that the hole was about a foot deep. It was noted that this occurred yesterday, that Petitioner limped around, and that his knees continued to hurt that day, and that he stepped into the hole with his right foot. It was noted that x-rays of the bilateral knees performed on September 19, 2017 were interpreted as revealing minimal early tricompartment osteoarthritis of the knee joints in a bilaterally symmetrical fashion; there is no acute bony fracture or loose body; a small knee joint effusion is seen on both sides, especially on the right. The assessment was noted to be that of a right knee sprain and a left knee sprain. It was noted that Petitioner was to return to work with restrictions for the bilateral knees, and that he was given DME of a right hinged knee brace. It was further noted that Petitioner had medications for pain and inflammation from a personal provider. (PX4).

The records of Dr. Chow reflect that Petitioner was seen on September 27, 2017, at which time it was noted that he was seen for a recheck of his bilateral knee sprain. It was noted that Petitioner's pain level of 4 in the right knee was constant, that the pain level was 2 in the left knee, that he was wearing a right knee brace, that he had not worked since September 20th, and that he was elevating his knees and using ice at home. It was noted that Petitioner had pain in the right knee on the inner knee and traveling around the knee cap but did not always hurt around the knee cap, that he was using the brace for the right knee and had difficulty sleeping without using the brace on the right knee, that he awakened from twisting the right knee when he was asleep when he did not use the knee brace, that the left knee felt achy and was not worse compared with last week, and that he was not limping with the left knee. The assessment was noted to be that of right knee sprain and left knee sprain. Petitioner was recommended to undergo an MRI of the right knee due to pain and swelling, and he was given bilateral knee restrictions. It was noted that Petitioner was to follow-up approximately three days after the MRI. (PX4).

The IME Report of Dr. Verma dated April 1, 2019 was entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The report reflects that Petitioner reported a history of an injury which occurred when he was walking, performing his normal occupation on the side of a highway, that he stated that there was a hole that was poorly marked, that he stepped into it, and that he fell backwards causing a twisting injury to his knees. It was noted that Petitioner reported immediate onset of knee pain, that prior to this time he denied prior history of knee injury or trauma, that he stated that he worked the rest of the day but had persistent pain and awoke with significant swelling, and that he reported the injury and an injury report was filed. It was noted that Petitioner indicated that he underwent knee MRIs and subsequently required surgery, first on the right knee on October 31, 2017 and subsequently on the left knee on December 28, 2017, and that he had had persistent pain in the knees. It was noted that Petitioner had been recommended to undergo right knee replacement, that he reported that the right knee was more symptomatic, that he reported swelling, occasional locking, difficulty with weightbearing, and end of the day discomfort, and that he was working full duty but noted that he was limping by the end of the day. (PX5).

The report reflects that Dr. Verma opined that he did not see evidence of symptomatic preexisting condition, and that MRIs disclosed mild preexisting chondromalacia prior to the work injury but that there was no active treatment or ongoing symptoms. It was noted that Dr. Verma did not see any evidence of abnormal behavioral observations and/or symptom magnification, that the diagnosis was status post left knee arthroscopy and partial meniscectomy with mild persistent pain, and that the diagnosis with regard to the right knee was status post medial meniscectomy with significant progression of medial compartment arthrosis. It was noted that it was Dr. Verma's opinion that a causal relationship existed between Petitioner's bilateral knee condition and the work injury based on the mechanism as described, acute onset of symptoms, and lack of preceding symptoms in regards to the bilateral knees, and that the MRIs were consistent with acute or traumatic meniscal tears. It was noted that Dr. Verma opined that treatment to date appeared to be reasonable and necessary in regard to the bilateral knee conditions, that Petitioner was taking Tramadol and Naprosyn on a PRN basis which was appropriate for knee pain, that additional medical treatment with regard to the right knee would include proceeding with total knee arthroplasty based on significant persistent pain and progression of chondromalacia symptoms both on exam, radiographs, and MRI scan, and that following surgery he would require physical therapy 2-3 times per week for anticipated duration of 16-24 weeks. It was noted that as to the left knee, Dr. Verma saw no indication for further treatment at that time. (PX5).

The report reflects that Dr. Verma opined that Petitioner was working and could continue to do so pending surgery, and that following surgery he would be available for sedentary duty at six weeks, light duty at 12 weeks, and full duty at approximately six months. It was noted that Petitioner had reached maximum medical improvement with regard to the left knee, and that, as to the right knee, the timeframe for maximum medical improvement was 6-8 months following knee arthroplasty. (PX5).

The Interpretive Report for the MRI of the Right Knee performed on October 5, 2017 was entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The report reflects that the films were interpreted as revealing a medial meniscal tear. (PX6).

The Operative Report dated October 31, 2017 was entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner underwent right knee arthroscopy, partial medial meniscectomy, loose body removal and microfracture chondroplasty medial femoral condyle on that date by Dr. Hanson for a pre-operative diagnosis of right knee traumatic medial meniscus tear and a post-operative diagnosis of right knee traumatic medial meniscus tear plus loose bodies and traumatic chondral defect medial femoral condyle. (PX7).

The Interpretive Report for the MRI of the Left Knee performed on December 5, 2017 was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The report reflects that the films were

interpreted as revealing partial radial tear of the posterior horn of the medial meniscus; focal moderate to high-grade chondromalacia along the posterior weightbearing surfaces of the lateral femoral condyle and lateral tibial plateau; low-grade patellofemoral chondromalacia; small joint effusion; tiny popliteal cyst; mild subcutaneous soft tissue edema along the anterior aspect of the knee. (PX8).

The Operative Report dated December 28, 2017 was entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The records reflect that Petitioner underwent left knee arthroscopy, partial medial meniscectomy, and partial lateral meniscectomy and microfracture chondroplasty lateral femoral condyle on that date by Dr. Hanson for a pre-operative diagnosis of left knee traumatic medial meniscus tear and a post-operative diagnosis of left knee traumatic medial meniscus tear plus traumatic lateral meniscus tear and traumatic chondral defect lateral femoral condyle. (PX9).

The Interpretive Report for the MRI of the Right Knee performed on April 9, 2018 was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The report reflects that the films were interpreted as revealing post-operative appearance of the medial meniscus; new cartilage changes in the medial femoral condyle; new subchondral marrow edema in the medial tibial plateau; chronic appearing sprain at proximal MCL. (PX10).

The Operative Report dated June 18, 2019 was entered into evidence at the time of arbitration as Petitioner's Exhibit 11. The records reflect that Petitioner underwent right total knee arthroplasty using DePuy Attune posterior stabilized rotating platform size 6 femur, 7 tibia, 10 polyethylene and 41 patella by Dr. Hanson for a pre- and post-operative diagnosis of right knee posttraumatic arthritis. (PX11).

Various Work Slips were entered into evidence at the time of arbitration as Petitioner's Exhibit 12.

The medical records of McLean County Orthopedics were entered into evidence at the time of arbitration as Petitioner's Exhibit 13. The records reflect that Petitioner was seen on August 2, 2018, at which time it was noted that he called complaining of increased right knee pain and swelling. It was noted that Petitioner stated that last week he walked over 70, 000 steps and was over 60,000 steps this week already, that he was requesting either Toradol or something to help with pain and swelling, and that he stated that the steroid injection had almost worn off. It was noted that Petitioner was wearing his knee brace, that he was notified that steroid injections were every 3-4 months, and that he may get another one in August. It was noted that Petitioner was also seen in follow-up on his right knee status post arthroscopy on October 31, 2017 with post-traumatic osteoarthritis, that he reported that his pain was constant but worse in the evening, when on his feet too long, and with changes in weather, and that the pain was primarily an ache but could be sharp at times which stopped him in his tracks. It was noted that Petitioner took Tramadol for pain control. The assessment as noted to be that of 9.5 months status post right knee scope with moderate-severe post traumatic arthritis. Petitioner was given a steroid injection to the right knee and was recommended to undergo an injection of the left knee at the next visit. It was noted that Petitioner was to follow-up in three weeks for a repeat steroid injection. (PX13).

The records of McLean County Orthopedics reflect that Petitioner was seen on May 15, 2018, at which time he was seen in follow-up of the right knee. It was noted that Petitioner related that his right knee pain had improved significantly since his last office visit on May 2nd where a steroid injection was administered, that he had very little soreness in the knee and had been able to discontinue all over-the-counter and prescription pain medications, that he took Naproxen daily for inflammation, and that his range of motion was improved with no limitations to his activities of daily living. The assessment was noted to be that of seven months status post right knee scope with moderate-severe post traumatic arthritis. It was noted that Petitioner was to follow-up as needed and would need steroid injections every 3-4 months. At the time of the May 2, 2018 visit, it was noted that Petitioner had continued right knee pain. It was noted that Petitioner presented with continued right knee pain status post arthroscopy in October, that he related that his pain was okay, that he was still stiff and had a limp with ambulation, and that his symptoms were

aggravated with increased walking. It was noted that Petitioner elected to proceed with a steroid injection into the right knee. The assessment was noted to be that of 17 weeks status post left knee arthroscopy, and right knee moderate to severe post-traumatic arthritis status post right knee scope October 31, 2017. Petitioner was recommended to follow-up in two weeks to discuss possible return to work. (PX13).

The records of McLean County Orthopedics reflect that Petitioner was seen on April 11, 2018, at which time it was noted that he was seen after a right knee MRI. It was noted that Petitioner continued to have pain with walking and standing in the right knee, that it was constant and could be sharp, that his range of motion was limited which affected his gait, and that he was taking Norco and Tramadol for his pain. The assessment was noted to be that of 15 weeks out from a left knee arthroscopy and right knee moderate to severe post-traumatic arthritis status post right knee scope October 31, 2017. It was noted that Petitioner had failed all previous therapy and that he was recommended to undergo a right total knee. At the time of the March 28, 2018 visit, it was noted that Petitioner was 13 weeks out from a left knee chondroplasty done in December due to a work injury, that he reported that the pain was mild and tolerable, that the swelling was gone, and that he had good range of motion and it was improving with therapy. It was noted that Petitioner was also administered a Durolane injection into the right knee at the last visit following a right knee scope on October 31, 2017, that his pain had become worse than before the injection with increased buckling, that the last few days the pain had calmed down some but was still worse than before, and that he denied being able to walk long distances and the swelling made his knee tight. It was noted that Petitioner was taking Tramadol for pain. The assessment was noted to be that of 13 weeks out from a left knee chondroplasty and right knee pain status post right knee scope October 31, 2017. It was noted that Petitioner was recommended to undergo an MRI of the right knee. (PX13).

The records of McLean County Orthopedics reflect that Petitioner was seen on March 15, 2018, at which time it was noted that he was 11 weeks out from a left knee scope, that he had just completed his four weeks of work conditioning and related that it helped but his muscles were very sore and he was stiff, and that he continued to take Tramadol and Naproxen or Ibuprofen for pain relief. It was noted that Petitioner's range of motion had not changed and seemed to have plateaued. The assessment was noted to be that of 11 weeks status post left knee arthroscopy, partial medial and lateral meniscectomies and chondroplasty, and knee pain status post right knee scope October 31, 2017. Petitioner was given a Durolane injection to the right knee. At the time of the January 31, 2018 visit, it was noted that Petitioner was five weeks out from a left knee scope, that he had improved greatly since the last visit but still had some pain present with increased walking, weather change, and trying to put pressure directly on his knees, and that he was taking Meloxicam and Norco daily. It was noted that the swelling came and went, that the incision site was doing very well, and that a scab had formed over the lateral incision. The assessment was noted to be that of five weeks out from a left knee scope. Petitioner was recommended to continue to wean off Norco and onto Tramadol, to continue therapy and begin work conditioning, and to follow-up as needed. (PX13).

The records of McLean County Orthopedics reflect that Petitioner was seen on January 9, 2018, at which time it was noted that he was seen for an incision check 11 days out from a left knee scope due to a work injury. It was noted that Petitioner reported that on Sunday he flexed his knee while driving and that blood saturated his pants, and that there was localized swelling at the incision site. The assessment was noted to be that of 11 days out from a left knee scope, incision check. Petitioner was recommended to continue Keflex, to continue wound care, and to follow-up as scheduled. At the time of the January 3, 2018 visit, it was noted that Petitioner was six days out from a left knee scope due to a work injury, that he related that he was doing okay overall and better than when he had surgery on his right knee, that there was a constant ache present and with twisting of the knee it was sharp, and that he had Percocet and Naproxen for pain. It was noted that therapy started on Friday, that the incision site was clean and intact with no drainage, and that the sutures were removed and steri strips were applied. The assessment was noted to be that of six days status post left knee scope, partial medial and lateral meniscectomies, microfracture

chondroplasty lateral femoral condyle. Petitioner was given prescription for Norco and Mobic, and was recommended to follow-up in one month. (PX13).

The records of McLean County Orthopedics reflect that Petitioner was seen on December 5, 2017, at which time it was noted that he was five weeks out from a right knee scope, that he related that about two weeks ago he overdid it with his home exercises and that set him back to where he was ambulating with a cane and lost range of motion, that now he could ambulate without the cane, and that the swelling went down and the pain was more manageable but that he got a sharp stabbing pain at the medial aspect of the knee which could almost "take him to his knees." It was noted that Petitioner was taking Norco, Tramadol, or Naproxen for his pain. It was further noted that Petitioner was also being seen for an MRI review of the left knee which showed a partial radial tear of the medial meniscus, and that the pain was located in the medial aspect and was sharp. The assessment was noted to be that of five weeks status post right knee scope with continued pain and inflammation, as well as left traumatic medial meniscus tear. It was noted that Petitioner was allergic to steroid injections and that they would get approval for Gelsyn. Petitioner was recommended to return in one month and was given a prescription for Percocet. At the time of the November 7, 2017 visit, it was noted that Petitioner was one week out from a right knee scope, that he reported that he was very tight and sore with sharp/stabbing pains with walking in his posterior knee as well as medial and lateral, that he had limited range of motion due to pain but was trying to work on his home exercises, and that he was taking Norco and Tramadol for pain. It was noted that Petitioner's incision site was clean and intact with no drainage, that the sutures were removed and steri strips were applied, and that his first therapy session was later that day. The assessment was noted to be that of one-week status post right knee arthroscopy, partial medial meniscectomy, loose body removal, and microfracture chondroplasty medial femoral condyle, as well as continued left medial knee pain. It was noted that Petitioner was to consider an MRI if the pain persisted. Petitioner was recommended to return in one month. (PX13).

The records of McLean County Orthopedics reflect that Petitioner was seen on October 10, 2017, at which time it was noted that he had continued right knee pain, that he was going over his right knee MRI results that day, and that his pain was rated 4/10 with a constant aching pain. It was noted that Petitioner denied any new symptoms from developing since the last visit, and that he stated the brace was helping with his symptoms. The assessment was noted to be that of right knee traumatic medial meniscus tear. It was noted that Petitioner was recommended to undergo right knee arthroscopy. At the time of the October 3, 2017 visit, it was noted that Petitioner was presenting with right knee pain after falling into a hole at work, hyperextending his knee. It was noted that Petitioner's pain was a constant ache with sharp pains during specific movements, that the pain increased with twisting, walking, knee flexion, sit to stand and stairs, that he was wearing a brace for support, that instability, clicking, popping, and swelling were present in the right knee, and that since both knees buckled, both the right and left were painful. The assessment was noted to be that of right probable medial meniscus tear, possible lateral meniscal tear. Petitioner was recommended to undergo an MRI of the right knee. (PX13).

Included within the records of McLean County Orthopedics was a Work Conditioning Discharge Note dated March 12, 2018, which noted that Petitioner reported that the right knee continued to be more painful than the left, and that he was going to pursue the gel injections into the right knee. It was noted that Petitioner was ready to return to work and thought he would be safe performing duties now, and that he spent the weekend chopping three trees' worth of wood. The FCE dated February 12, 2018 noted that Petitioner gave maximal effort on all test items, and that he had consistent limitations relating to right knee reduced load tolerance, functional weight bearing, extension, gait, standing, lifting, and carrying movement patterns which were consistent with injury and physical exam. It was noted that it was anticipated that Petitioner would meet performance goals with a work conditioning program, and that it was also anticipated that right knee pain would remain present at some level. It was noted that Petitioner performed in the Medium performance level, and that he needed to be performing at the Heavy Level. (PX13).

Additional medical records of McLean County Orthopedics were entered into evidence at the time of arbitration as Petitioner's Exhibit 14. The records primarily related to physical therapy visits. The records reflect that Petitioner was seen on October 25, 2019, at which time it was noted that he was 16.5 weeks status post right total knee arthroplasty, that he stated that he had continued pain in the right knee aggravated by increased activity, and that he noted continued swelling. It was noted that Petitioner had been discharged from physical therapy and work hardening. It was further noted that Petitioner was to continue full duty work and to follow-up in two months. At the time of the September 25, 2019 visit, it was noted that Petitioner was 12.5 weeks status post right total knee arthroplasty, that he stated that his pain and range of motion had improved since his last visit, that he noted physical therapy was helping but reported mild pain/soreness after a vigorous physical therapy session, and that he was taking Naproxen, Tramadol, and Norco for pain. It was noted that Petitioner noted popping in his right knee. Petitioner was issued work restrictions and was recommended to return to work on October 15th full duty. It was noted that when Petitioner's Norco 5s were gone, he was to step down to T3, Tramadol, or 800 mg Ibuprofen four times per day. Petitioner was recommended to follow-up in four weeks. (PX14).

The records of McLean County Orthopedics reflect that Petitioner was seen on September 4, 2019, at which time it was noted that he was 9.5 weeks status post right total knee arthroplasty, that he was doing well and reported continued improvements with therapy, that he noted starting work conditioning earlier that day at therapy and reported moderate soreness following exercises, and that he continued to take post-op pain medications which he was trying to wean off of by the end of the month. Petitioner was issued work restrictions and was recommended to follow-up in three weeks. At the time of the July 30, 2019 visit, it was noted that Petitioner was six weeks post-op and was currently in physical therapy. It was noted that x-rays of the right knee showed the components in excellent alignment and no signs of early loosening or failure. Petitioner was recommended to continue physical therapy and follow-up in one month. At the time of the July 1, 2019 visit, it was noted that Petitioner was two weeks status post right total knee arthroplasty and that he reported moderate pain/soreness since surgery that was not very well controlled with post-op pain medication. It was noted that Petitioner stated that he could not find a comfortable position during the day or at night to sleep, that he noted intermittent popping with range of motion and ambulation, and that he was ambulating with a cane for assistance. It was noted that Petitioner's incision was healing well without signs of infection. Petitioner was given a prescription for Percocet and was recommended to begin physical therapy. Petitioner was recommended to follow-up in one month. (PX14).

The records of McLean County Orthopedics reflect that Petitioner was seen on May 15, 2019, at which time it was noted that he returned for follow-up evaluation of his right knee. It was noted that Petitioner stated that conservative options had offered no relief and that he recently had a second opinion that was in agreement that he should discuss total knee arthroplasty of the right side. The assessment was noted to be that of right knee severe post-traumatic osteoarthritis. Petitioner was recommended to undergo a right total knee arthroplasty. At the time of the October 17, 2018 visit, it was noted that Petitioner had continued right knee pain and swelling that was now traveling down to his ankle, that he was given a steroid injection on August 2, 2018 and a Durolane on March 15, 2018, and that he was also status post right knee arthroscopy on October 31, 2018 [*sic*] as the result of a work injury and now suffered from moderate-severe post-traumatic osteoarthritis. It was noted that Petitioner stated that in the last 3-4 weeks he had had increased knee pain which he was attributing to the change in weather, that his symptoms were aggravated with sitting long periods, sit to stand and with ambulation, and that he continued to take Tramadol for pain control. The assessment was noted to be that of right knee severe post-traumatic osteoarthritis. Petitioner was recommended to continue Tramadol and Norco sparingly, and it was noted that he was awaiting right total knee arthroplasty. (PX14).

The records of McLean County Orthopedics reflect that Petitioner was seen on August 15, 2018, at which time it was noted that he presented with continued right knee pain and swelling, and that he received an injection on August 2, 2018 and noted no relief. It was noted that Petitioner had had no new

injury since his last office visit. The assessment was noted to be that of 10 months status post right knee scope with moderate-severe post-traumatic osteoarthritis, advanced since last x-ray. It was noted that Petitioner was recommended to undergo a right total knee arthroplasty. (PX14).

Additional medical records of McLean County Orthopedics were entered into evidence at the time of arbitration as Petitioner's Exhibit 15. The records reflect that Petitioner was seen on February 12, 2020, at which time it was noted that he presented eight months status post right total knee arthroplasty, that he stated that he had continued pain in the right knee aggravated by increased activity, and that he noted continued swelling. It was further noted that Petitioner stated that he had trouble with standing for long periods of time. The assessment was noted to be that of eight months status post right total knee arthroplasty with persistent pain. It was noted that Petitioner was recommended right knee arthroscopy with extensive synovectomy/debridement. At the time of the December 19, 2019 visit, it was noted that Petitioner presented six months status post right total knee arthroplasty, that he stated that he had continued pain in the right knee aggravated by increased activity, and that he noted continued swelling. It was noted that Petitioner stated that he had trouble with standing for long periods of time. The assessment was noted to be that of six months status post right total knee arthroplasty. It was noted that Petitioner was to continue to work full duty and was to undergo labs to rule out infection of the total knee arthroplasty. Petitioner was recommended to follow-up in two months. (PX15).

Additional medical records of McLean County Orthopedics were entered into evidence at the time of arbitration as Petitioner's Exhibit 16. The records reflect that Petitioner was seen on May 1, 2020 by Dr. Naour, at which time it was noted that he presented for follow-up on low back and right knee pain, and to review a recent MRI. It was noted that Petitioner stated that his right knee pain had improved since the last office visit. It was noted that Petitioner presented for potential genicular nerve block for right knee pain, that he stated that on that date he did not feel that he was having significant pain particularly after he began his Gabapentin, and that he also did not feel the swelling was significant. It was noted that Petitioner's lumbar MRI from April 27, 2020 revealed surgical changes indicative of a two-level hemilaminectomy, that they discussed that his low back may be more of a consequence of facet disease, and that they discussed medial branch blocks for diagnostic purposes. It was noted that Petitioner would consider this but seemed to be doing quite well and was not interested in any interventional care at that time. It was further noted that Petitioner was to continue his home exercise plan and would follow-up in two months to be certain that he was doing well, particularly even the medication change. The assessment was noted to be that of low back pain, right knee pain, history of total knee arthroplasty, and lumbosacral spondylosis without myelopathy. (PX16).

The records of McLean County Orthopedics reflect that Petitioner was seen on April 28, 2020 by Dr. Naour, at which time it was noted that he presented via Telehealth for follow-up on low back pain and to review his recent MRI. It was noted that Petitioner had not noticed significant change in his symptoms since the last visit, noting that he only began taking Gabapentin the day before. It was further noted that Petitioner underwent a right total knee arthroplasty by Dr. Hanson on June 18, 2019 due to blunt force trauma by a car related to a work accident, that his history of low back pain began when a pedestrian versus car accident in which he was the pedestrian in 2006, and that he complained on that date of low back pain that radiated into the right lower extremity along the antero-medial aspect of the leg along an L3-L4 dermatomal distribution. It was noted that Petitioner also noted significant tenderness and achiness along the medial aspect of the right knee and anterior aspect of the lower leg, and that he noted discomfort with extension of the knee. It was noted that Petitioner noted that he had functional mobility of his knee but with significant pain and that it was "noisy," that he noted frequent swelling of the right lower extremity, and that he noted difficulty with bending longer than five minutes and house/yard work. It was noted that Petitioner wore knee pads with kneeling activities with some benefit, and that he continued to work as a highway maintainer for the State of Illinois, walking up to 15,000 steps per day. It was noted that they

discussed the option of restarting Gabapentin titration as well as a lumbar MRI for likely radicular component of pain, and that they discussed planning a genicular nerve block. (PX16).

The records of McLean County Orthopedics reflect that Petitioner was seen on April 16, 2020 by APN Fader, at which time he was given a referral to see Dr. Naour for persistent pain to the right knee. It was noted that Petitioner presented with his wife for a long history of low back pain and right knee pain, that he was previously treated by Dr. Naour in 2015 for back pain, that he underwent a right total knee arthroplasty by Dr. Hanson on June 18, 2019 due to blunt force trauma by a car related to a work accident, and that his history of low back pain began when a pedestrian versus car accident in which he was the pedestrian occurred in 2006. It was noted that Petitioner complained on that date of low back pain that radiated into the right lower extremity along the antero-medial aspect of the leg along an L3-L4 dermatomal distribution, that he also noted significant tenderness and achiness along the medial aspect of the right knee and anterior aspect of the lower leg, and that he noted discomfort with extension of the knee. It was noted that Petitioner noted that he had functional mobility of his knee but with significant pain, and that it was "noisy." It was noted that Petitioner noted frequent swelling of the right lower extremity, that he noted difficulty with bending longer than five minutes and house/yard work, and that he wore knee pads with kneeling activities with some benefit. It was noted that Petitioner continued work as a highway maintainer for the State of Illinois walking up to 15,000 steps per day. Petitioner was recommended to undergo a lumbar MRI and a trial of Gabapentin, and to consider a right knee genicular nerve block. The assessment was noted to be that of history of arthroplasty of the right knee, low back pain, pain in right knee, and lumbar radiculopathy. (PX16).

The IME Report of Dr. Verma dated July 24, 2020 was entered into evidence at the time of arbitration as Petitioner's Exhibit 17. The report reflects that a repeat IME was performed in regard to the right knee. It was noted that Petitioner noted that he had persistent pain in the knee, that he had ongoing swelling, that he had difficulty with prolonged weightbearing or standing, and that he took Tramadol up to four times per day. It was further noted that Petitioner stated that he was evaluated for his back but did not feel the pain was coming from his back, and that he had been recommended a possible revision. (PX17).

The report reflects that Dr. Verma opined that the diagnosis was persistent pain and swelling status post right total knee arthroplasty, that the treatment to date appeared reasonable and necessary as to the right knee, that the nature of Petitioner's ongoing swelling was unclear and that it was prudent to rule out ongoing infection, and that he would recommend an aspiration of the right knee sent for cultures along with a bone scan. It was noted that if the diagnostic work-up was negative, then proceeding with an arthroscopy and debridement with intra-operative tissue biopsy would be appropriate. It was further noted that Dr. Verma opined that the additional treatment was necessary, that the prognosis was fair, that the nature of Petitioner's continuing pain and swelling was unclear and atypical at this time following knee replacement, and that it may be prudent to consider a second opinion evaluation by a joint replacement specialist. (PX17).

The report reflects that Dr. Verma further opined that Petitioner had not reached maximum medical improvement pending the further diagnostics and work-up as indicated, that it was unclear at that time as to whether he would reach maximum medical improvement within 60 days, and that maximum medical improvement was dependent on further diagnostic work-up as indicated. It was also noted that Dr. Verma further opined that Petitioner could continue to work full duty pending further treatment. (PX17).

The Three Phase Bone Scan dated September 2, 2020 was entered into evidence at the time of arbitration as Petitioner's Exhibit 18. The records reflect that Petitioner underwent three phase nuclear medicine bone scan on September 2, 2020, which was interpreted as revealing expected uptake in the distal femur and proximal tibia adjacent to prosthesis one year following placement; no scintigraphic evidence of loosening or infection. (PX18).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 19. The Orthopedic Rehabilitation Supply, LLC Patient Proof of Delivery Ticket was entered into evidence at the time of arbitration as Petitioner's Exhibit 20.

The Wage Statement was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The Payment Ledger was entered into evidence at the time of arbitration as Respondent's Exhibit 2.

CONCLUSIONS OF LAW

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

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

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner was employed as a highway maintainer at the time of the accident at issue and that he continues to hold this position with Respondent as of the date of arbitration. The Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 54 years old on his date of accident. Given the age of Petitioner and the fact that the medical records lack any reference to his having been placed under any permanent restrictions, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he continues to be employed by Respondent as a highway maintainer. As there was no direct evidence of reduced earning capacity contained in the record, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that since his accident on September 18, 2017, he has continued to have pain in both of his knees on a daily basis. Petitioner testified that he experiences increased bilateral knee pain while performing some of his work activities, that the cab of the truck he drives for IDOT is high and that it has three steps to get in and out, that his left leg is stronger than his right and that he leads with his right foot coming down. Petitioner testified that he used to be able to climb foot over foot up and down stairs, but that he now climbs one leg at a time. Petitioner testified that when he sits in his IDOT truck his knees stiffen and that he has trouble bending his knees if he sits for any length of time. Petitioner testified that some days were worse than others and that it depended upon what he did at work. Petitioner testified that if he is walking up and down hills with rough terrain at work, he experiences increased discomfort in both of his knees. Petitioner testified that after a day of weed eating at work, his right knee swells up and that he goes home to ice both knees. Petitioner testified that the right knee is far worse than the left, but that he experiences swelling in both knees. Petitioner testified that he takes Tramadol daily for the pain and that he also takes Naproxen or Ibuprofen. Petitioner testified that weather affects his knees, but that it affects the pain in the right knee the most. Petitioner testified that his right knee pops when he walks and that his right knee is hotter to the

touch than his left. Petitioner further testified that he wears compression hoses on both legs for swelling on occasion. At the time of the May 1, 2020 visit with Dr. Naour, it was noted that Petitioner presented for follow-up on low back and right knee pain, and to review a recent MRI. It was noted that Petitioner stated that his right knee pain had improved since the last office visit. It was noted that Petitioner presented for potential genicular nerve block for right knee pain, that he stated that on that date he did not feel that he was having significant pain particularly after he began his Gabapentin, and that he also did not feel the swelling was significant. (PX16). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and limitations, was only somewhat corroborated by his treating records. The Arbitrator accordingly places lesser weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of **45% loss of use of the right leg and 17.5% loss of use of the left leg** as provided in Section 8(e) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC000553
Case Name	BETTES, LAMONT v. ALL TRUCK TRANSPORTATION CO INC
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0279
Number of Pages of Decision	33
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Jose Rivero
Respondent Attorney	Brad Antonacci

DATE FILED: 6/9/2021

/s/Marc Parker, Commissioner

Signature

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

Lamont Bettes,

Petitioner,

vs. NO: 16 WC 553

All Truck Transportation Co., Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 20, 2019, 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.

June 9, 2021

/s/ *Marc Parker*
Marc Parker

MP:yl
o 6/3/218

/s/ *Barbara N. Flores*
Barbara N. Flores

/s/ *Christopher A. Harris*
Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0279
NOTICE OF ARBITRATOR DECISION

BETTES, LAMONT Case# **16WC000553**
Employee/Petitioner

ALL TRUCK TRANSPORTATION COMPANY INC
Employer/Respondent

On 12/20/2019, 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 1.55% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0147 CULLEN HASKINS NICHOLSON ET AL
JOSE M RIVERO
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

6205 HEYL ROYSTER VOELKER & ALLEN
BRAD ANTONACCI
33 N DEARBORN ST SUITE 7
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

LAMONT BETTES
Employee/Petitioner

v.

ALL TRUCK TRANSPORTATION COMPANY, INC.
Employer/Respondent

Case # **16** WC **553**

Consolidated cases: **D/N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **10/10/2019**. 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 **11/03/2015**, 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 established causation as to his cervical spine condition and the need for the three-level fusion performed in August 2016. Petitioner also established causation as to a lumbar spine condition that required surgery, per Dr. Sweeney, with Petitioner declining this option. Petitioner also established causation as to a right shoulder condition that required MRI imaging and conservative care.

In the year preceding the injury, Petitioner earned $**62,534.16**; the average weekly wage was $**1,202.58**.

On the date of accident, Petitioner was **56** years of age, ***married*** with **0** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

Respondent ***has in part*** paid appropriate charges for reasonable and necessary medical services. RX 7.

Respondent shall be given a credit of $**27,831.13** for TTD, $**10,666.99** for TPD, $**0.00** for maintenance, $**8,954.48** for a PPD advance, and $**85,850.30** for medical benefits, for a total credit of $**133,302.90**.

Respondent is entitled to a credit of $**16,563.40** under Section 8(j) of the Act.

ORDER

Medical benefits

Respondent shall pay the following reasonable and necessary medical expenses, subject to the fee schedule and with Respondent receiving credit for any payments reflected in RX 7: 1) Advocate Christ Medical Center, 11/3/15 and 11/4/15, $3,288.00; 2) Dr. Sweeney, $620.00; 3) Dr. Primus, 11/7/17, $909.00; 4) Tinley Park Open MRI, 10/31/16, $2,700.00 (PX 8); and 5) ATI, the expenses associated with the therapy Petitioner underwent between June 14 and June 19, 2017. See the attached decision for further details.

Temporary Total Disability

In addition to the temporary total disability benefits already paid to Petitioner (Arb Exh 1), Respondent shall pay benefits at the rate of $801.72/week from March 20, 2017 through the functional capacity evaluation of April 23, 2018. The Arbitrator finds that Petitioner reached maximum medical improvement as of April 23, 2018.

Permanent Partial Disability with 8.1b language (For injuries after 9/1/11)

Based on the factors as noted in Section 8.1b(b), and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of **45%** loss of use of **person-as-a-whole** pursuant to §**8(d)2** of the Act. Respondent is entitled to a credit of $**8,954.48** for a PPD advance paid prior to trial.

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

12/20/19
Date

Lamont Bettes v. All Truck Transportation Company, Inc.
16 WC 553

Summary of Disputed Issues

The parties agree that Petitioner, a 56-year-old truck driver and spotter, sustained an accident while working for Respondent on November 3, 2015. Petitioner testified he was using a hook to release a tandem pin when the hook gave way, causing him to fall backward. He landed on a concrete surface. His hat and glasses flew off. He worked for about three hours after the accident but began noticing neck pain when looking up. He sought Emergency Room care that day, with personnel noting complaints of neck pain radiating toward the shoulders. The Emergency Room records reflect that Petitioner denied back pain. The following day, Petitioner's own physician diagnosed a "back strain." Petitioner then began a course of treatment at Physicians Immediate Care, a medical facility of Respondent's selection. On November 6, 2015, Dr. Strange of Physicians Immediate Care noted that Petitioner was complaining of low back stiffness as well as neck pain. In mid-November 2015, a physician's assistant at the same facility noted that Petitioner was "still" complaining of his neck, back and shoulders. In late January 2016, she ordered a lumbar as well as a cervical spine MRI. Only the cervical spine MRI was authorized at that time. In April 2016, Petitioner began seeing Dr. Sweeney. This physician performed a three-level cervical fusion on August 9, 2016. After the lumbar spine MRI was performed, in late October 2016, Dr. Sweeney recommended lumbar spine surgery, which Petitioner declined. On November 7, 2017, Petitioner saw Dr. Primus for his right shoulder, with that physician recommending therapy.

Petitioner accepted Respondent's offer of "temporary alternative modified duty" at a Salvation Army thrift store between late November 2015 and the August 2016 cervical fusion. He testified that some of the lifting he was required to perform at this store exceeded his restrictions. Following the fusion, he remained off work. Respondent paid him temporary total disability benefits between August 8, 2016 and March 19, 2017, at which point he declined an offer of light duty at another not-for-profit called "Hearts in Motion." A functional capacity evaluation performed on April 23, 2018 showed he was capable of full-time sedentary work. As of the hearing, he had been receiving Social Security disability benefits for a year or two. He never conducted a job search.

Respondent's Section 12 examiner, Dr. Hennessy, linked only the cervical spine condition to the work accident. He agreed with the need for the three-level fusion. In his last report, he found Petitioner capable of full duty. RX 4.

Lisa Helma, CRC, a vocational counselor retained by Petitioner, opined that Petitioner lost access to his usual and customary occupation and was totally disabled. Respondent did not perform a vocational assessment or offer any vocational opinion.

The disputed issues include causal connection, medical expenses, temporary total disability from November 6, 2015 through April 23, 2018 and nature and extent. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified he began working for Respondent in approximately 2000. He worked as a driver, operating an 18-wheel International tractor and trailer, and as a spotter, operating a smaller truck with hydraulics known as a "yard jockey." By 2015, he was working only as a spotter. T. 43.

Petitioner testified he typically did not perform lifting when working as a driver but sometimes had to go into the back of the truck and reposition bundles of corrugated boxes that had shifted during travel. He testified each bundle weighed a couple hundred pounds. T. 45. He had to move the bundles on his own. He performed no loading when working as a spotter but, if he was not operating a hydraulically operated vehicle, he had to periodically get out and manually crank a handle to move dolly legs. T. 44, 47-48. The spotter job did not require him to load or unload. T. 48-49.

Petitioner testified he was working as a spotter at the time of the November 3, 2015 accident. A driver came in with an empty trailer. The trailer needed to be put in the dock. T. 49. Because the dock was slanted, the "tandems," or back wheels of the trailer, had to be positioned in such a way that the trailer would stay up. Petitioner testified he was using a hook to release a tandem pin that was rusty and stuck. The pin was a couple inches in diameter. He was using all his weight to pull back and release the pin when the hook gave way. When the hook slipped off, he fell backward, landing on his back on concrete. He testified the force was sufficient to cause his hat and glasses to fly off. He denied hitting his head. T. 51-52. The truck driver came to his aid and helped him get up. He felt "a little stunned" and realized his glasses had flown off. He resumed working but, over the next three hours, he began experiencing worsening neck pain. He would notice this pain when he looked up at trailer doors to make sure the latches were closed. He realized he needed medical attention and notified the shipping and safety supervisors. T. 53.

Petitioner went to the Emergency Room at Advocate Christ Medical Center the same day. T. 54. He reported falling backward at work earlier that evening. Hospital personnel recorded the following history:

> "Pt states was helping a fellow trucker and while pulling on some equipment handle, it gave way and caused him to lose his balance, falling backwards. denies loc but c/o neck with radiation towards his shoulders."

PX 1, p. 39. Hospital personnel also noted that Petitioner denied any injury to his head or back. PX 1, p. 3. The examining physician, Dr. Htet, noted restricted motion with neck flexion. She placed Petitioner in a cervical collar and ordered a cervical spine CT scan. The scan, performed without contrast, showed multi-level degenerative changes and no acute bony abnormality. PX

1, p. 30. At discharge, Petitioner was given Ibuprofen and Tramadol for pain and directed to follow up with his primary care physician. PX 1, pp. 5-6. [Also see RX 14.]

Petitioner saw his primary physician, Dr. Oladeinde, the following day, November 4, 2015. T. 54. The doctor described Petitioner as an established patient who he was seeing for ongoing hypertension and diabetes management as well as follow-up from the Emergency Room. He noted that Petitioner had been diagnosed with a cervical sprain at the Emergency Room. He described Petitioner's gait as normal. On examination, he noted tenderness on palpation of the upper back. He diagnosed a "back strain" secondary to the work fall. He directed Petitioner to continue taking the prescribed Ibuprofen and Tramadol, apply warm compresses and follow up in one month. PX 2, pp. 7-10.

On November 6, 2015, Petitioner began a course of treatment at Physicians Immediate Care. Petitioner testified that Respondent sent him to this facility. Dr. Strange recorded a consistent history of the work fall and subsequent Emergency Room care. He noted that Petitioner complained of 5/10 pain "primarily in the lower cervical and thoracic areas." He also indicated that Petitioner "feels stiff in the lower back with minimal pain." He noted that Petitioner "had no similar problems in the past." On examination, he noted a reduced range of lumbar spine motion, spasm of the cervical and thoracic muscles and neck stiffness. He described Petitioner as wearing a neck brace. He diagnosed a thoracic strain and low back pain. He directed Petitioner to continue wearing the brace and take Acetaminophen. He imposed restrictions of no bending, twisting, climbing or lifting over 30 pounds above shoulder level. PX 3, pp. 2-5.

Petitioner returned to Physicians Immediate Care on November 11, 2015 and saw a physician's assistant, Angela Blagojevski, PA-C. Blagojevski noted that Petitioner described his neck and thoracic pain as improved but complained of neck stiffness. She recommended that Petitioner apply ice and Icy/Hot cream and take Tylenol ES and Ibuprofen for pain. She released Petitioner to light duty with no prolonged bending or twisting, no lifting over 30 pounds above shoulder level and no pushing or pulling over 30 pounds. She directed Petitioner to return on November 17, 2015. PX 3, pp. 15-18.

Petitioner returned to Physicians Immediate Care on November 17, 2015 and again saw Blagojevski. Blagojevski noted that Petitioner reported improvement of his pain and range of motion but "still [complained of] limited neck ROM, shoulders and upper back with minimal pain." She also noted that Petitioner complained of occasional stiffness in his upper and lower back in the morning. She continued the previous restrictions and directed Petitioner to return on November 30, 2015. PX 3, pp. 27-30.

Petitioner testified that, in late November 2015, he began working 40 hours per week at a Salvation Army resale store, at Respondent's direction. His duties included sorting and hanging clothes, cleaning debris from the parking lot and sorting and moving appliances and televisions. He testified he did whatever his supervisor directed him to do, with the goal of

avoiding pain. He had co-workers but they did not assist him with lifting heavier items. T. 57-59.

Respondent offered into evidence a document Petitioner signed on November 23, 2015, accepting a temporary alternative modified work assignment at a Salvation Army thrift store in Chicago, Heights, Illinois. The document contains language indicating that Petitioner agreed to not perform duties outside his restrictions. It also contains language indicating that Petitioner would remain a Respondent employee while performing the assignment. RX 13.

On November 30, 2015, Petitioner complained to Blagojevski of 2/10 right-sided neck stiffness, slight low back stiffness and "slight R shoulder/neck pain." He reported "working at a light duty job at Salvation Army set up by his job." He indicated he was "required to be on his feet all day there," indicating this seemed to make his neck and low back "slightly worse." PX 3, pp. 39-42. Blagojevski prescribed physical therapy for "neck and low back muscle strain" and added a restriction of no prolonged standing. PX 3, pp. 41, 51-52.

Petitioner underwent an initial therapy evaluation at PTSR on December 7, 2015. The evaluating therapist noted a consistent history of the work accident and a complaint of "pain in bilateral cervical paraspinals from C6 to C7 and in bilateral upper trapezius muscles." The therapist also noted that Petitioner was currently performing a restricted job "which involves prolonged standing which seems to increase his symptoms." PX 3, p. 56.

On December 14, 2015, Petitioner returned to Physicians Immediate Care and complained of "a lot of stiffness in lower back" and spasm in the right shoulder and neck. PX 3, p. 57. Blagojevski added the following restriction: "please allow to sit every 2 hours for 15 minutes at a time." PX 3, p. 59.

A physical therapy progress note dated December 28, 2015 reflects that Petitioner reported improvement but "continued difficulty with prolonged sitting and standing as well as sleep disruption and difficulty lying supine for sleep." PX 3, p. 83.

On December 30, 2015, Petitioner returned to Physicians Immediate Care. He reported some improvement of his pain secondary to therapy but indicated his pain was exacerbated by "a lot of standing on the floors at Salvation Army stocking racks/shelves." Dr. Strange recommended continued therapy. PX 3, pp. 68-72. On January 13, 2016, Petitioner reported having missed his last two therapy sessions due to lack of a prescription. He reported an improved range of motion in his neck but complained of pain in his back with prolonged standing. The note also mentions that Petitioner was "following up on lower back and right shoulder injury." PX 3, p. 86. On January 28, 2016, Petitioner again reported that he had not restarted physical therapy "because PT did not receive an rx." He reported improved neck pain but "no improvement in the shoulder or back pain." PX 3, p. 97. Blagojevski prescribed cervical and lumbar spine MRIs, indicating she wanted to review the MRI results before extending therapy. PX 3, p. 99.

On January 22, 2016, Respondent wrote to Petitioner, offering him a "temporary alternative modified work assignment" at a Salvation Army thrift store on North Halsted in Chicago Heights, Illinois, beginning February 1, 2016.

Petitioner underwent the recommended cervical spine MRI on February 3, 2016. The history section of the report states: "neck pain extending to the right shoulder." The MRI, performed without contrast, showed "marked developmental spinal stenosis with moderate, superimposed degenerative spondylosis, including prominent broad-based disc abnormalities at C4-C5, C5-C6 and C6-C7. The radiologist described the stenosis as "most pronounced at C5-C6, "where it is moderate to severe." PX 3, pp. 119-120.

On February 10, 2016, Petitioner informed Blagojevski he had undergone the cervical spine MRI but "was unable to have MRI of low back" due to lack of approval. He complained of a limited neck range of motion and pain and stiffness in his lower back and shoulder. Blagojevski indicated she was awaiting the results of the cervical spine MRI. PX 3, p. 108. On February 16, 2016, Blagojevski noted that Petitioner reported no change and "still complains of intermittent mild R arm numbness" and neck stiffness. After reviewing the MRI results with Petitioner, Blagojevski prescribed Prednisone and referred Petitioner to a neurosurgeon "for severe neural foraminal narrowing and central disc extrusion." PX 3, pp. 122-126, 133-134.

There is no evidence indicating Petitioner returned to Physicians Immediate Care after February 16, 2016.

At Respondent's request, Petitioner underwent an examination by Dr. Hennessy, an orthopedic surgeon, on April 4, 2016. In his report of April 11, 2016, Dr. Hennessy indicated he reviewed an Illinois Form 45, an accident report, an Emergency Room discharge instructions sheet, Physicians Immediate Care records, therapy records and the cervical spine MRI report and images in connection with his examination.

Dr. Hennessy noted that Petitioner denied having cervical, thoracic or lumbar pain or radicular symptoms prior to the accident. He also noted that Petitioner reported being off work for two weeks after the accident and then being sent to a Salvation Army store where he sorted clothes, measured pants and tagged items. He indicated that Petitioner was still working at this store.

Dr. Hennessy noted complaints of pain at the base of the neck going to the interscapular region centrally, some right-sided trapezial pain which occasionally extended down his arm to his fingers and an occasional feeling of right arm weakness. He indicated that Petitioner denied left arm, left neck and left trapezius complaints. He also noted complaints of non-radiating interscapular pain and lumbosacral pain. He described Petitioner as right-handed.

Dr. Hennessy described Petitioner as "pleasant and cooperative throughout the entire visit." He did not note any pain behavior. He described Petitioner as being able to walk on his toes and heels and squat more than halfway. He described straight leg raising as negative

bilaterally. He described his bilateral shoulder examination as "benign bilaterally." He noted 5/5 rotator cuff strength bilaterally. He noted slightly decreased cervical and lumbar motion as well as slight right greater trochanter pain.

Dr. Hennessy described the February 3, 2016 cervical spine MRI as a "good quality study." He noted a central protrusion at C4-C5 causing some mild central and foraminal stenosis, a large right herniation at C5-C6 causing moderate stenosis and marked right foraminal stenosis, with some narrowing on the left side as well, and degenerative bulging and osteophytes at C6-C7.

Dr. Hennessy diagnosed "cervical degenerative disc disease with superimposed cervical strain, thoracic strain and lumbar strain" secondary to the work accident. He found the reported mechanism of injury to be a competent cause of the strains. He opined that the disc disease "clearly predated the accident but reportedly was asymptomatic prior to the accident." He noted that "no medical records refuted that statement." He opined that the underlying cervical degenerative disc disease at C5-C6 and C6-C7 "was made symptomatic by the accident." He noted that Petitioner "did have right shoulder complaints mentioned by the Physicians Urgent Care providers, although radiculopathy itself was not specifically mentioned." He found no evidence of thoracic or lumbar radiculopathy or intrinsic shoulder complaints. He indicated that the aggravation of disc disease would "still be considered temporary" but would be considered an aggravation six months after the accident. He found it appropriate for Petitioner to undergo an orthopedic spinal surgery consultation for his cervical spine but opined that Petitioner required no additional thoracic or lumbar spine treatment. He found that Petitioner reached maximum medical improvement for his thoracic and lumbar strains as of January 13, 2016, "after he completed a short course of physical therapy." He found that Petitioner was not at maximum medical improvement with respect to his cervical spine and required "further surgical consultation." He found Petitioner capable of full duty with respect to his thoracic and lumbar spine but in need of his current restrictions of no overhead work and no lifting over 30 pounds for his cervical spine. RX 1.

Petitioner began a course of treatment with Dr. Sweeney, a spine surgeon, on April 21, 2016. A "workers' compensation information" sheet bearing that date reflects that, on April 15, 2016, Heather Kimbro, R.N., a nurse case manager, relayed approval for an evaluation, via adjuster Kathryn Potter of CBCS Claims. PX 4, p. 295. A pain diagram dated April 21, 2016 documents complaints of pain in the right shoulder, thoracic area, low back and right leg along with numbness in the right lower leg. PX 4, p. 276.

Dr. Sweeney's initial note of April 21, 2016 sets forth a consistent history of the work accident and subsequent care. The doctor noted that Petitioner denied any pre-accident spine problems. He also noted that Petitioner denied improvement secondary to the therapy he underwent in November and December 2015. He indicated that Petitioner was still participating in a work program at a Salvation Army outlet and that Petitioner described having to perform tasks beyond his restrictions there.

Dr. Hennessy issued an addendum on June 7, 2016. He indicated he did not interview or re-examine Petitioner in connection with the addendum. He noted he reviewed his original report and Dr. Sweeney's initial note of April 21, 2016. He agreed with Dr. Sweeney's recommendation of a cervical fusion from C4 through C7. He noted that, while there was only mild stenosis at C4-C5, "it would not be unreasonable to include that level in a fusion construct, as that level already had moderate degeneration and stenosis." RX 2.

Dr. Sweeney operated on August 9, 2016, performing a C4-C7 anterior cervical discectomy and fusion with insertion of a plate, cage and screws. PX 5, pp. 10-12. Petitioner was discharged from the hospital the following day.

On September 22, 2016, Dr. Sweeney noted that Petitioner was continuing to wear a cervical collar and use a bone growth stimulator. He noted complaints of neck pain radiating into the right shoulder and upper back and "continued constant" low back pain. He indicated that Petitioner's left leg complaints had "returned." He obtained cervical spine X-rays, which showed good positioning of the surgical hardware. He recommended that Petitioner remain off work and return in one month. PX 4, pp. 174-176.

At the next visit, on October 20, 2016, Dr. Sweeney noted complaints of 3/10 neck pain radiating into the right shoulder, 6/10 right shoulder pain and 6/10 lower back pain. He also noted that Petitioner reported numbness in his left leg. He prescribed MRI scans of the lumbar spine and right shoulder. He directed Petitioner to remain off work. PX 4, pp. 171-173.

The right shoulder MRI, performed without contrast on October 31, 2016, showed supraspinatus insertional tendinosis, no rotator cuff tears and prominent acromioclavicular joint arthropathy with inferior spurring distorting the supraspinatus myotendinous junction. The interpreting radiologist indicated that the glenoid labrum and biceps tendon appeared to be intact. PX 4, pp. 215-216. PX 8, pp. 4-5. The lumbar spine MRI, performed without contrast the same day, showed "lumbar spondylosis with significant annular disc bulging, most severe from L4-S1 contributing to significant bilateral neural foraminal stenosis." PX 8, pp. 2-3.

On November 17, 2016, Dr. Sweeney discussed the MRI results with Petitioner. He indicated he saw a rotator cuff tear on the right shoulder MRI but acknowledged the radiologist did not see this. He also noted that the right shoulder MRI showed severe acromioclavicular arthritis. He agreed with the radiologist's reading of the lumbar spine MRI. He recommended a trial of physical therapy for both the right shoulder and the lumbar spine. He directed Petitioner to remain off work. PX 4, pp. 168-170.

On December 15, 2016, Dr. Sweeney noted that Petitioner was still experiencing low back and left leg complaints but did not want to proceed with lumbar spine surgery. He also noted that Petitioner reported some progress following his cervical fusion. Petitioner reported some ongoing neck pain at night and some difficulty looking up, down and to the left and right. Petitioner requested a Norco refill. Cervical spine X-rays showed early signs of healing. The

doctor directed Petitioner to remain off work and to see Dr. Primus to evaluate his right shoulder complaints. PX 4, p. 264.

Petitioner underwent physical therapy at ATI between February 16, 2017 and April 17, 2017. The therapy notes reflect complaints of some neck stiffness and increasing right shoulder pain and dysfunction. The discharge summary of April 17, 2017 reflects that Petitioner described his neck as "about as good as it's going to get." The discharge summary also reflects complaints of low back pain and significant right shoulder pain and weakness. PX 9, p. 60.

Petitioner testified that, following his cervical spine surgery, he received temporary total disability benefits through March 19, 2017. T. 57. Petitioner acknowledged that, in March 2017, Respondent offered him alternative light duty at another thrift store [Hearts in Motion in Schererville, Indiana] beginning March 30, 2017. RX 9. PX 10. He declined this offer. Dr. Sweeney still had him off work at this point. T. 59-60.

Lisa Helma, CRC, a certified rehabilitation counselor, conducted an interview of Petitioner at the offices of her then employer, Vocamotive, on June 12, 2017. In her report of July 12, 2017 (PX 10), Helma noted that Petitioner reported graduating from Curie High School in Chicago in 1977 and studying merchandising and marketing at Daley College between 1978 and 1979. Helma indicated that Petitioner reported working in various capacities at Jewel between 1975 and 1988 and as a food representative for PMI between 1989 and 1995. Helma also noted that Petitioner acknowledged undergoing training at work as to how to operate the computer in his truck.

On June 1, 2017, Dr. Sweeney prescribed four more weeks of physical therapy for Petitioner's post-operative cervical spine condition. PX 9, p. 38.

Petitioner underwent a physical therapy evaluation at ATI on June 14, 2017. The itemized ATI bill reflects he attended therapy thereafter on June 15, 16, 19, 21, 22 and 26, 2017. PX 9.

Telephone message notes in the ATI records reflect that, on June 15, 2017, a nurse case manager called ATI, indicating that the adjuster planned to send the therapy prescription to "UR" and that both she and the adjuster were "a bit confused on why pt is continuing PT." PX 9, p. 49.

Respondent offered into evidence a "Peer Review Final Report" dated June 20, 2017. The reviewer, David Trotter, M.D., who is identified as an orthopedic surgeon, concluded that the additional cervical spine therapy recommended by Dr. Sweeney was not medically indicated per ODG guidelines. The report reflects that a message was left with Dr. Sweeney's assistant, with that individual indicating the doctor was out of the office that day. RX 5.

On June 21, 2017, CBCS Integrated Claims Solutions sent a facsimile to ATI indicating that workers' compensation would not be authorizing additional therapy based on a utilization review determination. PX 9, p. 37.

Petitioner last attended therapy at ATI on June 26, 2017. PX 9, p. 32.

Respondent offered into evidence a "Peer Reviewer Final Report" dated August 7, 2017. In this report, reviewer Jeffrey Middledorf, DC, DO, MS, whose specialty is described as physical medicine and rehabilitation, noted that Petitioner had been discharged from physical therapy as of July 10, 2017, due to "non-compliance." The reviewer supported the therapy "through visit number 11" but did not support the request for twelve more therapy sessions for the neck. He cited ODG guidelines supporting up to 24 therapy sessions following an anterior cervical discectomy and fusion, noting Petitioner had already completed 19 sessions. He indicated that Petitioner could pursue home exercises and would "obviously have some permanent restricted mobility in the cervical spine given the multi-level fusion he underwent." RX 6.

On September 28, 2017, Dr. Sweeney noted that Petitioner remained off work and was still awaiting authorization of right shoulder care. He noted complaints of 5/10 neck pain, 7/10 right shoulder pain and 7/10 low back pain. He recommended that Petitioner remain off work. PX 4, pp. 142-144.

On October 26, 2017, Petitioner returned to Dr. Sweeney and complained of 3/10 neck pain, 6/10 right shoulder pain and 7/10 low back pain. Petitioner reported having seen Dr. Silva at Jackson Park Hospital, with that doctor "recommending physical therapy for frozen shoulder." [No records from Dr. Silva or Jackson Park Hospital are in evidence.] Petitioner also reported taking Norco at least once a day. Dr. Sweeney described his examination findings as unchanged. He refilled Petitioner's medication and directed Petitioner to remain off work. He referred Petitioner to Dr. Primus for his shoulder. PX 4, pp. 139-141.

Petitioner saw Dr. Primus, an orthopedic surgeon, on November 7, 2017. In his note of that date, the doctor indicated he was seeing Petitioner for "right shoulder pain due to a work-related injury 11/3/15." He indicated that Petitioner reported falling "flat onto his back and right shoulder region." He noted that Petitioner was initially diagnosed with a cervical strain "but he kept mentioning his entire right arm was hurting including his shoulder." He also noted that Petitioner reported no relief following a right shoulder injection administered by Dr. Sweeney in June 2017.

Dr. Primus noted no abnormalities on left shoulder examination. On right shoulder examination, he noted no atrophy, positive impingement and Hawkins signs, limited motion, breakaway weakness, mild pain on resisted forward elevation and external rotation and positive Jobe's testing. Dr. Primus interpreted the October 31, 2016 right shoulder MRI as showing "no frank evidence of [rotator cuff] tear but small partial tear at the most lateral aspect of the supraspinatus with clear acromioclavicular joint impingement with inferior

spurring and acromial impingement." He obtained right shoulder X-rays which showed a Type 2 acromion with "large sharp spur" and no fracture.

Dr. Primus addressed causation as follows: "This appears to be right shoulder pain related to his original work related fall as it was documented after the fall that he also had shoulder and right arm pain as well."

Dr. Primus prescribed four to six weeks of right shoulder therapy. He released Petitioner to work with no use of the right arm. He directed Petitioner to return to him in four to six weeks. He indicated he would consider ordering a repeat MRI at that point if Petitioner failed to improve secondary to therapy. PX 7, pp. 1-9.

On November 30, 2017, Dr. Sweeney noted ongoing neck, right shoulder and low back complaints along with a "new low back complaint at the kidney level" of two weeks' duration that Petitioner described as "different" from his usual low back pain. He also noted that Petitioner planned to schedule an appointment with his primary care physician to evaluate this new pain. The doctor recommended that Petitioner remain off work and pursue the right shoulder therapy recommended by Dr. Primus. PX 4, p. 137.

On January 4, 2018, Dr. Sweeney noted that Petitioner had begun experiencing "sharp pain on right side of low back" one month earlier. He noted a history of kidney stones and indicated that Petitioner likened his new complaints with the kind of pain he experienced with kidney stones. He described Petitioner's lumbar complaints as "worse at moment due to new pain being worked up by PCP." He directed Petitioner to remain off work and pursue right shoulder therapy with Dr. Primus. PX 4, pp. 134-136.

On February 15, 2018, Dr. Sweeney noted a "new onset of left leg pain" that worsened with transitioning from sitting to standing. He also noted an upcoming "third IME." PX 4, pp. 130-132.

On March 12, 2018, Dr. Hennessy re-examined Petitioner on behalf of Respondent. In his report of March 22, 2018, the doctor indicated he reviewed numerous records and radiographic images in connection with the re-examination. The doctor noted that, while Petitioner "was fairly certain that he reported cervical pain without radiculopathy, right shoulder pain and low back pain with left leg radiculopathy" to the initial Emergency Room providers, Dr. Oladeinde and the providers at Physicians Immediate Care, "the records from those medical facilities did not correlate with his recollection." The doctor listed the records he reviewed. The Arbitrator notes that this list does not include any treatment records generated between Petitioner's November 6, 2015 visit to Physicians Immediate Care and the cervical spine MRI of February 3, 2016. The doctor concluded that the first time any provider documented a complaint of right shoulder pain was on April 21, 2016, the date of Petitioner's first visit to Dr. Sweeney.

Dr. Hennessy noted that Petitioner described himself as "still only 50% better from the surgery in August 2016" and no better than he was as of the February 2017 examination. He indicated that Petitioner reported improved swallowing but complained of numbness and tingling in his right hand and all of the fingers of that hand, with those symptoms having "returned over the last year." He also noted complaints of "global" right shoulder pain, with occasional popping and feelings of instability, central lumbosacral pain, some right flank pain and occasional numbness and tingling in all ten toes. He noted that Petitioner reported taking Norco once or twice daily for his orthopedic issues.

Dr. Hennessy described Petitioner as "pleasant the entire visit" and "cooperative for the most part, except during the physical examination, where he had diffuse give-way behavior."

On examination, Dr. Hennessy noted 5/5 strength in all four extremities, negative straight leg raising bilaterally and no atrophy to the shoulder girdles. He also noted markedly decreased cervical spine motion in all directions and negative Spurling's. He indicated it was difficult for him to examine Petitioner's right shoulder "secondary to self-restrictions," noting some global acromioclavicular biceps and rotator cuff tenderness. He noted that Petitioner was able to toe and heel walk and could squat more than halfway down and come back up.

Dr. Hennessy interpreted the most recent cervical spine X-rays of August 17, 2017 as showing some slight kyphosis at C6-C7 and a little settling of the disc space at C4-C5. Based on the May 30, 2017 cervical spine CT scan, he agreed with the radiologist and Dr. Sweeney that the C4-C7 fusion had fused solidly and the hardware was in the appropriate position. He interpreted the right shoulder MRI as "essentially normal," noting some mild acromioclavicular osteoarthritis and some distal clavicle edema. He interpreted the lumbar spine MRI as showing some mild bulges at L3-L4, L4-L5 and L5-S1, with "no central stenosis at any level."

Dr. Hennessy indicated that the opinions he had previously expressed concerning the cervical spine were largely unchanged. He did not find the markedly decreased cervical spine motion to be supported by the surgery, noting that a "C4-C7 fusion would typically allow 60-70% range of motion and those lower levels contribute less to head movement than the two upper levels." He described the cervical spine treatment as reasonable and appropriate. He found that, with respect to the cervical spine, Petitioner reached maximum medical improvement and was capable of full duty as of May 30, 2017.

On April 12, 2018, Dr. Sweeney noted that Petitioner had seen his family doctor for "right sided LBP and was diagnosed with sciatica." He also noted a diagnosis of left knee bursitis. He continued to keep Petitioner off work. PX 4, pp. 127-129.

Petitioner underwent a functional capacity evaluation at Ergo Science on April 23, 2018. It is not clear who prescribed this evaluation. The evaluator, Susan Hardin Rocchini, PT, described Petitioner as cooperating fully with the evaluation. She indicated Petitioner self-limited due to increasing low back pain during only one task. She noted that Petitioner reported being unable to use his right upper extremity. She also noted the following ranking:

"the low back gives him the most pain followed by the right shoulder and then the knees followed by the neck." She found Petitioner capable of sustaining a sedentary level of work 40 hours per week, noting the following:

> "Though the driving part of his former job is sedentary, The very limited range of motion of the cervical spine Is of some concern as it may affect safety while driving. Because of the vibratory environment when driving an 18-wheeler, the sitting may aggravate the low back pain as well as the neck pain. He is incapable of lifting, carrying, pushing or pulling more than 18 pounds . . . He is limited in his ability to use the right upper extremity overhead or in tasks requiring reaching away from his body."

Rocchini noted that Petitioner drove to the evaluation and reported regularly driving but complained of having to turn his entire body to look behind him. She described Petitioner as right-handed. PX 4, pp. 322-329.

On August 23, 2018, Dr. Sweeney noted that Petitioner was still awaiting authorization of the right shoulder therapy recommended by Dr. Primus. He noted ratings of 3/10 neck and right shoulder pain and 7/10 low back pain. On examination, he noted a limited range of cervical spine, right shoulder and lumbar spine motion. He described Petitioner's lumbar spine pain as "worse at moment due to new pain being worked up by PCP." He recommended that Petitioner remain off work and undergo the therapy recommended by Dr. Primus. PX 4, pp. 123-126.

On November 15, 2018, Dr. Sweeney noted complaints of neck, right shoulder and low back pain along with bilateral knee pain. He also noted a "new complaint over the past two months of intermittent extreme right-sided low back pain with bending and twisting." He indicated that Petitioner's primary care physician was "ruling out anything kidney related and currently feels it is sciatica." On examination, he described sitting straight leg raising as negative to 90 degrees. He noted a limited range of cervical spine and right shoulder motion. He diagnosed "cervical fusion, shoulder and lumbar derangement due to work injury." He recommended therapy for the right shoulder. He directed Petitioner to remain off work. PX 4, pp. 120-122.

Petitioner returned to Dr. Sweeney on February 7, 2019. The doctor noted complaints of 3/10 neck pain, 4/10 right shoulder pain and 8/10 low back pain. He also noted that Petitioner was walking about three times per week. On cervical spine examination, he noted limited rotation, especially to the right, and limited extension. He described Petitioner as "overall mov[ing] in a very arthritic manner." He diagnosed "chronic pain due to multiple work-related injuries." He directed Petitioner to remain off of work permanently and seek alternative sources of care. He indicated it was possible that "delays in care related to injury have resulted in further deterioration and probably depression." PX 4, pp. 117-119.

Petitioner testified he last saw Dr. Sweeney on May 30, 2019. The doctor noted complaints of 3/10 neck and right shoulder pain and 8/10 low back pain. He also noted a new complaint of left hip pain. He described Petitioner as being able to transition from sitting to standing with little difficulty and being able to walk without assistance. He diagnosed "chronic pain due to multiple work-related injuries." He directed Petitioner to continue off work on a permanent basis. He transferred care to Petitioner's primary care physician. PX 4, pp. 115-116.

In addition to the exhibits previously described, Petitioner offered in evidence a transcript of the deposition testimony of Dr. Erickson taken on August 7, 2019. PX 6. Dr. Erickson is a board certified orthopedic surgeon who examined Petitioner at the request of Petitioner's counsel. [The examination took place on April 18, 2017, according to Dr. Hennessy. Dr. Erickson's examination report is not in evidence.]

Dr. Erickson testified he is a general orthopedic surgeon. He treats shoulder injuries. PX 6, p. 6. He had no independent recollection of Petitioner and relied on his notes while testifying. PX 6, p. 6.

Dr. Erickson testified that Petitioner provided a history of the work accident. Specifically, Petitioner told him he was pulling a pin while adjusting the tandem wheels of a trailer when the pin released unexpectedly, causing him to fall backward and "injure his neck, back." PX 6, p. 7.

Dr. Erickson testified he reviewed the cervical spine MRI in connection with his examination. He could not recall whether he reviewed the actual images or just the report. PX 6, p. 8. He also reviewed Dr. Hennessy's report. PX 6, p. 9.

Dr. Erickson testified that, on cervical spine examination, he noted some loss of motion and minimal pain with extremes of motion. On right shoulder examination, he noted a reduced range of forward elevation and abduction, 20 degrees of external rotation and diminished internal rotation. He testified that the right shoulder MRI showed "some thickening of the supraspinatus tendon with some tendinosis." If the rotator cuff tendons become thick enough, they can start to rub across the adjacent acromion. This can cause pain and some inflammation. PX 6, p. 11.

Dr. Erickson opined that the need for the cervical spine fusion was related to the work injury. He further opined that Petitioner has right shoulder adhesive capsulitis secondary to the work injury and immobilization following the cervical spine fusion. He based the diagnosis of adhesive capsulitis on his examination findings, not the right shoulder MRI. PX 6, p. 12. He further opined that the work injury caused a lumbar strain and a "contracture presenting itself as some loss of flexion." He viewed this as an aggravation of a pre-existing condition.

Dr. Erickson recommended that Petitioner undergo physical therapy and an intra-articular cortisone injection with respect to the right shoulder and therapy, possibly followed by injections, with respect to the lumbar spine. PX 6, pp. 14-15.

Under cross-examination, Dr. Erickson testified that it is especially important to obtain an accurate history from a patient when addressing the issue of causation. If the history that Petitioner provided was inaccurate, that could affect his causation opinions. PX 6, p. 16. He does not know how much force Petitioner was applying when he was pulling on the hook. PX 6, p. 17. Nor does he know the force with which Petitioner struck the ground or which part of Petitioner's back struck the ground. Petitioner never told him that his right arm or shoulder came into contact with the ground. PX 6, p. 18. Petitioner did not indicate that he fell onto his outstretched right hand. He does not know which arm Petitioner was using when he was pulling on the hook. Based on the history Petitioner provided, there is no evidence of any mechanical strain to the right shoulder during the fall. He agreed there are many details about how the accident occurred that he does not know. PX 6, pp. 18-19. Petitioner told him he began developing neck pain after the accident occurred. Petitioner did not tell him he started experiencing right shoulder pain. PX 6, p. 19. At the initial Emergency Room visit, Petitioner primarily complained of his neck. PX 6, p. 19. The Emergency Room records reflect that Petitioner denied back pain. PX 6, p. 21. There is no indication that Petitioner complained of his right shoulder at the Emergency Room. PX 6, p. 21. Dr. Oladeinde's note of November 4, 2016 contains no mention of right shoulder or low back pain. PX 6, pp. 21-22. At such point that Petitioner did complain of his right shoulder, his symptoms seemed to be more trapezial in nature. That could be a sign that the symptoms were more related to the neck than to any specific right shoulder pathology. PX 6, p. 22. The pathology demonstrated on the right shoulder MRI could be degenerative in nature. That pathology could have taken years to develop. PX 6, p. 23. The right shoulder findings could have been in existence before the work accident. PX 6, p. 23. The lumbar spine MRI also showed degenerative changes and bulges that could have taken years to develop. Those changes and bulges could have been in place before the work accident. PX 6, pp. 24-25. Petitioner has a body mass index of 39.9, which means he is obese. Obesity can have a significant impact on the lumbar spine. PX 6, p. 25. Greater weight causes arthritis and an increased risk of degenerative changes. Petitioner is almost 60 years old. Petitioner's lower back complaints and MRI findings could be normal for an obese 60-year-old male. PX 6, pp. 25-26. He saw no records indicating that Petitioner's right shoulder was immobilized following the cervical fusion. PX 6, p. 26. He acknowledged that, given Petitioner's age and obesity, along with the complaints recorded at the Emergency room, the degenerative nature of the right shoulder and back MRI findings and the lack of evidence of right shoulder immobilization, Petitioner's right shoulder and back conditions could be related to something other than the work accident. PX 6, p. 27. His neurological examination was normal, meaning he found no focal areas of loss of sensation or motor weakness indicative of a nerve injury. The size of the cervical disc herniation could have been expected to cause neurological findings but you would not have expected to see such findings based on the lumbar spine pathology. Petitioner denied radicular symptoms in 2015 and at the time of his examination. There was a period in December 2015 during which Petitioner was no longer voicing lower back complaints. PX 6, p. 29. The lower back examinations stopped during that

time. PX 6, p. 29. Based on the early records from Physicians Immediate Care, Petitioner's low back condition "could have resolved" by December 2015. PX 6, p. 30. Those records could support the conclusion that the work accident caused a lumbar strain that resolved within a short period of time. PX 6, p. 30. Petitioner reported improvement of his cervical spine condition following the fusion. At the time of his examination, Petitioner indicated his neck pain was not constant. PX 6, pp. 30-31. Petitioner described that pain as dull, mild and non-radiating. PX 6, p. 31. As of the examination, Petitioner's complaints centered around his low back and right shoulder. PX 6, p. 31.

Petitioner testified he has not returned to work. He calls Dr. Sweeney when he needs medication but is not undergoing any active treatment. He takes Norco for pain on an "as needed" basis. T. 60-61. He has been receiving Social Security disability benefits for over a year and "maybe closer to two years." T. 62-63.

Petitioner testified that, when he stands for an extended period, he experiences lower back pain that goes "up to [his] shoulders and chest." He finds it difficult to sit for extended periods. He is able to lift items such as groceries and pans but "not without some repercussions." He does all the cooking because his wife has lupus. T. 63. He also has pain and stiffness in his neck but "it's mostly [his] back." He uses a "grabber" to retrieve items so that he does not have to bend over. T. 63-64.

Under cross-examination, Petitioner reiterated that he began experiencing neck stiffness after the accident. It was this symptom that prompted him to go to the Emergency Room. He fell onto his back. He did not fall onto his shoulder. T. 65. He was honest with the personnel he encountered at the Emergency Room. He provided them with accurate histories. T. 65. He advised them of all of his symptoms. He had no reason to lie to them. T. 66. He was also honest with Dr. Oladeinde when he saw her on November 4, 2015. He was also honest with his physical therapists and the providers he saw at Physicians Immediate Care. T. 66. Petitioner denied that his lower back had improved as of December 2015. If his records reflect this he would disagree with them. T. 67. He denied undergoing lower back care before the November 3, 2015 accident. He would disagree with his records if they reflect that he underwent care for lower back pain at Advocate Christ Medical Center on March 7, 2011. T. 67. He acknowledged complaining of a backache when he saw Dr. Oladeinde on June 23, 2015. He then denied complaining of back pain to his doctor. T. 68. He denied experiencing neck pain before November 3, 2015. He denied undergoing a neck X-ray in June 2010. T. 69. When he first experienced right shoulder pain, after the accident, the pain radiated from the shoulder to the base of his neck. T. 69. He noted decreased shoulder symptoms before his cervical spine surgery. T. 70. He accepted Respondent's offer to perform light duty at a Salvation Army store. He worked at that store between November 2015 and his surgery in August 2016. His duties there included sorting clothes, measuring pants, tagging clothing and acknowledging customers if they spoke to him. T. 70. He was not a greeter per se. T. 70. At the Salvation Army store, he was told to handle items such as furniture and televisions only if that activity did not cause him pain. T. 71. Respondent again offered him alternative light duty, at a not for profit called "Hearts in Motion," in March 2017. He was not told what his precise tasks would be there. He

declined that position. T. 71. He last saw Dr. Sweeney on May 30, 2019. At that time, he primarily complained of his low back and right shoulder but he was also experiencing limited mobility in his neck. T. 72. He experiences neck pain at night, when trying to sleep in a flat position. He has to sleep in a "propped up" position. T. 72. His neck symptoms did not improve after the surgery. If his records document improvement, he would disagree with them. T. 72. His arm numbness and tingling did not resolve after the surgery. Since the surgery, his back and right shoulder complaints have been worse than his neck complaints. T. 73. By August 2017, he was rating his neck pain at 2-3/10 when he saw Dr. Sweeney. T. 73. In April 2018, he told the functional capacity evaluator that his primary complaints were in his right shoulder and lower back. T. 73. During the evaluation, he also complained of knee pain. He has bursitis in his left knee. He had to discontinue some activities during the evaluation due to lower back pain. T. 74. He walks approximately 30 minutes per day for exercise. T. 74-75. His hobbies before and after the work accident were sedentary in nature. He considers cooking one of his hobbies. He still cooks. He has no problems with his left arm. His left arm is "fine." T. 75. The truck driving he performed for Respondent was basically local. Unless he got caught in a snowstorm, he returned home each night. T. 76. He is still able to drive. He currently holds a valid driver's license. No doctor has restricted his driving. T. 76. He continues to drive. T. 76-77. He has not looked for work anywhere since he last performed alternative light duty at the Salvation Army store. T. 77. He has not submitted any resumes or conducted any job search. T. 77. He graduated from high school and took one year of college courses. He used a computer when he drove a truck. He does not currently use a computer but does use a smart phone. T. 77.

On redirect, Petitioner testified his right arm is his dominant arm. T. 78.

Lisa Helma, CRC, a certified vocational rehabilitation counselor, testified on behalf of Petitioner. Helma testified she initially obtained national certification in 2008, after meeting certain pre-requisites and passing an examination. She currently works for the Shirley Ryan Ability Lab. As of June 2017, she worked for Vocamotive. T. 11-12. She met with Petitioner in June 2017. After assessing Petitioner and reviewing a note from Dr. Sweeney indicating Petitioner should be off work, she concluded that Petitioner had lost access to his usual and customary occupation and that he was totally disabled. T. 13. She interviewed Petitioner a second time, following a functional capacity evaluation, and issued another report in May 2018. The evaluator found Petitioner capable of functioning at a sedentary physical demand level. Based on this evaluation and her assessment of Petitioner's age, educational and work history, physical capabilities and transferable skills, she concluded that Petitioner had lost access to any stable labor market. T. 15. She identified PX 10 as her reports. T. 15.

Under cross-examination, Helma testified she performed a transferable skills analysis. She concluded that Petitioner has no transferable skills. T. 17. She did not perform any vocational testing of Petitioner. Nor did she perform any analysis of the job Petitioner held with Respondent. She had no contact with Respondent. She did not conduct a labor market survey. She did not attempt any job placement for Petitioner. She admitted she did not do everything she could have done to better assess Petitioner's employability. She did not issue a

vocational plan. T. 20. She met with Petitioner on June 12, 2017, April 20, 2018 and July 24, 2019. She did not issue a third report after meeting with Petitioner on July 24, 2019 because there were no significant changes in Petitioner's situation. T. 21. Neither Petitioner's attorney nor any Respondent representative attended the meetings. T. 22. Her understanding of Petitioner's job with Respondent is based on the description Petitioner provided and the Dictionary of Occupational Titles. If Petitioner's description was inaccurate, that could potentially affect her opinions concerning his ability to return to his job. T. 23. If Petitioner's job did not require him to exert force beyond the sedentary level, she would still need additional information because Petitioner's restrictions were not solely lifting-related. She believes he was subject to other non-material handling restrictions. T. 23-24. If the job met the parameters of the functional capacity evaluation, Petitioner could perform that job. If Petitioner had been able to resume his job, he would not have experienced any reduction in working power. T. 24. She is basing her opinions on Dr. Sweeney's restrictions as well as the functional capacity evaluation. T. 24. The driving portions of Petitioner's job would be considered sedentary in nature. T. 25. However, if Petitioner found a job that involved only driving, he would not be able to perform that job because of the very limited motion of his cervical spine. That motion deficit could affect safety while driving. T. 25. The functional capacity evaluator expressed concern about this but did not recommend any specific driving-related restrictions. T. 25-26. She did not review Dr. Hennessy's March 2018 report and is not aware of the doctor's opinions concerning Petitioner's work capacity. T. 26. She is not a medical doctor and is not able to conclude which physician is correct when it comes to the need for restrictions. T. 26-27. She is not addressing causation insofar as the restrictions are concerned. T. 27. Petitioner told her he drove locally, delivering freight. Petitioner acknowledged he did not need to load or unload his truck but stated he needed to be able to lift at least 50 pounds in the event his load shifted. T. 28. She has attempted to perform labor market surveys for truck driving jobs that are labeled "no touch." Many employers report that, while the position is 99% "no touch," the employee must perform physical tasks if the load shifts. T. 28. The fact that Petitioner has a high school degree makes him more marketable than if he lacked this degree. T. 28-29. Petitioner reported receiving grades ranging from Bs to Fs. She did not review any transcripts. T. 29. Petitioner told her he obtained at least twelve college credits. T. 29. He took courses in marketing and merchandising. He also worked in the merchandising trade for six years. T. 30. The Dictionary of Occupational Titles describes merchandising displayer as skilled work. T. 30. However, a merchandising displayer is classified as a medium physical demand level job and is thus not within Petitioner's sedentary restrictions. Petitioner is a United States citizen. He speaks fluent English. He has no arrest history. He denied having any kind of computer or keyboarding skills. He reported being unable to send an E-mail but indicated he was "learning Facebook." T. 32. Based on this reporting, she would not conclude that Petitioner has any transferable computer skills. T. 32. However, Petitioner had to use a computer while driving a truck for Respondent. He underwent formal training on the job. He also acknowledged having a computer at home. T. 33. Helma acknowledged that, although she would consider Petitioner to be a "person of advanced age," most 58-year-olds remain employed. Age, in and of itself, does not contraindicate a return to work. T. 33. When she met with Petitioner in 2018, he still held a valid driver's license and continued to drive. Before the accident, when he was an "individual

without a disability," he had the skills to look for work on his own. In her 2017 report, she noted that Petitioner denied looking for work. She would agree that there are jobs that involve driving that are at the sedentary or light physical demand levels. Many courier jobs are commission-based, however. T. 35. Additionally, many couriers are expected to use their own vehicles. T. 36. She would be concerned about Petitioner's ability to drive safely on a full-time basis given the functional capacity evaluator's commentary about his very limited range of cervical spine motion. T. 36. She was paid for preparing her reports and is being paid for her testimony. T. 36-37.

Arbitrator's Credibility Assessment

Petitioner's lengthy tenure with Respondent weighs in his favor, credibility-wise.

Under cross-examination, Petitioner denied undergoing Emergency Room care for low back pain on March 7, 2011. He indicated he would disagree with records bearing that date if they documented low back treatment. Records in RX 14 reflect that Petitioner did in fact undergo treatment for right-sided low back pain at Advocate Christ Medical Center on March 7, 2011. Those records also reflect, however, that Petitioner denied trauma, complained of "right flank pain x 4 days" and indicated he had experienced kidney stones in the past. The Emergency Room physician ordered a urinalysis and a CT scan of the abdomen. The scan showed a left-sided kidney stone. Differential diagnoses included a renal stone. Petitioner was discharged with Norco and instructions to return to the Emergency Room if his symptoms worsened. Respondent would have the Arbitrator conclude that Petitioner's denial of low back care on March 7, 2011 undermined his credibility. The Arbitrator is unable to draw this conclusion. The back pain that prompted Petitioner to seek care was not the kind typically associated with overexertion or an injury.

In his first and third reports, Respondent's examiner, Dr. Hennessy, described Petitioner as fully cooperative. RX 1, 3. In his last report, dated March 22, 2018, he described Petitioner as cooperative "for the most part" but exhibiting some self-limiting. RX 4.

The therapist who conducted the April 23, 2018 functional capacity evaluation described Petitioner as fully cooperative. PX 4, pp. 322-329.

The Arbitrator finds Dr. Hennessy's back-related causation opinions inconsistent and unpersuasive. In his first report, he opined that the accident caused a lumbar strain that required no additional care. RX 1. In his final report, the doctor concluded that the work accident resulted in no back injury. He relied on incomplete records in reaching this conclusion. The timeline in his final report contains no mention of the back-related findings and recommendations that providers at Physicians Immediate Care made between November 6, 2015 and February 3, 2016. RX 4.

The Arbitrator also places little stock in Dr. Hennessy's opinions concerning Petitioner's work capacity. The doctor agreed with the need for the three-level cervical fusion and noted a

"markedly decreased" range of cervical spine motion "in all directions" at his last examination yet found Petitioner capable of full duty. RX 4. That finding is inconsistent with the functional capacity evaluation of April 23, 2018, which the doctor apparently never reviewed. It is also inconsistent with the notations the doctor made in his first report concerning the tasks Petitioner was required to perform when dealing with the "fifth wheel" and coupling/uncoupling trailers. RX 1.

The Arbitrator also finds unpersuasive certain of the opinions that Petitioner's examiner, Dr. Erickson, voiced under cross-examination. Like Dr. Hennessy, Dr. Erickson incorrectly assumed that Petitioner stopped complaining of his low back in December 2015. This is not the case.

Dr. Primus, who examined Petitioner on one occasion, two years after the work accident, found causation as to the right shoulder but based that finding on Petitioner's history of falling onto his right shoulder and back. At the hearing, Petitioner described falling backward and hitting the ground but admitted he did not strike his right shoulder in the process. The Arbitrator finds Dr. Primus's causation-related comments unpersuasive because he assumed that Petitioner sustained a direct blow to the right shoulder.

Arbitrator's Conclusions of Law

Did Petitioner establish causation as to his various claimed current conditions of ill-being?

Petitioner claims cervical spine, lumbar spine and right shoulder conditions of ill-being. Respondent disputes causation only insofar as the claimed lumbar spine and right shoulder conditions are concerned.

With respect to the lumbar spine. Respondent argues that, at most, the work accident caused a lower back strain that resolved by December 2015. In support of this argument, Respondent points to the records from Physicians Immediate Care and Dr. Hennessy's initial report. Respondent also relies on Dr. Erickson's testimony, under cross-examination, that the records from Physicians Immediate Care could support the conclusion that Petitioner's back condition essentially resolved by December 2015. PX 6, pp. 29-30. Dr. Erickson made this concession but the records from Physicians Immediate Care, a facility of Respondent's selection, do not, in fact, reflect that Petitioner's lower back complaints disappeared as of December 2015. On January 28, 2016, Petitioner denied improvement of his back and right shoulder complaints. Blagojeski ordered MRIs of the lumbar as well as cervical spine, although subsequent records show that the lumbar spine MRI was not authorized. When Respondent's examiner, Dr. Hennessy, first saw Petitioner, on April 4, 2016, he noted complaints of pain in several body parts, including the lumbosacral area, although he did not recommend any additional back-related care. RX 1. Dr. Sweeney's initial records of April 21, 2016 include a diagram showing that Petitioner complained of pain in his lower back as well as other areas. The lumbar spine MRI that Respondent's selected facility prescribed in late January 2016 was not actually performed until October 31, 2016. It showed "lumbar spondylosis with significant

annular disc bulging most severe from L4-S1 contributing to significant bilateral neural foraminal stenosis." PX 8, pp. 2-3. Dr. Sweeney reviewed the lumbar spine MRI with Petitioner on November 17, 2016 and prescribed "physical therapy trial for both shoulder and lumbar." On December 15, 2016, Dr. Sweeney indicated that he "previously discussed surgical intervention for the lumbar pathology at L4-S1 but patient doesn't want to pursue." PX 4, p. 166. In late November 2017, Dr. Sweeney noted ongoing low back complaints but also indicated that Petitioner was now reporting a different, potentially kidney-related back pain of two weeks' duration. He also noted that Petitioner planned to see his primary care physician for an evaluation of this pain. Approximately a year later, Dr. Sweeney noted "new complaints over the past two months of intermittent extreme right-sided LBP with bending and twisting." He went on to state that Petitioner's primary care physician was "ruling out anything kidney-related" and "currently feels it is sciatica."

The Arbitrator finds that the work accident caused a low back condition of ill-being for which Dr. Sweeney recommended surgery in late 2016, with Petitioner declining to pursue this. The Arbitrator is unable to conclude, however, that the newest, primarily right-sided low back complaints recorded in November 2017 and November 2018, stem from the work accident. Dr. Sweeney's notes reflect that a primary care physician characterized these complaints as potentially kidney-related. [No records from this physician are in evidence.] His notes also reflect a history of kidney stones. It appears to the Arbitrator that the symptoms that evolved in 2017 and 2018 could stem from a systemic condition rather than the work accident.

The Arbitrator turns to the right shoulder condition. Respondent maintains that no shoulder complaints are mentioned in the treatment records until December 2015. In fact, the Emergency Room records from the date of the accident document complaints of pain radiating from the neck into the shoulders. RX 14, p. 49 of 59. On November 17, 2015, Blagojevski, a physician's assistant affiliated with Physicians Immediate Care, noted that Petitioner was "still" complaining of his shoulders, along with other body parts. On November 30, 2015, Blagojevski noted a complaint of neck/right shoulder pain. In December 2015, therapists noted right shoulder complaints. On April 4, 2016, Respondent's examiner, Dr. Hennessy, noted shoulder complaints, although he did not view those complaints as "intrinsic" in nature. RX 1. When Petitioner first saw Dr. Sweeney, in April 2016, he or someone acting on his behalf completed a diagram showing he was experiencing right shoulder pain. While Petitioner was undergoing therapy, in 2017, the therapists documented right shoulder complaints that increased over time. The Arbitrator finds that Petitioner established causation as to a right shoulder condition that required MRI imaging and conservative care but relies on the foregoing records, rather than Dr. Primus, in so doing. Dr. Primus described Petitioner as landing on his right shoulder as well as his back when he fell. Under cross-examination, Petitioner acknowledged he did not strike his right shoulder. T. 65. The Arbitrator notes, however, that Petitioner did not testify to any current complaints specifically involving the right shoulder. T. 63-64.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims the following medical expenses: 1) Advocate Christ Medical Center, $3,288.00 (Emergency Room, 11/3/15 and cervical spine CT scan, 11/4/15, PX 1, p. 2); 2) Dr. Sweeney, $620.00; 3) Dr. Primus, $1,409.00, November 7, 2017 (PX 7); 4) Tinley Park Open MRI, $2,700.00 (right shoulder and lumbar spine MRIs of October 31, 2016, PX 8); and 5) ATI, $1,187.36 (balance due after payments and discounts, PX 9, p. 9).

The Advocate Christ Medical Center bills relate to care Petitioner underwent on the day of the accident and the following day. Respondent's examiner did not take issue with this care. The Arbitrator awards Petitioner the $3,288.00 bill, subject to the fee schedule and with Respondent receiving credit for the $1,803.59 payment reflected in RX 7.

The Arbitrator views Dr. Sweeney's care as reasonable and necessary. The Arbitrator awards the claimed bill of $620.00, subject to the fee schedule and with Respondent receiving credit for any payments it has made toward this bill.

The Arbitrator has found causation as to the need for right shoulder MRI imaging and conservative care. The Arbitrator finds it reasonable for Dr. Sweeney to have referred Petitioner to Dr. Primus for evaluation of the shoulder. Dr. Primus's bill for services provided on November 7, 2017 includes an unexplained $500.00 charge for a "disability examination." The bill also reflects several CBCS payments and adjustments and a $0 balance. PX 7. The Arbitrator finds the treatment-related expenses (the expenses other than the $500.00 charge) to be reasonable and necessary. The Arbitrator awards these charges, subject to the fee schedule. RX 7 does not reflect any payments to Dr. Primus.

The Arbitrator has found causation as to the need for the lumbar spine and right shoulder MRIs that Blagojevski prescribed on January 28, 2016. Blagoveski is a physician's assistant affiliated with Physicians Immediate Care, a facility of Respondent's selection. The Arbitrator awards Petitioner the Tinley Park Open MRI bill of $2,700.00 (PX 8), subject to the fee schedule. RX 7 does not reflect any payments to Tinley Park Open MRI.

Much has been made of the therapy Petitioner underwent at ATI in June 2017. The Arbitrator notes that, while a nurse case manager communicated with ATI on June 15, 2017, indicating that there was some confusion as to why Dr. Sweeney was prescribing more therapy (PX 9, p. 49), it was not until early in the morning on June 21, 2017, the day after Dr. Trotter's review, that anyone notified ATI that additional therapy was not authorized. The Arbitrator has considered the two utilization review reports offered by Respondent (RX 5-6) but has also considered the foregoing timeline. There is no evidence indicating the nurse case manager or adjuster declined to authorize therapy, or suggested that ATI hold off on more therapy, during the phone conversation of June 15, 2017. The Arbitrator awards Petitioner the charges associated with the therapy he underwent at ATI on June 14, 15, 16 and 19, 2017, subject to the fee schedule.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims he was temporarily totally disabled from November 6, 2015 through the functional capacity evaluation of April 23, 2018. Arb Exh 1. Respondent claims Petitioner was temporarily totally disabled only during a brief initial period, from November 4 through November 22, 2015. [The parties agree that Respondent paid temporary total disability benefits (totaling $27,831.13) during this period and from August 8, 2016 through March 19, 2017. They also agree that Respondent paid $10,666.99 in temporary partial disability benefits and a permanency advance. Arb Exh 1.]

The alternative/offsite light duty that Respondent offered Petitioner is not contemplated by the Act. Moreover, Petitioner was still off work, per Dr. Sweeney, when he declined Respondent's final offer of such duty in March 2017. RX 9. The Arbitrator has previously found that it was reasonable for Dr. Sweeney to send Petitioner to Dr. Primus in the latter part of 2017 for a right shoulder work-up. The Arbitrator views Petitioner as reaching maximum medical improvement as of the April 23, 2018 functional capacity evaluation. The Arbitrator awards Petitioner additional temporary total disability benefits from March 20, 2017 through April 23, 2018.

What is the nature and extent of the injury?

Petitioner claims that no jobs are available to him based on his age, training, education, experience and restrictions. He seeks an award of "odd lot" permanent total disability benefits. Respondent maintains that Petitioner is capable of full duty and that permanency should be awarded under Section 8(d)2 of the Act.

The Arbitrator finds that Petitioner is significantly disabled but failed to establish "odd lot" permanent total disability. The therapist who conducted the April 23, 2018 functional capacity evaluation found Petitioner capable of performing at a sedentary physical demand level forty hours per week. PX 4, p. 322-329. She noted significant limitations relative to the knees, body parts that Petitioner does not claim to have injured in the work accident. She noted that Petitioner described the essentially undisputed part of this claim, i.e., his cervical spine condition, as the least of his problems, symptom-wise. She concluded that Petitioner's restricted neck motion prevented him from being able to drive safely but noted that Petitioner did drive and in fact drove to the evaluation. Under cross-examination, Petitioner conceded he continues to drive. On direct examination, Lisa Helma, CRC, opined that Petitioner has lost access to his usual occupation and is permanently disabled. Under cross-examination, however, she acknowledged she did not pursue conventional measures, such as vocational testing or a labor market survey, before rendering this opinion. The work history she obtained reveals that Petitioner was employed in the grocery/food industry for a lengthy period, although admittedly in the remote past. Petitioner acknowledged that cooking remains one of his hobbies and that he regularly pursues this hobby, despite his limitations. Petitioner also acknowledged he never conducted any type of job search.

As noted earlier, Respondent essentially conceded causation insofar as Petitioner's cervical spine condition and the need for the three-level fusion are concerned. The Arbitrator

has also found that Petitioner established causation as to a lumbar spine condition for which Dr. Sweeney recommended surgery in late 2016, following the October 31, 2016 MRI. Petitioner declined to pursue this. Dr. Sweeney subsequently noted a "new" complaint of a different kind of intense back pain for which Petitioner sought treatment with his primary care physician. The records of that physician are not in evidence. The Arbitrator is unable to conclude that the new complaints, documented in 2017 and 2018, stem from the 2015 work accident, particularly because there is a suggestion those complaints were kidney-related. The Arbitrator has also found causation as to a right shoulder condition that required MRI imaging and care but Petitioner did not testify to any ongoing right shoulder problems at the hearing.

Because the accident occurred after September 1, 2011, the Arbitrator looks to Section 8.1b of the Act for guidance in assessing permanency. That section sets forth five factors to be considered in determining the nature and extent of an injury, with no single factor predominating. The Arbitrator gives the first factor, any AMA Guides impairment rating, no weight since neither party offered such a rating into evidence. The Arbitrator assigns some weight to the second and third factors, Petitioner's age at the time of the accident and occupation. Petitioner was 56 years old as of the 2015 accident. The Arbitrator views him as an older individual who, from a statistical perspective, might remain in the workforce for another eight to ten years. He testified he drove an 18-wheeler locally before 2015 but, by that year, was "just a spotter," typically using a "yard jockey", or hydraulically operated vehicle, to move trailers. The Arbitrator finds credible Petitioner's testimony that, when he drove a truck, he was occasionally required to move loads that had shifted in transit and that, as a spotter, he also had to be able to manually crank a handle to lift dolly legs when he did not have access to a hydraulically equipped vehicle. T. 46-48. These tasks exceed the parameters of the functional capacity evaluation. The Arbitrator also assigns some weight to the fourth factor, future earning capacity. The Arbitrator does not find persuasive Dr. Hennessy's opinion that Petitioner could resume his former duties at Respondent despite having undergone a three-level cervical fusion. As for the fifth and final factor, evidence of disability corroborated by the treatment records, the Arbitrator notes Dr. Sweeney's operative report and the functional capacity evaluation.

Having considered the foregoing, along with the opinion of Dr. Middeldorf, one of Respondent's utilization reviewers, that Petitioner "will obviously have some permanent restricted mobility in the cervical spine given the multi-level fusion he underwent" (RX 6), the Arbitrator finds that Petitioner is permanently partially disabled to the extent of 45% loss of use of the person as a whole, representing 225 weeks of benefits under Section 8(d)2 of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC033999
Case Name	STEVENS,AMBER v. TRIAD CUSD #2
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0280
Number of Pages of Decision	14
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Robert Nelson
Respondent Attorney	Brian Rosenblatt

DATE FILED: 6/9/2021

/s/ Stephen Mathis, Commissioner

Signature

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

AMBER STEVENS,

Petitioner,

vs. NO. 17WC 33999

TRIAD COMMUNITY UNIT SCHOOL DISTRICT #2,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 31, 2020 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 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.

June 9, 2021

/s/ *Stephen J. Mathis*
Stephen J. Mathis

SJM/sj
o-5/18/2021
44

/s/ *Deborah Baker*
Deborah Baker

/s/ *Deborah Simpson*
Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STEVENS, AMBER Case# **17WC033999**

Employee/Petitioner

TRIAD COMMUNITY UNIT SCHOOL DISTRICT #2

Employer/Respondent

On 8/31/2020, 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 0.12% 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:

0384 NELSON & NELSON ATTY AT LAW PC
ROBERT NELSON
420 N HIGH ST
BELLEVILLE, IL 62220

2795 HENNESSY & ROACH PC
PAUL BERARD
415 N 10TH ST SUITE 200
ST LOUIS, MO 63101

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Amber Stevens
Employee/Petitioner

v.

Triad Community Unit School District #2
Employer/Respondent

Case # **17- WC-33999**

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 **Linda J. Cantrell**, Arbitrator of the Commission, in the City of **Collinsville**, on **June 26, 2020**. 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 3, 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 $**65,464.82**; the average weekly wage was $**1,722.76**.

On the date of accident, Petitioner was **38** 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 $**0.00** 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 $**All Paid** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, totaling $10,084.22, equating to $2,531.00 due and owing Washington University Physicians; $1,014.72 due and owing Gateway Regional Medical Center; $4,118.50 due and owing Apex Physical Therapy; and $2,420.00 due and owing BJC Hospital, as provided in Section 8(a) and Section 8.2 of the Act. Respondent shall be given a credit for any amounts previously paid under Section 8(a) of the Act for medical benefits and Respondent shall hold Petitioner harmless from claims by any providers of the services for which Respondent is receiving this credit.

Respondent shall further reimburse Petitioner for out-of-pocket medical expenses in the amount of $1,469.17 and hold Petitioner harmless from any and all subrogation claims that may or have been asserted by UHC Insurance.

Respondent shall pay petitioner permanent partial disability benefits of **$790.64**/week for 37.5 weeks, because the injuries sustained caused **7.5% loss of the person as a whole,** as provided in Section 8(d)2 of the Act, and **$790.64**/week for 21.5 weeks because the injuries sustained caused **10% loss of the leg** as provided in Section 8(e)12 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

8/27/20
Date

AUG 31 2020

STATE OF ILLINOIS)
) **SS**
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

AMBER STEVENS, Employee/Petitioner, v. TRIAD COMMUNITY UNIT SCHOOL DISTRICT #2, Employer/Respondent.	)	Case No.: 17-WC-33999

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Collinsville on June 26, 2020. The issues in dispute are accident, medical bills, and nature and extent of Petitioner's injuries. All other issues have been stipulated.

TESTIMONY

Petitioner is a certified kindergarten through 12th grade music teacher at the Silver Creek Elementary School in Troy, Illinois where she has worked for ten years. As a music teacher, one of her assigned periods is recess duty. Only P.E., computer, music, and art teachers are assigned recess duty due to the flexibility in their schedules.

Petitioner testified that on 11/3/17 she went outside for recess duty where she monitored a game of kickball. Three students played four others and the short-sided team loaded the bases and were without a player to kick the ball causing the students to argue. Petitioner testifies she engaged in play to avoid arguments. Petitioner kicked the ball and fell on slick asphalt while running to first base. Petitioner landed on her right leg and she could not immediately stand or put weight on her right knee. A student brought her her lens from her sunglasses that broke and a playground aide noticed her head was bleeding. When she stood up she noticed she had urinated her pants when she was on the ground. She walked to the school nurse's station where an ice pack was applied to her head. Petitioner testified she finished her recess duties with an ice pack on her head. Petitioner testified that the asphalt on the playground is always slick even when it is dry. She recalled the weather being nice the day of her accident and could not recall if it had rained that day.

Petitioner testified that kickball is not an activity she engages in outside her work duties. She stated that at the beginning of each school year she attends a meeting with teachers,

administration, and aides who are assigned recess duty where ideas and suggestions are exchanged. Petitioner testified she was instructed by several different administrators throughout the years to engage and interact with students at recess. Petitioner understood interaction to mean monitor behavior, mediate disagreements, encourage the kids to play, and to play with them if needed. She was not criticized or sanctioned for her activities that day. She testified she did not receive additional compensation for engaging with students at recess, but if she did not engage she might have lost her job for not performing her duties. She testified her engagement with students at recess was not a factor in her annual reviews.

Petitioner did not take time off from teaching following the accident and worked on a crutch and her arm in a sling. She was in charge of the 1st through 5th grade students' winter program, a very well-attended program at Silver Creek Elementary, and she did not want to let the students or attendees down.

Petitioner testified that all teachers participate with students at recess, including playing tag football, basketball, and kickball. She stated these duties were not voluntary and were absolutely her assigned duties she was ordered to perform. She testified that administration witnessed the teachers' participation on the playground. In her 2016 evaluation she was complimented for having started a walking club on recess duty. She believed that the administration benefited from her participation as it eliminated arguments and disagreements between the students and established a good rapport with them.

Petitioner testified she still has pain and discomfort in her right knee, particularly ascending stairs after doing squats and lunges as part of her at-home workout. She experiences pain if she bumps her right knee. She has pain in her knee a few times per week if she exercises and she rates her pain 3 to 4 out of 10. She has trouble kneeling on a hard surface. Petitioner demonstrated she cannot raise her left arm as high as her dominant right arm since the accident. She alleges she lost two to three inches of reach. Petitioner testified she has lost the same reach when reaching behind her back. Her shoulder pain is rated 5 out of 10 if she puts pressure on her left side. Lifting her 5-year-old son is painful and she cannot put him on her shoulders. Physical activity involving her shoulder causes 2 to 4 out of 10 pain. Shivering from cold temperatures also causes pain in her shoulder.

Petitioner called Charlotte Rodriquez as a witness. Mrs. Rodriquez testified she was working as a recess aide on the day of Petitioner's accident. Mrs. Rodriquez testified that it rained that day and the asphalt was wet and slippery, particularly in the area painted for kickball games. Mrs. Rodriquez witnessed people slipping while running on asphalt playing kickball that day. She has witnessed teachers and aides participating in recreation with students at recess. She was a few feet from Petitioner when she fell. She observed Petitioner was bleeding from the head and trying to protect her arm and leg.

Mrs. Rodriquez testified that they were all encouraged to participate in recreation with the students at recess. The principal and assistant principal were present during the teachers' participation and they encouraged staff to be part of what the students were doing. Staff were encouraged to pitch the ball, play basketball, etc. by the principal and assistant principal. Mrs. Rodriquez testified that staff participation was not voluntary but part of their job duties.

Respondent called Kennan Fagan to testify. Mr. Fagan is the Assistant Superintendent for the Triad Community School District. Mr. Fagan testified there is no district policy regarding teachers participating in recreational activities with students. He testified that teachers' compensation is not based on recreational participation and is not a factor in annual reviews. Mr. Fagan testified he is not aware that teachers are reprimanded if they decide not to participate in recreation with students.

Mr. Fagan testified there are no descriptive statements in teachers' job descriptions or contracts that mandate the teacher engage in recreational activities with students. Mr. Fagan testified that staff participation with students in recreation is voluntary. Mr. Fagan has not observed the level of participation at Silver Creek Elementary specifically and he did not attend any of the meetings at Silver Creek where Petitioner testified the teachers were encouraged to participate in recreation with students.

Mr. Fagan testified he did not know what Silver Creek's principal, Mr. Schomber, told his staff. Playing with the children is not addressed in the teacher's contract and therefore would be covered by the principal's explaining expectations. He could not judge whether the Petitioner's testimony regarding such meetings is accurate or not. Mr. Fagan testified there is no prohibition against teachers engaging with students in recreation at recess if they are assigned recess duty. He could address the issues of the School Board's general policy for the district but did not know what was said by the Silver Creek Elementary principal or assistant principal, Mr. Schomber. He testified that Mr. Schomber was still employed by the district. Mr. Shomber did not testify at arbitration.

MEDICAL HISTORY

On 11/5/17, Petitioner presented to the emergency room at Gateway Regional Medical Center with complaints of left shoulder pain, bruising around her left eye, and right knee and ankle pain. Petitioner reported a black left eye and facial abrasions from her sunglasses hitting her face when she fell. Petitioner reported no prior injuries or problems with her leg or arm. She was taking over-the-counter NSAIDs with minimal relief. X-rays revealed right knee suprapatellar joint effusion. She was diagnosed with a right knee and left shoulder sprain. She was prescribed an arm sling and Naproxyn.

On 11/13/17, Petitioner was examined at Washington University Physicians for right knee pain. Dr. Halstead's physical examination revealed full range of motion of the right knee with pain reported with plantar flexion, dorsi flexion, and inversion. She exhibited mild effusion, tenderness along the deltoid ligament and distal tibia, and medial and lateral swelling. A right knee MRI was performed on 11/15/17 that revealed a subchondral fracture in the central weightbearing lateral femoral condyle and the anterior medial femoral condyle with small effusion, and mild lateral patella facet chondrosis.

On 11/16/17, Petitioner was examined at Washington University Physicians for left shoulder pain. She described the shoulder pain as continuous, sharp, burning, and moderate to severe. She reported difficulty sleeping. She denied similar difficulties prior to her accident. Physical examination revealed restricted range of motion, rotator cuff weakness, and pain over the clavicle and anterior shoulder regions. Physical therapy and an MRI was ordered that

revealed a partial tear of the acromioclavicular capsule with minimal edema around the ligaments. The report concluded there was a partial rupture of the left acromioclavicular joint capsule and a low-grade sprain of the left coracoclavicular ligaments. The findings were consistent with a low grade acromioclavicular joint separation. Dr. Aaron Chamberlain examined Petitioner's shoulder on 11/27/17 and noted pain specifically over the right AC joint. He opined the MRI demonstrated a rupture of the acromioclavicular joint capsule consistent with a grade 1 AC joint injury and a sprain of the coracoclavicular ligaments, with a specific diagnosis of grade 1 AC separation. Dr. Chamberlain ordered Petitioner to avoid heavy impact activities and take Toradol.

On 12/15/17, Petitioner followed up with Dr. Halstead for the right knee at which time she reported doing much better and had only a slight limp with weight bearing. Physical examination revealed full range of motion without pain, minimal tenderness over the lateral femoral condyle, and resolved joint swelling. Dr. Halstead ordered Petitioner to discontinue crutches with limited weight bearing.

Petitioner returned to Dr. Chamberlain for her left shoulder on 12/18/17. Petitioner's left shoulder pain persisted with range of motion and palpation at the AC joint. Dr. Chamberlain noted a 70% improvement but Petitioner was not able to carry a purse on her left shoulder. Dr. Chamberlain released Petitioner to perform tolerated activity and to return for AC joint injections if her symptoms persisted.

On 2/05/18, Petitioner was examined by Dr. Halstead and reported pain going up stairs and exercise with no pain at rest. Physical examination revealed good range of motion with tenderness along the medial patella border. Dr. Halstead's impression was patellofemoral pain related to quadriceps and hip girdle weakness. He ordered physical therapy and to return if her symptoms persisted after therapy.

Petitioner began physical therapy on 2/9/18 at Apex Network where her pain level at best was a 2, at worse was a 6, and was aggravated by climbing. She was discharged on 3/23/18 with no palpable edema. She was taking Advil.

CONCLUSIONS OF LAW

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

To obtain compensation under the Act, an injury must "arise out of" and "in the course of" employment. 820 ILCS 305/1(d). An injury arises out of one's employment if its origin is in a risk connected with or incidental to the employment so that there is a causal relationship between the employment and the accidental injury. *Orsini v. Indus. Comm'n*, 509 N.E.2d 1005 (1987). In order to meet this burden, a claimant must prove that the risk of injury is peculiar to the work ***or*** that he or she is exposed to the risk of injury to a greater degree than the general public. *Id.* "In the course of employment" refers to the time, place and circumstances surrounding the injury. *Lee v. Indus. Comm'n*, 656 N.E.2d 1084 (1995); *Scheffler Greenhouses, Inc. v. Indus. Comm'n*, 362 N.E.2d 325 (1977). That is to say, for an injury to be compensable, it

generally must occur within the time and space boundaries of the employment. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 671 (2003).

For an injury caused by a fall to arise out of the employment, a claimant must present evidence which supports a reasonable inference that the fall stemmed from a risk associated with her employment. Employment related risks associated with injuries sustained as a consequence of a fall are those to which the general public is not exposed such as the risk of tripping on a defect at the employer's premises, falling on uneven or slippery ground at the work site, or performing some work related task which contributes to the risk of falling. *First Cash Fin. Services v. Indus. Comm'n*, 367 Ill. App. 3d 102, 105–06, 853 N.E.2d 799, 803-804 (1st Dist. 2006).

The issue in dispute is whether Petitioner's accident arose out of her employment with Respondent. The Arbitrator finds that Petitioner met her burden that she sustained an accident arising out of her employment with Respondent on 11/3/17. The Arbitrator finds that Petitioner testified credibly that she slipped on asphalt while participating in kickball during her recess duties. Petitioner testified that as a music teacher, one of her assigned work periods was recess duty. Petitioner testified that kickball is not an activity she engages in outside her work duties. She stated that at the beginning of each school year she attends a meeting with teachers, administration, and aides who are instructed to engage and interact with students at recess. Petitioner understood interaction to mean monitor behavior, mediate disagreements, encourage the kids to play, and to play with them if needed.

Petitioner testified she engaged with the students on 11/3/17 to avoid an argument. She was not criticized or sanctioned for her activities that day. She testified she did not receive additional compensation for engaging with students at recess, but if she did not engage she might have lost her job for not performing her duties.

Petitioner testified that all teachers participate with students at recess, including playing tag football, basketball, and kickball. She stated these duties were not voluntary and were absolutely her assigned duties she was ordered to perform. She testified that administration witnessed the teachers' participation on the playground. A playground aide, Charlotte Rodriquez, testified she was working on the playground the day Petitioner was injured and agreed with Petitioner's testimony that teachers and aides participate in recreation with students at recess. Mrs. Rodriquez testified that they were all encouraged to participate in recreation with the students at recess. The principal and assistant principal were present during the teachers' participation and they encouraged staff to be part of what the students were doing. Staff were encouraged to pitch the ball, play basketball, etc. by the principal and assistant principal. Mrs. Rodriquez testified that staff participation was not voluntary but part of their job duties.

The Assistant Superintendent for the Triad Community School District, Kennan Fagan, testified there is no district policy regarding teachers participating in recreational activities with students. Mr. Fagan testified there are no descriptive statements in teachers' job descriptions or contracts that mandate the teacher engage in recreational activities with students. Although Mr. Fagan testified that staff participation with students in recreation is voluntary, he confirmed he did not attend any of the meetings at Silver Creek where playground duties were discussed and

would defer to the principal at the school as to what level of participation was mandated. Further, he was not aware what Silver Creek's principal, Mr. Schomber, told his staff and he could not judge whether Petitioner's or Mrs. Rodriquez's testimony was accurate or not. He did not observe the level of participation at Silver Creek.

There is ample evidence to support Petitioner's injury was peculiar to her recess duties and that she was exposed to the risk of injury to a greater degree than the general public. It was unrebutted that it was common practice for Petitioner and other certified teachers on recess duty to engage in their students' recreation and therefore her accident was foreseeable. Respondent had no policy prohibiting such conduct; to the contrary both Petitioner and Mrs. Rodriquez testified they were encouraged to play and that testimony was unrebutted. The Arbitrator finds that Petitioner was performing acts she was instructed to perform by her employer. The acts were ones that Respondent reasonably and explicitly ordered her to perform as part of her assigned duties. The risk had employment related characteristics. The Arbitrator finds that Petitioner was exposed to a risk distinctly associated with her employment. *Potenzo v. IWCC,* 378 Ill.App.3d 113 (2007); *Litchfield Healthcare Center v. I.C.,* 349 Ill.App.3d 486 (5th Dist. 2004).

Further, the Arbitrator finds that Petitioner is exposed to the risks of falling on a hard and slick surface more frequently than the general public because she played regularly with the students. The Arbitrator finds that the recreational exclusion found in Section 11 of the Act does not apply in this case. Section 11 states that accidental injuries incurred while participating in voluntary recreational programs, including but not limited to athletic events, do not arise out of and in the course of employment even though the employer pays some or all of the costs thereof. *Dowdle v. South Berwyn School,* 18 I.W.C.C. 0710 (2018). This exclusion, though, shall not apply in the event the injured employee was ordered or assigned by her employer to participate in the program. Petitioner and Mrs. Rodriquez did not believe that participation in recreation at recess was voluntary and they both testified they were ordered to engage in various recess activities as part of their job duties. The Arbitrator finds that Petitioner and Mrs. Rodriquez were credible in their testimony that the activity was part of their assigned duties. Playing kickball with second graders was also not a recreational program for Petitioner.

The Arbitrator further distinguishes this case from the many Illinois Workers Compensation cases that have interpreted the meaning of Section 11, including whether an activity is actually voluntary or recreational, and whether it occurs during the course of employment or provides some benefit to the employer, and if the employee feels pressure to participate in an event even when it is not mandatory to participate. In Pickett v. Industrial Commission, 252 Ill. App.3d 355, 192 Ill Dec.109, 625 N.E.2d 69 (1st District 1993), the employee was a sheriff who was injured while playing for the sheriff department's basketball team. The employee was on the team voluntarily and admitted he was never asked, told or made to feel like he needed to play on the basketball team. However, the department had a lot of control over the team. The department provided the practice location and uniforms in addition to paying wages for travel and game time to the players if their working hours conflicted with the game. The Pickett court ultimately held that the injuries were not compensable because the employee's participation was completely voluntary. In addition, the court noted that the employee was paid during working hours to participate in the activity, but still construed the activity as completely voluntary. Even though the Police department was providing everything

for the game including travel, uniforms, and location, participation was still voluntary, and the department did not pressure the employee.

In the present case, Petitioner's participation in recreation at recess was part of her job duties she was encouraged and instructed by Respondent to perform. Petitioner's co-worker supported Petitioner's understanding that all recess attendants were to engage in recreational activities on the playground. The principal that mandated such interaction was not present to testify at arbitration. The Assistant Superintendent did not rebut whether Petitioner and her co-worker were mandated to participate as part of their job duties. The only evidence produced at arbitration supports a finding that Petitioner's duties were not voluntary.

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?

Based on the above findings regarding accident and the stipulation by the parties as to causal connection, the Arbitrator finds Petitioner is entitled to medical benefits related to her right knee and left shoulder. The Arbitrator finds Respondent has not paid all charges relating to Petitioner's reasonable and necessary medical care. As a result, Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, totaling $10,084.22, equating to $2,531.00 due and owing Washington University Physicians; $1,014.72 due and owing Gateway Regional Medical Center; $4,118.50 due and owing Apex Physical Therapy; and $2,420.00 due and owing BJC Hospital, as provided in Section 8(a) and Section 8.2 of the Act. Respondent shall be given a credit for any amounts previously paid under Section 8(a) of the Act for medical benefits and Respondent shall hold Petitioner harmless from claims by any providers of the services for which Respondent is receiving this credit.

Respondent shall further reimburse Petitioner for out-of-pocket medical expenses in the amount of $1,469.17 and hold Petitioner harmless from any and all subrogation claims that may or have been asserted by UHC Insurance.

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

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party submitted an impairment rating. 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 Petitioner continues to work full duty as a music teacher for Respondent, without restrictions. She has been employed by the Respondent for 10 years. No evidence was introduced

that Petitioner's current condition interferes with the performance of her job, therefore the Arbitrator places greater weight on this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 38 years old at the time of the accident. In Jones v. Southwest Airlines, 16 I.W.C.C. 0137 (2016), the Commission concluded that greater weight should be given to Petitioners who are younger in age because they would have to work with a disability for an extended period of time. While Petitioner is 38 and not near retirement age, she does have over 27 years before ordinary retirement age, working with ongoing symptoms and limitations for the remainder of her work life. The Arbitrator places some weight on this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes there is no evidence of reduced earning capacity contained in the record. Petitioner testified she has returned to full-duty work for Respondent in the same position she was working prior to the accident. There is no evidence that Petitioner is unable to perform her work duties. The Arbitrator therefore gives greater weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner was a credible witness. Petitioner has a subchondral fracture in the central weight-bearing lateral femoral condyle and the anterior medial femoral condyle of her right knee. She sustained a rupture of the acromioclavicular capsule in her left shoulder. Both her right knee and left shoulder were treated conservatively. Despite being released at MMI without restrictions, Petitioner testified she has discomfort in her right knee ascending stairs, performing moderate exercise, and kneeling on hard surfaces. She experiences knee pain a few times per week and rates her pain 3 to 4 out of 10.

She continues to experience left shoulder pain with lifting, arm motion, and sleeping on her left side. Petitioner demonstrated she cannot raise her left arm as high as her dominant right arm since the accident. She alleges she lost two to three inches of range of motion. Petitioner testified she has lost the same range when reaching behind her back. Petitioner testified that her shoulder pain is rated 5 out of 10 if she puts pressure on her left side. Lifting her 5-year-old son is painful and she cannot put him on her shoulders. Physical activity involving her shoulder causes 2 to 4 out of 10 pain. Shivering from cold temperatures also causes pain in her shoulder. Taking into consideration Petitioner's continued symptoms and limitations with respect to her left shoulder and right knee, none of which she experienced before the accident of 11/3/17, the Arbitrator gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds Petitioner sustained permanent partial disability to the extent of 7.5% of the body as a whole related to her left shoulder under §8(d)2 of the Act, and 10% loss of the right leg pursuant to Section §8(e)12 of the Act.

Linda Cantrell, Arbitrator

8/27/20
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC014307
Case Name	TREJO,ENEDINO v. SIGNODE INDUSTRIAL GROUP
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0281
Number of Pages of Decision	24
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Mark Schaffner
Respondent Attorney	Leonardo Morales

DATE FILED: 6/9/2021

/s/ Stephen Mathis, Commissioner

Signature

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

ENEDINO TREJO,

Petitioner,

vs. NO: 15WC 14307

SIGNODE INDUSTRIAL GROUP,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue(s) of 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 November 8, 2019 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 $9,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

June 9, 2021

/s/ *Stephen J. Mathis*
Stephen J. Mathis

SJM/sj
o-5/18/2021
44

/s/ *Deborah Baker*
Deborah Baker

/s/ *Deborah Simpson*
Deborah Simpson

21IWCC0281

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TREJO, ENEDINO Case# **15WC014307**
Employee/Petitioner

SIGNODE INDUSTRIAL GROUP
Employer/Respondent

On 11/8/2019, 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:

1218 MARK S SCHAFFNER LAW OFFICES
100 N RIVERSIDE PLZ
SUITE 2150
CHICAGO, IL 60606

0766 HENNESSY & ROACH PC
PETER J PUCHALSKI
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF **COOK**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ENEDINO TREJO,
Employee/Petitioner

v.

SIGNODE INDUSTRIAL GROUP,
Employer/Respondent

Case # **15** WC **14307**

Consolidated cases: **n/a**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **JANUARY 23, 2019**. 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 **ATTORNEY'S FEES FOR FORMER ATTORNEY**

FINDINGS

On **AUGUST 20, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**40,066.00**; the average weekly wage was $**770.50**.

On the date of accident, Petitioner was **56** years of age, ***married*** with **1** dependent child.

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

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

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

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

ORDER

As detailed in the attached memorandum discussing the *Findings of Fact and Conclusions of Law:*

- The Arbitrator finds the Respondent shall pay Petitioner the sum of **$462.30** per week for a period of **20 weeks**, as provided in **Section 8(d)2** of the Act, because the injury to the Petitioner caused **a 4% loss of use of the person-as-a-whole.;** and,

- The Arbitrator finds no causal connection exists between any bilateral hernia condition and a work accident of August 20, 2014. Additionally, the Arbitrator finds no causal connection exists between any lumbar spine condition and a work accident of August 20, 2014, after October 6, 2014 as Petitioner reached maximum medical improvement at that time.; and,

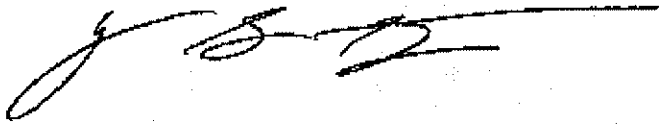
- The Arbitrator finds the Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, for all treatment with the Clearing Clinic pursuant to stipulation of the parties. Additionally, Petitioner's request for medical services from any provider other than Clearing Clinic is denied because Petitioner's current condition of ill-being is not causally related to his work accident of August 20, 2014.; and,

- The Arbitrator finds Petitioner's claim for TTD benefits from May 6, 2016 through July 18, 2017, and TPD benefits from July 18, 2017 through July 18, 2018 is denied as Petitioner's current condition of ill-being is not causally related to his August 20, 2014 work accident.; and,

- The Arbitrator finds the Respondent shall pay those benefits that have accrued in a lump sum, and shall pay the remainder, if any, in weekly payments.

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

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



Signature of Arbitrator

NOVEMBER 8, 2019
Date

NOV 8 - 2019

ENEDINO TREJO v. SIGNODE INDUSTRIAL GROUP

15 WC 14307

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried before Arbitrator Steffenson on January 23, 2019. The issues in dispute were causal connection, medical bills, TTD and TPD benefits, nature and extent, and attorney's fees for a former attorney. (Arbitrator's Exhibit 1). The parties agreed to receipt of this Arbitration Decision via e-mail and requested a written decision, including findings of fact and conclusions of law, pursuant to Section 19(b) of the Act. (Arbitrator's Exhibit (*hereinafter*, AX) 1).

FINDINGS OF FACT

On August 20, 2014, Petitioner was 56 years old and worked for Signode Industrial Group as a machine operator. (Transcript P 16 – 17). He suffered a workplace injury on August 20, 2014.[1] Petitioner testified that he was pulling a heavy coil and felt pain in his lower back and left testicle. (Transcript (*hereinafter*, TX) P 22-23).

Petitioner did not present for any immediate medical treatment. Petitioner did not seek treatment for eight days. (TX P. 57). During those eight days Petitioner continued to work as a machine operator with an assistant. (TX P. 57).

Petitioner testified that he first treated with the Clearing Clinic between August 28, 2014 and October 8, 2014. (TX P 30). When Petitioner was first seen on August 28, 2014, he reported pain in the lower back and lower left side of stomach. (Respondent's Exhibit 3). There was no recorded complaint of testicular pain. On examination, Petitioner had full range of motion in the lumbar spine with a negative straight leg raise test; Petitioner had full and symmetrical strength in the bilateral lower extremities. (Respondent's Exhibit (*hereinafter*, RX)

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[1] The parties stipulated the accident "arose out of and in the course of" Petitioner's employment with Respondent. (AX 1).

3). No inguinal hernia was present on examination. (RX 3). Petitioner was diagnosed with a lumbar strain and was not placed under any form of work restriction. (RX 3).

Petitioner returned to the Clearing Clinic on September 3, 2014 and reported a 40% improvement in his symptoms. (Petitioner's Exhibit 6). Petitioner was again diagnosed with a lumbar strain and was released full duty. (Petitioner's Exhibit (*hereinafter*, PX) 6).

The next visit was September 10, 2014. A Review of Systems found that no abdominal pain was present. (PX 6). Petitioner was diagnosed with a lumbar strain and was released full duty. (PX 6). Petitioner began performing physical therapy through the Clearing Clinic on September 15, 2014. Petitioner reported improvement in his symptoms when he was seen on September 17, 2014. Petitioner's pain was rated at 3/10. (PX 6). Petitioner was instructed to continue performing physical therapy. (PX 6).

Petitioner was seen at the Clearing Clinic on September 29, 2014 and rated his pain at 1/10. (PX 6). Petitioner was diagnosed with a lumbar strain. Petitioner was not placed under any work restriction. (PX 6).

Petitioner returned for evaluation on October 6, 2014. Petitioner was discharged from care at that time. (PX 6). On examination, Petitioner had full and pain free range of motion, full and symmetrical strength in the bilateral lower extremities, normal reflexes and no tenderness to palpation. (PX 6). Petitioner rated his pain at 1/10. Petitioner was released to return to work on a full duty basis. (PX 6).

Petitioner completed a total of eight physical therapy sessions with the Clearing Clinic. The final session took place on October 8, 2014. The final therapy note indicates that Petitioner's pain was rated at 0-1/10. (PX 6). Petitioner was able to lift a 50-pound box cart and push/pull a 150-pound sled for 50 feet without any lower back pain. (PX 6). Petitioner reported no functional limitations and was found to be able to perform his job requirements without modifications. (PX 6).

Petitioner continued working from October of 2014 through March of 2015. Petitioner testified that he worked on a full-time basis during this time frame. (TX P 61). Petitioner testified that he continued to work as a machine operator. (TX P 61). Petitioner testified that he took pain medication but did not seek any medical treatment with the Clearing Clinic. (TX P 62). During this same time frame, Petitioner was treated by his primary care physician for various health conditions. Petitioner's treatment records from the Mirshed Medical Center were admitted into evidence as Respondent's Exhibit #11. Dr. Mirshed was identified as Petitioner's primary care physician. (TX P 70). Petitioner claimed that he was never seen by Dr. Mirshed for abdominal pain. (TX P 71). Petitioner claimed that Dr. Mirshed never physically examined his groin or abdomen in October 2014. (TX P 71).

Petitioner was evaluated by Dr. Mirshed on October 20, 2014. This was two months after Petitioner's work accident. Dr. Mirshed noted complaints of abdominal pain, epigastric pain and depression. (RX 11). Dr. Mirshed did not record any complaints of lower back pain. In the review of systems section Dr. Mirshed notes that Petitioner was "negative" for back pain. (RX 11). Petitioner reported that his abdominal/epigastric pain began two months prior and that there was "no apparent trigger." (RX 11). Dr. Mirshed completed a physical examination and no masses were identified in the gastrointestinal region. (RX 11). No swelling was present in the inguinal region. (RX 11). Dr. Mathur diagnosed abdominal pain.

Dr. Mirshed next examined Petitioner on November 3, 2014. No masses were identified in the gastrointestinal region and no swelling was present in the inguinal region. (RX 11). There was no recorded complaint of lower back pain. In the review of systems section Dr. Mirshed notes that Petitioner was "negative" for back pain. (RX 11).

Dr. Mirshed completed an annual physical on November 8, 2014. At this time, Petitioner was found to be negative for abdominal pain and negative for back pain. (RX 11). Dr. Mirshed found no swelling in the inguinal region and Petitioner's musculoskeletal and neurological examination were normal. (RX 11). There are subsequent notes from November 17, 2014, December 1, 2014, December 10, 2014, December 27, 2014, April 4, 2015 and July 10, 2015. There is no recorded complaint of lower back pain in these six office notes. (RX 11). There is no recorded complaint of abdominal, groin or testicle pain in these six office notes. (RX 11). There was no swelling in the inguinal region noted throughout these six office visits. (RX 11). Petitioner did report left foot pain on December 27, 2014 that was not attributed to any event or injury. (RX 11).

In March of 2015, Petitioner testified that he returned to the Clearing Clinic due to ongoing pain complaints. (TX P 36). His records from Clearing Clinic document an office visit on March 16, 2015. This examination was approximately seven months after the August 2014 injury and five months after his last service date (October 2014). Petitioner reported low back pain with throbbing pain into the left testicle and abdomen. (PX 6). On examination, Petitioner had diminished range of motion, but a negative straight leg raise test, bilaterally, full and symmetrical strength in the bilateral lower extremities and normal reflexes. (PX 6). There were no palpable masses in the abdomen, no hernia identified in the inguinal region and no enlargement of the testicle. (PX 6). Petitioner was diagnosed with a lumbar strain and was placed under a 15-pound lifting restriction.

Petitioner was next seen at the Clearing Clinic on March 23, 2015. Petitioner was instructed to perform physical therapy and an MRI was ordered. (PX 6). The same recommendations were offered on April 2, 2015. (PX 6). On April 13, 2015, Petitioner reported that his symptoms had worsened. Petitioner was maintained under a 15-pound lifting

restriction. (PX 6). He completed a total of nine physical therapy sessions at the Clearing Clinic lasting through April 21, 2015. The final physical therapy note indicates that Petitioner had normal active range of motion in the lumbar spine and a negative straight leg raise test bilaterally. (PX 6). Petitioner reported 50% improvement in his pain and mobility. (PX 6).

Petitioner returned to the Clearing Clinic on April 23, 2015 and reported improvement in his lower back pain. Petitioner was diagnosed with a lumbar strain and epididymitis; Petitioner's testicular pain was found to be "unspecified" and unrelated to work. (PX 6). Petitioner was advanced to a 25-pound lifting restriction. (PX 6).

The final office visit with the Clearing Clinic took place on April 30, 2015. Petitioner was discharged from care and was released to return to work on a full duty basis. (PX 6). Throughout his treatment at the Clearing Clinic Petitioner never reported right-sided abdominal, groin or testicle complaints. On the same day that he was released to return to work on a full duty basis at the Clearing Clinic, Petitioner was seen with a new medical provider, La Clinica. Petitioner testified that he was directed to La Clinica by his attorney. (TX P 64).

Petitioner was first seen by a chiropractor, Dr. Eugene Jao on April 30, 2015. As part of the initial evaluation, a history survey/questionnaire was completed. Petitioner denied any past low back pain and injuries. (PX 9). Petitioner did not disclose any prior tests involving the lower back including his MRI, CT Scan and EMG from July 2013. (PX 9). The initial note reflects a diagnosis of low back pain and pain the left testicle and inguinal region. (PX 9). Petitioner began performing therapy/chiropractic treatment with La Clinica.

On May 6, 2015, Petitioner was seen by Dr. Goldvekht at La Clinica. A lumbar spine MRI was ordered. Petitioner was referred to a general surgeon for his inguinal and testicular symptoms. (PX 9). The lumbar spine MRI was completed on May 9, 2015 at Archer Open MRI. The study demonstrated a broad-based left disc protrusion at L3-4 contributing to neural foraminal and central canal stenosis. (PX 9).

On May 13, 2015, Dr. Goldvekht ordered a bilateral lower extremity EMG and referred Petitioner to Dr. Glaser for pain management. (PX 9). The EMG study was completed through La Clinica on May 15, 2015. The study was normal with no evidence of lumbar radiculopathy. (PX 9).

Petitioner was seen by a general surgeon, Dr. Bernardo Duarte, on June 8, 2015. Petitioner presented with complaints of left groin and testicle pain; Petitioner reported no pain or discomfort on the right side. (PX 5). Dr. Duarte diagnosed bilateral inguinal hernia and recommended surgical repair. (PX 5). Petitioner did not return for additional treatment with Dr. Duarte until August 2016.

On November 19, 2015, Petitioner was referred by La Clinica for a surgical consultation with Dr. Kevin Koutsky of Elmhurst Orthopaedics. (PX 9). On November 30, 2015, Dr. Koutsky completed his initial evaluation of the Petitioner. Petitioner presented with complaints of low back pain radiating down the left lower extremity. (PX 8). Dr. Koutsky diagnosed L3-4, L4-5 left lower extremity radiculopathy. (PX 8). Dr. Koutsky discussed surgical intervention. An L3-4, L4-5 decompression and fusion was formally recommended by Dr. Koutsky on December 28, 2015. (PX 8).

Thereafter, on January 25, 2016, Dr. Koutsky recommended physical therapy and ordered a lumbar discogram. (PX 8). Petitioner then was seen by Dr. Koutsky on March 2, 2016 and trigger point injections were completed. (PX 8). On April 4, 2016, Dr. Scott Glaser performed a discogram involving L2-3, L3-4, L4-5 and L5-S1. (PX 8)

Dr. Koutsky subsequently reviewed the discogram results on April 6, 2016 and interpreted the study to demonstrate concordant pain at L3-4 and L4-5. (PX 8). Surgery was recommended. Thereafter, on May 10, 2016, Dr. Kevin Koutsky completed a L3-4, L4-5 decompressive laminectomy and posterior interbody fusion at Elmhurst Memorial Hospital. (PX 7,8).

Petitioner returned for evaluation with Dr. Duarte for his groin pain on August 20, 2016. Dr. Duarte diagnosed bilateral inguinal hernias and recommended a surgical repair. (PX 5). On August 29, 2016, he completed a laparoscopic preperitoneal repair of Petitioner's bilateral inguinal hernias. (PX 5).

Petitioner was seen by Dr. Koutsky on November 10, 2016 and a repeat lumbar spine MRI ordered. Petitioner was using a cane to ambulate. (PX 8). Dr. Koutsky reviewed the MRI results on December 15, 2016 and found no evidence of hardware complications. (PX 8). Then, throughout 2016 and 2017, Petitioner remained under the care and treatment of Dr. Koutsky and he performed post-operative physical therapy through La Clinica. (PX 8, 9).

On July 13, 2017, Dr. Koutsky ordered an FCE. (PX 8). The FCE was completed on August 8, 2017 at Elite Physical Therapy. Petitioner was found to be functioning at a sedentary-light physical demand level and demonstrated the ability to lift loads up to 15 pounds occasionally. (PX 10). Dr. Koutsky then examined Petitioner on September 28, 2017. Petitioner was placed at maximum medical improvement and was released to return to work with permanent restrictions, per the FCE results. (PX 8).

Petitioner returned for evaluation with Dr. Duarte on December 2, 2017, almost nine-month after his last visit. Petitioner reported ongoing left groin pain and Dr. Duarte diagnosed a recurrent left-sided hernia. (PX 5). Accordingly, on December 29, 2017, Dr. Duarte completed surgical repair of a left indirect recurrent inguinal hernia. (PX 5). The last office note from Dr.

Duarte is dated January 6, 2018. Petitioner was instructed to increase his exercise level slowly. (PX 5).

The final office visit with Dr. Koutsky was November 19, 2018. Petitioner reported residual low back and lower extremity pain. Dr. Koutsky prescribed pain medication. (PX 8).

The records from La Clinica demonstrate that through May 25, 2017, Petitioner had no less than 196 service dates, 94 in a pre-operative setting and 102 post-operative sessions. (PX 9).

Petitioner's therapy and chiropractic treatment with La Clinica was subject to a retroactive utilization review completed by Dane Street. In a report dated December 31, 2018, Dr. David Trotter certified a total of 10 pre-operative therapy sessions and 34 post-operative physical therapy/chiropractic/work conditioning sessions. (RX 13).

Petitioner testified that he continued working with the help of an assistant from August 20, 2014 through May 6, 2016. (TX P 45). Petitioner was then taken off work by Dr. Koutsky (TX P 45-46). Following his lumbar spine surgery, Petitioner testified that he later returned to work on a modified basis effective July 18, 2017. (TX P 46). Petitioner testified that he worked restricted hours from July 18, 2017 through July 18, 2018. (TX P 47). Petitioner offered into evidence wage records documenting Petitioner's earnings during this time frame. (PX 3, 4). Petitioner testified that since returning to work in July 2017 he has not missed any time from work due to lower back pain. (TX P 67-68). Petitioner is seeking an award of TTD benefits from May 6, 2016 through July 18, 2017, a period of 62 4/7 weeks. (AX 1). Petitioner is seeking an award of TPD benefits from July 18, 2017 through July 18, 2018, a period of 52 weeks. (AX 1).

Petitioner was questioned about his current condition and testified that he suffers from back pain associated with prolonged sitting or walking and is not able to lift over ten pounds. (TX P 49-50). Petitioner testified that he takes pain medication to help alleviate his symptoms. (TX P 51).

Petitioner testified that he has group health coverage through his employer and that his group plan paid for some of his lower back and hernia treatment. (TX P 49, 71). Petitioner's medical bills were entered into evidence as Petitioner's Exhibit #1. An itemization of group health payments by Petitioner's group health carrier, Blue Cross Blue Shield, was entered into evidence as Respondent's Exhibit #14.

Petitioner categorically denied ever suffering from lower back pain or treating for lower back injuries prior to August 20, 2014. Petitioner testified that his treatment with Dr. Mathur and Dr. Troy in 2013 was for the left ankle only and did not involve any other body part. (TX P 54). Petitioner denied reporting lower back pain to Dr. Troy and Dr. Mathur. (TX P 55).

Petitioner denied reporting left lower extremity symptoms to either Dr. Troy or Dr. Mathur. (TX P 56). Petitioner twice denied ever experiencing lower back pain prior to August 20, 2014. (TX P 56, 70).

Petitioner testified that he received two injections from Dr. Troy in 2013. Petitioner testified that the injections were administrated to his lower back and not his left ankle. (TX P 55). Petitioner admitted to completing a lumbar spine MRI in July 2013. (TX P 55). Petitioner admitted to completing a left lower extremity EMG in July 2013. (TX P 55).

Records from Petitioner's primary care physician, Dr. Virenda Mathur/Midway Internal Medicine, were admitted into evidence as Respondent's Exhibit #7. These records document the presence of low back pain on October 26, 2012. When Petitioner was seen on that date he rated his low back pain at 8/10. (RX 7). Dr. Mathur ordered lumbar spine x-rays. (RX 7).

Petitioner returned on November 24, 2012. The note references a diagnosis of degenerative joint disease of the lumbosacral spine. (RX 7). Dr. Mathur recommended physical therapy.

Petitioner was seen on June 21, 2013 with significant left leg pain rated at 8-9/10. (RX 7). Dr. Mathur diagnosed trochanteric/hip bursitis and administered a corticosteroid injection to the hip. (RX 7). Under re-direct examination from his own attorney, Petitioner denied suffering from hip pain and testified that if his physician found left hip bursitis that would not be correct. (TX P 74-75).

Left leg symptoms were noted on June 28, 2013 and Dr. Mathur diagnosed peripheral neuropathy. (RX 7).

Petitioner returned for evaluation with Dr. Mathur on July 26, 2013. Petitioner reported ongoing back pain of a gradual onset. (RX 7). Dr. Mathur diagnosed spine osteoarthritis and Petitioner was scheduled to be evaluated at a pain clinic. (RX 7). A subsequent note dated October 25, 2013 instructed Petitioner to follow-up with Dr. Troy for a third injection. (RX 7)

A bilateral lower extremity EMG was completed by Dr. Putnam at Little Company of Mary Hospital on July 5, 2013. The history section of this records indicates that Mr. Trejo had low back and left lower limb pain rated at 10/10. (RX 2). On examination, Dr. Putnam found decreased motor strength in the left lower extremity. (RX 2). The EMG/NCS found chronic left L5 radiculopathy and coexisting sensorimotor polyneuropathy associated with diabetes mellitus. (RX 2).

A CT Scan of the lumbar spine was performed at Skan Radiology on July 12, 2013. Mild to moderate neural foraminal narrowing was present at L3-4 and L4-5. (RX 9).

A lumbar spine MRI was completed at DAC Imaging on July 31, 2013. At L3-4 there was moderate neural foraminal and lateral recess stenosis. (RX 8). Moderate stenosis was also present at L4-5. (RX 8).

Petitioner presented for an initial orthopaedic evaluation with Dr. Troy on July 27, 2013. Petitioner reported back pain with symptoms in the left buttock, lateral hip into his posterior thigh, calf and top of his foot. (RX 7). On examination, Dr. Troy found a positive straight leg raise test on the left. X-rays were completed, and Dr. Troy noted moderate degenerative disc disease at L4-5 and L5-S1 with multi-level spondylosis and disc osteophytes. (RX 7). Dr. Troy diagnosed lumbar spinal stenosis with left radiculopathy and polyneuropathy associated with diabetes mellitus. Dr. Troy ordered a lumbar spine MRI. (RX 7).

Petitioner's treatment records with Dr. Troy were entered into evidence as Respondent's Exhibit #1. On September 4, 2013, Dr. Troy completed an epidural steroid injection at the L4-5 level. The diagnosis was bilateral recess stenosis at L4-5, left greater than right. (RX 1).

On October 16, 2013, Dr. Troy administered a left L3-4 and left L4-5 epidural steroid injection. (RX 1). This injection was completed approximately ten months prior to Petitioner's work accident. The two levels Dr. Troy injected were the same lumbar levels involved in the fusion surgery completed by Dr. Koutsky.

At the request of Petitioner's attorney, Dr. Kevin Koutsky prepared a narrative report dated January 3, 2018. In that report, Dr. Koutsky addressed the issue of causal connection and opined that Petitioner's condition of ill-being in the lumbar spine was causally related to a work accident of August 20, 2014. The basis of Dr. Koutsky's opinion was, "He did have some changes which preexisted his work-related injury; however, it was the work-related injury which caused these asymptomatic preexisting changes to become symptomatic." (PX 11). Dr. Koutsky placed emphasis on the fact that "Prior to the work-related injury, Mr. Trejo was not complaining of any radiating symptoms to his leg." (PX 11). Dr. Koutsky's report did not address Petitioner's pre-existing low back and left lower extremity symptoms from July through October 2013, Petitioner's prior low back treatment with Dr. Mathur and Dr. Troy or the results of a prior lumbar spine MRI, CT Scan and lower extremity EMG completed in July 2013. (PX 11).

The parties completed Dr. Koutsky's evidence deposition on April 30, 2018. Dr. Koutsky testified that Petitioner had preexisting degenerative changes that were aggravated and made symptomatic by his work accident of August 20, 2014. (PX 12, P 22). Dr. Koutsky testified that any opinion he offered was not based on treatment Petitioner completed with Dr. Troy in 2013 (P. 50), was not based on a review of lumbar spine MRI films from 2013 (P. 51) and was not based on a review of a left lower extremity EMG from 2013 (P 58). (PX 12).

Dr. Koutsky admitted that Petitioner never reported any prior lower back symptoms or medical treatment in 2013. (PX 12, P 32). Dr. Koutsky testified that Petitioned failed to disclose his lumbar spine MRI, CT Scan and bilateral lower extremity EMG from 2013. (PX 12, P 32).

Petitioner's 2013 records and reports were reviewed by Dr. Koutsky during his deposition. Dr. Koutsky admitted that the physical examination findings made by Dr. Troy on July 27, 2013 were like his own findings including full and symmetrical strength in the bilateral lower extremities, normal reflexes and a positive straight leg raise on the left side. (PX 12, P 47-48). Dr. Koutsky admitted that his own diagnosis of lumbar spinal stenosis and left radiculopathy was the same diagnosis reached by Dr. Troy on July 27, 2013. (PX 12, P 49). Dr. Koutsky testified that the lumbar level that Dr. Troy found to have the most severe degenerative changes, L3-4, was one of the lumbar levels that Dr. Koutsky fused. (PX 12, P 50). Dr. Koutsky testified that Petitioner's EMG from July 2013 demonstrated a chronic L5 radiculopathy. (PX 12, P 55). Dr. Koutsky attributed that finding to the L4-5 level and admitted that the L4-5 level was one of the lumbar levels he later fused. (PX 12 P 55). Dr. Koutsky reviewed Petitioner's initial treatment note from the Clearing Clinic from August 28, 2014 including Petitioner's subjective complaints, physical examination findings and diagnosis. (PX 12, P 60-64). Dr. Koutsky admitted that Petitioner's subjective complaints and his own physical examination findings and diagnosis from his initial orthopaedic evaluation of the claimant in November of 2015 were more consistent with the symptoms/examination findings/diagnosis of Dr. Troy from 2013 as opposed to the Clearing Clinic in August 2014. (PX 12, P 62-64).

Petitioner was examined by Dr. Stephen Boghossian pursuant to Section 12 of the Act on November 5, 2015 for his abdomen/groin/testicle symptoms. Dr. Boghossian recorded complaints of low back pain and groin pain radiating into the left testicle. (RX 10). On physical examination, Dr. Boghossian found a non-tender abdomen with no evidence of a ventral, incisional or inguinal hernia. (RX 10). Dr. Boghossian opined that Petitioner did not suffer from a left sided inguinal hernia. As no hernia was identified Dr. Boghossian opined that Petitioner did not require a laparoscopic hernia repair. (RX 10).

Petitioner was examined by Dr. Kern Singh pursuant to Section 12 of the Act on December 14, 2015. Petitioner had a normal motor and sensory examination and Dr. Singh found 5/5 positive Waddell signs. (RX 5). Dr. Singh diagnosed a lumbar muscular strain and degenerative disc disease at L3-4. (RX 5). Dr. Singh opined that Petitioner had non-anatomic pain complaints, a normal-appearing MRI, a normal EMG and a normal neurological examination. Dr. Singh opined that Petitioner had reached maximum medical improvement and could perform full duty work. (RX 5).

Dr. Singh prepared an addendum report dated May 21, 2018. In that report, Dr. Singh reviewed prior treatment records and diagnostic studies from 2012 – 2013, along with records

after the original independent medical examination. Dr. Singh opined that there was no appreciable difference between the pre-accident diagnostic studies in 2013 and the post-accident MRI completed on May 9, 2015. (RX 6). Dr. Singh opined that Petitioner had preexisting spondylosis and was clearly symptomatic prior to his work accident of August 20, 2014. (RX 6). Dr. Singh opined that Petitioner was not a candidate for an L3-5 decompression and fusion as there was no evidence of instability, no spondylolisthesis and no stenosis. (RX 6). Dr. Singh maintained his prior opinions that Petitioner had reached maximum medical improvement and was capable of full duty work by the time of his original independent medical examination. (RX 6).

Dr. Singh's evidence deposition was completed by the parties on May 31, 2018. Dr. Singh testified that when he completed his independent medical examination of Mr. Trejo, Petitioner denied any prior lower back injury and medical treatment. (RX 12, P 9). Dr. Singh testified that Petitioner had a normal sensory, motor and reflex examination with full and symmetrical strength in the bilateral lower extremities. (RX 12, P 25-26). Dr. Singh testified that he diagnosed Petitioner with a lumbar muscular strain and degenerative disc disease at L3-4. (RX 12, P 11). Dr. Singh opined that Petitioner's strain resolved approximately four weeks from the date of injury. (RX 12, P 12). Dr. Singh testified that Petitioner's subjective complaints did not correlate with his physical examination findings or the results of the lumbar spine MRI. (RX 12, P 12). Dr. Singh testified that Petitioner had completed excessive treatment and did not require facet injections and chiropractic sessions. (RX 12, P 13).

Dr. Singh testified that the subjective complaints recorded by Dr. Troy in July 2013, including low back and left lower extremity pain were the same complaints recorded by Dr. Singh at the time of his independent medical examination in December 2015 and by Dr. Koutsky throughout 2015 to 2018. (RX 12, P 18). Dr. Singh testified that the two lumbar levels treated by Dr. Troy in July 2013, L3-4 and L4-5, were the same two levels fused by Dr. Koutsky in May of 2016. (RX 12, P 19). Dr. Singh testified that there was no appreciable difference between the MRI and CT scan films from 2013 and the MRI films from May 2015. Specifically, Dr. Singh found that there was no new structural abnormality present in 2015 nor was there significant progression of any degenerative condition. (RX 12, P 20-21).

Dr. Singh testified that Petitioner did not suffer an aggravation of any pre-existing degenerative condition in the lumbar spine based on the following factors:

> The patient has similar pain complaints that predate the injury in question, back and left leg. He has an MRI that is unchanged from pre- to post-injury. Furthermore, he has an EMG, which occurs before the injury, which delineates potential L5 radiculopathy. And then after his injury itself, he has a normal EMG with no evidence of a radiculopathy, suggesting that there's, in fact, no active

> nerve root compression. In addition, his examination is normal with no sensory loss, motor loss or reflex change. RX 12, P 21-22.

Dr. Singh testified that Petitioner was not a candidate for a lumbar fusion based on the following factors:

> He has no stenosis, he has a normal EMG, there's no active nerve root compression, there's no evidence of instability that would indicate a fusion, and there was no stenosis that would indicate a need for a laminectomy; as such, I do not believe that an L3-4 and L4-5 laminectomy and fusion were indicated. (RX 12, P 23).

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

Issue F: *Causal connection*

The Arbitrator finds that there is no causal connection between any bilateral hernia condition and a work accident of August 20, 2014. The Arbitrator finds that Petitioner suffered a lumbar strain as the result of a work accident on August 20, 2014 and that Petitioner reached maximum medical improvement on October 6, 2014.

The Arbitrator's Decision is based on the findings and opinions of Dr. Troy, Dr. Mathur, Dr. Mirshed, Dr. Boghossian, Dr. Singh and the Clearing Clinic. The Decision is also based on Petitioner's lack of credibility as a trial witness.

There is no dispute that Petitioner suffered a work accident on August 20, 2014 as the result of pulling a heavy coil. Petitioner did not seek treatment for eight days. The uncontroverted medical evidence from 2014 confirms that Petitioner suffered a strain injury to the lumbar spine. Petitioner continued working as a machine operator and was discharged from care at the Clearing Clinic on October 6, 2014. Petitioner's pain complaints at this time were rated at 0-1/10.

There is a five-month gap as Petitioner did not return for treatment until March 16, 2015. Petitioner continued to work on a full-time basis during this time frame; there was no

medical evidence presented by Petitioner to suggest any form of work restriction or modification during this time frame. Petitioner testified that he was still working as a machine operator. Petitioner attempted to explain away this gap by testifying that he was still suffering from lower back pain, used pain medication and had an assistant helping him with his work activities. Petitioner's testimony was not substantiated by his treatment records. Petitioner was seen on multiple occasions by his primary care physician during those five months and Dr. Mirshed's records confirm that no back pain was present; Petitioner had a normal musculoskeletal examination.

The Arbitrator was presented with conflicting medical opinions as to whether Petitioner suffered an aggravation of a pre-existing degenerative condition in the lumbar spine. The Arbitrator places greater emphasis on the opinions offered by Respondent's examining physician, Dr. Kern Singh. Dr. Singh's opinions were based upon his own physical examination along with a review of pre and post-injury treatment records and diagnostic studies. Specifically, Dr. Singh reviewed films from a lumbar spine MRI and CT Scan completed in July 2013 along with a lower extremity EMG also performed in July 2013. Dr. Singh's opinions contemplated Petitioner's recorded complaints, treatment and diagnostic studies from July 2013 through October 2013. Conversely, Dr. Koutsky admitted that he was never informed by Petitioner about any prior lower back symptoms or treatment, including all prior diagnostic studies.

The Arbitrator also notes that the causation opinions offered by Dr. Koutsky were based on factual error. In his narrative report of January 3, 2018, Dr. Koutsky explains the basis of his aggravation opinion, "it was the work-related injury which caused these asymptomatic preexisting changes to become symptomatic." (PX 11, *emphasis added*). The report also states: "Prior to the work-related injury, Mr. Trejo was not complaining of any radiating symptoms to his leg." (PX 11, *emphasis added*). Petitioner's records from Dr. Mathur and Dr. Troy clearly document that Petitioner's pre-existing, degenerative changes were in fact symptomatic prior to August 20, 2014. Moreover, Petitioner reported low back and left lower extremity symptoms throughout the summer of 2013 rated as high as 10/10. (RX 2).

The Arbitrator's Decision is based on the opinion of Dr. Singh that Petitioner suffered a soft tissue lumbar strain as the result of his work accident on August 20, 2014 and that the strain resolved within approximately four weeks. (RX 12, P 12). This opinion is consistent with Petitioner's discharge from the Clearing Clinic on October 6, 2014. This opinion is consistent with Petitioner's subsequent records from Dr. Mirshed where Petitioner denied any lower back pain.

The Arbitrator specifically finds that Petitioner was not a credible trial witness. Petitioner explicitly denied ever suffering from lower back and left lower extremity symptoms prior to August 20, 2014. Curiously, Petitioner admitted to undergoing a lower back MRI in July 2013, a left lower extremity EMG in July 2013 and two injections with Dr. Troy that were administered to the lower back. Petitioner testified that his treatment in 2013 was for a left ankle injury. Petitioner's testimony was impugned by the records/reports from Dr. Troy, Dr. Mathur, DAC Imaging, Little Company of Mary Hospital and Skan Radiology.

The Arbitrator finds that Petitioner actively concealed a significant history for lower back and left lower extremity symptoms from all his medical providers. The Arbitrator finds that Petitioner incredulously failed to admit to any prior lower back and left leg symptoms and medical treatment at the time of hearing. The Arbitrator notes that an award of benefits after October 2014 would rely too heavily upon Petitioner's trial testimony that was repeatedly proven to be untruthful and therefore should be given no meaningful weight.

The Arbitrator's Decision that there is no causal connection between any bilateral hernia condition and a work accident of August 20, 2014 is based on the findings and opinions of Dr. Boghossian, Dr. Mirshed and the Clearing Clinic. The Decision is also based on Petitioner's lack of credibility as a trial witness.

Petitioner did report left-sided abdominal pain when he was first examined at the Clearing Clinic on August 28, 2014. No inguinal hernia was present on examination. Contrary to Petitioner's trial testimony, there was no complaint of testicular pain recorded at this time. There were no recorded complaints of testicular pain throughout Petitioner's initial course of treatment from August to October 2014.

The Arbitrator places emphasis on the records from Petitioner's own primary care physician, Dr. Nayeh Mirshed. Petitioner testified that he was never seen by Dr. Mirshed for abdominal issues which was not truthful. Petitioner was evaluated by Dr. Mirshed on October 20, 2014 some two months after Petitioner's work accident. Dr. Mirshed noted complaints of abdominal pain, epigastric pain and depression. Dr. Mirshed completed a physical examination and no masses were identified in the gastrointestinal region. No swelling was present in the inguinal region. Subsequent records from Dr. Mirshed throughout 2014 and 2015 confirm that no masses were identified in the gastrointestinal region and no swelling was present in the inguinal region.

When Petitioner returned to the Clearing Clinic on March 16, 2015, on examination there was no palpable masses in the abdomen, no enlargement of the testicle and no hernia identified in the inguinal region. On April 23, 2015, Petitioner's testicular pain was found to be "unspecified" and unrelated to work.

The Arbitrator's Decision is further supported by the findings and opinions of Respondent's examining physician, Dr. Stephen Boghossian. Dr. Boghossian examined Petitioner on November 5, 2015 for his abdomen/groin/testicle symptoms. On physical examination, Dr. Boghossian found a non-tender abdomen with no evidence of a ventral, inscisional or inguinal hernia. (RX 10). Dr. Boghossian opined that Petitioner did not suffer from a left-sided inguinal hernia.

The findings and opinions of Dr. Boghossian, the Clearing Clinic and Dr. Mirshed are all entirely consistent. Between August 28, 2014 and November 5, 2015 these three medical providers examined Petitioner for abdominal/groin/testicle pain and none of these three providers identified any palpable masses or diagnosed Petitioner with an inguinal hernia. These three medical providers clearly represent a preponderance of the medical evidence on this issue.

Based on the foregoing, the Arbitrator finds that there is no causal connection between any bilateral hernia condition and a work accident of August 20, 2014. The Arbitrator finds that Petitioner suffered a lumbar strain as the result of a work accident on August 20, 2014 and that Petitioner reached maximum medical improvement by October 8, 2014; no causal connection exists thereafter.

Issue J: *Medical bills*

The Arbitrator finds that Respondent has paid all appropriate charges for all reasonable and necessary medical services. This is based on a finding that Petitioner reached maximum medical improvement by October 8, 2014. The Petitioner's only treatment through that date was with the Clearing Clinic. By stipulation, Respondent agreed to pay for any treatment with the Clearing Clinic.

Accordingly, the Arbitrator rejects any request for medical bills after October 6, 2014, as no causal connection exists.

Issue K: *TTD and TPD benefits*

The Arbitrator finds that entitlement to TTD and/or TPD benefits is a moot issue as no causal nexus existed between Petitioner's condition of ill-being during any requested period to TTD/TPD benefits and a work accident of August 20, 2014.

Issue L: *Nature and extent of injury*

Pursuant to Section 8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability ("PPD"), for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all 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 from (a) above;
(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.

(See 820 ILCS 305/8.1b)

With regards to factor (i) of Section 8.1b of the Act:

i. The Arbitrator notes that neither party submitted into evidence an AMA rating report. As such, the Arbitrator gives ***no weight*** to this factor.

With regards to factor (ii) of Section 8.1b of the Act:

ii. The Arbitrator finds the Petitioner was employed as a machine operator for the Respondent. He returned to his usual and customary position with the Respondent upon a full duty release. The Petitioner reported residual complaints after his full duty release. As such, the Arbitrator gives ***some weight*** to this factor.

With regards to factor (iii) of Section 8.1b of the Act:

iii. The Arbitrator notes that the Petitioner was 56-years-old at the time of the accident. The Arbitrator therefore gives ***some weight*** to this factor.

With regards to factor (iv) of Section 8.1b of the Act:

iv. The Arbitrator notes that the record lacks any evidence pertaining to the Petitioner's future earning capacity because of this August 20, 2014 work accident. As such, the Arbitrator therefore gives ***no weight*** to this factor.

With regards to factor (v) of Section 8.1b of the Act:

v. Evidence of disability corroborated by the treating medical records finds that the Petitioner was seen at Clearing clinic on October 6, 2014, and had full and pain free range of motion, full and symmetrical strength in the bilateral lower extremities, normal reflexes and no tenderness to palpation. (PX 6). Petitioner rated his pain at 1/10. (PX 6). Petitioner's final physical therapy session with the Clearing Clinic took place on October 8, 2014. The records of that visit indicate Petitioner's pain rated at 0-1/10. (PX 6). He was able to lift a 50-pound "box cart" and push/pull a 150-pound sled for 50 feet without any lower back pain. (PX 6). Petitioner reported no functional limitations and was found to be able to perform his job requirements without modifications. (PX 6). On October 20, 2014, Dr. Mirshed reported Petitioner had no recorded complaints of lower back pain. Additionally, he also noted Petitioner was "negative" for back pain. (RX 11). Due to the Petitioner's medically documented injuries, course of medical care, and post-surgical comments, the Arbitrator therefore gives ***significant weight*** to this factor.

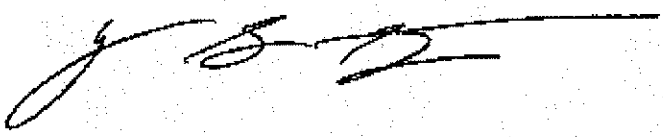
Based on the above factors, and the entire record, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of **a 4% loss of use of the person-as-a-whole** pursuant to **Section 8(d)2** and Section 8.1b of the Act.

Issue N: *Respondent's credit*

The Arbitrator finds that Respondent's credit is a moot issue. The record contains an itemization of medical benefits paid by Petitioner's group health carrier, Blue Cross Blue Shield, for hernia and lower back treatment. (RX 14). The benefits provided by Blue Cross Blue Shield were for service dates after October 6, 2014. As no causal connection exists after October 6, 2014, the issue of Respondent's Section 8(j) credit is rendered moot.

Issue O: *Other issues*

The parties submitted a Request for Hearing form with a notation concerning a pending petition for attorney's fees by a former attorney. (AX 1 and TX P 5-6). However, no such petition for attorney's fees was admitted into evidence and no testimony was offered on this subject. Furthermore, a review of the 15 WC 14307 IWCC file failed to locate any such petition for attorney's fees submitted by any prior attorney. Therefore, the Arbitrator makes no finding regarding any petition for attorney's fees by any former attorney.



Signature of Arbitrator

NOVEMBER 8, 2019
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	09WC003082
Case Name	JUKNUIS, BRIAN v. PATTEN INDUSTRIES
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0282
Number of Pages of Decision	12
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	Daniel Capron
Respondent Attorney	Daniel Swanson

DATE FILED: 6/11/2021

/s/Maria Portela, Commissioner

Signature

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

Brian Juknuis,

Petitioner,

vs. NO: 09 WC 003082

Patten Industries,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 19, 2019 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.

JUNE 11, 2021

/s/ *Maria E. Portela*
Maria E. Portela

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MEP/ypv
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/s/ *Thomas J. Tyrrell*
Thomas J. Tyrrell

/s/ *Kathryn A. Doerries*
Kathryn Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0282

JUKNUIS, BRIAN
Employee/Petitioner

Case# **09WC003082**

PATTEN INDUSTRIES
Employer/Respondent

On 6/19/2019, 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 2.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2208 CAPRON & AVGERINOS PC
DANIEL F CAPRON
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

2097 GRANT FANNING & OLSEN
DANIEL K SWANSON
300 S RIVERSIDE PLZ SUITE 2050
CHICAGO, IL 60606

STATE OF ILLINOIS)
) SS.
COUNTY OF DU PAGE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Brian Juknuis
Employee/Petitioner
v.
Patten Industries
Employer/Respondent

Case # **09** WC **03082**

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 **Wheaton**, on **August 29, 2018, 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. 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. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. X What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **November 4, 2008,** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$65,368.16**; the average weekly wage was **$1,257.08**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **3** 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 **$330,590.06** in TTD & TPDF and/or for maintenance benefits, and is entitled to a credit for any and all amounts paid.

Respondent shall be given a credit of **$309,363.74** for TTD, **$21,226.32** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$330,590.06.**

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

ORDER

Permanent Disability

Respondent shall pay petitioner permanent total disability as of August 29, 2018 at the rate of $838.05 per week for petitioner's life pursuant to §8 (g) of the Act.

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

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

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

Christine MOny

Signature of Arbitrator

June 18, 2019

Date

IC.ArbDec p. 2

JUN 19 2019

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brian Juknuis	)	
Petitioner,	)	
vs.	)	**No. 09 WC 03082**
Patten Industries	)	
Respondent.	)	

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing in Wheaton on August 29, 2018 The parties agree that on November 4, 2008, 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 his employment with respondent; and petitioner earned $65,368.16, and that his average weekly wage, in accordance with §10, was $1,257.08

At issue in this hearing was:

1. Whether petitioner's current condition of ill-being is causally connected to the work injury.
2. The nature and extent of injury.

FINDING OF FACTS

Petitioner began working for respondent in June, 1994 as a journeyman technician. As such, he rebuilt engines on tractor trailer rigs; he was a diesel mechanic. The job required him to lift up to 150 pounds.

Prior to November 4, 2008, petitioner had no problems with his left shoulder or his gastrointestinal system. On November 4, 2008, petitioner was installing a 120-pound air compressor when he felt a pull in his left shoulder. He reported it to his manager but continued to work.

Thereafter, he was referred by respondent to Concentra Clinic and received physical therapy. He continued working until December 12, 2008. He was then referred by the Concentra doctors to orthopedic surgeon, Dr. Theodore Suchy. He saw Dr. Suchy on December 23, 2008, who prescribed physical therapy and injected the shoulder. As the treatment did not solve the problem, Dr. Suchy performed surgery on February 3, 2009 to petitioner's left shoulder. Postoperatively petitioner was prescribed hydrocodone, an anti-inflammatory, and physical therapy.

On August 20, 2009, petitioner sought a second opinion from Dr. Guido Marra. Dr. Marra injected his shoulder and prescribed more physical therapy. Dr. Marra did not believe additional surgery would help. Therefore, petitioner sought another opinion from Dr. Verma at Rush.

Petitioner saw Dr. Verma on November 2, 2009, who performed additional surgery to petitioner's left shoulder on December 8, 2009. Dr. Verma tried repairing the surgery done by Dr. Suchy. Post-operatively petitioner was prescribed more opioid pain medication.

Petitioner returned to work in a volunteer job at Arts of Life building picture frames and other things on March 5, 2010. This job was found by the insurance company. As it was at less pay, petitioner received supplemental checks from the insurance company.

He underwent a functional capacity evaluation (FCE) on May 17, 2010. Dr. Verma released petitioner to return to work with respondent; not as a truck mechanic but as a tool crib attendant. As a tool crib attendant he would supply technicians with tools, clean the shop and run for parts. His wages were cut. On October 22,2 012, this job was eliminated. Petitioner has remained off work since that time.

In February, 2013, Dr. Verma released petitioner orthopedically and referred him to Dr. Sandeep Amin with Rush for pain management. Petitioner continues under Dr. Amin's care for pain management. His condition is managed with medication. He was on pills until he had stomach issues and they tried a patch, as well as a variety of other things. He last saw Dr. Amin on August 20, 2018. He sees Dr. Amin every six months for pain medication renewals.

Petitioner began having gastrointestinal issue right after his first surgery with Dr. Suchy; or in February, 2009. One diagnosis was c.diff infection which petitioner carried for six years. He was diagnosed with Crohn's disease, which a new gastrointestinal doctor ruled out. He has had chronic diarrhea and has had to wear a diaper for the past six years. The condition began less than a month after his first surgery and has not gone away.

He has chronic diarrhea, stomach pain and headaches. He has trouble eating. Petitioner testified that from the time he gets up in the morning at 6:00 A.M. until about noon he has to go to the bathroom 15 to 20 times; after that its hit or miss all day. As to when he will need a bathroom is unpredictable, has to be within ten feet of a bathroom.

Dr. Amin has prescribed Belbuca, which is a strip that he puts in his mouth twice a day. He also takes an anti-inflammatory, Metaxalone. He takes Loperamide, which is a prescription strength Imodium A-D, for diarrhea.

He has treated with various gastrointestinal doctors including Dr. Bernthal and Dr. Manual Alva

Petitioner's left shoulder is in constant pain; it never goes away. If he tries to lift something with his left hand, it gives out.

His only education included a high school diploma and trade school for diesel mechanics. The only job petitioner has held, besides that of a diesel mechanic, was as a tool crib attendant.

On cross-examination, petitioner advised he was seeing his family doctor, Dr. Dettore, when he was still employed. After he lost his job and insurance, he began seeing Dr. Bernthal at MacNeal Hospital on July 30, 2012. Petitioner did not recall undergoing laparoscopic surgery on November 6, 2011 for gallstones by Dr. Jaime Moreno at MacNeal Hospital.

Petitioner underwent two FCEs; one on July 29, 2009 and another on May 17, 2010. Both demonstrated petitioner could perform only medium level work. Petitioner can only lift up to 50 pounds and nothing overhead.

At respondent's request, petitioner was examined by Dr. Cherf on December 2, 2013.

Petitioner applied for social security disability about three or four years ago and continues to be denied.

Petitioner agreed he had not applied for any jobs; given his need to go to the bathroom constantly and the pain medication he is on for his shoulder. He also has debilitating migraines. He has tried various diets, to stop the diarrhea, without success. He continues to smoke.

Dr. Theodore Suchy Records (PX.1)

Petitioner was seen by Dr. Suchy on December 23, 2008, January 13, 2009 and February 3, 2009 for rotator cuff tear with impingement of the left shoulder.

Loyola University Medical Center/Dr. Guido Marra Records (PX.2)

Dr. Marra saw petitioner initially on August 20, 2009 for shoulder pain with signs of impingement and labral irritation; Celebrex was prescribed. On September 3, 2009, Dr. Marra offered additional surgery, physical therapy and an injection, which was administered. On October 1, 2009, as petitioner did not have improvement from the injection, Dr. Marra did not recommend surgery. An FCE was recommended.

Midwest Orthopaedics at Rush/Dr. Nikhil Verma Records (PX.3)

Petitioner was first seen by Dr. Verma on November 2, 2009 for a second opinion. Dr. Verma performed left shoulder arthroscopic debridement and revision of the subacromial decompression, as well as mini open subpectoral biceps tendinosis.

Petitioner was seen in follow up by Dr. Verma on December 17, 2009 and then on January 21, 2009. A refill of Norco was provided. He was doing well. On February 18, 2010, petitioner reported problems with the anti-inflammatory prescribed and was taking ibuprofen without complications. On April 29, 2010 physical therapy was continued.

On June 10, 2010, petitioner was released to return to work on a trial basis. On July 8, 2010, petitioner reported he had returned to work as a less manual job with respondent; Dr. Verma declared petitioner was at maximum medical improvement.

Petitioner returned to Dr. Verma on January 6, 2011 with weakness and atrophy of the left shoulder; an EMG as ordered.

On May 19, 2011, Dr. Verma reported the EMG showed a potential suprascapular nerve neurapraxia involving the spinoglenoid notch that would only affect the infraspinatus and did not explain petitioner's distal symptoms in is hand and wrist. He was discharged from Dr. Verma's care.

Petitioner returned to Dr. Verma on February 16, 2012, seeking approval to continue with his primary care doctor for pain management with Norco. Dr. Verma again released petitioner from care and referred to his family doctor for pain management.

Petitioner returned to Dr. Verma on November 29, 2012 and was referred for an MRI due to ongoing symptoms. On December 13, 2012, based upon the MRI findings, Dr. Verma ordered another EMG.

On February 7, 2013, Dr. Verma reported the EMG was normal. Dr. Verma had no surgical option to offer and referred petitioner to Dr. Amin for pain management.

Dr. Sandeep Amin Records (PX.4)

Petitioner was first seen by Dr. Amin on March 4, 2013. Dr. Amin thought petitioner showed signs of CRPS, but ordered a cervical MRI to rule out a radicular cause. Dr. Amin reported the March 29, 2013 MRI showed left foraminal stenosis at the C3-C4 level, with small, broad-based extradural defect, as well as bilateral foraminal stenosis at C6-C7 level.

On May 1, 2013, Dr. Amin administered a left stellate ganglion block for chronic CRPS and neuropathic pain of the left upper extremity. Additional left stellate ganglion blocks were administered on May 29, 2013 and July 17, 2013. A cervical epidural steroid injection was also administered on July 31, 2013.

In January and April, 2014 Dr. Amin sought approval for cervical injections.

On May 14, 2014, Dr. Amin advised that petitioner was now being prescribed Nucynta as he was not able to tolerate other opioid medications due to GI upset and opioid induced fertility changes. He was also prescribed muscle relaxant Skelaxin. He was prescribed these medications as he was not able to tolerate other medications.

MacNeal Hospital Records (PX.5)

Petitioner was seen in the emergency room on November 14, 2011 due to epigastric pain after eating ice cream. The diagnosis was gall stones; gallbladder or biliary colic. He was prescribed Bentyl and Norco.

On November 8, 2011, petitioner returned to the hospital. He reported similar symptoms came on four days earlier after eating a Big Mac. He reported he had worsening pain in the right upper quadrant after eating bacon the day before. He was admitted to the hospital and underwent a cholecystectomy.

Petitioner underwent a colonoscopy by Dr. Bernthal on July 30, 2012.

On August 12, 2013 petitioner underwent a CT of the abdomen and pelvis with contrast due to abdominal pain, night sweats and weight loss and another on September 13, 2013.

On September 30, 2013 petitioner was seen by gastroenterologist, Dr. Manuel E. Alva, as referral from Dr. Nasreen Ansari due to abdominal pain. An upper endoscope was performed on October 1, 2013 which showed gastric polyps, bile acid reflux, gastritis and duodenitis.

On September 9, 2014, petitioner was seen in the emergency room due vomiting, diarrhea and abdominal pain for the past 16 hours.

Dr. Diamond Donald Detttore February 1, 2016 Letter (PX.6)

Dr. Dettore authored this letter to petitioner's attorney. In the letter, Dr. Dettore advised he had been petitioner's primary care physician for twenty years. He would not state the petitioner's GI problems were the result of the opioid medication he was taking for his work injury; however, he agreed taking pain medication on a regular basis could exacerbate his gastrointestinal problems. He had no opinion regarding the diagnosis of Crohn's Disease.

Dr. Manuel E. Alva February 12, 2016 Report (PX.7)

On February 12, 2016, Dr. Alva reported he had treated petitioner for gastrointestinal problems since September, 2013. Dr. Alva believed there was a direct cause between petitioner's use of opioid pain medication for his shoulder and neck and his GI problems, which included frequent diarrhea, lower abdominal pain and weight loss.

Dr. Alva also concluded that due to petitioner's ongoing chronic diarrhea, it would be difficult, if not impossible to find gainful employment. Dr. Alva also believe the GI difficulties were permanent.

Vocamotive Vocational Evaluation Report (PX.8)

Joseph Belmonte, CRC, interviewed and provided a vocational evaluation report of petitioner on February 6, 2017. Mr. Belmonte identified barriers to petitioner being re-employed that included the petitioner had been out of the work place for four to five years, the FCE was over seven years old, accommodations for petitioner to have close proximity to a bathroom and allowed frequent bathroom breaks, and petitioner had no keyboard or computer proficiencies. Given these

limited parameters, Mr. Belmonte concluded there was no identifiable stable labor market for petitioner.

Dr. John Cherf December 2, 2013 Report (RX.1)

Dr. Cherf examined petitioner at respondent's request on December 2, 2013 and reviewed center medical records. Dr. Cherf was asked to determine whether petitioner's cervical problem was caused by, or contributed by, petitioner's November 4, 2008 work accident. Dr. Cherf concluded petitioner's diagnosis was CRPS and that the work accident did not cause or contribute to petitioner's cervical problem.

Dr. Joel Pekow August 2, 2016 Report (RX.2)

At respondent's request, Dr. Pekow, a gastroenterologist, performed a records review of petitioner's medical records in regard to his gastroenterology symptoms. Dr. Pekow could not negate or confirm a correlation between petitioner's shoulder injury and subsequent medication prescribed and petitioner's gastrointestinal disorder.

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

F. In support of the Arbitrator's decision with regard to whether petitioner's condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions of law:

There is no dispute petitioner's left shoulder injury, that required two surgeries and developed into CRPS requiring ongoing use of opioid pain medication, was caused by the work accident of November 4, 2008.

As to petitioner's cervical condition, it was not until petitioner began pain management with Dr. Amin in March, 2013 that petitioner's cervical condition became an issue. Dr. Amin was not able to determine whether petitioner's cervical condition was caused or aggravated by the work accident. Respondent's examining physician, Dr. John Cherf, concluded petitioner's cervical problem was not caused or aggravated by the work accident. Accordingly, the Arbitrator finds petitioner's cervical condition was not caused by the work accident.

As for petitioner's gastrointestinal disorder, Dr. Alva, who had treated petitioner since September of 2013 for his gastrointestinal disorder, determined there was a direct correlation between petitioner's opioid pain medication use for his shoulder and neck pain and his GI problems that included frequent diarrhea, lower abdominal pain and weight loss.

Petitioner's primary care physician, Dr. Dettore, could not state that petitioner's GI problems were the result of opioid pain medication for the work injury. However, Dr. Dettore, agreed that taking the pain medication on a regular basis could exacerbate petitioner's gastrointestinal problems.

Dr. Pekow, who performed a records review for respondent, could not negate or confirm there was a correlation between the use of the medication used to treat petitioner's shoulder injury and his gastrointestinal disorder. Dr. Pekow agreed the use of pain medication could have contributed to petitioner's gastrointestinal disorder.

Based upon the foregoing, the Arbitrator finds petitioner's present gastrointestinal disorder was caused by the opioid medication use for petitioner's work injury.

L. In support of the Arbitrator's decision with regard to the nature and extent of petitioner's injury, including whether petitioner is entitled to permanent total disability benefits, the Arbitrator makes the following conclusions of law:

Petitioner's left shoulder injury in and of itself would not prohibit petitioner from obtaining gainful employment. However, according to Dr. Alva and vocational counselor, Joseph Belmonte, petitioner's ongoing chronic diarrhea would prohibit petitioner from obtaining gainful employment. Dr. Alva believed petitioner's gastrointestinal disorder was permanent.

Accordingly, as the Arbitrator, having determined petitioner's permanent gastrointestinal disorder, that is prohibiting him from obtaining gainful employment, was caused by his opioid use for treatment of his left shoulder injury, finds petitioner is permanently and totally disabled as a result of his work accident of November 4, 2008. The Arbitrator awards permanent total disability as of August 29, 2018 at the rate of $838.05 per week for petitioner's life pursuant to §8 (g) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC021827
Case Name	MONTIEL, ALEXANDER v. WAHL CLIPPER CORPORATION
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0283
Number of Pages of Decision	13
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	Jason Esmond
Respondent Attorney	Kevin Luther

DATE FILED: 6/11/2021

/s/Maria Portela, Commissioner

Signature

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

Alexander Montiel,

Petitioner,

vs. NO: 16 WC 021827

Wahl Clipper Corporation,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 14, 2020 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.

JUNE 11, 2021

/s/ *Maria E. Portela*
Maria E. Portela

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/s/ *Thomas J. Tyrrell*
Thomas J. Tyrrell

/s/ *Kathryn A. Doerries*
Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MONTIEL, ALEXANDER Case# **16WC021827**
Employee/Petitioner

WAHL CLIPPER CORPORATION
Employer/Respondent

On 4/14/2020, 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 0.29% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2489 BLACK & JONES ATTY AT LAW
JASON ESMOND
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

0264 HEYL ROYSTER VOELKER & ALLEN
KEVIN LUTHER
120 W STATE ST 2ND FL
ROCKFORD, IL 61105

STATE OF ILLINOIS)
)SS.
COUNTY OF **Rock Island**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Alexander Montiel
Employee/Petitioner

v.

Wahl Clipper Corporation
Employer/Respondent

Case # **16** WC **021827**

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 **Adam Hinrichs**, Arbitrator of the Commission, in the city of **Rock Island**, on **2/04/2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **3/01/2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**23,505.23**; the average weekly wage was $**940.21**.

On the date of accident, Petitioner was **36** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**0.00** for other benefits, for a total credit of $**0.00**.

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

ORDER

The Petitioner has failed to prove his claim by a preponderance of the evidence. The Arbitrator finds that the Petitioner has failed to establish: 1) a repetitive trauma injury occurred arising out and in the course of his employment, and 2) that a work-related accident aggravated the degenerative condition in his neck, or accelerated the processes, which led to his current condition of ill-being. Petitioner's claim for workers' compensation 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

APR 14 2020

April 6, 2020
Date

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION
ARRBITRATION DECISION

ALEXANDER MONTIEL,	)	
	)	
Petitioner,	)	
	)	
vs.	)	Case # 16 WC 28127
	)	
WAHL CLIPPER CORP.,	)	
	)	
Respondent.	)	

ARBITRATOR'S FINDINGS OF FACT AND CONCLUSIONS OF LAW

This case involves Alexander Montiel ("Petitioner"), who alleges to have a repetitive trauma injury to his cervical spine manifesting on March 1, 2016, while working for Wahl Clipper Corp. ("Respondent"). The parties proceeded to hearing on the following disputed issues: 1) accident; 2) notice; 3) causation; 4) medical; 5) TTD; and 6) the nature and extent of the alleged injury.

The parties stipulated that Petitioner was an employee of Respondent on March 1, 2016, that his average weekly wage was $940.21, and that he was 36 years of age, single, with 2 dependent children at the time of his alleged injury.

The parties stipulated that Respondent paid $61,879.36 in medical bills through its group medical plan for which a credit may be allowed under Section 8(j) of the Act and that Respondent paid $1,438.46 in non-occupational disability benefits for which a credit may be allowed under Section 8(j) of the Act.

FINDINGS OF FACT

The Petitioner testified that he started working for the Respondent in July of 1998. He started out as a blade packer and worked his way up into the Magerle grinding machine position. He held the Magerle position for 10 years before the alleged injury in this matter. Petitioner testified he was a full-time employee working 50-60 hours per week. The Petitioner testified that he is approximately 5' 8" tall.

Petitioner testified that in his job on the Magerle grinding machine, he loads and unloads small blades into a machine that grinds them. He testified that the machine had a surface below chest

level. Petitioner testified that he lifts a container of blades, weighing 50-90 pounds from the floor to approximately shoulder height 5-6 times a day. Petitioner then scoops blades from the container into a pan and lifts the pan to the top of his table. From there, he would manually load blades into the machine. He testified he performed this portion of his job as if he were dealing a deck of cards. He noted he would be in a hunched position, leaning over the machine with his head over it while setting the blades onto pins. He would load 50-100 blades at a time for grinding. Petitioner testified that he did this activity approximately 160 times a day, for approximately 14,000 blades per shift.

Petitioner also testified to changing out grinding wheels. With that activity, he would lift two grinding wheels, from the floor to above his head to load it onto an arbor. The wheels weighed approximately 40 to 50 pounds. Petitioner testified changing out grinding wheels varied in frequency from once every other day, to up to three times a day. In Petitioner's treating medical records he indicated his work at Wahl Clipper is "Light." (Px. 1, p. 291).

Petitioner had been off work on FMLA leave for 26 weeks from June to December of 2015 with multiple medical complaints. (Px. 1, Rx. 7). Petitioner testified he had five brain seizures in two weeks in 2015 and was referred to the Mayo Clinic as his doctors at the CGH Medical Center in Sterling, IL ("CGH") believed he had a degenerative neurological condition. Petitioner testified that after approximately six months off work on FMLA, followed by Respondent's two-week shutdown, he returned to his regular job.

Petitioner testified he began to experience some pain upon his return to work, approximately three to four months prior to March 1, 2016. He took Ibuprofen and continued at work. Petitioner had no break in treatment for his myriad medical complaints following his January 2016 return to work.

On February 1, 2016, Petitioner presented to Dr. Buddaraju at CGH with a primary complaint of joint pains, with no obvious injury, and did not report any aggravating factor other than walking. (Px. 1, p. 164). Petitioner was diagnosed with knee pain, hip pain, chronic low back pain, degenerative disc disease, and osteoarthritis. (Px. 1, p. 167). Petitioner was noted to have good flexion/extension and lateral rotation in his neck, and no swelling, no tenderness and good range of motion in his shoulders. (Px. 1, p. 166).

On February 5, 2016, Petitioner presented to Dr. Malki at CGH with multiple complaints of generalized pain with "no aggravating factor" and "no relieving factors." (Px. 1. p. 154).

On February 17, 2016, Petitioner again presented to Dr. Malki with severe generalized pain and seven potential diagnoses, including MS, Parkinson's, and cervical spine pathology. He was referred to a neurologist while he waited to get into the Mayo Clinic. (Px. 1. pp. 140-142).

On February 19, 2016, Petitioner followed up on his severe generalized pain with Dr. Malki. Dr. Malki reviewed a reportedly unremarkable spinal tap, and waited for Petitioner to undergo a cervical spine MRI. Petitioner did not mention anything related to work at this visit. (Px. 1, pp. 135-137).

On February 29, 2016, Petitioner followed up again with CGH and it was noted that his arm pain was getting worse and he had to call off work. (Px. 1, p. 129).

Petitioner testified that on March 1, 2016, he woke up at home with pain shooting down his left arm and was unable to move his neck. Petitioner testified that these were new complaints from those he had suffered in the past. Petitioner returned to Dr. Malki.

Petitioner presented at the CGH on March 1, 2016 with the following history: "Patient is here stating yesterday woke up with severe pain in the left side of the neck and left arm associated with numbness and weakness, he could not elevate the left arm, also complaining of dizziness and able (sic) to ambulate because was losing balance and continued to have tremors in the left upper extremity. Today the pain is improving as well as the dizziness." (Px. 1, pp. 125-127). There is no indication in the chart note of the Petitioner giving a history of complaints arising from his work duties.

On March 2, 2016, Petitioner contacted Ms. Dolphin, Respondent's nurse, to advise her that he had been prescribed an MRI due to his symptoms. Petitioner testified that he had been in contact with Ms. Dolphin on a daily basis, regarding his increasing symptoms upon returning to work.

On March 3, 2016, Petitioner presented to Dr. Buddaraju at CGH where he reported multiple complaints to multiple body parts, did not mention anything related to work except that he did not go to work yesterday and today "secondary to knee pain." (Px. 1, pp. 117-120).

A cervical MRI was performed on March 4, 2016, revealing a left-sided disc bulge at C6-7 causing left neuroforaminal narrowing at the left C7 nerve root. (Px. 1, p. 332).

In the March 23, 2016, EMG report of Dr. Delacruz at CGH, the Petitioner reported pain, tingling, and weakness from the shoulder down through all five digits in the left arm. The report states, "It began several months ago. No known accident or injury." (Px 1, p. 327.)

The Petitioner followed up with Dr. Malki on March 31, 2016, there was no mention of anything related to his work, only that Petitioner worked as a machinist. Petitioner complained of pain in the left arm, headache, and sometimes pain in the right side. The chart note indicates that there were no aggravating factors. Dr. Malki noted that Petitioner may have radiculopathy in C6-7 causing his left arm pain, and referred Petitioner to a neurosurgeon. (Px. 1, pp. 97-99).

On April 28, 2016, Petitioner presented to Dr. Michael Roh, a neurosurgeon, at the Rockford Spine Center. On that date Petitioner completed the "Rockford Spine Center Registration" form. On the second page of that form, signed by the Petitioner, the form asks, "Was your injury the result of an accident?" The Petitioner circled "No." The form also asks, "Did your injury happen on the job?" The

Petitioner circled "No." Finally, the form asked, "Did you report the accident to your employer?" The Petitioner, again, circled "No." (Px. 2, pp. 354-355).

On his initial visit to Dr. Roh, Petitioner reported approximately three years of the same cervical symptoms, with approximately six months of cervical radiculopathy. The record notes that Petitioner denied a traumatic or inciting event. Dr. Roh interpreted the MRI to show a left-sided herniation at C6-7 causing severe compression of the left C7 nerve root and recommended surgery. There is no mention of the Petitioner relating his condition to any of his work duties. (Px. 2, p. 370).

In his May 9, 2016 visit to CGH Rehab, when asked "How did this injury occur?", the Petitioner left the answer blank. In the note from the same date, Petitioner denied any injury or pathology, however, he indicated aggravating factors included "working for extended periods of time," sitting, and sleeping. Petitioner advised the therapist that he works at a machine at Wahl Clipper where he looks down for extended periods. (Px. 1, p. 313).

On June 29, 2016, Dr. Roh performed a C6-7 decompression, discectomy, and disc replacement. (Px. 2, pp. 395-396). After surgery, Petitioner testified he returned to work for approximately three days, but was terminated for "points" due to attendance issues. Petitioner underwent a course of physical therapy following his surgery, and was released from care without restrictions on September 29, 2016. (Px. 2, p. 394).

Dr. Roh noted in his discharge note that "there may be some secondary gain overlay" for the Petitioner who indicates he is pursuing a workers' compensation claim. (Px. 2, p. 394).

Petitioner testified that after completion of physical therapy, he has some ongoing pain in his left arm and neck. He has trouble lifting heavy items with his left arm. He takes Ibuprofen or Aleve to dull his pain, but has not required any formal treatment since his release from care in September 2016.

The Petitioner is currently working for Menards. He has worked his way up to a supervisor position.

Section 12 Exam and Testimony of Dr. Jeffrey Coe

Petitioner's Exhibit 3 is the evidence deposition of Dr. Jeffrey E. Coe taken on August 7, 2017, as well as his report dated December 6, 2016. Dr. Coe is board certified in occupational medicine and does not perform neck surgeries. Dr. Coe testified that Petitioner described his work duties as requiring him to constantly bending his neck back and forth. (Px 3, p. 411) Dr. Coe's opinion was that, based on the "nonstop continuous flexion and extension" of Petitioner's neck in the performance of his job duties, the Petitioner suffered repetitive strain injuries which were a causative factor in the breakdown of the C6-7 disc with left-sided herniation and radiculopathy, and subsequent need for surgical intervention. (Px. 3, pp. 425-426).

Dr. Coe did not review the job duty videos offered into evidence by Respondent. (Rx. 8, Rx. 9, Rx. 10)

Record Review and Testimony of Dr. Andrew Zelby

Dr. Zelby never physically examined the Petitioner, however, he testified that he reviewed diagnostic tests, medical records, Dr. Coe's report, and the job duty videos introduced as Respondent's Exhibits 8, 9, and 10. Dr. Zelby is a board-certified neurosurgeon who performs neck surgeries. (Rx. 1)

At his evidence deposition, Dr. Zelby opined the Petitioner's medical condition was not a result from the Petitioner's work duties which required minimal cervical flexion and extension. Dr. Zelby testified that the types of disc herniations the Petitioner suffered requires a clear and distinct injury or force to result in the disc herniation and extrusion. (Rx. 1, pp. 14-17).

Respondent's Job Videos of Petitioner's Job Duties

The Arbitrator has reviewed the job duty videos. (Rx. 8, Rx. 9, Rx. 10). The videos show two different individuals, a female and a male, of differing heights, performing the same job duties on the Magerle blade washing and grinding machine. Both individuals showed very little flexion and extension of their respective necks, with little, if any, hunching required to complete these duties. The individuals filmed stand frequently on the video waiting for the machine to finish its process.

CONCLUSIONS OF LAW

"An employee who alleges injury based on repetitive trauma must still meet the same standard of proof as other claimants alleging an accidental injury. There must be a showing that the injury is work related and not the result of a normal degenerative aging process." *Peoria County Belwood Nursing Home v. Industrial Com.*, 115 Ill. 2d 524, 530 (1987). The evidence in the record must be able to support an inference that the accident aggravated the condition or accelerated the processes which led to the claimant's current condition of ill-being. *Cassens Transp. Co. v. Industrial Comm'n (Shaw)*, 262 Ill. App. 3d 324, 331, (1994) citing *Mason & Dixon Lines, Inc. v. Industrial Comm'n*, 99 Ill. 2d 174, 181-82 (1983).

In proving a repetitive stress work-related injury, it is crucial to have a work-related etiology corroborated by the medical record, as well as medical testimony establishing the requisite causal connection. *Darling v. Industrial Com.*, 176 Ill. App. 3d 186, 193 (1988). Further, "a causal connection is shown from the events which reveal a prior state of good health; a good work record; a definite accident date; a resulting disability; and petitioner's inability to work or even to use his [injured body part] at all, after that date." Quoting *Darling*, at 193.

The Arbitrator finds that the Petitioner has not met his burden of proof in regard to accident and causal connection. The Petitioner's testimony regarding a work-related injury is inconsistent with the treating medical records. The treating medical records do not corroborate the Petitioner's testimony.

The record shows that the Petitioner was off work on FMLA leave from June 2015 to December 2015, treating for multiple medical problems unrelated to his work activities. When he returned to work for Respondent in January 2016, he continued to treat for his ongoing, multiple medical issues.

Petitioner had many opportunities during his extensive and ongoing course of medical care to provide his treating physicians with a history of his work duties aggravating a degenerative neck condition. Petitioner failed to do so. The record shows that the Petitioner repeatedly affirmed to his treating physicians that he did not relate his neck condition to his work duties.

On Petitioner's alleged manifestation date of March 1, 2016, there is no mention in the chart note of the Petitioner giving a history of complaints arising from his work duties. Two days later, Petitioner returned to his treating physician reporting he had missed work the last couple days due to knee pain. In the March 23, 2016, EMG report, "no known accident or injury" was reported by the Petitioner.

To Dr. Roh, his treating neurosurgeon, Petitioner denied a traumatic or inciting event, and advised that his injury was not the result of an accident, and that his injury did not happen at his job. Dr. Roh is silent on the issue of causation. Dr. Roh was aware of Petitioner's workers' compensation claim, and the only opinion he provided was that he believed there may be secondary gain overlay issues involved for the Petitioner.

Petitioner introduced the opinion of their Section 12 examiner, Dr. Jeffrey Coe. Dr. Coe is a specialist in occupational medicine, not neurosurgery, and he does not perform neck surgeries. Dr. Coe was given a description of the Petitioner's work duties by the Petitioner, which is at odds with the Petitioner's testimony at the hearing. When Dr. Coe asked the Petitioner about his work duties, the Petitioner told him that he is required to move his neck constantly during his job at his workplace. At hearing, the Petitioner did not mention the frequency of his neck movements, but instead described being in a hunched position all day, and that he was required to pick up items a few times per day, mostly from the floor to no higher than bench level.

Dr. Coe opined that the Petitioner suffered repetitive strain injuries which were a causative factor in the breakdown of the C6-7 disc with left-sided herniation and radiculopathy, and subsequent need for surgical intervention. Dr. Coe's opinion was based on the Petitioner's description of his job duties requiring "nonstop continuous flexion and extension" of his neck in the performance of his job duties. Dr. Coe's opinion is based on information which was inconsistent with Petitioner's description of his work duties at trial, as well as the job duties depicted in Respondent's job duty videos.

Dr. Zelby never examined the Petitioner, but he reviewed Petitioner's treating medical records, wherein Petitioner repeatedly denied that his neck condition was related to his work duties. Dr. Zelby also reviewed the job duty videos on the Magerle machine. Dr. Zelby testified that minimal flexion and extension was required to perform the job duties in these videos. Dr. Zelby opined that minimal cervical flexion and extension could not produce the force necessary to result in a disc herniation. Dr. Zelby is a board-certified neurosurgeon who performs neck surgeries.

The Petitioner has the burden of proving his claim for benefits under the Act by a preponderance of the evidence. The Petitioner has failed to do so. The Petitioner's request for workers' compensation benefits are denied, as the Petitioner has failed to establish: 1) a repetitive trauma injury occurred arising out and in the course of his employment, and 2) that a work-related accident aggravated the degenerative condition in his neck, or accelerated the processes, which led to his current condition of ill-being. All other issues are rendered moot.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC028504
Case Name	PADILLA, NARCISO v. ARAMARK CAMPUS, LLC
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0284
Number of Pages of Decision	19
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	Catherine Krenz Doan
Respondent Attorney	Patrick D. Duffy

DATE FILED: 6/11/2021

/s/Maria Portela, Commissioner

Signature

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

Narciso Padilla,

Petitioner,

vs. NO: 18 WC 028504

Aramark Campus, LLC,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 2, 2020 is hereby affirmed and adopted.

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

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

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

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

JUNE 11, 2021

/s/ *Maria E. Portela*
Maria E. Portela

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MEP/ypv
049

/s/ *Thomas J. Tyrrell*
Thomas J. Tyrrell

/s/ *Kathryn A. Doerries*
Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

21IWCC0284

PADILLA, NARCISO
Employee/Petitioner

Case# **18WC028504**

ARAMARK CAMPUS LLC
Employer/Respondent

On 3/2/2020, 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 1.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1987 RUBIN LAW GROUP LTD
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1739 STONE & JOHNSON CHARTERED
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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)/8(a)

Narciso Padilla
Employee/Petitioner

v.

Aramark Campus, LLC
Employer/Respondent

Case # **18** WC **28504**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Chicago**, on **August 14, 2019**. 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 _____

Narciso Padilla v. Aramark Campus, LLC, 18 WC 28504

FINDINGS

On the date of accident, **April 11, 2018**, 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 $**39,912.08**; the average weekly wage was $**767.54**.

On the date of accident, Petitioner was **60** 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 $**N/A** under Section 8(j) of the Act.

ORDER

Petitioner sustained accidental injury on April 11, 2018 that arose out of and in the course of his employment with Respondent. Petitioner failed to prove that his current lumbar condition is causally related to the accident.

No benefits are awarded.

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

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

Signature of Arbitrator

February 27, 2020
Date

MAR 2 - 2020

STATEMENT OF FACTS

Petitioner testified via interpreter Marco Garcia.

Petitioner, an 11-year employee, was working a housekeeping / set up position on 4/11/18 involving the preparation and cleaning of meeting rooms. He testified he has to push/pull chairs, tables and folding platforms and set them up, as well as to clean and empty trash. The heaviest thing he lifts would be a 5-gallon container which he estimated weighed 40 to 50 pounds. He does a lot of walking, bending and squatting to clean, but does no climbing. The company sets up and takes away equipment for conventions at McCormick Place, and he worked in the Grand Ballroom. Petitioner described the platforms as being like a butterfly that opens into a stage and then can be closed including a "multi-high", a 36"x47" platform which he estimated weighed over 500 pounds.

Petitioner testified he had two prior accidents involving his back in 2004 and approximately 2014, but that he had been performing his work and feeling fairly normal while doing so. In 2004, he underwent physical therapy and took medication before being released to return to unrestricted work that same year. In 2010 he treated for his back, including therapy, medication and an injection, and he believed he was released in 2011 with no work restrictions. He initially testified he didn't think surgery was discussed at that time, but then indicated surgery had been discussed but was not recommended because it was "a little risky." He agreed he has followed up with his primary care provider for back treatment since 2011, the last time being 2013, and hadn't undergone further back treatment after that until the 4/11/18 accident date.

On 4/11/18, Petitioner testified he had no back problems when he reported to work. He was working in the Grand Ballroom cleaning and collecting trash and testified the room is larger than a football field. That day there was a stage and 6,000 seats set up that are in rows. With cleaning, he would hold a trash bag at the level of the top of his head in his left hand and would bend down to pick up trash with his right hand, including things like bottles, cups, glasses, paper, etc., from around and under the seats. When the bag was full, which he estimated would weigh 20 to 30 pounds, he would put it in a large gondola and start with a new bag. On 4/11/18, towards the end of his shift Petitioner testified: "in bending down, I lost my balance, and I got up bad. And I had to sit down in a seat right away because I felt a pull or a strain in my back." He testified he believed he was reaching down to pick up a soda bottle and felt a pop in his back as he was getting back up. He was holding the bag in his other hand. He testified he had to sit down. He said he had been picking up "thousands" of pieces of trash in the approximate half hour he was performing this activity on 4/11/18.

Petitioner testified he felt significant pain in his back and left leg. He continued working but used a broom and pan to pick up the trash so he didn't have to bend as much, and was no longer using the bag. He testified that his condition at this point was much worse than his back condition in 2013, noting he had no prior left leg pain. He testified he reported the injury to his supervisor that same day.

Petitioner was initially seen at Occupational Health Centers of Illinois (Concentra) on 4/13/18. The history recorded by Dr. Sorokin was of Petitioner picking up garbage from the floor on 4/11/18 and injuring his low back with pain and numbness into his right leg. He reported a back injury "a while ago" with no injections or surgery. He was noted to be a housekeeper, involving cleaning and carrying garbage. He had tenderness at L4/5 on exam, but positive Waddell test was noted. Petitioner was diagnosed with a lumbar strain and was prescribed x-rays and medication. He was restricted to modified work duties. (Px1).

It appears the Petitioner saw primary care provider Dr. Thiti Jaojaroenkul (hereinafter, Dr. Thiti) as well on 4/13/18, and the report noted mild lower back pain with no neurological deficits. The visit appears to have been for a general check-up and it is unclear if this visit took place before or after the visit to Concentra. (Rx4).

On 4/17/18, Petitioner reported back pain that radiated into the left leg at a 7 out of 10 (7/10) level. Dr. Sorokin prescribed physical therapy and continued modified duty. On 4/24/18, Dr. Sorokin indicated Petitioner was there for recheck of work injury to both legs, noting Petitioner had no left leg complaints but his right leg felt numb with shooting pain at times. However, later in the report it states Petitioner had shooting pain over both thighs and left anterior shin numbness. Modified duty and therapy were continued. (Px1).

Petitioner underwent therapy at Concentra from 4/17/18 to 5/3/18. The initial therapy report states: "Pt reports that he was picking up garbage from floor, doing that for over 1 hour and felt pain the next day in the morning." Petitioner also reported pain in the left buttocks radiating to the leg to the foot, and that he had a back injury 13 years prior with occasional soreness since. On 4/23/18, Petitioner indicated he felt a lot better but had pain that was now in the bilateral back. On 4/25/18, he reported his legs were sore due to walking so much at work. On 4/27/18, he reported his back was improving but he had pain down both legs. On 4/30/18, he reported he would feel better after therapy, but his pain would return at work. On 5/1/18, he reported his pain was worse when he was still. By 5/3/18, it was noted Petitioner was making minimal progress towards his therapy goals. (Px2).

On 5/1/18, minimal improvement was noted, and Dr. Sorokin ordered a lumbar MRI and discontinued Petitioner's medication. On 5/15/18, Petitioner reported pain through his legs and numbness over his right feet and toes. Medication was reinstituted and light duty was continued. (Px1).

The 5/18/18 MRI reportedly showed: 1) multilevel disc bulges causing a varying degree (generally moderate to severe from L2 to L5) of foraminal/canal stenosis from L5/S1, most pronounced at L2/3 and L4/5; 2) multilevel spondylosis; and, 3) reversal of normal lumbar lordosis with kyphosis from L2 to L5. (Px3). On 5/22/18, Dr. Sorokin referred Petitioner to a physiatrist for intractable back pain. While the report stated, "See Referral Comment!", the Arbitrator saw no additional documentation in Px1. Therapy and modified duty were to continue. (Px1).

Petitioner saw physiatrist Dr. Murtaza at Concentra on 6/1/18. He provided a history to Dr. Murtaza of re-injuring his back while picking up trash in a theater, and that he had to "squeeze between the seats" to do so. He reported back pain down both legs, left greater than right, since the 4/11/18 injury. He reported that "at this occasion, when he bent over, the pain has not subsided", but also notes he had some relief with therapy and that "every now and then he feels aggravation of pain, and he is quite concerned about the weakness, numbness and radicular pain, particularly on the left side, but it is bilateral." Petitioner reported this was his third episode of low back pain from a work injury, noting that following the second incident he underwent an injection "which did get him functional." He also reported two prior surgeries, though what type of surgeries was not specified. The report further states: "Also, he tells me in the past, he has been recommended for a possible surgery as well." Dr. Murtaza noted the MRI report reflected "significant amount of issues" from L2 to L5, but that he wanted to review the films themselves. Dr. Murtaza's examination was positive for a significant antalgic gait, tenderness over the lumbar spine, limited range of motion, positive impingement signs (worse on the left), tenderness in the lower extremities, decreased reflexes, and decreased sensation. Dr. Murtaza diagnosed significant stenosis in the lower lumbar spine with significant nerve impingement, left greater than right, and multilevel spondylosis and facet arthropathy, causing radiculopathy. He prescribed a Medrol Dosepak, anti-inflammatory medication and an epidural steroid injection, and he continued Petitioner's work restrictions. (Px4; Rx5).

Petitioner initially testified he had "discussed" surgery while receiving treatment prior to the current accident, indicating it wasn't recommended "because it was a little risky." Petitioner then also testified he told Dr. Murtaza on 6/1/18 that back surgery had previously been discussed but wasn't undertaken: "it wasn't so bad as far as to have surgery, and they recommended an injection" in 2011. Following that injection he felt a lot better.

As noted by Dr. Murtaza on 7/13/18, Respondent did not authorize the recommended epidural and he referred Petitioner to neurosurgeon Dr. Salehi. (Px4).

Petitioner initially saw Dr. Salehi on 7/30/18. The report states Petitioner: "describes that they had hour and a half to turn over a room and was picking up garbage, twisting and bending, reaching underneath chairs to pick up the garbage. He did this for over an hour when he started feeling pain in the low back. He thought nothing of it, but with time the pain started worsening and soon started going down into the left leg." His current complaints were low back pain radiating into the left leg to the foot with weakness, sometimes into the right leg. Petitioner reported two prior work injuries to the back, one 13 to 14 years prior and the other 3 to 4 years prior, both of which involved therapy and an injection each time that led to symptom resolution. Following examination and review of the lumbar MRI, Dr. Salehi diagnosed lumbar degenerative disc disease and stenosis with neurogenic claudication. Given the degree of stenosis seen, particularly at L2/3, he opined that Petitioner should undergo laminectomies from L2 to S1 without delay. In the meantime, he restricted Petitioner to sedentary "desk" duty. At an 8/27/18 follow up, Dr. Salehi again recommended that surgery be performed urgently. Noting Petitioner was to be examined at Respondent's request, he continued Petitioner's work restrictions. (Px5; Rx6).

On 9/7/18, Petitioner was examined at the Respondent's request by Dr. Graf. He testified the exam was very short. There was an interpreter, and Dr. Graf spoke some Spanish as well, though Petitioner didn't feel the communication was very good because his Spanish wasn't very good but understood him the best he could. He testified that when Dr. Graf asked about his condition prior to the accident, he indicated he "didn't have much pain and it wasn't hurting me a lot." He further testified Graf's indication that he reported 7/10 pain prior to the accident "makes no sense." However, he was then asked by his attorney how much pain he was in prior to the April 2018 accident and he testified it was 4 or 5/10 "at its highest" and it increased a lot after the accident.

On 9/24/18, Dr. Salehi indicated he continued to await the report of Dr. Graf and continued to recommend surgery and sedentary work duties. (Px5).

Petitioned testified he sought a second opinion with orthopedic surgeon Dr. Lorenz on 10/17/18. Petitioner reported low back pain radiating into both legs to the feet, left worse than right, with numbness and tingling. The description of injury indicates he was picking up garbage on the floor between six thousand chairs in football size room on 4/11/18, involving bending and navigating around chairs. Petitioner "admits to sharp shooting pain across his lumbar with radiation of pain extending down lower extremities bilaterally, left > right, with associated numbness and tingling." Dr. Lorenz noted Petitioner had undergone therapy and two epidurals without relief. Petitioner reported similar injuries in 2004 and 2010 and that he "admits to chronic dull ache across his lumbar spine however he was never seeking chronic treatment for his lumbar back complaints." Exam indicated Petitioner stood pitched to the right due to pain and had positive left straight leg raise testing but was otherwise relatively normal. Noting he reviewed both x-rays and MRI, the latter of which he found to be of poor quality, Dr. Lorenz diagnosed an aggravation of L2 to L5 central canal stenosis secondary to the 4/11/18 injury. Given Petitioner's report of no relief with two epidurals, a third was not recommended and Dr. Lorenz ordered a new MRI and noted surgery would likely be recommended after review. A ten-pound lifting restriction was issued. (Px6).

The 2/27/19 repeat MRI was noted to reflect: 1) severe central canal stenosis with moderate bilateral foraminal stenosis at L2/3 with severe hypertrophic facet arthropathy, thickening of the ligamentum flavum as well as disc bulging and lateralizing spondylosis; 2) severe left foraminal narrowing with moderate central canal and right foraminal narrowing at L4/5 due to hypertrophic facet arthropathy, disc bulging and spondylitic spurring left greater than right; 3) severe left foraminal narrowing with moderate central canal and right foraminal narrowing at L3/4; and, 4) moderately severe right and moderate left foraminal narrowing at L5/S1. (Px7).

On 3/11/19, Petitioner was reexamined by Dr. Lorenz and had continued complaints of low back pain with radiation into the left lower extremity. Dr. Lorenz again noted that Petitioner pitched to the right when standing and had a positive left straight leg raise. The MRI was reviewed, and his impression again was aggravation of L2/3, L3/4 and L4/5 central canal stenosis secondary to the 4/11/18 work-related accident. Dr. Lorenz recommended a decompressive laminectomy with possible fusion from L2 to L5, depending on how much bone structure had to be removed, and continued to restrict Petitioner to modified work duties. It was noted that Petitioner had high blood pressure, and this needed to be cleared up before surgery could be performed. (Px6).

Dr. Lorenz's office called Petitioner on 3/17/19 to inquire about his blood pressure status, and Petitioner reported he saw his primary provider and was to take oral medication and follow up in 6 weeks. He was advised to call at that time so surgical authorization could be obtained through workers' compensation. (Px6).

On 12/12/18, Dr. Lorenz drafted a narrative report. The history indicated in this report again notes the Petitioner was picking up garbage on the floor between chairs in a large room, but now stated: "he admits to a sharp, shooting pain across his lumbar with radiation of pain" into both legs. Dr. Lorenz again opined that the need for surgery was due to the 4/11/18 incident aggravating Petitioner's preexisting condition. Responding to Dr. Graf, Dr. Lorenz indicated he agreed the Petitioner's spinal stenosis was preexisting, but disagreed with his analysis of causation, noting Petitioner had been working full duty prior to 4/11/18 and was not seeking treatment for chronic low back pain. (Px8).

Records of Petitioner's low back treatment prior to 4/11/18 were also submitted into evidence. In 2009, he saw Dr. Thiti multiple times. On 3/20/09, Petitioner complained of a 1 to 2 month history of occasional back pain with certain movements, i.e. turning his body to the left. Lumbar x-rays and Meloxicam were ordered. On 8/7/09, Dr. Thiti noted "No Back Pain Now." On 11/20/09, Petitioner noted occasional low back pain with weather change, relieved with Meloxicam, which was refilled. (Rx3).

On 5/3/13, Dr. Thiti noted "occasional lower back pain (5/10) radiating to rt. Hip for more than a month. No trauma or heavy lifting history." Lumbar and pelvic x-rays were prescribed. The 5/7/13 films reflected progressive and moderate degenerative disc disease, significantly at L4/5 and L5/S1, with increased spondylitic changes and slight increased rotatory dextroscoliosis versus 3/20/09 films. On 9/13/13, Dr. Thiti indicated Petitioner complained of minimal back pain and hip pain relieved with ibuprofen.

Respondent submitted a 2/13/19 letter from Petitioner's attorney into evidence which states that "Petitioner received prior medical treatment with Dr. Barry Ring, MercyWorks and Midway Clinic", and that those records were being subpoenaed. (Rx9). Also submitted were forms from Advanced Pain Care/Dr. Ring from 5/19/19 indicating they had no records regarding Petitioner (Rx7), and a letter that had been sent to Midway Clinic which appears to have been returned to Respondent's counsel with a handwritten statement: "No records found." (Rx8). During the hearing, Petitioner's counsel indicated she received the same response as Respondent from these providers.

As a result of the Petitioner's 2004 accident he pursued a workers' compensation claim. He testified he didn't know how much the settlement was for, but documentation from the Commission (Rx2) indicates Petitioner's prior workers compensation claim, 04 WC 41281, against a janitorial service for an 8/27/04 accident settled in June 2006 for 5% of the person as a whole for a "back" injury without further specificity. The parties stipulated to this as accurate. There is a discrepancy between the percentage loss of use and the amount paid, and the Commission documentation reflects that the settlement was for 5% loss of use of the person as a whole and payment of medical bills. (Rx2).

The evidence deposition of Dr. Lorenz was completed on 4/30/19. Dr. Lorenz obtained a history that Petitioner was picking up garbage between seated chairs in an arena with 6,000 chairs, . . . "And after moving them for a while, he bent over to pick something up and he had back pain with radiation to the lower extremity that has not left since that time. . ." Dr. Lorenz was aware that Petitioner had a prior back condition but noted the Petitioner's symptoms had resolved and he was functioning without pain, dysfunction or radicular disability until the work-related accident. Dr. Lorenz documented that Petitioner had the subjective complaints of difficulty with ambulation, bilateral leg pain, left greater than right, and back pain. On physical examination, Petitioner pitched to the right, testifying that this occurs when a person tries to enlarge the canal to get some relief from pressure on the nerve. Exam findings included positive straight leg raise on the left, and the MRI demonstrated severe narrowing and compression of the nerves. Dr. Lorenz stated that the subjective findings were consistent with the objective findings. His diagnosis was spinal stenosis from L2 to L5 with radiculopathy and neurologic claudication. Dr. Lorenz recommended a decompression and possible fusion of L3/4 and L4/5. (Px9).

Asked about his understanding of Petitioner's mechanism of injury, Dr. Lorenz testified that Petitioner had clearly preexisting degenerative changes, including the spinal stenosis, that had been managed conservatively and he was asymptomatic. He testified: "back injuries can occur when you have a weakened segment and the segment is weak based on the thickening of the arthritic changes that are present, and when the fatigue occurs after frequent bending over a period of time, the musculature no longer lends its support to the biomechanically abnormally functioning spine and then an injury to the soft tissue can occur, at least the swelling and symptoms at that point in time can bring out the stenosis." Therefore, Dr. Lorenz opined that the 4/11/18 accident aggravated the preexisting condition. Dr. Lorenz again indicated Petitioner's prior back problems resolved with conservative treatment including injections, and that the injections after the current work accident didn't work, noting repeated injuries can sometimes result in a failure to improve. He testified Petitioner's prior treatment "substantiates all of my opinions (regarding causation) because it is a classic picture of this type of problem." Dr. Lorenz testified that the medical treatment provided was reasonable and necessary, as is his recommended decompression surgery with possible fusion, noting the recommendation is consistent with the surgical recommendation of Dr. Salehi. Dr. Lorenz testified surgery in a situation like Petitioner's is recommended when there is enough dysfunction to stop everyday work activities, an intolerable pain level that is unmanageable, failure of conservative treatment and an underlying pathology that is amenable to surgical intervention. Dr. Lorenz testified that Petitioner wanted to return to work so he provided work restrictions including no more than 10 pounds of lifting and limited walking and bending. (Px9).

Dr. Lorenz reviewed the report of Dr. Graf, indicating he disagreed with Graf's causation opinion, as Petitioner's history of bending and feeling pain that then never resolved is a competent cause of creating the symptoms and back pain. Dr. Lorenz stated that there are numerous articles in OSHA about the fatiguing of a back condition and then of some back flexion, which can cause injury. The findings were consistent with the complaints of back pain and abnormal clinical findings, and Petitioner had a history of previously successfully treating for his degenerative back condition. Thus, he had a weakened back to begin with and was subjected to the bending activity at work, which caused a micro injury to his spine that rendered him symptomatic and now unresponsive to conservative treatment. Dr. Lorenz explained that a micro injury is an injury where there is movement beyond the normal range of tissue that causes tissue failure or damage and an inability to repair it. He did not recommend an epidural injection because two prior injections hadn't helped. (Px9).

On cross-examination, Dr. Lorenz testified he didn't recall if he reviewed any of Petitioner's records from prior to the accident date. Dr. Lorenz acknowledged that he didn't know how many times the Petitioner had bent over on the alleged accident date, other than he did it "many" times, and at one time bent over and had this pain. He also did not know how long the Petitioner had been performing this activity that day. Dr. Lorenz testified a pre-accident surgical recommendation would not impact his opinion because he didn't understand why such a

recommendation would have been made given Petitioner's history of symptom resolution with conservative treatment prior to April 2018. His basis for his causation opinion is Petitioner's comment that he was functional before but not after the accident, and "the inconsistency with the reports of some repetitive movement, fatiguing, degenerative changes that preexisted and then one flexion movement to pick up something that then subjects the disc, the prestressed disc to lead to the injury." Noting he believed the cause was the bending, not the lifting, Dr. Lorenz further testified bending forward places two to three times the body weight across the level of the spine and is enough to create an injury to the spine that is inefficient to begin with because of degeneration. He did not know the weight of the objects that Petitioner lifted that day. (Px9).

Dr. Lorenz reiterated that Petitioner told him he was fully functional and had no restrictions and had really no pain up until the date of accident, so he did not know what Dr. Graf was talking about in terms of Petitioner having a higher pain level prior to the accident than after. He acknowledged he did not ask Petitioner about his pre-accident pain level because it would depend on the patient's recall and is not accurate. He testified that people develop bias towards their pain and memories fade. An AMA disability questionnaire indicating Petitioner had mild disability is not relevant in this case because the questionnaire is used for a post MMI situation, and Petitioner had not yet reached MMI. Dr. Lorenz expects a high level of success following the surgery given historically people with Petitioner's particular problem have 90% success with this surgery. (Px9).

On redirect, Dr. Lorenz testified that Petitioner's injury and treatment in 2011 was inconsequential except to establish that the Petitioner had a pre-existing condition, which was then aggravated in 2018. The three components to the accident are that Petitioner had a pre-existing degenerative condition, but Petitioner was functioning normally; the back was fatigued by repeated bending; and bending overloaded the spine creating a micro injury. Knowing the number of times Petitioner had bent over is not necessary, "it suffices to know that this was a repetitive activity." Bending over with rotational activity may herniate a disc. Bending over makes the weight no longer close to the trunk. The weight on the fulcrum increases. Again, he was not aware of Petitioner having any prior surgical recommendations, and even if he had Lorenz would need to see the data of why it had been recommended. If Petitioner had an injection and was asymptomatic, he would not operate on Petitioner. Again, Dr. Lorenz's understanding is that the onset of pain occurred while Petitioner was bent over to pick up an object. (Px9).

Orthopedic surgeon Dr. Graf also testified via deposition on 6/12/19. Almost 100% of his practice is to the spine. Dr. Graf examined Petitioner on 9/7/18. He agreed Petitioner spoke Spanish and testified that not only was an interpreter present who was doing a good job, he himself also understands "medical" Spanish, though not particularly conversational Spanish. He recalled examining Petitioner because it was an unusual history, i.e. that he indicated he had more pain before the alleged accident than he did afterwards. Dr. Graf was comfortable that he was communicating with Petitioner at the examination. Petitioner said that his job consisted of setting up and taking down chairs and tables, and it was sometimes a heavy job. On 4/11/18, there was garbage under the tables and chairs. Petitioner was trying to squeeze underneath the tables, the size of a football field, and was working quickly. He had back pain, told his supervisor, and was sent to a clinic. Petitioner's prior history of low back pain included trying to break down a conference room in 2004, involving twisting and lifting, and he had low back pain. At that time, he was given medications and received physical therapy and injections. He had another injury five years before the accident at issue when he was lifting a platform which fell. He had low back pain, was again given therapy, medication, and injections, and while this treatment helped him temporarily, he had ongoing symptoms ever since. Petitioner assessed his low back and right and left leg pain prior to the 4/11/18 accident at a 7 out of 10 (7/10) level. After the accident, he assessed his pain at 6/10. On the date of the evaluation, Petitioner assessed his pain at 6/10 and located in the back radiating bilaterally to the thigh and ankle, left greater than right. He was working light duty at that time and was taking over the counter Motrin. Dr. Graf testified he clarified Petitioner's pain ratings with him because he had indicated his pain was

worse before the accident than after the accident. Dr. Graf asked the question because Petitioner said that he had ongoing pain for five years. (Rx1)

Dr. Graf's examination of the low back was positive for decreased sensation in the entire left lower extremity which followed no specific anatomic nerve distribution. Straight leg raise was equivocal on the left tested supine and was negative bilaterally seated "in the distracted scenario." Findings that did not correlate with an organic cause and were inconsistent were low back pain with simulated axial compression and axial rotation, non-anatomic distribution of symptoms, and pain improvement with distraction. Dr. Graf testified he reviewed records from 2009 and 2013. He also reviewed Dr. Sorokin's Concentra records referencing a Waddell sign, i.e., an inconsistent finding. He reviewed 4/30/18 and 5/3/18 physical therapy notes referencing Petitioner's improvement until he would return to work. Dr. Graf reviewed x-rays from 5/7/13 and 4/13/18, indicating that both films showed moderate degeneration throughout the lumbar spine and scoliosis. He reviewed the 5/18/18 MRI films showing degenerative changes from L1 through S1, L2/3 stenosis secondary to facet arthrosis and mild stenosis at L3/4. He did not see any disc herniations at any level. There were no acute findings, and Dr. Graf testified that the MRI findings certainly pre-dated 4/11/18. In his opinion, Petitioner's diagnosis was preexisting lumbar spinal stenosis and spondylosis. Given Petitioner's stated history of ongoing back pain after an injury five years prior and pain levels that were somewhat improved after 4/11/18, Dr. Graf testified: "I could not causally connect any aggravation or any exacerbation of his preexisting condition." Regardless of causation, Dr. Graf agreed that Petitioner's treatment to date for his condition was reasonable and necessary. In his opinion, while unrelated to the alleged work accident, Petitioner should undergo an epidural injection, noting "I know he had been recommended for a five-level laminectomy which in my opinion was a bit extreme." (Rx1).

On cross-exam, Dr. Graf agreed he only saw Petitioner once, and he did not provide any treatment, and he acknowledged that the vast majority of his Section 12 exams are requested by employers. His examination of Petitioner took 23 minutes. He didn't know what Petitioner's current condition was. In addition to the interpreter and his own knowledge of Spanish, he had a medical assistant with him who spoke Spanish and to assist if something isn't being translated correctly. Dr. Graf agreed that he did not specify a time frame as to when Petitioner's pain level was 7/10 prior to the accident, but testified his understanding is that it was directly prior to the claimed injury. He testified: "I usually would not ask what is your pain before an injury. The only reason I asked that question is because he said that he had ongoing pain from five years prior and the treatments he received helped him only temporarily at that time and he noted ongoing symptoms since that injury." (Rx2).

Dr. Graf testified that for the distracted straight leg exam, the patient isn't informed of what he is looking for but he looks at their verbal and nonverbal responses: "Somebody who has 7 out of 10 pain is going to wince or pull back and I'll observe to see if there's a difference in such." He agreed that just because there were inconsistencies in the exam did not mean that there was not a problem. He agreed that pain is subjective and people recognize pain levels differently. He also believed that an orthopedic surgeon would be in a better position to evaluate a patient for a back injury than an occupational medicine doctor, such as Dr. Sorokin. Dr. Graf agreed that Petitioner's back symptoms had not fully resolved in the 5/3/18 therapy note, and that its possible that back pain can wax and wane. All of the prior medical records he reviewed involved Petitioner's primary provider, not an orthopedic surgeon, and he reviewed no medical records indicating treatment between 9/13/13 and 4/11/18. Dr. Graf assumed Petitioner had a prior MRI at some point, as epidurals typically will not be performed without reviewing one, but he was not provided such films. He also acknowledged that in September 2013, Petitioner only complained of minimal low back pain, and he saw no prior surgical recommendations in the records he reviewed. Dr. Graf acknowledged the medical records from 9/13/13 indicated minimal back pain, and he agreed that his pre-accident treatment was sporadic per the records he reviewed, while he received fairly continuous treatment after 4/11/18. In comparing the 9/13/13 and 4/13/18 medical reports, Dr. Graf agreed that the Petitioner's complaints did appear different. However, he testified that

it was clear he didn't have all of Petitioner's prior records given he had previously undergone therapy and injections. (Rx2).

Dr. Graf agreed he did not review any of Petitioner's medical records from after 9/30/18, including the records of Dr. Lorenz or the 2/27/19 MRI study. He agreed with the diagnosis of spondylosis with spinal stenosis at L2/3 and L3/4. He testified that the main basis for his causation opinion was that Petitioner had ongoing back complaints prior to the accident and that that his pain was worse prior to the injury than after the injury. Dr. Graf testified that if the histories were different, then the causation opinion would be different. He acknowledged that spondylosis can be asymptomatic and can be aggravated by trauma, which could cause it to become symptomatic. Dr. Graf testified that that lifting or bending repetitively could cause such a preexisting condition to become symptomatic. He agreed that not all people with spondylosis require medical treatment, and that whether medical treatment would be offered would depend on the subjective complaints as well as neurologic status, i.e. nerve root compression, weakness, etc. Dr. Graf agreed that Petitioner was working without restrictions prior to the accident and was working with restrictions when he examined him. His opinion that Petitioner could work unrestricted was based on his condition being unrelated to the accident. Dr. Graf testified that regardless of causation, work restrictions would be reasonable. He also testified that surgery could be reasonable down the road following an epidural attempt, that and a surgical decompression recommendation at L2/3 and L3/4 would not be unreasonable, though he noted that stenosis at L3/4 was mild and he questioned the applicability of a fusion. (Rx2).

Petitioner testified he wants to undergo the surgery Dr. Lorenz has recommended. He has continued to work light duty for Respondent since the accident, which still involves gathering trash, but not with a bag. He puts coverings on the tables, and he does help push things, but testified this is now with the help of two other people. He still feels insecure and unsteady at work, even just walking. Currently, Petitioner testified it really hurts and he walks crooked, leaning to his right, while he walked fine prior to the accident. His pain is in the lower back and all the way down his left leg to the big toe. For the pain he tries to do recommended exercises and he takes ibuprofen, noting he takes 3 or 4 pills when he has severe pain. He no longer performs the same chores at home and sleeps with pain that wakes him up sometimes with left leg cramps, testifying he didn't have this prior to the accident "so much."

On cross-examination, Petitioner agreed an interpreter was present when he was examined by Dr. Graf in September. He said he told Dr. Graf he was working at McCormick Place working in a very large room performing housekeeping and setting up tables, chairs and platforms, and that he was working quickly that day and had low back pain. He told Dr. Graf he reported the injury to his supervisor. He testified: "I've always had some pain and discomfort, but it never prevented me from doing my normal job." Dr. Graf did ask him what his pain level was before and after the accident. Respondent's attorney asked Petitioner if he told Dr. Graf he had low back pain while working. He appeared confused by the question and answered that he always had low back pain, but it never prevented him from performing his job.

Petitioner was working for A&R Janitorial when he hurt his back in 2004 and did have a workers' compensation claim for it. As to his treatment prior to 4/11/18, Petitioner denied treating at Union Health Clinic. He agreed he saw Dr. Thiti for back treatment in 2009, complained of a one or two month history of low back pain on 3/20/09, and on 11/20/09 told him he had occasional low back pain. He testified: "Yes, it's always hurt me, yes." He did not recall telling Dr. Thiti on 5/3/13 that he'd had low back pain radiating into his right hip for over a year, testifying his right leg has never hurt him.

Referencing his attorney's indication that he had previously treated with Dr. Ring and Midway Clinic prior to 2018, Petitioner testified he did not recall treating with these providers. He agreed he had a back injection at MercyWorks prior to 2018. Petitioner agreed he didn't seek treatment after the 4/11/18 injury until two days

later. He agreed he told the physical therapist on 4/17/18 that he had injured his back 13 years before and has had occasional pain ever since then. He agreed he told the therapist on 4/23/18, 4/27/18 and 4/30/18 that he was feeling better "at that moment." When Petitioner on cross examination was asked if he told Dr. Murtaza on 6/1/18 that surgery had been recommended to him in the past, he responded "yes."

On redirect, Petitioner testified that when surgery had been discussed prior to the 4/11/18 accident "the doctor told me that it wasn't really so bad to require surgery. He said that he had more benefits than I. . . He said it was not recommended." He did again testify that surgery was discussed, adding "in part."

As to the physical therapy he underwent in April and May of 2018, Petitioner testified he would feel relief but that later in the day or in the following days he would feel "bad and worse." As to his back pain prior to 4/11/18, Petitioner testified it was not constant, but has been fairly constant since that time. On further redirect, Petitioner testified it's possible that Dr. Ring is part of Advanced Pain Medicine, and he did treat at that facility. When he sought treatment in May 2013, he did not complain of left leg pain, and he testified his pain now is "almost double" what it was at that time. He agreed he settled his prior workers' compensation case but did not recall how much it settled for. The parties at this point stipulated that the settlement was for 5% of the person as a whole.

Petitioner testified that he occasionally followed up with his primary care physician regarding his low back and was last examined by this provider in 2013. Petitioner testified that he had occasional low back pain and advised Dr. Thiti of this, but he denied telling him that he experienced right leg pain. He did not experience left leg pain in May of 2013. Petitioner further testified that from 2014 to April 11, 2018, he had not received any medical treatment for his low back. He testified that when he reported to work on April 11, 2018, his back felt normal. Petitioner testified that he felt pain in his back over the last 13 years. However, the pain was not constant. He testified that since the accident his pain has been constant.

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 Petitioner sustained accidental injury arising out of and in the course of his employment on 4/11/18. However, the Arbitrator further finds that the Petitioner has failed to prove that his current low back condition is causally related to the 4/11/18 accident.

The Arbitrator initially notes that the issue of accident is a close call. There are somewhat varying histories in the medical records that make it unclear if the injury involved a specific trauma or an allegation of a repetitive trauma. However, the Petitioner was in the course of his employment that day when he was picking up trash from in and around approximately 6,000 chairs at the McCormick Place Grand Ballroom. He testified that he had to bend and reach repeatedly to pick up the items of trash and developed back pain, noting he had to sit down for a while after the pain started and then reported it to his supervisor. Respondent did not rebut the testimony that he reported the incident.

The type of activities the Petitioner testified he was performing are a competent cause of a low back injury, and these activities would constitute an increased risk of injury which arose from an employment risk. As such, the Arbitrator finds that the Petitioner sustained his burden of proof on this issue.

That being said, there are discrepancies in this case with the Arbitrator can't ignore. For example, Petitioner testified that he spent about a half hour performing this activity, and that somehow in that time period he picked up "thousands" of pieces of garbage. This does not appear to be possible to the Arbitrator. Petitioner testified that he had no back problems when he came into work that day, lost his balance while bending down and felt a pull or strain in his back, as well as a pop. Thereafter he had severe pain in his back and left leg. None of the medical records reference a "pop." Petitioner's testimony that he had to hold the garbage bag at head level, and that Dr. Graf's exam was quick when the doctor documented 23 minutes spent directly with Petitioner, appears somewhat exaggerated to the Arbitrator as well.

Petitioner then did not seek treatment until 4/13/18. Petitioner told Dr. Sorokin he injured his low back and developed pain into his *right* leg. He also reported that he had prior back injury with no injections or surgery, while his testimony indicated he had an injection in the past. Interestingly, there is another report from the same date (4/13/18) from Dr. Thiti which references mild low back pain with no neurologic deficits and no indication of a work injury.

On 4/17/18, Petitioner reported pain radiating into the *left* leg, and on 4/24/18 reported pain into *both* legs with numbness and occasional shooting pains in the *right* leg. Later in the report it notes shooting pain over both thighs and left shin numbness.

An initial therapy report from Concentra on 4/17/18 stated Petitioner had been performing the cleaning activity for over an hour and felt pain in the morning the next day. He also reported pain into the left leg to the foot, and that he had a back injury 13 years prior with occasional soreness in his back ever since. On 4/27/18, Petitioner told the therapist he had pain down both legs. On 5/15/18, Dr. Sorokin recorded complaints of pain through his legs and numbness over his right foot and toes.

When he saw Dr. Murtaza on 6/1/18, he reported injuring his back while picking up trash and having pain down both legs, left greater than right since that time. At that time, Dr. Murtaza recorded that he had previously had surgery recommended to him. Petitioner initially testified that surgery was only discussed and not recommended because it was "risky", and then testified that his condition wasn't so bad that he should have surgery and instead had an injection recommended in 2011.

When Petitioner saw Dr. Salehi, he reported "they had an hour and a half to turn over a room." The report states he did this for over an hour and started to feel low back pain. There is no description of a specific injury, but the report states Petitioner "thought nothing of it", but that the pain then started worsening and going down the left leg.

Petitioner was examined by Dr. Graf at Respondent's request, and he testified he specifically remembered Petitioner's case because he had reported having more pain before the accident than after it. Petitioner was asked by his attorney how much pain he had prior to the accident, and he indicated 4/10 or 5/10 at the highest. While this is different than Dr. Graf's indication he reported 7/10 level pain, it nevertheless is a significant degree of pain.

When Petitioner saw Dr. Lorenz, the history was unclear, again, as to whether there was a specific trauma or not, but Petitioner was complaining of pain radiating to both feet with numbness. Petitioner acknowledged he had a chronic dull back ache but indicated he had not sought any chronic treatment until after the accident in 2018. Dr. Lorenz also indicated he reported having undergone two epidurals, but there is absolutely no record of any injections occurring after April 2018 in the records in evidence, and Petitioner testified that he had no injections because Respondent didn't authorize any.

The Petitioner also testified to prior treatment, including therapy and an injection or injections following accidents/injuries in approximately 2004 and 2014, per his testimony. But he also testified to treatment in 2011 and 2013, and there are records in evidence referencing visits for back pain in 2009 as well. Only a few records of this treatment were submitted into evidence. Additionally, it appears the Petitioner told his attorney he had treatment with three other facilities, and Respondent indicated these facilities responded that they had no records of treatment. Petitioner's counsel also was unable to obtain documentation from these facilities. Very little of Petitioner's prior treatment was referenced in Dr. Thiti's records. It appears from the records that are in evidence that Petitioner's low back pain that waxed and waned since 2004.

The Arbitrator also notes with interest that it is undisputed that the significant degenerative findings on the lumbar MRI pre-dated 4/11/18, and that Petitioner testified that his pain prior to 4/11/18 was at a level of 4/10 to 5/10.

While there may have been issues at various times given the Petitioner's language being Spanish and the use of interpreters, there are simply too many discrepancies and holes in the story due to missing medical records to support a finding that the Petitioner's lumbar condition, and that any need for surgery is causally related to the 4/11/18 accident. The burden of proof is on the Petitioner, and given the significant degenerative versus acute findings on the MRI, and the prior recommendation of discussion of surgery before April 2018, the prior records of Petitioner's treatment are very important pieces of evidence that are lacking in this case.

The Arbitrator finds that the preponderance of the evidence supports the determination that the Petitioner failed to prove his ongoing low back condition and any need for surgery, as recommended by Dr. Lorenz and Dr. Salehi, is causally related to the 4/11/18, and that he failed to prove that his preexisting lumbar condition was accelerated or aggravated by the 4/11/18 accident.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings with regard to causation, this issue is moot.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings with regard to causation, this issue is moot.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	14WC003311
Case Name	ROBINSON, ERIC v. ITW-SIGNODE
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0285
Number of Pages of Decision	22
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Leticia Ardon
Respondent Attorney	James Moran

DATE FILED: 6/11/2021

/s/ Stephen Mathis, Commissioner

Signature

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

ERIC ROBINSON,

Petitioner,

vs. NO: 14WC003311

ITW SIGNODE,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, causal connection, notice, 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 January 3, 2020 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 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.

June 11, 2021

/s/ *Stephen J. Mathis*
Stephen J. Mathis

SJM/sj
o-4/20/2021
44

/s/ *Deborah Baker*
Deborah Baker

/s/ *Deborah Simpson*
Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0285

ROBINSON, ERIC
Employee/Petitioner

Case# **14WC003311**

ITW SIGNODE
Employer/Respondent

On 1/3/2020, 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 1.56% 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:

0598 JOHN E LUSAK
221 N LASALLE ST
SUITE 1700
CHICAGO, IL 60601

2461 NYHAN BAMBRICK KINZIE & LOWRY
MICAELA M CASSIDY
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

ERIC ROBINSON
Employee/Petitioner

v.

ITW SIGNODE
Employer/Respondent

Case # **14** WC **003311**

Consolidated cases: **D/N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly C. Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **08/20/19 & 11/19/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **5/04/2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**33,640.93**; the average weekly wage was $**841.02**.

On the date of accident, Petitioner was **46** 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 $**2,809.49** for other benefits, for a total credit of $**2,809.49**.

Respondent is entitled to a credit of $**2,809.49** under Section 8(j) of the Act.

ORDER

Some of Petitioner's testimony was not credible. Petitioner failed to meet his burden of proof on the issues of accident, notice and causal connection. The Arbitrator views the remaining disputed issues as moot. 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.

Molly C Mason

Signature of Arbitrator

1/3/20
Date

JAN 3 - 2020

Eric Robinson v. I.T.W. Signode
14 WC 3311

Summary of Disputed Issues

Petitioner's Application for Adjustment of Claim alleges an injury of May 4, 2011 secondary to "exposure to substances and heat." Petitioner filed this Application on January 31, 2014.

Petitioner did not testify to any event occurring on May 4, 2011. Instead, he targeted the date May 11, 2011. He indicated this was the last day he worked. During the six months prior to this date, he worked as a welder. He testified he always wore ear plugs when welding, in accordance with Respondent's rules. He denied experiencing dizziness or ear problems before 2011 but some of his records document a long history of dizziness. While welding during his night shift on May 11, 2011, he suddenly started feeling queasy and dizzy. He then passed out and "woke up in the locker room." He testified he told his supervisor, Phil, what had happened. His records reflect that, on May 4-5, 2011, he was taken to the Emergency Room at Mercy Hospital, where a physician linked his vertigo to an upper respiratory infection. He followed up with his primary care physician, Dr. Noriega, who attributed his vertigo to chronic sinus infections. He also saw a neurologist, Dr. Chaudry, an ENT physician whose name he could not recall and, ultimately, Dr. Xiao, a resident at the University of Chicago who advanced a causation theory in late 2016. He received both short- and long-term disability benefits.

Respondent's Section 12, examiner, a neurologist, found no link between the episode at work and the claimed vertigo condition.

The disputed issues include accident, notice, causal connection, medical expenses and nature and extent. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified he has not worked since 2011. He recalled working for Respondent during two periods. Respondent produces steel straps. He worked as a line worker between 2005 and 2007 and was then on layoff for about a year. He testified that Respondent recalled him in approximately late 2008 but a form in RX 5 reflects a date of hire of August 9, 2010. He started working as a welder about six months before his claimed accident. When he worked as a welder, he wore a hard hat, gloves, a shirt with long sleeves, steel-toed shoes and earplugs. He identified PX 1 as a "rulebook" disseminated by Respondent. He testified Respondent's rules required him to wear earplugs while welding. He always wore earplugs while welding.

On direct examination, Petitioner acknowledged losing three days of work at some point due to a sinus infection. He denied losing any time due to dizziness or ear problems. He denied experiencing dizziness or ear problems before 2011.

Emergency Room records in RX 2 reflect that, on October 26, 1997, Petitioner complained of various symptoms, including episodes of lightheadedness occurring "when standing, often when hot (exposed to steam)." The Emergency Room provider diagnosed a viral syndrome. University of Chicago Medical Center Emergency Room records in RX 3 reflect that Petitioner complained of dizziness, lightheadedness and diarrhea on July 15, 2008.

Petitioner testified he last worked for Respondent on May 11, 2011. He started his shift at 11 PM on that date. He testified he felt "okay" before he went out on the floor to begin working. He was assigned to perform welding. He worked in a line of eight employees. As he started welding, he suddenly started feeling queasy and dizzy. He went into the locker room and splashed himself with water. He then returned to the line. He activated the stop button and suddenly passed out. He had never passed out before. Two co-workers, Jose and Pedro, were nearby. Someone alerted Phil, a supervisor. Phil punched an emergency stop to shut the line down. A crew came in and carried him to the locker room. He woke up in the locker room and told Phil what had happened. Phil called the plant manager. Phil and Petitioner's wife then transported Petitioner to Mercy Hospital. He stayed at the hospital for one night.

Petitioner did not offer into evidence any Emergency Room records dated May 11 or May 12, 2011. PX 4, a compilation of records from Mercy Hospital and Medical Center, contains Emergency Room records dated May 5, 2011. Those records reflect Petitioner arrived at the Emergency Room at about 1:36 AM. A triage note reflects Petitioner complained of dizziness and nausea when turning his head to the left. This note also reflects that Petitioner reported "recent sinus problems." Another note reflects Petitioner also complained of congestion. RX 4, p. 18 of 32. A provider named Anand Karsan recorded the following history:

> "46 yo male, history of GERD, presents with one day of sinus congestion as well as vertigo when he turns his head towards the left. He noticed this especially at night when he was at work. History of similar in the past when he has upper respiratory congestion. Denies headache. Denies fall. Denies fever, chills, chest pain, shortness of breath, numbness, diarrhea, constipation, dysuria, hematuria. He was given Fluticasone per his primary care physician, Dr. Noriego [sic], but he decided to stop it after 2 weeks. He hasn't taken any medications for this tonight."

Dr. Heinrich examined Petitioner, noting no nystagmus and mild excoriation with blood of the left medial nare. The doctor assessed Petitioner as having "vertigo most likely secondary to URI with congestion." He indicated that the vertigo improved after he performed the Epley maneuver. He re-examined Petitioner at 3:14 AM and described the vertigo as "resolved." At discharge, he prescribed Antivert, Musinex and Clarinex. He directed Petitioner to seek follow-up care with his personal care physician and to call the "dizziness center." PX 4. RX 4. He also directed Petitioner to remain off work for one day. PX 4.

Petitioner testified that the Emergency Room physician directed him to follow up with Dr. Noriega, his primary care physician. He had seen Dr. Noriega in the past for check-ups and hypertension but never for vertigo or ear problems.

Petitioner did not testify to resuming work after his Emergency Room visit but an Aetna "Employee Request for Information" form in RX 5 reflects that Karen Smith of Respondent indicated Petitioner last worked on May 10, 2011. This form also reflects that Petitioner "experienced dizziness at work" with his "group leader" transporting him to the hospital.

Petitioner returned to Mercy Hospital and Medical Center on May 13, 2011 and saw Dr. Noriega. The doctor noted that Petitioner had been off hypertension medication since January. She also noted that Petitioner had been diagnosed with vertigo and had been given a referral to the "dizziness clinic" that week. On examination, she noted "nystagmus to the right." She indicated she completed a form allowing Petitioner to take a leave from work from May 10 through May 13, 2011. She directed Petitioner to return to have insurance paperwork completed "after making appt. with dizziness clinic." RX 4.

Petitioner testified he telephoned Respondent after seeing Dr. Noriega and spoke with Karen in the administrative office. Petitioner testified he told Karen he could not return to work. She recommended that he apply for short-term disability benefits if he was going to be off work for a long time. [The Aetna "Employee Request for Information" form referenced above is dated May 13, 2011. RX 5.]

The electronic records in RX 4 are not easy to understand, in terms of a chronology, but it appears Petitioner saw Dr. Noriega again on May 18, 2011. The doctor noted complaints of dizziness, nausea and vomiting. She indicated that, according to Petitioner, these symptoms started in 2009 or "a couple of years ago." She noted that Petitioner's symptoms "seemed to be worsening lately" and that he had obtained good relief from medication he received at Mercy's Emergency Room. She indicated that Petitioner requested a refill of this medication and asked her to complete a form verifying a leave of absence from May 10, 2011 to May 27, 2011 "and to be able to return to work 5/30/2011." She noted, however, that Petitioner was scheduled to be evaluated by a "dizziness therapist" on May 23 and 27, 2011. She noted that these evaluations might result in a change in the leave of absence dates. She refilled the Meclizine and completed a form indicating Petitioner would be "totally/partially disabled" from May 10, 2011 to May 27, 2011 and able to return to work as of May 30, 2011, with his restrictions dependent "on the results of what the therapist finds in the dizziness clinic."

Petitioner underwent a "vestibular evaluation" by Jim Buskirk, PT, SCS, on May 24, 2011. Buskirk noted a history of vertigo of "many years." He indicated the most recent episode followed an upper respiratory infection. He described Petitioner as working at a steel mill. He indicated that Petitioner "was at work May 6" and experienced vertigo when he "bent down to pick up steel piece." He described Petitioner as falling to the floor. He noted that Petitioner underwent care at Mercy's Emergency Room. He described Petitioner as having positional vertigo to the left side and denying photosensitivity. He indicated that Petitioner "uses hearing

protection w/ earplugs @ work." On examination, he noted nystagmus to the left and positive Dix-Hallpike testing. He diagnosed "left BPPV" and performed a left Epley maneuver. RX 2, 4, 5.

On May 25, 2011, a representative of Aetna wrote to Petitioner, indicating that his claim for short-term disability had been certified for the period May 11 through May 29, 2011. In this communication, the representative advised Petitioner that "a disability absence is time lost from work because of a non-occupational injury or disease." RX 5.

On May 27, 2011, Dr. Noriega noted that Petitioner was following up for vertigo. She indicated that Petitioner's symptoms "initially started 2 years ago." She noted that the symptoms would sometimes resolve on their own but "seem to have worsened in the last month." She indicated that Petitioner described his vertigo as "intolerable" and was deriving little benefit from medication. On examination, she noted nystagmus bilaterally. She also noted mild inflammation of the "left ear tm." She started Petitioner on Cipro for "left otitis media" and recommended Petitioner attend vestibular therapy. RX 2.

On May 31, 2011, a representative of Aetna wrote to Petitioner again, informing him that his short-term disability benefits had been extended through June 28, 2011. The representative again advised Petitioner that "a disability absence is time lost from work because of a non-occupational injury or disease." RX 5.

Petitioner returned to Dr. Noriega on July 8, 2011. In her note of that date, the doctor described Petitioner as having "peripheral vertigo" and being compliant with therapy. She noted Petitioner was no longer taking Meclizine. She recommended he continue attending "dizzy therapy" until he was "completely resolved." She also noted that Petitioner's blood pressure was elevated. She indicated she had taken him off medication at the previous visit "due to controlled bp." She noted that Petitioner wanted to hold off on medication and change his diet. She indicated that Petitioner would restart the medication at his next visit if his blood pressure remained elevated. RX 2, 4.

A document in Dr. Noriega's chart reflects that a claim analyst affiliated with Aetna wrote to the doctor on August 23, 2011, requesting clarification of Petitioner's medical and work status. Dr. Noriega responded by indicating she had last seen Petitioner on July 8, 2011 and that no future appointment was scheduled. RX 2, 4.

Petitioner returned to Dr. Noriega on September 16, 2011, with the doctor recording the following:

> "Pt states his vertigo is not completely resolved. Pt realizes the vertigo symptoms are directly related to his chronic sinus infection exacerbations. Pt accompanied by wife. Pt was given Ocean nasal spray from PT with minimal improvement."

RX 2, 4.

Petitioner underwent a brain MRI at Mercy Hospital on October 5, 2011. The report identifies Dr. Gruber as the ordering physician. [The Arbitrator was unable to find any records from Dr. Gruber among the records in evidence.] The reason for the scan is described as "dizziness." The radiologist compared the results with a non-contrast head CT scan performed on July 15, 2008. He noted non-specific subtle small T2 hyperintense foci in the periventricular white matter of both frontal lobes, "likely representing either or microvascular ischemic sequelae (considered the most likely explanation) versus early/mild demyelinating disease." He indicated there were other "rare causes," including "atypical infection or inflammatory processes." RX 2, 4.

Petitioner first saw Dr. Chaudry on December 30, 2011. He testified that Dr. Noriega referred him to Dr. Chaudry. The doctor's handwritten note of that date reflects that Petitioner reported having experienced intermittent vertigo since 2005, with that condition worsening. The doctor noted that positional changes brought the vertigo on. The doctor described Petitioner as a steel worker but made no mention of any work accident or episode. She noted a past history of Bells palsy. She also noted that Petitioner had undergone vestibular therapy and that his brain MRI was normal. On examination, she noted intact motor and sensory, normal reflexes, negative Romberg testing and no nystagmus. She diagnosed "chronic vertigo." PX 2.

Petitioner returned to Dr. Noriega on January 6, 2012. The doctor noted a one-month history of low back pain that started after Petitioner lifted a heavy box. She also noted that Petitioner was seeing "ENT Dr. Gruber" for "chronic sinusitis which may be contributing to the vertigo." [The Arbitrator again notes that Dr. Gruber's records are not in evidence.] She documented an elevated blood pressure, noting that Petitioner preferred to monitor his blood pressure at home and to bring in the log in three months, at which point he would restart his medication if the pressure remained elevated. RX 4.

Petitioner returned to Dr. Chaudry on January 13, 2012. The doctor noted that Petitioner described himself as "much improved" but was still experiencing mild positional vertigo "lasting a few seconds." She noted that Petitioner denied nausea, vomiting, tinnitus and falls. Her examination findings were unchanged. She noted that Petitioner remained off work. She indicated he needed to be re-evaluated by a vestibular clinic to determine whether he still had nystagmus or not. She indicated that, he was cleared by the vestibular clinic, he could return to work but subject to restrictions of no lifting heavy objects, no ladder usage and no work at heights. PX 2.

On January 30, 2012, Dr. Chaudry noted that Petitioner had undergone a functional capacity evaluation by "Jim" at the vestibular clinic and that "Jim" cleared Petitioner for work. She described a neurological examination as "completely normal." Her examination findings were unchanged. She released Petitioner to work "per neuro" and directed him to return as needed. PX 2.

Petitioner went to Mercy Hospital's Emergency Room on February 10, 2013 due to diarrhea. The examining physician noted a history of vertigo and hypertension, indicating that Petitioner was not on any hypertension medication. The physician assessed Petitioner as likely having gastroenteritis. He noted that Petitioner had not kept a blood pressure log or followed up with Dr. Noriega. He "stressed importance of f/u on this ASAP." PX 4.

On February 13, 2013, Petitioner saw a nurse practitioner Theresa Flerick, APN [hereafter "Flerick"] at Friend Family Health Center for hypertension and in follow-up from the Emergency Room visit. Flerick noted that Petitioner had previously been started on medication for hypertension but had discontinued it "a few years ago" because "he felt better." She also noted that Petitioner denied headaches and dizziness. She prescribed Lisinopril and directed Petitioner to return in one month. PX 3.

Petitioner went to the Emergency Room at Mercy Hospital on March 5, 2013, complaining of a high blood pressure reading at home and an inability to sleep for the previous few days. Providers noted a history of vertigo but noted that Petitioner denied feeling dizzy PX 4.

On April 8, 2013, nurse practitioner Flerick noted that Petitioner was following up for his blood pressure. She described Petitioner as "coaching 7-year-old basketball as a job" and "stay[ing] very active." She described Petitioner's hypertension as "much better" secondary to diet and exercise. PX 3.

Petitioner went to the Emergency Room at Mercy Hospital on May 26, 2013, following an elevated blood pressure reading at home, but later signed out, indicating he felt he no longer needed to be seen. The Emergency Room records reflect that Petitioner reported "vertigo at times" but denied feeling dizzy that day. PX 4.

On July 1, 2013, Petitioner went to the Emergency Room at Mercy Hospital and complained of dizziness and generalized weakness during the preceding two hours. The records reflect Petitioner provided a history of vertigo for which he took Meclizine as needed. Petitioner was admitted to the hospital for blood pressure monitoring. A progress note reflects that Petitioner indicated "this episode of dizziness was not at all like prior episodes of vertigo" and had not recurred. Dr. Kukor noted he suspected that the episode of dizziness was "symptomatic of accelerated HTN." PX 4.

Petitioner filed his Application for Adjustment of Claim on January 31, 2014.

On February 11, 2014, Flerick noted that Petitioner had been attending therapy for vertigo but had not yet seen a neurologist because his previous neurologist was at Mercy Hospital, which would not accept his insurance. The nurse practitioner noted that Petitioner reported feeling "pretty good" but "sometimes a little dizzy." She referred Petitioner to neurology. PX 3.

Petitioner returned to Dr. Chaudry on February 21, 2014. The doctor noted that Petitioner reported experiencing positional vertigo daily. She noted no abnormalities on re-examination. She recommended that Petitioner continue taking Meclizine and undergo vestibular therapy. PX 2.

On April 3, 2014, Petitioner returned to Dr. Chaudry and reported that he could not currently see "Jim" due to "insurance reasons." Petitioner also reported that he was continuing to experience positional vertigo daily. On re-examination, the doctor noted nystagmus when Petitioner was looking to the left. She again recommended vestibular therapy. She started Petitioner on Klonopin. PX 2.

Dr. Chaudry decreased Petitioner's Klonopin dosage on May 1, 2014. She noted that Petitioner described this medication as "working very well for his vertigo but making him drowsy." She noted no nystagmus on re-examination. PX 2. At the next visit, on July 14, 2014, Dr. Chaudry noted that Petitioner was still experiencing flare-ups and taking Klonopin two to three times per week. She noted no nystagmus on re-examination. PX 2.

On October 21, 2014, Petitioner saw a different nurse practitioner at Friend Family Health Center for blood pressure monitoring. The nurse practitioner noted that Petitioner had recently seen a neurologist "for his recurrent vertigo" and was awaiting a functional capacity evaluation by a physical therapist. The nurse practitioner also noted that Petitioner "states he has been having vertigo which he believes prevents him from being able to work." PX 3.

Jim Buskirk, PT, wrote to Dr. Chaudry on October 22, 2014, indicated he re-evaluated Petitioner that day, having last seen him almost a year earlier. Buskirk noted that Petitioner's complaints remained the same and that he exhibited left beating nystagmus on re-testing. He described this finding as consistent with his previous finding of February 2, 2012. He opined that Petitioner was not capable of returning to his prior job or performing any job requiring heavy lifting, driving a forklift, welding or climbing. He found Petitioner employable "most likely on a part-time basis in limited capacity of sedentary supervisory work." PX 2.

On October 27, 2014, Dr. Chaudry noted Buskirk's findings and recommendations. She noted no nystagmus on re-examination. She recommended vestibular therapy. PX 2. On March 9, 2015, she noted that Klonopin was helping Petitioner's symptoms "a lot" and that his insurance had authorized five vestibular therapy sessions. She again noted no nystagmus. PX 2.

Jim Buskirk, PT, wrote to Dr. Chaudry again, on February 19, 2015, indicating he had re-evaluated Petitioner. He noted that while, left beating nystagmus was again documented, "there was no evidence of true benign paroxysmal positional vertigo." He indicated his opinions concerning Petitioner's work capacity remained unchanged. PX 2.

On March 10, 2015, Flerick noted that Petitioner was following up after a recent Emergency Room visit for headaches. Flerick noted that the headaches were "thought to be

triggered by missing his Amiodipine for a few nights" and that Petitioner had resumed this medication for his blood pressure. She also noted that Petitioner reported getting headaches from straining to see while playing games on his phone. PX 3.

On August 5, 2015, Flerick noted that Petitioner was following up for his hypertension and diabetes. She also noted that Petitioner "has been feeling well except for the vertigo which is still bothersome sporadically." PX 3.

On September 29, 2015, the Social Security Administration wrote to Petitioner, notifying him he was entitled to monthly disability benefits beginning September 2015. In the letter, the Administration advised Petitioner that it found he became disabled under its rules on March 2, 2015. RX 6.

Petitioner saw Dr. Xiao at the University of Chicago on November 28, 2016. Petitioner testified that Dr. Chaudry referred him to the University of Chicago. He then called the neurology department at the University of Chicago and received Dr. Xiao's telephone number.

Dr. Xiao noted that Petitioner was there for a "second opinion about longstanding vertigo." He recorded a consistent history of the May 2011 work episode, indicating that Petitioner started feeling hot while working on the line, turned his head to the right, became disoriented and "blacked out." He also recorded a consistent history of the subsequent care. He noted that Petitioner reported experiencing five to six episodes per week of blurry vision, tinnitus and a "room spinning sensation." He directed Petitioner to bring in records from his prior work-ups.

On December 19, 2016, Dr. Xiao indicated that Petitioner brought in records concerning his May 5, 2011 Emergency Room visit and his vestibular therapy. He noted that Petitioner was pursuing a workers' compensation case:

> "By history his sx started at work after a period of wearing earplugs and it appears like he has symptoms of ear inflammation (tinnitus, itch, irritation). It is plausible that this led to an ear infection which was a proximal cause to his vertigo which remained after his infection has resolved. However, on review of his initial ER visit note to Mercy on 5/5/11, the HPI states he had similar vertigo prior in setting of URI sx and he was formally diagnosed with URI although his discharge information included inner ear infection (among other generic causes) as possible cause to his vertigo. As such, all we are not [sic] able to establish plausible causality because we did not see a record of an ear infection at time of his initial sx onset. However, the records we reviewed were incomplete."

Dr. Xiao directed Petitioner to bring in more extensive records along with his MRI. RX 2.

Dr. Xiao issued a letter the same day. He addressed causation as follows:

> "This letter is to inform that we have been evaluating [Petitioner] for vertigo since 11/26/16. It is clear that [Petitioner] has had vertigo since 2011 that started when he was performing his job duties. He wore ear plugs for work-related purposes around that time which can predispose him to ear infections. Based on the records from his initial physician visits and physical therapy notes, he was initially diagnosed with benign paroxysmal positional vertigo [BPPV], which can be caused by an infection. We cannot say for certain if his vertigo was caused by an inner ear infection as the records that we have reviewed are incomplete."

See PX 2 attached to Dr. Itkin's deposition transcript. Respondent objected to the admission into evidence of this document and a subsequent letter that Dr. Xiao issued on February 20, 2017 (PX 1). Respondent maintains that Dr. Xiao prepared both documents in anticipation of litigation. Dr. Xiao was never deposed, although the parties disagree as to why. [See RX 1, pp. 60-61.] Upon review of the transcript and Dr. Itkin's report, the Arbitrator overrules the objection as to PX 2. PX 2 came as no surprise to Respondent since Dr. Itkin "published" most of the document in his report. Moreover, PX 2 has elements of a treatment note and thus has greater reliability, in the Arbitrator's view. The Arbitrator rejects PX 1.

On February 20, 2017, Dr. Xiao indicated he reviewed certain medical records, including records from the initial Mercy Hospital Emergency Room visit of May 5, 2011, Peak Physical Therapy and Dr. Noriega. He noted that Petitioner denied experiencing vertigo before May 2011. He described Petitioner as trying to stay active "but old job requires operating heavy machinery which is unsafe with vertigo." He noted that Petitioner "currently has disability w/ability to work part time" and was pursuing workers' compensation. On neurologic examination, he noted no nystagmus, right pronator drift, no sensory deficits, normal coordination and "mild difficulty w/ tandem gait." He recommended that Petitioner again try Meclizine as needed. He referred Petitioner to Dr. Hain, a "vertigo specialist." He indicated he discussed his findings with Dr. Reder. RX 2.

Petitioner saw Dr. Xiao again on March 20, 2017 "for assistance with medical record review." The doctor noted that Petitioner's vertigo was unchanged and that he had elected to "hydrate" rather than use any PRN medications. He indicated he conducted a "detailed and lengthy discussion of workman's comp." He also indicated he discussed the case with Dr. Reder. RX 2.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Itkin on September 7, 2017. Itkiin Dep Exh 2. See further below.

Dr. Itkin testified by way of evidence deposition on July 18, 2019. RX 1. Dr. Itkin testified he is board certified in neurology and electromyography/electrophysiologic disease. He underwent fellowship training at Loyola, after attending medical school at the University of Chicago. RX 1, p. 5. Itkin Dep Exh 1. He is a general neurologist with special interest in multiple sclerosis and headaches. RX 1, p. 6. About 5% of his patients present with vertigo-type symptoms. RX 1, p. 6.

Dr. Itkin testified he performs one independent medical examination per week, on average. He has never conducted an examination at the request of the claimant. RX 1, p. 8. He has very little recollection of examining Petitioner and needs to rely on his report to testify. RX 1, p. 9. He examined Petitioner on September 7, 2017, at Respondent's request. He identified Itkin Dep Exh 2 as the report he generated. RX 1, p. 10. He reviewed many records along with brain MRI images in connection with his examination. RX 1, pp. 10-11.

Dr. Itkin testified that Petitioner told him he became dizzy and fell to the floor while working on a line at Respondent on May 4, 2011. Petitioner denied experiencing dizziness in the past but acknowledged having high blood pressure. RX 1, p. 12. He reported having undergone Emergency Room care following the May 4, 2011 incident and then seeing Dr. Noriega, his primary care physician, who prescribed Meclozine, an anti-dizziness medication. Petitioner described his dizziness as positional. Petitioner also reported hearing sound tones, exacerbated with a pulsatile sensation in the ears. RX 1, pp. 13-14. Some patients who experience vestibular disturbances report having these sensations. RX 1, p. 15. Petitioner reported having seen an ENT and then switching his care to the University of Chicago. Later, a neurological resident, Dr. Xiao, made a reference to otitis externa, "an external injury to the ear canal." RX 1, p. 16. Dr. Noriega indicated Petitioner had had similar problems in the past. Petitioner underwent a vestibular evaluation in 2006. The records he reviewed also showed that Petitioner has hypertension and diabetes. Dr. Itkin testified he does not consider these conditions to be related to the positional dizziness. RX 1, p. 17. Hypertension can cause dizziness but "it's a different kind of dizziness." RX 1, p. 18. Dr. Noriega attributed Petitioner's dizziness to chronic upper respiratory infections. RX 1, p. 18. Dr. Itkin testified he believes he saw a notation concerning Petitioner's use of earplugs. RX 1, p. 19. Based on the records he reviewed, Dr. Xiao was a "PGY 3," or second year neurology resident, as of the time he wrote his note. RX 1, p. 21. He believes Petitioner saw Dr. Xiao once or twice. Dr. Xiao did not refer Petitioner for vestibular testing or therapy. RX 1, p. 22.

Dr. Itkin testified he examined Petitioner. Petitioner's gait was antalgic. Petitioner was able to tandem walk. Romberg testing, which is balance-related, was negative. RX 1, p. 27. Petitioner's sensory examination was preserved but, with the Dix-Hallpike maneuver, Petitioner had a subjective feeling of dizziness. This maneuver did not produce any objective findings of nystagmus, which is "an objective correlate of dizziness or intranuclear ophthalmoplegia." RX 1, pp. 23-25. Dr. Itkin testified he noted a "non-physiologic" response to tuning fork testing.

Petitioner had the unusual response of having vibration more on the left side than the right. This was not an organic finding. Otherwise, he saw no symptom magnification. RX 1, p. 24.

Dr. Itkin testified that, as a neurologist, he diagnosed Petitioner with "some chronic vestibular process" that "very chronically preced[ed] the date of May 4, 2011." RX 1, p. 28. His neurologic examination was "entirely unremarkable." RX 1, p. 28. In his opinion, there was no causal relationship between Petitioner's employment on May 4, 2011 and his dizziness. RX 1, p. 28. There was evidence that Petitioner had dizziness before May 4, 2011 and the area of pathology is the inner ear, "which could not be affected in any way possible objectively from the history that was provided." In addition, his neurologic examination was normal. Petitioner "perhaps" requires restrictions related to vertigo but the need for those restrictions is not related to the work he performed for Respondent on May 4, 2011. He bases the possible need for restrictions on Petitioner's reported chronic dizziness, which Petitioner described as impairing his balance. RX 1, p. 30. The outer ear, or otitis externa, identified by Dr. Xiao, has nothing to do with the middle or inner ear. Later in the same note, in a section labeled "workers' compensation," Dr. Xiao indicated he had no causation opinion. RX 1, p. 31. Petitioner denied experiencing dizziness before May 4, 2011 but that denial is inconsistent with his records. RX 1, pp. 32-33.

Under cross-examination, Dr. Itkin testified he charges $500 per hour for the examinations he performs, all of which are for insurance carriers. He would like to be retained by claimants. RX 1, pp. 33-34. In the majority of cases he reviews, "there was an injury and some neurologic problem." RX 1, p. 34. Petitioner's case is unusual in that there was no event or concussion. RX 1, p. 35. He never talked with Respondent's counsel. He issued the report and she had to accept it. RX 1, p. 36. If a patient has an inner ear infection, and Petitioner was never diagnosed with one, he might benefit from seeing an ENT or a neurologist, depending on the case of the infection. RX 1, p. 38. He cannot think of an anatomical way that the use of earplugs, barring any perforation of the eardrums, would cause an inner ear infection directly. Dr. Xiao made an assumption of external ear infections with wearing earplugs. RX 1, p. 40. He relied on Dr. Xiao's reports in concluding that there was no causal connection between Petitioner's work and his claimed condition. RX 1, p. 44. He is affiliated with Christ Hospital but used to be a resident at the University of Chicago. RX 1, p. 45. He disagrees with the idea that the use of earplugs can cause inner ear infections. He also disagrees that benign paroxysmal positional vertigo can be caused by an infection. That is a "medically incorrect" statement. RX 1, p. 46. The physician who is in the best position to address causation "is the one who takes the most time, has the most information and has the most experience and the most thorough evaluation and knowledge." RX 1, p. 48. He does not disagree with Dr. Noriega's opinions. He has "much, much more experience" than Dr. Xiao, who was a resident under Dr. Reder's supervision. RX 1, pp. 49-50. In response to a question posed by Respondent's counsel, he indicated he could not determine whether the vertigo was related to a chronic upper respiratory infection. RX 1, p. 50. If therapist Buskirk opined that there was a relationship between Petitioner's use of earplugs and his vertigo, he would disagree based on Buskirk's vestibular evaluation but other evidence, which he might not have, could prompt him to change

his opinion. RX 1, pp. 52-53. He does not believe he has dealt with Respondent's counsel in the past. RX 1, pp. 53-54.

On redirect, Dr. Itkin testified there is no evidence of a head injury in this claim. Dr. Noriega diagnosed Petitioner with an inner ear infection. Earplug usage would not cause such an infection. He does not believe Petitioner provided a history of using earplugs. RX 1, p. 56. He did not see Dr. Xiao rendering opinions based on a reasonable degree of certainty. RX 1, p. 57. When he evaluated Petitioner on September 7, 2017, he saw no consistent evidence of vertigo or a vestibular problem on examination. RX 1, p. 57.

Under re-cross, Dr. Itkin reiterated that he reviewed Dr. Xiao's records. He believes the doctor "plainly and explicitly" discussed in those records whether he felt his opinions were to a reasonable degree of medical certainty. RX 1, p. 58. He did not use the term "reasonable degree of medical certainty" in his own report but, when he writes such a report, that is implicit. RX 1, p. 59.

On further redirect, Dr. Itkin testified the opinions he voiced are based on a reasonable degree of medical and neurological certainty. RX 1, pp. 59-60.

Petitioner testified he continues to undergo treatment on a monthly basis. He is "still somewhat the same." He last saw Dr. Chaudry on August 19, 2019. [No treatment note from that date is in evidence.] He continues to experience dizzy spells but has not fainted. No medical provider has released him to return to work. He is now receiving Social Security disability benefits.

Under cross-examination, Petitioner initially denied undergoing any treatment at the University of Chicago before his claimed accident. After being shown records from this facility, he acknowledged it was "possible" he underwent Emergency Room treatment on July 15, 2008. He denied, however, that he underwent treatment for dizziness and lightheadedness on that date. He recalled being diagnosed with Bell's palsy at that time. He did not recall being diagnosed with this condition in January 1995. After looking at records dated January 26, 1995, showing a complaint of facial numbness, he indicated the records refreshed his recollection. His Bell's palsy resolved over time. He acknowledged undergoing treatment for hypertension with Dr. Noriega before the claimed accident. He would disagree with the doctor's records, however, if they show he stopped taking prescribed medication for hypertension. He testified he "always" took this medication. He recalls going to the Emergency Room at Mercy Hospital late in the evening on May 11, 2011. He is not denying, however, that he went to that Emergency Room earlier the same week. Respondent had two shifts. His shift started at 11 PM. He did not recall going to the Emergency Room at Mercy Hospital at 1:40 AM on May 5, 2011. He took over the counter medication for an upper respiratory infection. He never received a prescription for sinus medication. His fainting episode at work occurred on May 11, 2011, not May 4, 2011. He saw Dr. Noriega after his Emergency Room visit. He went to Mercy on May 13, 2011 to request leave of absence forms. If the records reflect he had been off hypertension medication since January, the records are incorrect. He never stopped taking

medication for hypertension. He saw Dr. Chaudry about three weeks after the fainting episode. She referred him to Peak Therapy, where he saw a therapist named Buskirk. It was later that he saw a neurologist. If his records show his dizziness started in 2009, the records are wrong. He would not have been able to perform his job if he had experienced vertigo. If Buskirk's records document a long history of vertigo, he would disagree with those records. If Dr. Noriega's records from September 2011 relate his vertigo to sinus problems, he would dispute this. He cannot recall the day of the week he experienced the fainting episode at work. He applied for short-term disability benefits through Respondent in May 2011. Aetna issued short-term disability checks to him. He needed a certificate showing he was off work. Short-term disability benefits were the only benefits he was familiar with. Dr. Noriega completed reports for Aetna. He is not sure when he last received short-term disability benefits. After those benefits ran out, he began receiving long-term disability benefits. He received those benefits from UNUM for two years. It was after those benefits ran out that he applied for workers' compensation benefits. He never completed any workers' compensation paperwork at Respondent. He told his supervisor that the earplugs irritated his ears. He never reported that wearing the earplugs made him feel dizzy. Matt gave him new earplugs but the new ones still irritated his ears. Matt worked the first shift. He was out the night that the fainting episode occurred. Phil, another line supervisor, substituted for Matt that night. Respondent rotated him (Petitioner) to different shifts and lines. He originally wore foam earplugs. Later he was given rubber earplugs that were blue and orange in color. He never resumed wearing the foam earplugs. Dr. Noriega attributed his fainting episode to the earplugs. She said that the earplugs caused an infection at the beginning, when he started experiencing vertigo. Dr. Noriega did not release him to return to work on May 30, 2011. After looking at a form showing the doctor did release him to work on that date, he testified he did not return to work. He complained of his ears when he first saw Dr. Noriega after his Mercy Hospital Emergency Room visit. If the doctor's note of May 13, 2011 shows a two-year history of dizziness, he does not understand the expression "couple of years." He does not recall seeing Dr. Noriega on July 8, 2011. If, on that date, Dr. Noriega described him as presenting with peripheral vertigo, he would dispute that record. If the same note shows that he complained of his left ear, with the doctor prescribing antibiotics, he does not recall this. He cannot remember back that far. Drs. Noriega and Chaudry certified his entitlement to long-term disability benefits. He saw Dr. Flerick around February 2013. If this doctor [sic] indicated he has hypertension but has not taken medication for years, he would dispute this. He always took his hypertension medication. He does not recall going to the Emergency Room on July 1, 2013. If his blood pressure was 214/117 in May 2013, he would agree. He applied for Social Security disability benefits in 2015. He was found eligible but the payment was not retroactive to May 2011. He had group health coverage with Respondent. Later he had coverage through County Care. After he left Respondent, County Care covered his bills. He signed the second page of RX 4, an Aetna benefits application but "it looks like" his wife completed this application for him. His wife handled a lot of paperwork for him.

On redirect, Petitioner acknowledged he is not good with dates. He thinks his work accident occurred on May 11, 2011. His Application alleges an accident date of May 4, 2011. He went to the Emergency Room on May 5, 2011. He completed the paperwork that Aetna mailed to him. No one instructed him how to complete it. He did not receive paperwork from

Respondent. The form from Aetna is not dated. Dr. Noriega gave him antibiotics after May 2011.

After Petitioner testified, Respondent's counsel requested bifurcation for the purpose of finding the supervisors that Petitioner identified by name. Petitioner's counsel did not object. No Respondent witnesses testified at the continued hearing, held on November 19, 2019.

Arbitrator's Credibility Assessment

Petitioner's description of the dizziness he experienced at work was detailed and believable but he insisted he developed this dizziness on May 11, 2011 rather than May 4, 2011, the date of accident he alleged in his Application. He ultimately advanced the theory that his mandated earplug usage resulted in an ear infection which in turn resulted in vertigo. However, only one of his initial providers, Jim Buskirk, P.T. mentioned the earplugs and then only in the context of documenting hearing protection. Petitioner denied experiencing dizziness before the May 2011 work episode but Buskirk, Petitioner's primary care physician, Dr. Noriega, and Dr. Chaudry indicated that the dizziness pre-dated this episode. Buskirk, in fact, indicated that Petitioner had experienced dizziness "for many years." The Arbitrator finds Petitioner's denial of previous dizziness not credible.

Petitioner also disputed an entry in Dr. Noriega's chart that described him as "realizing," presumably based on what she told him, that his vertigo was related to "chronic sinus infection exacerbations". This further undermined Petitioner's credibility.

Petitioner also claimed to have no recollection of telling Dr. Chaudry in January 2012 that his vertigo had resolved. Nor did he recall being released to return to work that same month. Petitioner's testimony on these points was not credible.

Petitioner's testimony that he has not worked since 2011 is inconsistent with Flerick's note of April 8, 2013. In that note, Flerick indicated that Petitioner was "staying very active" and coaching children "as a job."

Respondent's Section 12 examiner, Dr. Itkin, noted a non-physiologic response when he saw Petitioner on September 7, 2017. In his report (Itkin Dep Exh 2), he described Petitioner as an unreliable historian.

Overall, the Arbitrator found Petitioner less than credible on certain issues.

With respect to the physicians who addressed causation, the Arbitrator finds Dr. Itkin's opinions more persuasive than those voiced by Dr. Xiao. While Dr. Itkin exhibited some potential for bias, given that he has acted as an examiner only for insurance carriers, he has many years of experience and was able to explain why the use of earplugs would not cause the kind of inner ear infection Dr. Noriega diagnosed after the claimed accident. He also explained that hypertension, a condition Petitioner suffers from, can cause dizziness, albeit not positional

in nature. At least one of Petitioner's post-accident episodes of vertigo was attributed to his hypertension. Dr. Xiao, a third year resident, relied on Petitioner's representation that his dizziness started with earplug usage at work. No provider who treated Petitioner early on recorded a similar history.

Arbitrator's Conclusions of Law

Did Petitioner sustain an accident on May 4, 2011 arising out of and in the course of his employment? Did Petitioner provide Respondent with timely notice?

The Arbitrator has no reason to doubt that Petitioner became dizzy at work and "passed out." Based on the Emergency Room records in evidence, it appears this episode occurred on the night of May 4-5, 2011, although Petitioner, somewhat insistently, testified it occurred on May 11th. The Arbitrator finds that Petitioner developed symptoms at the workplace, likely on May 4-5, 2011, that brought about the need for medical attention. The Arbitrator further finds, however, that Petitioner failed to establish a work accident arising out of the employment. In his Application, Petitioner attributed the episode to exposure to heat and unidentified substances but he did not testify to any such exposure. He did testify to using earplugs, per Respondent's regulations, and ultimately advanced a causation theory based on this usage, but the initial Emergency Room records do not reflect that he attributed his symptoms to any workplace condition. In fact, those records document a history of recurring vertigo associated with respiratory infections and sinus congestion. Dr. Noriega, the primary care physician who saw Petitioner in follow-up, endorsed this history, although Petitioner took issue with her records. Before late 2016, when Petitioner began seeing Dr. Xiao, the only provider who mentioned earplugs was therapist Jim Buskirk, who, during his vestibular evaluation, simply noted that Petitioner used earplugs for hearing protection at work. Petitioner testified that Dr. Noriega and Buskirk told him his vertigo might be work-related but their records do not remotely suggest such a connection.

The Arbitrator turns to the issue of notice. Petitioner's testimony concerning the events immediately following his episode was believable but ultimately not probative of this issue. Petitioner indicated that a line supervisor named Phil came to his aid after the episode and took him to the Emergency Room. This testimony is consistent with the information Karen Smith of Respondent provided to Aetna. RX 5. Petitioner testified he "told Phil what happened" but he did not further elaborate. Petitioner also testified he contacted "Karen", via telephone, after seeing Dr. Noriega (in follow-up from the Emergency Room). He indicated he told Karen he "couldn't return to work" and then followed her recommendation that he apply for short-term disability benefits. He did not claim to have described his condition or disability as work-related. He admitted signing an Aetna short-term disability application form that describes his condition as not work- or accident-related, although he maintained it was his wife who filled out this form. RX 5. Dr. Noriega, the physician who provided information to Aetna, did not describe Petitioner's condition as work-related. Petitioner did not file an Application until February 2014. Although it appears a Respondent supervisor was aware that Petitioner developed symptoms at work in May 2011 for which he required medical care, there is no

evidence that Petitioner reported a work injury or work-related condition to Respondent within the statutory 45-day notice period. The purpose of the notice provision is to enable an employer to investigate the alleged event or condition. Seiber v. Industrial Commission, 82 Ill.2d 87 (1980). [See also White v. IWCC, 4-06-0566WC (4th Dist. 2007), a case in which the Appellate Court upheld the Commission's finding of untimely notice. The Court noted that the claimant received sickness and accident benefits while off work, that a benefits application form was marked in such a way as to describe his condition as not work-related and that he did not file an Application until long after the alleged manifestation date. The Court held that "an employer's mere knowledge of 'some type of injury' does not establish statutory notice."]

The Arbitrator finds that Petitioner failed to provide timely notice to Respondent.

Did Petitioner establish causal connection?

As noted above, Petitioner ultimately advanced the theory, via Dr. Xiao, that the earplugs he wore at work, as required by Respondent, predisposed him to ear infections which, in turn, put him at risk for positional vertigo. The Arbitrator has previously found Dr. Itkin's causation-related opinions more persuasive than those voiced by Dr. Xiao. The Arbitrator has also found Petitioner not credible as to certain subjects bearing on the issue of causation. The Arbitrator finds that Petitioner failed to meet his burden of proof on this issue.

The Arbitrator views the remaining disputed issues as moot and makes no findings as to those issues. Compensation is denied.

14 WC 28514

STATE OF ILLINOIS)
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT ROVY,)
Petitioner,
vs.)
14 WC 28514
METROPOLITAN WATER DISTRICT OF)
CHICAGO,
Respondent.)

DECISION AND OPINION

Petitioner, Robert Rovy filed a Motion to Reinstate his Application for Adjustment of Claim which he asserts was improperly dismissed by Arbitrator Ciecko on September 26, 2019. The Commission's case information system shows that the claim was voluntarily dismissed on September 26, 2019. Petitioner represents that the Arbitrator dismissed the claim on that date and that it was not voluntarily dismissed, Respondent does not dispute this assertion.

On October 21, 2019 Petitioner's counsel filed a Notice of Motion to Reinstate the claim, to which Respondent objected. The Arbitrator denied the Petition on December 3, 2019 without creating a record. The parties dispute whether the Petition should have been denied and the reasons why the Arbitrator denied the Petition.

On January 2, 2020, Petitioner filed a timely Petition for Review on which he checked "Other" and listed the issue on review as: "Arbitrator denied a properly filed Motion to Vacate an Order of Dismissal and reinstate a case."

Section 9020.90 (c) of the Rules Governing Practice before the Illinois Workers' Compensation states that a record must be made of any contested Petition to Reinstate.

The Commission finds that there are insufficient facts for it to determine whether the Arbitrator correctly dismissed the claim and the Arbitrator erred in failing to create a record at the time the Arbitrator denied Petitioner's Petition to Reinstate.

Accordingly, the Commission remands the case to the Arbitrator assigned to the docket on which this case appeared prior to the instant review, with instructions to obtain a court reporter, create a record of proceedings, and make a ruling on Petitioner's Petition to Reinstate.

IT IS THEREFORE ORDERED BY THE COMMISSION that this matter is hereby remanded to the Arbitrator assigned to the docket on which the case appeared prior to the instant review, and that said proceedings be conducted in the presence of a court reporter, that a record of proceedings be prepared, and that a ruling be made on Petitioner's Petition to Reinstate.

June 11, 2021

/s/ *Stephen J. Mathis*
Stephen J. Mathis

SJM/msb
o-4/7/2021
44

/s/ *Deborah Baker*
Deborah Baker

/s/ *Deborah Simpson*
Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC010739
Case Name	FISHER, ROBERT v. KNIGHT HAWK COAL, LLC
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0287
Number of Pages of Decision	24
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Kirk Caponi
Respondent Attorney	Julie Webb

DATE FILED: 6/11/2021

/s/Deborah Baker, Commissioner

Signature

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

ROBERT FISHER,

Petitioner,

vs. NO: 16 WC 10739

KNIGHT HAWK COAL, LLC,

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 whether Petitioner suffers from the occupational diseases of chronic bronchitis and coal workers' pneumoconiosis causally related to his exposure as a coal miner, whether there is any resulting disablement pursuant to sections 1(d) through (f) of the Workers' Occupational Diseases Act, and the nature and extent of Petitioner's permanent disability, and being advised of the facts and law, finds a new analysis of the threshold issue of whether Petitioner suffers from occupational chronic bronchitis and coal workers' pneumoconiosis is required, but otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

REDACTION

To comply with Supreme Court Rule 138, the Commission has redacted personal identity information from the Decision of the Arbitrator (hereafter, "Decision").

CONCLUSIONS OF LAW

I. Chronic Bronchitis

Petitioner has a 40-plus year history of working in coal mines, with his last date of employment being February 5, 2016. Petitioner alleges he suffers from chronic bronchitis causally

related to his coal mine exposure. Both parties obtained an expert medical opinion on the issue. Petitioner relies on Dr. Istanbouly and Respondent on Dr. Castle. In advancing their competing positions, the parties each emphasize purported flaws with the opposing party's expert opinions. Specifically, Respondent notes Dr. Istanbouly did not review Petitioner's medical records and Petitioner notes Dr. Castle did not examine or take a history from Petitioner.

Dr. Istanbouly examined Petitioner on March 17, 2016. As part of the examination process, Dr. Istanbouly queried Petitioner about his respiratory complaints, and Petitioner reported he "has been coughing on a daily basis for the last few years." Pet.'s Ex. 1, Dep. Ex. 2. The doctor performed a physical examination and conducted pulmonary function tests, and the results were within the range of normal. Pet.'s Ex. 1, Dep. Ex. 2. During his deposition, Dr. Istanbouly defined chronic bronchitis as coughing on a daily basis for at least three months in a row for at least two consecutive years. Pet.'s Ex. 1, p. 9. Dr. Istanbouly confirmed Petitioner's history of coughing on a daily basis for the prior few years meets the criteria for chronic bronchitis, explaining the persistence of the cough was determinative regardless of sputum production. Pet.'s Ex. 1, p. 9. The doctor further explained having pulmonary function testing in the range of normal does not rule out chronic bronchitis, particularly when considered in concert with Petitioner's symptoms and physical exam. Pet.'s Ex. 1, p. 12. Noting the only risk factor Petitioner has for chronic bronchitis is long-term coal dust inhalation, Dr. Istanbouly concluded Petitioner's development of chronic bronchitis is causally related to his coal mine exposure. Pet.'s Ex. 1, p. 11, 17.

Dr. Castle in turn performed two record reviews and opined the data demonstrates Petitioner does not suffer from any pulmonary disease or impairment as a result of his occupational exposure. Resp.'s Ex. 2, Dep. Ex. C; Resp.'s Ex. 3. During his deposition, Dr. Castle acknowledged coal mine exposure can result in chronic bronchitis, sometimes called industrial bronchitis, and offered a similar definition as Dr. Istanbouly, explaining the American Thoracic Society defines it as a chronic cough productive of sputum on most days for three consecutive months for two successive years. Resp.'s Ex. 2, p. 85-86, 41-42. Directed to Petitioner's statement to Dr. Istanbouly of cough without significant sputum, Dr. Castle testified that does not meet the criteria for chronic bronchitis. Resp's Ex. 2, p. 42. Turning to his record review, Dr. Castle observed there is only one documented instance of Petitioner being diagnosed with chronic bronchitis, this on September 24, 2012, and this was in the context of a recent diagnosis of pneumonia. Resp.'s Ex. 2, p. 42. Dr. Castle explained Petitioner had numerous other factors commonly associated with a cough, including GERD, use of an ace inhibitor, and recurrent sinusitis and allergic rhinitis. Resp.'s Ex. 2, p. 44.

The Commission finds the preponderance of the credible evidence establishes Petitioner suffers from chronic bronchitis as a consequence of his occupational exposure. The Commission observes the diagnosis of chronic bronchitis was made initially by Dr. Oestmann. Pet.'s Ex. 7. We are not persuaded by Dr. Castle's opinion that Dr. Oestmann diagnosed chronic bronchitis in error. As Petitioner's primary care physician for over a decade, Dr. Oestmann routinely treated Petitioner for cough; Dr. Oestmann's records reflect Petitioner presented with an active cough and/or mentioned cough in his review of symptoms on approximately 30 occasions. Pet.'s Ex. 7. The Commission notes Dr. Oestmann is most familiar with Petitioner's upper respiratory complaints, and we find the fact that Dr. Oestmann diagnosed chronic bronchitis to be significant. The Commission further finds Dr. Istanbouly's conclusions to be credible and we afford them

significant weight. While Dr. Istanbouly was not given the opportunity to review the medical records, the Commission has analyzed Petitioner's treatment history and we find the records support Dr. Istanbouly's opinions. Moreover, regarding Dr. Castle's speculative implication that Petitioner's cough is possibly a consequence of his recurrent sinusitis and rhinitis, the Commission notes Dr. Istanbouly addressed that possibility and differentiated those as separate respiratory issues, acknowledged they are unrelated to and not indicative of chronic bronchitis, and nonetheless concluded Petitioner suffers from chronic bronchitis. Pet.'s Ex. 1, p. 10-11. The Commission further observes Dr. Istanbouly credibly opined Petitioner's only risk factor for chronic bronchitis is his long-term occupational exposure.

The Commission finds Petitioner suffers from chronic bronchitis. We further find Petitioner's chronic bronchitis is causally related to his coal mine exposure.

II. Coal Workers' Pneumoconiosis

Coal workers' pneumoconiosis is a slowly progressing lung condition caused by long-term exposure to coal dust and must be proven by medical documentation and opinion testimony. *See Zeigler Coal Co. v. Industrial Commission*, 237 Ill. App. 3d 213, 218-219, 604 N.E.2d 481, 484-485 (5th Dist. 1992). While the Decision includes discussion of negative X-rays being without probative value as well as studies showing the incidence of coal workers' pneumoconiosis being found on autopsy despite negative X-rays, the Commission notes neither the presence of a negative X-ray nor statistical evidence of the incidence of pathologic coal workers' pneumoconiosis are dispositive as to the compensability of Petitioner's claim. The claimant in an occupational disease case has the burden of proving both that he suffers from an occupational disease and that a causal connection exists between the disease and his employment. *Anderson v. Industrial Commission*, 321 Ill. App. 3d 463, 467, 748 N.E.2d 339, 342 (2001). The question of whether a claimant has coal workers' pneumoconiosis is a question of fact to be established by competent medical evidence. *Zeigler Coal Co.*, 237 Ill. App. 3d at 219, 604 N.E.2d at 485.

The Commission notes there is no question that Petitioner's pulmonary function tests were normal. The experts all agree, however, that fact does not rule out a diagnosis of coal workers' pneumoconiosis. Pet.'s Ex. 1, p. 12; Resp.'s Ex. 1, p. 73; Resp.'s Ex. 2, p. 68, 83. Given the claimed coal workers' pneumoconiosis is in the simple/early stage without measurable impact on Petitioner's pulmonary function, the Commission finds resolution of whether Petitioner has coal workers' pneumoconiosis rests on which radiographic interpretations are adopted. While Dr. Meyer provided B-readings of CT scans taken in 2008 and 2012 (Resp.'s Ex. 1, Dep. Ex. B), the Commission observes those CT scans predate Petitioner's last date of exposure by several years, and we find them too old to be probative. The Commission focuses our analysis on the interpretations of the March 17, 2016 radiograph, which is the only X-ray in evidence. Petitioner relies on the conclusions of Dr. Smith and Dr. Istanbouly. Respondent in turn relies on the conclusions of Dr. Meyer and Dr. Castle. We address each expert's qualifications and conclusions in turn.

Dr. Smith is board certified in radiology and a NIOSH certified B-reader. When Dr. Smith interpreted Petitioner's March 17, 2016 films, he concluded the films were of grade 1 quality and revealed simple coal workers' pneumoconiosis with small opacities, primary p, secondary s, mid

to lower zones involved bilaterally, of a profusion 1/0. Pet.'s Ex. 2. Dr. Smith was not deposed so his conclusions are confined to his April 7, 2016 report.

Dr. Istanbouly is board certified in internal medicine, pulmonary medicine, critical care medicine, and sleep medicine, and is Medical Director of Carbondale Memorial Hospital ICU and the Pulmonary Department at Herrin Hospital; the doctor is not a NIOSH certified B-reader. Pet.'s Ex. 1, p. 4-5. The March 17, 2016 X-rays were taken as part of Dr. Istanbouly's pulmonary consultation. Dr. Istanbouly concluded the images revealed early stage coal workers' pneumoconiosis. Pet.'s Ex. 2, Dep. Ex. 1. The doctor noted he was subsequently provided with Dr. Smith's report and his reading was consistent with Dr. Smith's. Pet.'s Ex. 1, Dep. Ex. 2. Dr. Istanbouly did not provide a profusion rating in his report, however during his deposition, he testified, "I roughly agree with 1/0." Pet.'s Ex. 1, p. 48.

Dr. Meyer is board certified in radiology, Vice Chair of Finance and Business Development and Professor of Diagnostic Radiology at University of Wisconsin Hospital, and a NIOSH certified B-reader. Resp.'s Ex. 1, p. 3, 7, 13. Dr. Meyer indicated the March 17, 2016 film was of grade 1 quality and revealed no radiographic findings of coal workers' pneumoconiosis. Resp.'s Ex. 1, Dep. Ex. B. During his deposition, Dr. Meyer agreed equally qualified B-readers can disagree on an interpretation and stated "[m]aking the distinction between zero/one, and one/zero opacities is one of the most difficult processes of the entire B-Reader - - B-Reader form." Resp.'s Ex. 1, p. 61.

Dr. Castle is board certified in internal medicine and pulmonary disease and was a NIOSH certified B-reader, though his certification has since expired. Resp.'s Ex. 2, p. 4, 13-14. Upon review of the March 17, 2016 X-ray, Dr. Castle opined it was grade 3/underexposure and poor contrast. Resp.'s Ex. 2, Dep. Ex. C. Dr. Castle then interpreted the film as showing no parenchymal abnormalities consistent with pneumoconiosis and no findings of coal workers' pneumoconiosis. Resp.'s Ex. 2, Dep. Ex. C. The Commission notes Dr. Castle is the only physician to classify the March 17, 2016 film as less than diagnostic quality. We find this adversely affects Dr. Castle's credibility.

The Commission finds the preponderance of the credible evidence establishes Petitioner suffers from coal workers' pneumoconiosis as a consequence of his occupational exposure. Petitioner has a 40-plus year coal mine exposure history and is a lifetime non-smoker. Four experts were retained to interpret his March 17, 2016 X-rays. We observe each of the experts has impressive qualifications. We further note the distinction between a 0/1 film and 1/0 film is subtle and difficult for the experts to make. Ultimately, the Commission finds the conclusions of Dr. Smith and Dr. Istanbouly are more persuasive than those of Dr. Meyer and Dr. Castle. We note Dr. Smith's and Dr. Istanbouly's conclusions are consistent with one another, and while Dr. Meyer's contrary conclusion is credible, the Commission finds Dr. Castle's interpretation of what he deemed unsatisfactory imaging is suspect and unpersuasive. Once coal workers' pneumoconiosis is found, disablement follows as a matter of law. *See Freeman United Coal Mining Co. v. Illinois Workers' Compensation Commission*, 2013 IL App (5th) 120564WC, ¶ 35, 999 N.E.2d 382, 392.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 28, 2020, as amended above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $755.22 per week for a period of 40 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused 8% loss of use of the person as a whole.

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 the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $30,300.00. 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.

June 11, 2021

/s/ *Deborah J. Baker*

DJB/mck

O: 4/20/21

/s/ *Stephen Mathis*

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/s/ *Deborah L. Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0287

FISHER, ROBERT
Employee/Petitioner

Case# **16WC010739**

KNIGHT HAWK COAL LLC
Employer/Respondent

On 2/28/2020, 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 1.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

ROBERT FISHER
Employee/Petitioner

v.

KNIGHT HAWK COAL, LLC.
Employer/Respondent

Case # **16** WC **10739**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **November 22, 2019**. 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/exposure, causation, Sections 1(d)-(f), 19(d).**

FINDINGS

On**02/05/16**, 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 **$77,593.36**; the average weekly wage was **$1,492.18**.

On the date of accident, Petitioner was **66** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $755.22/week for 40 weeks, because the injuries sustained caused the 8% loss of the person as a whole, as provided in Section 8(d) 2 of the Act.

Respondent shall further pay for necessary future medical services, as provided in Section 8(a) of the Act.

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

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

Signature of Arbitrator

2/20/20
Date

FEB 28 2020

STATEMENT OF FACTS

Petitioner, Robert Fisher, of Herrin, IL was 69 years of age at the time of arbitration with a birth date of [redacted]1950. He is married to Melanie K. Fisher. He is a high school graduate of Herrin High School and had 2 years of college at John A. Logan but did not obtain any degrees or certificates. He worked 42 or 43 years in the coalmine with approximately 30 of those years underground. In addition to coal dust he was regularly exposed to and breathed silica dust, roof bolting glue fumes, diesel fumes and battery fumes. The Petitioner last worked in the mines in February of 2016. He was working for Knight Hawk Coal at their Cutler mine. He was 66 years of age with the job classification of mechanic/repairman. Petitioner was exposed to coal dust on that last day. Petitioner testified that was his last day of work because he had decided to quit mining due to his health concerns. He testified he was concerned about his breathing and his body was worn out and he had reached retirement age. Petitioner has had no employment since leaving the mines.

Petitioner began his mining career on January 31, 1972. He started working at Peabody River King mine in Freeburg, IL. He was hired in as a belt maintenance man. A belt maintenance man is in charge of extending and retracting belt lines in the units. Petitioner testified this is a fairly dusty job. He did this for about a year and then went to a shuttle car. A shuttle car hauls the coal from where it is cut in the mine to the belt line. Petitioner described how the particular buggy car he was on was the car that had the most dust exposure of the two. He did this job for approximately six months. He then left that mine and went to Zeigler 4 in Johnston City. He was hired in as a utility man. A utility man fills in for anyone who is off. These jobs in the unit included roof bolting, cutting machine operator, shooter, and coal drill operator. He was a utility man for approximately and year and a half and then bid on a cutting machine job. Petitioner then went to the surface and worked in the plant where the coal is cleaned and loaded onto the trains. Petitioner described quite a bit of dust exposure in this job. Petitioner then went to work for Classic Coal in Pittsburg, IL. At that mine he was a tipple mechanic and a surface electrician. He worked both in the mine and on the surface. He worked there for 3 years till the mine shut down. He then went to Kerr-McGee in Galatia and was hired in as a mechanic. A mechanic repairs the equipment that breaks down in the mine. That equipment is repaired inside the mine where it breaks down and is not brought to the surface to be repaired. Therefore the mechanic is exposed to the same amount of exposures as any of the miners working around him. This is where the Petitioner had a great deal of exposure to diesel fumes. He also was a bulldozer operator. He would push the coal to the hopper to load it onto the conveyer belt. Petitioner describes this bulldozing job as a very dusty job. Petitioner then went to Knight Hawk Coal in 2008 and worked there until his retirement.

Petitioner first started noticing breathing problems when he was at Zeigler 4, which would have been in the late 1970's. He noticed shortness of breath and hacking up black. Petitioner testified initially, his breathing difficulties seemed a little better at Classic Coal but then got worse again at Kerr-McGee. Petitioner testified since he left the mine he isn't hacking up black like he used to but, his breathing isn't as good as it used to be. He has used an inhaler from time to time but doesn't use on regularly. His breathing difficulties do affect his daily living. He has trouble in the heat and the cold. He notices he has to take breaks and slow down. He cannot work at the pace he used to.

Petitioner's family doctor is Dr. Kevin Oestmann. Petitioner said that he has had discussions with Dr. Oestmann about his breathing difficulties. Petitioner never smoked. Besides breathing difficulties he has had his left knee replaced, his left shoulder rebuilt, two stints put in his heart and diabetes. Petitioner also takes medication for blood pressure.

Dr. Henry K. Smith

At Petitioner's request, b-reader, Dr. Henry K. Smith reviewed a grade 1 chest x-ray dated 3/17/16. Dr. Smith found interstitial fibrosis of classification p/s, bilateral mid to lower zones involved, of a profusion 1/0. There are no chest wall plaques or calcifications. There is accentuated Kerley-B septal lines in the lung bases. Heart size is normal. There is noted either old healed fracture deformities or congenital variation of bifid anterior right 5th rib. There is mild to moderate mid to lower dorsal degenerative vertebral spurring. Dr. Smith's impression was simple coal worker's pneumoconiosis with small opacities, primary p, secondary s, mid to lower zones involved bilaterally, of a profusion 1/0. Slightly elevated right diaphragm and minimal linear streaky density changes related to accentuated Kerley-B septal lines in both lung bases at the lateral CP angles. Either congenital variation of bifid anterior right 5th rib vs old healed fracture deformities.

Dr. Castle Charges

At Respondent's attorney's request, Dr. Castle performed a forensic review of medical films, a supplemental report and gave his deposition. He charged $1,900.00 for his deposition, $3,200.00 for his review of the medical films, and $4,550.00 for his supplemental report for a total in charges of $9,650.00.

Dr. Suhail Istanbouly

Petitioner's attorney requested Petitioner was examined by Suhail Istanbouly. Dr. Istanbouly is board certified in internal medicine, pulmonary medicine, critical care medicine and sleep medicine. (px 1, p 4 & 5) He is also the medical director of the intensive care unit at Carbondale Memorial Hospital and the medical director of the pulmonary department at Herrin Hospital. In taking history from the Petitioner, Dr. Istanbouly testified that it seemed Petitioner definitely had a heavy exposure to dust through out his career as a coal miner. (px 1, p 8) Petitioner had a history of a cough on a daily basis for the past few years, usually mild, but it was getting worse during peak allergy season, transitional seasons. Cough was described as mild to moderate in intensity. Sometimes it gets aggravated by strenuous activities. No significant sputum production. No hemoptysis. Dr. Istanbouly went on to testify that the Petitioner was diagnosed with chronic bronchitis based on the consistence of his cough rather then sputum production. (px 1, p 9) Dr. Istanbouly testified that when a person is cut off from the exposure that is causing the chronic bronchitis the symptoms would get much better but may not go away or resolve completely. Petitioners pulmonary function testing was within the range of normal. (px 1, p 12) You can have chronic bronchitis and CWP and still have a normal pulmonary function study. (px, 1 p 12) Dr. Istanbouly reviewed a chest X-ray and found it to be compatible with coal workers pneumoconiosis. (px 1, p 12) Dr. Istanbouly was aware of studies that

concerned themselves with long – time coal miners on whether they have coal workers pneumoconiosis at autopsy, which may or may not have been found radiographically during their life. Dr. Istanbouly's understanding was that there are a significant percentage of coal miners with negative chest X-rays who were found to have coal workers' pneumoconiosis on autopsies. (px 1, p 13) Dr. Istanbouly based his determination of coal workers' pneumoconiosis not only on X-ray but also occupational history, symptoms, physical exam, and pft. (px 1, p 14) Dr. Istanbouly testified that when a coal miner with the number of years as the Petitioner leaves the coal mine, there would be a percentage of fine particles that will remain in the airways and lung tissue that is permanent. Therefore the lung tissue next to the trapped coalmine dust will be exposed to the coalmine dust for the rest of the coal miner's life. (px 1, p 15) Dr. Istanbouly testified that the Petitioner has clinically significant pulmonary or airway impairment. The only risk factor in the Petitioner's history is long-term coal dust exposure. (px 1, p 16) Dr. Istanbouly gave the opinion to a reasonable degree of medical certainty that Petitioner has coal workers pneumoconiosis which was caused by long-term coal dust exposure. (px 1, p 17) In light of the diagnosis of coal workers pneumoconiosis, Petitioner cannot have any further exposure to the coalmine environment. (px 1, p 18) The same would be true for Petitioner's chronic bronchitis. He can no longer have any further exposure to the coalmine environment. (px 1, p 18) By definition if you have coal workers pneumoconiosis it is true that you can have some impairment in the function of the lung at the site of the scarring, whether it can be measured by spirometry or not. (px 1, p 20) A person can have shortness of breath despite having pulmonary function tests within the normal range. (px 1, p 20) A person can have coal workers pneumoconiosis that's radiographically significant but not have shortness of breath. (px 1, p 23)

Dr. Cristopher Meyer

At Respondent attorneys request Cristopher Meyer reviewed a chest CT dated July 22, 2008 from Herrin Hospital, CT dated September 16, 2012 from Herrin hospital and a PA chest radiograph from Herrin Hospital dated March 17, 2016. The images were of diagnostic quality. (rx 1, p 40) On the CT from July 22, 2008, there were no small opacities. There was a linear scar in the right middle and right lower lobe, and there were no large opacities. There was a calcified granuloma in the left lower lobe with calcified left hilar lymph nodes. (rx 1, p 40) Dr. Meyer testified that the 2008 chest CT revealed no findings of CWP and findings of healed Granulomatous Disease. (rx 1, p 40 & 41) The CT scan from September 16, 2012 demonstrated some new centrilobular and tree–in-bud opacities in the right upper lobe and the dependant segments of the right lower lobe, so those were new from 2008, and the calcified granuloma in the left lower lobe. (rx 1, p 41) His impression from that CT was there were no findings of coal workers pneumoconiosis. The findings of opacities in the dependent portions of the right upper and the right lower lobes were most consistent with cellular bronchiolitis, which is seen in infection or aspiration. (rx 1, p 41) The PA chest radiograph of March 17, 2016, was Quality 1, revealed no small or large opacities and an old fracture of the right sixth and lateral left seventh ribs. There were no findings of coal workers pneumoconiosis. (rx 1, p 41) On cross examination, Dr. Meyer testified that it is possible for a coal miner to have CWP that can be found on pathological review that may not be apparent on CT scan. (rx 1, p 49) Because a CT is read negative for CWP that does not rule out that the miner might have it on a pathological review. (rx 1, p 50) Dr. Meyer admitted that if he was to assume that the coal miner left mining in 2016 and take the time from the earliest CT from 2008 up until 2018 when he would have to prove he

had CWP there would have been enough time for CWP to develop within that 10 year period. (rx 1, p 52) A coal miner who has worked 30 or even 40 years in the coal mines would have an amount of coal mine dust that would remain trapped in his lungs for the rest of his life. (rx 1, p 53) Dr. Meyer testified that while coal mine dust is typically less latent and progressive than other fibrogenic dust like silica, there certainly is the possibility that the disease may progress when the individual is removed from the exposure. (rx 1, p 54) When a miner has mixed dust exposure resulting in these macules instead of pure coal dust, it is fair to say that there can be a more toxicity to the lung tissue, for instance, if there is more silica involved. (rx 1, p 68) Dr. Meyer said it was his understanding that most coal miners would have some level of mixed dust exposure. It won't just be pure coal dust or an area of pure silica dust. (rx 1, p 68) The macule of CWP is a permanent abnormality. (rx 1, p 69) The only treatment for a person who has CWP when you don't want to take any chance that it would progress would be to remove them from any further exposure. (rx 1, p 72 & 73) The rate of progression of CWP would vary from miner to miner rather than exactly the same in all miners. (rx 1, p 74) Dr. Meyer testified that histoplasmosis is most likely to occur where the soail has been disturbed particularly where there has been a lot of bird activity and bird droppings. (rx 1, p 79 & 80) It would be fair to say that an operating coal mine is a place where the soil is disturbed. (rx 1, p 80) When a person has histoplasmosis, it is true that there is nothing on x-ray that tells you where the histoplasmosis came from. (rx 1, p 80) Dr. Meyer testified that it is probably true that CWP could develop at anytime during a miner's career including the last month or so; even show up radiographically a month or so after he left the coal mine. (rx 1, p 82) Dr. Meyer testified that there are studies that show that at autopsy as much as 50 percent of coal miners are found to have abnormalities of CWP when they might not have been apparent radiographically during their life.

Dr. James Castle

At Respondent's request Dr. James Castle did a records review. Dr. Castle reviewed a radiograph of March 17, 2016. It is his opinion that there were no findings of CWP. (rx 2, p 55) Dr. Castle gave an opinion to a reasonable degree of medical certainty that Robert Fisher does not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure to the coal mines. (rx 2, p 56) Dr. Castle testified that if possible he would always want his own examination. He went on to say that he would have a better database if he had everything he has now and an examination. (rx 2, p 64) The effected lung tissue where the scarring and emphysema is located cannot perform the function of normally healthy lung tissue. (rx 2, p 66 & 67) There can be mixed dust pneumoconiosis from coal mining, which would include silica. Silica dust is toxic to the surrounding lung tissue and more fibrogenic than coal dust. It is possible that a person who has trapped silica in their lungs, that toxic effect would then be emitted to the surrounding tissue for the rest of that person's life. (rx 2, p 72) Dr. Castle acknowledged that the American Thoracic Society's official position is that once a person has been diagnosed with CWP there is no safe level of exposure to coal mine dust. (rx 2, p 73 & 74) There is no cure for CWP. (rx 2, p 74) Dr. Castle indicated that he is familiar with studies that have shown that as much as 50% of long term coal miners have CWP that can be determined pathologically at autopsy which was not appreciated radiographically during their life. (rx 2, p 79) Dr. Castle admitted that there was a diagnosis of chronic bronchitis in the treatment records. He acknowledged that Petitioner was a life long non-smoker and had 44 years of coal mine exposure. Coal mine exposure can result in what Dr. Castle called industrial bronchitis. Dr.

Castle went on to admit that he did not take a history from Petitioner, never met him, and never talked to him. (rx 2, p 85 & 86)

Medical Report of Dr. Castle Dated 7/19/19

Dr. Castle reviewed additional medical records since the time of his initial report. Dr. Castle in summary stated that after reading all the additional medical records it was his opinion with a reasonable degree of medical certainty, that Mr. Robert Fisher did not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure during his coal mining employment. (rx 3, p 19)

NIOSH Records

Respondent produced NIOSH records showing chest x-rays of various readings throughout Petitioner's mining career. All of these readings were negative for coal worker's pneumoconiosis.

Medical Records of Prairie Cardiovascular

On an office note dated 8/9/17 under History of Present Illness: Overall the patient has been doing well he has occasional shortness of breath he had undergone a stress test earlier this year, which indicated an ejection fraction of 45%. (rx 6, p 22) On the same office note, under diagnoses/impression: 1. Shortness of breath. On a progress note dated April 30, 2018 under diagnoses/impression: 1. Shortness of breath. (rx 6, p 28)

Medical Records of Logan Primary Care

On an office note dated 1/9/18 under review of systems: respiratory: positive for cough. Negative for shortness of breath. On and office note dated 2/15/18 under assessment: acute pansinusitis, recurrence not specified. 2. Cough. 3. PND (post-nasal drip) (px 7, p 32) On an office note dated 3/19/18 under patient active problem list: sore throat, acute pansinusitis, cough and PND (post-nasal drip). (rx 7, p 37) On an office note dated 10/2/18 under patient active problems list: sore throat, acute pansinusitis, cough, and PND (post-nasal drip). (rx 7, p 43) On an office note dated 12/20/18 under cough: cough characteristic: productive. Sputum characteristics: nondescript. Severity: moderate. Onset quality: sudden. Duration: 1 day. Timing: intermittent. Progression: waxing and waning. Chronicity: new. Under Rhinorrhea: quality: green.. Severity: mild. Duration: 1 day. Timing: intermittent. Progression: waxing and waning. (rx 7, p 48) Under assessment: 1. Upper respiratory tract infection, unspecified type. 2. PND (post-nasal drip) 3. Cough. (rx 7, p 52) Under MDM number of diagnoses or management options: cough: new and does not require workup. PND (post-nasal drip): new and does not require workup. Upper respiratory tract infection, unspecified type: new and does not require workup. (rx 7, p 53) On an office note dated 1/10/19 under patient active problem list: acute pansinusitis, cough, PND (post-nasal drip), and upper respiratory tract infection. On an office note dated 2/26/19 under patient active problem list: acute pansinusitis, cough, PND (post-nasal drip), and upper respiratory tract infection. (rx 7, p 65) On an office note dated 2/9/16 under subjective: chief complaint: sinus congestion. This 66 year old male presents with URI

symptoms. Current symptoms: duration 2 days, runny nose yes, congestion yes, mucopurulent nasal discharge no, fever no, cough no, sneezing yes. Under review of systems: sinus pressure, no sore throat or ear pain. (rx 7, p 147) On an office note dated 4/11/15 under subjective: this 65 year old male presents with a 1 days history of fever yes, cough yes, sore throat yes, runny nose yes, congestion yes, headache yes, myalgias yes, fatigue yes. (rx 7, p 165) On an office note dated 3/12/15 under chief complaint: cough and congestion. This 65 year old male presents with URI symptoms. Current symptoms: duration 6 days, runny nose yes, congestion yes, mucopurulent nasal discharge yes, fever no, cough yes, sneezing yes. History of present illness: onset - gradual, location - bilateral, quality - continuous, duration - 6 days. (rx 7, p 173) Review of systems: sinus pressure, pressure on ears, occasional ear pain. No sore throat. No other signs or symptoms. Refer to History of Present Illness above. (rx 7, p 173) On an office note dated 1/25/15 under chief complaint: sinus congestion. This 64 year old male presents with URI symptoms. Current symptoms: duration 2 days, runny nose yes, congestion yes, mucopurulent nasal discharge yes, fever no, cough yes, sneezing yes. History of present illness: onset- gradual, location – bilateral, quality – continuous, duration – 2 days. Review of systems sinus pressure, sore throat, ear pressure. No other signs or symptoms. (rx 7, p 176) Under assessment acute sinusitis. (rx 7, p 177) On an office note dated 5/4/14 under subjective: History of Present Illness: this 64 year old male presents with the following upper/lower respiratory symptoms. Onset: gradual, duration: 2 weeks, runny nose yes, nasal congestion yes, post nasal drip yes, sore throat yes, headache yes, sinus pressure yes, cough yes, chest congestion yes, productive sputum yes, wheezing yes. (rx 7, p 187) On an office note dated 11/25/13 under T: sinus: cough. This 63 year old male patients comes in for problems mentioned above. Problem/character sinus congestion and drainage. Has a productive cough. White cloudy mucous. He had some levaquin left over from last rx and he took 750mg dly x last 3 days. (rx 7, p 203) On an office note dated 6/17/13 T: sinus congestion. Subjective: Chief Complaint: sinus congestion. This 63 year old male presents with URI symptoms. Current symptoms: duration 3 days, runny nose yes, congestion yes, mucopurulent nasal discharge yes, cough yes, sneezing yes. History of present illness: onset – gradual, location – bilateral, quality – continuous, duration – 3 days. Review of systems: sinus pressure, sore throat, ear pain. No other signs or symptoms. Refer to History of Present Illness above. Past Medical, Family, and Social Histories: History of sinusitis – yes. (rx 7, p 227) Under objective: vitals: nose: mucosa congested and inflamed. Assessment: acute sinusitis. (rx 7, p 228) On a progress note dated 9/24/12; T: dizziness: pneumonia. This 62 year old male patient comes in for problems mentioned above. Problem/character cough, feels much better less productive brown/black worse in am less often headache better but still present. Abdominal pain has improved no complaints of dizziness. Has occasional cough productive black/yellow color. (rx 7, p 277) Under exam: CT chest without contrast. History: Pneumonia. Findings: There is minor interstitial opacity within the right upper and lower lobes. These may represent scarring or residual infiltrates. The left lung is clear. Calcified left hilar lymph node and small calcified mediastinal lymph nodes. No adenopathy or pleural effusion. There is mild deformity and a bony bridge pacing the angle of the right fifth/sixth ribs. Adjacent pleural reaction. This is consistent with old healed fracture. 1. Minor right upper lobe and right lower lobe opacities as above. 2. Right lateral thoracic deformity as a result of old healed rib fracture. (rx 7, p 278) On an office note dated 9/16/12 T: CT Chest. Diagnostic Imaging Report. Reason for Admission: pneumonia vertigo headache n/v. Exam: CT chest without contrast. History: pneumonia. Findings: There is a minor interstitial opacity within the right upper and lower lobes. These may represent scarring or residual infiltrates. The left lung is clear. Calcified left hilar

lymph node and small calcified mediastinal lymph nodes. No adenopathy or pleural effusion. There is mild deformity and a bony bridge pacing the angle of the right fifth/sixth ribs. Adjacent pleural reaction. This is consistent with old healed fracture. 1. Minor right upper lobe and lower lobe opacities as above. 2. Right lateral thoracic deformity as a result of old healed rib fracture. (rx 7, p 283) On an office note dated 9/4/12 T: cough. This 62 year old male comes in for problems mentioned above. Problem/character cough, non productive, headache, abdominal pain r/t coughing, was at company picnic Saturday and wind was blowing and sxs started that night, pt states it seems like he gets this cough after we have very windy weather. Onset ongoing, duration 4 days, location pulmonary. Cough is minimally productive. No sneezing. (rx 7, p 292) On an x-ray of 9/4/12 under signs and symptoms: acute bronchitis fever acute sinusitis. Indication: cough, fever. Acute bronchitis. Acute sinusitis. Comparison: none available. Findings: Heart size is normal. There is no vascular congestion. There are old bilateral rib fractures. There is consolidation seen in the right upper lobe in the peripheral aspect of the right lung base. Blunting of the right costophrenic angle noted. Left lung is clear. No pneumothorax identified. Surgical clips seen in the right upper quadrant of the abdomen. (rx 7, p 296) On an office note of 5/18/12 T: URI/SINUSITIS. History of present illness: this 62 year old male presents with the following upper/lower respiratory symptoms: runny nose yes, nasal congestion yes, post nasal drip yes, sore throat yes, headache yes, sinus pressure yes, cough yes. (rx 7, p 307) On an office note dated 2/24/12 T: sinusitis. Under subjective: chief complaint: cough, congestion, chills and bodyaches. This 62 year old male presents with these symptoms: did not have flu shot. Nasal discharge yes, face pain yes, fever yes, duration of symptoms 2 days. History of present illness: onset – sudden, location – bilateral, quality – continuous, duration – 2 days. (rx 7, p 318) On an office note dated 8/29/11 T: cough, sore throat. Under history: patient. This 61 year old male patient comes in for problems mentioned above. Problem/character non productive cough, sore throat. Onset sudden. Duration 3 days. Location pulmonary. Severity mild. Relief nothing, started taking left over refill of amoxicillian on Saturday. (rx 7, p 335) On an office note dated 3/25/10 This 60 year old male patient comes in for problems mentioned above. Sinusitis are better. Bronchitis is better. Onset resolving. Duration 2-3 weeks. Location pulmonary. Severity better. Relief steroids. CT of sinuses. Impressions: mild to moderate mucosal thickening in the inferior maxillary sinuses. The remainder the paranasal sinuses are normal aerated. There is no osseous erosion. (rx 7, p 364) On a progress note dated 3/15/10 T: sinus:cough. This 60 year old male patient comes in for problems mentioned above. Sinusitis bronchitis productive cough yellow phlegm. Onset ongoing came to med station given steroid injection and continued on levaquin. Duration 2-3 weeks. Location pulmonary ENT. Severity mild. Relief steroids. (rx 7, p 369) On a progress note dated 3/6/10 T: URI. Subjective: cc: cough congestion. This 62 year old male presents with URI symptoms. Current symptoms: duration 3-5 days. Runny nose: yes. Congestion: yes. Mucopurulent nasal discharge: yes. Cough: yes. (rx 7, p 372) On a progress note dated 12/28/09 T: sinus. This 59 year old male patient comes in for problems mentioned above. Sinus congestion yellow rhinorrhea. Onset 3 days. Duration constant. Location head. Severity mild. Relief Tylenol Cold. (rx 7, p 374) Under OP: sinusitis acute unspecified. OP: allergic rhinitis cause unspecified. (rx 7, p 391) On a progress note dated 3/8/09 T: cough and congestion. This 59 year old male presents with URI symptoms. Current symptoms: duration 3 weeks. Runny nose yes, congestion yes, mucopurulent nasal discharge yes, fever low grade temperature observed, cough yes, sneezing yes. (rx 7, p 392) On an office note dated 2/19/09 T: URI. Chief complaint: nasal congestion, cough. This 59 year old male presents with the following upper/lower respiratory symptoms: duration 6 days. Body aches yes, runny

nose yes, congestion yes, post nasal drip yes, mucopurulent nasal discharge no, sinus pressure yes, cough yes, chest congestion yes. (rx 7, p 394) On and office note dated 10/13/08 T: acute bronchitis. This 58 year old male comes in for the above complaints. Overall patient is feeling better. Cough is improving. (rx 7, p 402) On an office note dated 10/8/08 T: uri rib pain. This 58 year old male patients comes in for the above complaints. Has deep cough. (rx 7, p 405) On an x-ray of 10/8/08 reason for admission: cough. Signs and symptoms: cough. Exam description: rad chest 2 views, frontal, lateral 10/8/08. Clinical information: cough. Comparison 6/30/08. Findings: The heart size and pulmonary vascular are within normal limits. There is chronic blunting of the right costophrenic sulcus and minor chronic elevation of the right hemidiaphragm. Posttraumatic deformity involved the latera right rib cage. The appearance of the posterior left 7th rib is unchanged. This may represent posttraumatic deformity as well. There is no pleural effusion. There is flowing osteophytosis within the mid and lower thoracic spine. No pneumothorax is seen. Impression: 1. No acute disease. 2. No significant change compared to 6/30/08. (rx 7, p 408) On a progress note dated 10/4/08 T: URI. This 58 year old male presents with URI symptoms. Current symtoms: duration 1 week, runny nose yes, congestion yes, mucopurulent nasal discharge yes, cough yes, sneezing yes, coughing up dark colored mucus. Nonsmoker. History of bronchitis sinusitis in the past. Taking clarinex but not helping. Symptoms are continuous and bilateral. Denies chest pain dyspnea n/v diarrhea visual problems or slurred speech. Feels fatigued. (rx 7, p 409) On an x-ray dated 7/22/08 under reason for admission: abnormal xray irregular density. Signs and symptoms: abn xr irregular density. CT chest without contrast. Comparison: chest x-ray 6/30/08. Findings: There is no axillary lymphadenopathy. There are multiple subcentimeter lymph nodes cavitating mediastinum but no mediastinal lymphadenopathy. There are calcified lymph nodes in the left hilum. Mild atherosclerotic calcifications are noted. Limited evaluation of the upper abdominal soft tissures demonstrate surgical clips in the gallbladder fossa. Lung windows demonstrate no evidence of pneumothorax, lobar consolidation or suspicious pulmonary mass. There is mild linear atelectasis or scarring in the right midlung. The trachea and mainstem bronchi are patent. There is a 1.8cm gas density collection noted in the anterior and medial to the right lung apex with no perceptible wall. Under impression: No acute cardiopulmonary diease. Evidence of atherosclerosis, prior granulomatosis and posttraumatic deformity in the right lateral rib cage. (rx 7, p 415) On a 7/14/08 x-ray of the right ribs. History: bronchitis, cough, abnormal chest x-ray. Findings: comparison is made to 6/30/08 and 10/18/08 chest x-rays. These again demonstrate chronic appearin deformity involving the right fifth and sixth ribs with bridging osteophyte. There is minimal deformity of the right seventh rib as well. There is no acute fracture. There is no osseous erosion. There is no underlying pneumothorax. Surgical clips are noted in the right upper abdominal quadrant. (rx 7, p 416) Chest x-ray dated 6/30/08 reason for admission: chronic cough. Signs and symptoms: chronic cough. History: chronic cough. Comparison: 4/18/08. Impression: no acute pulmonary disease. (rx 7, p 423) On an office note dated 6/30/08. This 58 year old male present for episodic visit regarding bronchitis. The patient was seen in the med station 6/14/08 and prescribed depomedrol, rocephin, zithromax, and tessalon perles. He states his cough is the predominant problem. The patient states he has been having runny nose as well. He started zyrtex yesterday and this helped with the runny nose. Still coughing all day. No shortness of breath. Some chest pain with coughing. Cough is nonproductive. No pleuritic chest pain. This has been going on for > 2 weeks. (rx 7, p 425) On an office note dated 6/14/08 T: sinusitis. This 58 year old male presents with these symptoms: nasal discharge: yes, purulent nasal discharge yes, cough yes, face pain yes, maxillary toothache yes, duration of symptoms 12

weeks. No history of allergies or sinusitis. Sore throat. No otc meds taken w/o relief. Nonsmoker. Symptoms are continuous and bilateral. Denies dyspnea chest pain n/v diarrhea or visual problems. (rx 7, p 428) On a progress note dated 12/26/03 T: sinusitis. This 53 year old male presents with these symptoms. Nasal discharge yes, purulent nasal discharge yes, cough yes, face pain yes, maxillary toothache yes, duration of symptoms 1 week. Past history: allergic rhinitis yes, sinusitis yes. (rx 7, p 507) On a progress note dated 12/27/00 this 54 year old male presents with URI symptoms. Current symptoms: duration last week started with sore throat and then went away and then came back. Runny nose yes, congestion yes, mucopurulent nasal discharge yes, fever low ghrade temperature observed, cough yes chest hurting, sneezing yes. Assessment DX: sinusitis. (rx 7, p 603) On an x-ray of the chest dated 10/19/00 findings: compared with previous examination of 7/21/00. Since physical examination there is no significant interval change. There is again a demonstration of right pleural thickening. No pleural effusions noted. Both lungs appear unremarkable without any active infiltrates or mass lesion. Heart and mediastinum appear within normal limits. Impression: no active cardiopulmonary disease. No change since 7/21/00. (rx 7, p 608)

Medical Records of Herrin Hospital

Office note dated 2/9/19. Cough 2/15/18 – present. Upper respiratory tract infection 12/20/18 – present. (rx 8, p 11) Office note dated 2/8/19. Review of systems: Respiratory positive for chest tightness (rx 8, p 14) Pulmonary Function Test 3/21/16 this was a normal study. (rx 8, p 310, 311, 312) On a CT dated 3/19/10 under history: Sinusitis. Impression: Mild to moderate mucosal thickening in the inferior maxillary sinuses. The remainder of the paranasal sinuses are normally aerated. There is no osseous erosion. (rx 8, p 389) On a chest X-rays dated 10/8/08 Clinical Information: Cough. Comparison 6/30/08. Impression: No acute disease. There is no significant change compared to 6/30/08 (rx 8, p 395) On a chest X- ray dated 7/14/08 Reason for Admission: Cough, Bronchitis, Abnormal Chest X-ray Signs and Symptoms: Cough, Bronchitis, Abnormal Chest X-ray. History: Cough, Bronchitis, abnormal chest X-ray. Comparison: 6/30/2008 and 4/18/2008. On X-rays of the right rib dated 7/14/08 Reason for Admission: Cough, Bronchitis, abnormal chest X-ray. Signs and symptoms: Bronchitis, cough, abnormal chest X-ray. History: Bronchitis, cough, abnormal chest X-ray. Impression: chronic appearing deformity involving the right fifth, sixth and seventh ribs, probably posttraumatic. (rx 8, p 407) On chest X-rays dated 6/30/08 Reason for Admission: chronic cough Signs and Symptoms: chronic cough. History: chronic cough. Comparison: 4/18/08. Impression: No acute pulmonary disease. (rx 8, p 412) Chest X-rays dated 4/18/08 subtle density in the left lateral midlung measuring 16mm by 5 mm. This is over the posterior left seventh rib. Finding may represent underlying calcified granulomas in this patient with the evidence of prior granulomatosis. (rx 8, p 418)

Medical Records of Logan Primary Care dated November 11, 2019

On an Office note dated March 6, 2019. There has been no fever. Associated symptoms include congestion, coughing, rhinorrhea, sinus pain and a sore throat. Respiratory: Positive for cough. Negative for chest tightness, shortness of breath and wheezing. (rx 10, p 25)Assessment/ Plan: Robert was seen today for URI Diagnosis and all orders for this visit: URI with cough and congestion (rx 10, p 29)

CONCLUSIONS OF LAW

Issue (C) and (O): Did Petitioner suffer disease which arose out of and in the course of his employment by Respondent?

The Arbitrator resolves the issue of occupational disease and causation in Petitioner's favor. The Arbitrator concludes that Petitioner suffers from coal worker's pneumoconiosis (CWP), and chronic bronchitis, each of which was caused by his exposures as a coal miner. He worked as a coal miner for 42 to 43 years, 30 of which were underground. He is a lifelong never smoker of cigarettes. As a coal miner, he was regularly exposed to coal dust, roof bolting glue fumes, diesel fumes, battery fumes, and silica. He first noticed his breathing problems in the late 1980's when he would become short of breath and would hack up black sputum. He testified that since leaving the mines, his breathing is not as good as it used to be. He has taken an inhaler at times, but not on a regular basis. Regarding how his breathing difficulties affect his activities of daily living, he testified, "Well, I have trouble in the heat, and I have trouble in the cold, but I have to take breaks and slow down. I can't work at the pace I used to work at, and I have to be very careful." The Arbitrator found Petitioner to be a candid and credible witness.

Regarding the disease of chronic bronchitis, the argument of the Petitioner is most strong. Dr. Istanbouly diagnosed chronic bronchitis; in 2012, Petitioner's primary care physician diagnosed it; and Dr. Castle did not diagnose it. Chronic bronchitis is primarily a diagnosis made based on the patient history, and Dr. Istanbouly conducted such patient history. Obviously, the primary care physician conducted numerous patient histories. But Dr. Castle did not perform a patient history. He conducted only a records review and never spoke to or met Petitioner. Further, while Dr. Castle's only contribution was to perform a records review, he did not believe the histories and diagnoses contained in the records he reviewed. It is significant that Respondent decided to have a records review with no patient history by its expert even though it knew that chronic bronchitis was one of the diseases alleged, and even though it knew that the primary care physician had diagnosed it and had prescribed multiple pulmonary medications in the past. Based on the above, the Arbitrator concludes that the case for chronic bronchitis is strong, and finds in Petitioner's favor.

Dr. Istanbouly examined Petitioner on 3/7/16 at Petitioner's request. Dr. Istanbouly is Board Certified in Internal Medicine, Pulmonary Medicine, and Critical Care. He has worked in Southern Illinois for decades as a pulmonologist and has privileges at a number of hospitals in the Herrin area. He regularly performs black lung evaluations for Illinois claims and Federal claims. He performed a full examination of Petitioner, and diagnosed CWP and chronic bronchitis. His pulmonary function testing was within the range of normal; however, he testified that one can have CWP and chronic bronchitis with such testing in the range of normal. Such was the universal testimony of the experts. He read Petitioner's chest x-ray as positive for CWP, and he also relied on the b-reading of Dr. Smith, which showed interstitial fibrosis, p/s bilaterally in the mid and lower zones in a profusion of 1/0. Dr. Smith also found accentuated Kerley-B septal lines. and a slightly elevated right diaphragm.

Medical records from Logan Primary Care were documented by Dr. Castle to show eight entries of cough, six entries of acute bronchitis, three entries of acute sinusitis, and one entry each of chronic bronchitis (on 9/20/12), allergic rhinitis, and acute bronchiolitis. The Arbitrator finds these records to be consistent with Dr. Istanbouly's diagnosis of chronic bronchitis, and notes the specific diagnosis of chronic bronchitis from 9/20/12.

The reports of four NIOSH screening x-rays, from 1/23/74, 11/5/85, and two from 8/20/00 were offered by Respondent. The Arbitrator notes that Petitioner's date of last exposure was 2/5/16, and that the expiration of his two-year 1(f) period was on 2/4/18. Therefore, none of the NIOSH x-rays were probative relative to the question of whether or not Petitioner had radiographic CWP on 2/4/18, the end of his 1(f) period.

Dr. Meyer read a chest x-ray dated 3/17/16, and CT scans from Herrin Hospital dated 7/22/08 and 9/16/12. He found all three radiographic studies to be completely negative for CWP. However, in the 2008 CT scan, which was taken with 5mm slice thickness and 5mm increments, Dr. Meyer found linear scarring associated with callous formation from a prior right-sided rib fracture in the subadjacent right middle and right lower lobe, and also densely calcified left hilar lymph nodes with calcified left lower lobe granuloma. On the 2012 CT scan, also taken with 5mm slices at 5mm increments, he found new centrilobular and tree-in-bud opacities in the posterior segment of the right upper lobe and also dependent segments in the right lower lobe that were new compared to the 2008 CT scan. He also found dependent cellular bronchiolitis in the right upper and right lower lobe most consistent with infection or aspiration, and also new compared to 2008. Dr. Meyer testified that a coal miner's exposure never ends. After the coal miner leaves the coal mine, much of the coal mine dust he has inhaled remains trapped in his lungs for the rest of his life. He said that as much as 50% of the weight of a long-term miner's lungs can be composed of such trapped coal mine dust. He also testified that studies show that over 50% of long term coal miners are found to have CWP at autopsy if such is performed at death, and that older studies show a much higher incidence than that.

The Arbitrator notes that the studies cited by Dr. Meyer indicate that it would be more likely than not that Petitioner would have CWP at the time of his death if an autopsy were taken. The Arbitrator also notes that the two CT scans read by Dr. Meyer suffered the same lack of timeliness as the NIOSH screening x-rays. The 2008 CT scan was taken eight years prior to Petitioner's date of last exposure and ten years prior to the running of his 1(f) period. The 2012 CT scan was taken four years prior to Petitioner's date of last exposure and six years prior to the running his section 1(f) period. Further, the chest x-ray Dr. Meyer read was taken on 3/17/16, which was one month following his date of last exposure, but two years prior to the running of his section 1(f). Had any of these three radiographic studies been found to be positive, such would have provided a timely diagnosis which could establish CWP, because the universal testimony is that CWP is a permanent disease. However, negative x-rays prior to the running of Petitioner's 1(f) period, cannot prove an absence of radiographic CWP on the relevant date of 2/4/18. In addition, the unrebutted testimony was that a negative x-ray could never rule out the existence of CWP, and Dr. Meyer testified that notwithstanding his negative readings, Petitioner could still suffer from CWP. Dr. Castle provided similar testimony regarding the lack of probity of negative chest x-rays and that his negative reading would not rule out CWP in Petitioner.

The Arbitrator is aware that one might argue that Dr. Meyer and Dr. Smith disagreed on the x-ray of 2016 and if Dr. Meyer's readings were preferred, such could be used to negate this timeliness argument. However, that analysis only looks at one side of the coin. The pertinent remaining fact is that for each x-ray read by Dr. Meyer, there was still sufficient time for it to become positive in the eyes of Dr. Meyer, which would have left with both experts finding the x-ray positive, although at different times. The Arbitrator concludes that Dr. Meyer's reading is evidence that Dr. Meyer did not find the radiographs positive on the days that they were taken, but there is no evidence that he could not have found more recent and timely radiographs to be positive. In sum, the evidence of Dr. Meyer that the radiographs did not show evidence of an absence of CWP are not timely, and are not complete.

Dr. James Castle performed a records review for Respondent dated 10/3/17. He found no coal mine related pulmonary disease. The Arbitrator notes that while Respondent was allowed a full examination, it determined to only obtain a review of the medical records. Dr. Castle, who performed the records review, has been retired for a number of years, and has not seen patients in his office for a decade nor in the hospital for 14 years. His practice consists of records reviews and depositions such as he did in this case. He did not examine, speak to, nor see Petitioner. And his conclusions following his records review were inconsistent with the findings of the treating physicians.

The Arbitrator further notes that both Dr. Castle and Dr. Istanbouly testified that chronic bronchitis is determined by a patient history of sufficient cough. However, while Dr. Istanbouly examined Petitioner and took his own patient history, Dr. Castle never met nor talked to Petitioner, and could not take a patient history. Between Dr. Istanbouly and Dr. Castle, Dr. Istanbouly was the only expert to take a patient history; therefore, the Arbitrator gives Dr. Istanbouly's opinions regarding chronic bronchitis greater weight than those of Dr. Castle. The Arbitrator further notes that the diagnosis of chronic bronchitis contained in the medical records of the treating physician provides sufficient support for such diagnosis by Dr. Istanbouly. The Arbitrator further notes that at the time Respondent engaged Dr. Castle to perform only a records review, and not an examination, it was aware that Petitioner was alleging chronic bronchitis. Dr. Castle took no patient history because of the specific decision of Respondent. Respondent purposefully left itself with no sufficient evidence to counter Petitioner's evidence establishing chronic bronchitis.

The Arbitrator also notes that the totality of the testimony in this case establishes the medical difference between a positive x-ray reading and a negative x-ray reading for CWP. A positive reading, combined with a sufficient history of exposure is an adequate basis for a diagnosis of CWP; however, a negative x-ray reading can never rule CWP out.

The Arbitrator notes that the issue at stake is "CWP," not "radiographic CWP," not "clinically significant" CWP, and not "physiologically significant" CWP. Our Appellate Court has noted that CWP is a slowly progressive disease which is composed of abnormalities consisting of coal mine dust wrapped in scar tissue and surrounded by emphysema. There is no cure for it; it results in an impairment in the function of the lung at the site of the scarring, whether such can be measured by testing or not; and the sufferer cannot return to the environment of a coal mine without endangering his health.

The Arbitrator turns to the deposition of Respondent's b-reader/radiologist, Dr. Meyer, to describe the significance of the disease of CWP in this case. Having no medical evidence at all, it would still be more likely than not that Petitioner could have CWP. Dr. Meyer cited studies showing that at autopsy, 50% or more of long-term coal miners have CWP that can be diagnosed pathologically that was not diagnosed radiographically during life. And he said that there are older studies which show a much higher incidence than that. Petitioner worked as a coal miner for 42 to 43 years, 30 of which were underground, and this testimony provides a part of the support for the Arbitrator's conclusion that Petitioner suffers from CWP.

Dr. Meyer testified regarding the nature of pathologic CWP, saying that the abnormalities found pathologically which were not found radiographically would have the same constitution as the macules or nodules that would show up on x-ray, just perhaps smaller. They would still be subject to potential progression as any other CWP abnormality might be. In terms of the miner's awareness of his CWP, Dr. Meyer said that a miner with 1/0 CWP probably won't know he has it, and he won't complain to his doctor. He said CWP is similar to prostate cancer or colon cancer in that most people won't have any idea that they have it until they take the appropriate test and get the diagnosis. As to the specific nature of the exposure of a coal miner, he testified that the body's ability to clear the dust is important, but that the amount of dust in the lung can be as much as one-half the total weight of the lung itself. He added that with mixed dust exposure, including silica, there is much more toxicity. And Petitioner's unrebutted testimony is that he was exposed to silica in his mining work.

Regarding records reviews and determining the existence of CWP, Dr. Meyer said that if he reads the x-ray positive, entries in treatment records of clear lungs wouldn't change his diagnosis. Pulmonary function tests, be they good or bad, wouldn't have a bearing. And complaints of shortness of breath or a failure to find shortness of breath would have no effect on the reading of the x-ray. Again, he said that reading an x-ray as negative does not rule out the possibility that CWP exists. Dr. Castle, Respondent's other expert, did not disagree with Dr. Meyer.

In weighing the evidence, the Arbitrator finds the preponderance of the evidence in Petitioner's favor. On chronic bronchitis, such was diagnosed by both Dr. Istanbouly and in the medical records. On CWP, Respondent chose to offer only readings by its expert that could not be used to prove that Petitioner did not have radiographic CWP on the date of the expiration of his 1(f) period. Ample time remained after the most recent radiographs for Respondent's experts to find them positive for CWP.

Petitioner suffers from CWP and chronic bronchitis, each of which was related to his coal mine exposures. The Arbitrator notes that Petitioner is a lifelong never smoker of cigarettes. In addition, the studies brought forth by Dr. Meyer establish that it is more likely than not that Petitioner would have CWP diagnosed pathologically were an autopsy to be taken at his death. The Arbitrator is not speculating nor engaging in conjecture that Petitioner has pathologically significant CWP; however, the Arbitrator does take note of these studies in support of his conclusion that Petitioner has met his burden.

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

As noted above, the Appellate Court has settled the issue of disablement. When a miner has proven the existence of CWP, he has also proven disablement by both an impairment in the function of the lungs and by a medical contraindication of further coal mine exposure. The universal testimony in this record agrees with the Court. Regarding chronic bronchitis, the Arbitrator finds that a chronic cough is not a natural state and represents a pulmonary impairment. The Arbitrator also notes that the records from Logan Primary Care support Petitioner's testimony that he had used inhalers in the past and also the diagnoses of Dr. Istanbouly. Such records contain two prescriptions for Depo Medrol, two for Tessalon Perles, and one each for Rocephin, Zithromax, Proventil, and Biaxin.

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

The Arbitrator notes that as of the time of Dr. Istanbouly's testing, Petitioner's pulmonary function testing was within the range of normal. At Arbitration, Petitioner gave credible testimony as to his pulmonary condition since leaving the mines.

The Arbitrator specifically notes that there is no testimony tying Petitioner's chronic bronchitis and CWP to any exposures other than those he encountered in his work as a coal miner.

(i) Impairment rating. Petitioner's pulmonary function testing was within the range of normal based on the AMA Guides. However, given the nature of Petitioner's two diseases, such rating does not negate disablement in this case.

(ii) Occupation of Injured Employee. The Arbitrator notes that coal mining involves daily exposure to coal mine dust, and that the unrebutted testimony of Petitioner was that he was also regularly exposed to silica dust, roof bolting glue fumes, and diesel exhaust. The clear preponderance of the evidence, as well as a ruling of the Appellate Court establish that when a miner has CWP, he has an impairment in the function of his lungs whether such can be measured or not. It also establishes that there is no safe level of coal mine exposure for a miner who has been diagnosed with CWP. Based on the evidence in this case, the coal mine environment contains many exposures in addition to just coal dust, and each of these exposures presents a significant risk to the miner's pulmonary system. This Petitioner has no apparent exposures other than coal mining which could be responsible for his multiple diseases, and as a result of those diseases, he is obviously medically precluded from returning to the coal mine environment. It is also the universal testimony that Petitioner will have exposure to the coal mine dust trapped in his lungs for the rest of his life, confirming the possibility of a future worsening of his pulmonary condition.

(iii) Petitioner's age. Petitioner was 65 years of age when he ended his coal mine employment with Respondent, and was 69 years of age at the date of arbitration. While his age at his date of last employment would not prevent

further coal mine employment, his diagnoses render him medically precluded from such.

(iv) Petitioner's future earning capacity. Petitioner's determination to end his coal mine employment due at least in part to his pulmonary difficulties has caused a reduction of his earning capacity as noted in (iii) above.

(v) Evidence of disability. The Arbitrator concludes that as per past decisions of the Appellate Court, Petitioner's CWP results in disablement from both a functional standpoint as in terms of a reduction of his earning capacity. The very definition of chronic bronchitis provides proof that Petitioner suffers an impairment in his pulmonary system---chronic cough.

In light of the above five factors and the record as a whole, the Arbitrator finds Petitioner to be disabled to the extent of 8% person as a whole.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC014811
Case Name	COOPER, CASSANDRA v. LAND OF LINCOLN LEGAL ASSISTANCE FOUNDATION INC
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0288
Number of Pages of Decision	20
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Robert Butler
Respondent Attorney	Mary Flanagan-Dean

DATE FILED: 6/11/2021

/s/Deborah Baker, Commissioner

Signature

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CASSANDRA COOPER,

Petitioner,

vs. NO: 17 WC 014811

LAND OF LINCOLN LEGAL ASSISTANCE FOUNDATION, 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, causal connection, the reasonableness and necessity of medical expenses, temporary total disability, the nature and extent of the disability, and occupational disease, and being advised of the facts and law, modifies the Decision of the Arbitrator on the nature and extent of Petitioner's injuries and makes other corrections and clarifications as set forth below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

At the outset, the Commission clarifies that although the Petition For Review indicates occupational disease issues are on review, the Commission makes findings in this case under the Illinois Workers' Compensation Act and not the Illinois Workers' Occupational Diseases Act. *See Luttrell v. Industrial Comm'n*, 154 Ill. App. 3d 943, 956, 507 N.E.2d 533, 542 (2d Dist. 1987) (finding that carpal tunnel syndrome is not a disease within the meaning of the Workers' Occupational Diseases Act.)

In the Decision of the Arbitrator ("Decision"), the "accident" date was found to be "12/2/2019," which appears to be a typographical error. At the hearing, Petitioner alleged a manifestation date of December 2, 2016. The Commission finds that December 8, 2016 is a more reasonable manifestation date as it is the date when Dr. Abel documented that Petitioner had positive bilateral Phalen's tests, diagnosed Petitioner with carpal tunnel syndrome, and placed her

off work. Specifically, Dr. Abel noted: "mild CTS bilat due to overuse…." (Pet.'s Ex. 2 at 12-14.) While Petitioner alleged a manifestation date of December 2, 2016, Petitioner did not testify as to the significance of this date and there are no records indicating that there was medical treatment on this date. Based on the evidence provided in the record, it is the Commission's view that December 8, 2016 is the proper manifestation date as this was the date when Petitioner received medical confirmation of the link between her job duties and her carpal tunnel syndrome diagnosis, and she became unable to work due to her symptoms and treatment. *See Durand v. Industrial Comm'n (RLI Insurance Co.)*, 224 Ill. 2d 53, 68-69, 862 N.E.2d 918, 927 (2006).

Further, the Commission finds that the number of weeks used to calculate the benefit rate for the specific loss of use of the right and left hands was incorrect. Section 8(e)(9) of the Act states that the following number of weeks should be used to compensate for a specific loss of the hand: "190 weeks if the accidental injury occurs on or after June 28, 2011 (the effective date of Public Act 97-18) and if the accidental injury involves carpal tunnel syndrome due to repetitive or cumulative trauma …" In this case, the accidental injury occurred after June 28, 2011 and the claimed injuries that the Commission agrees were caused by repetitive trauma at work involve carpal tunnel syndrome. Accordingly, Petitioner's permanency award for the right and left hands should be calculated using 190 weeks as required by the Act.

With respect to the permanency awards for the left hand and left arm, it is the Commission's view that the analysis of Section 8.1b(b), subsection (v) of the Act did not include and appreciate the differences between Petitioner's right upper extremity (Petitioner's dominant arm and hand), in contrast to Petitioner's left upper extremity (Petitioner's non-dominant arm and hand). The Arbitrator awarded 10% loss of use of each hand and 10% loss of use of each arm. However, the Commission finds that Petitioner testified she is right-hand dominant. (Tr. at 40.) Additionally, the medical records from The Orthopedic Center of St. Louis show that after the bilateral carpal tunnel releases and bilateral ulnar nerve decompression surgeries, Petitioner had some complaints of continued pain primarily with respect to the right side. (Pet.'s Ex. 1.) Placing more weight on these facts and finding that they weigh in favor of a decreased permanency award for the left hand and left arm, the Commission modifies the permanent partial disability awards to 7.5% loss of use of the left hand and 7.5% loss of use of the left arm. The Commission agrees with the Arbitrator's award of 10% loss of use of the right hand and 10% loss of use of the right arm.

Finally, the Commission corrects the amount paid by group health insurance on page seven (7) of the Arbitrator's decision from $1,578.00 to $1,578.89.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 3, 2020, as corrected and modified above, is hereby affirmed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable, necessary, and causally related medical expenses for treatment, pursuant to the fee schedule, of $857.07 to Dr. Kosit Prieb, $3.26 to Dr. Richard Hehmann, $30,689.93 to Orthopedic Ambulatory Surgery Center of Chesterfield, $25,638.90 to Dr. Nathan Mall and reimburse $40.00

to Petitioner for bills paid to Belleville Family Medical Association as provided in §8(a) and subject to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $489.31 per week for a period of 8 and 5/7 weeks, representing June 1, 2017 through July 31, 2017, 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 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 including a credit of $1,578.89 for medical benefits that have been paid by group health insurance, 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) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $440.38 per week for a period of 77.53 weeks as provided in Section 8(e) of the Act, because the injuries sustained caused 10% loss of use of the right hand (19 weeks), 10% loss of use of the right arm (25.3 weeks), and 7.5% loss of use of the left hand (14.25 weeks), and 7.5% loss of use of the left arm (18.98 weeks).

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.

JUNE 11, 2021

/s/ *Deborah J. Baker*
Deborah J. Baker

DJB/cak

O:4/20/21

/s/ *Stephen J. Mathis*
Stephen J. Mathis

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/s/ *Deborah L. Simpson*
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0288
NOTICE OF ARBITRATOR DECISION

COOPER, CASSANDRA Case# **17WC014811**

Employee/Petitioner

LAND OF LINCOLN LEGAL ASSISTANCE

Employer/Respondent

On 3/3/2020, 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:

3181 BUTLER & KEMPER
ROBERT W BUTLER
2421 CORPORATE CENTRE DR #101
GRANITE CITY, IL 62040

2871 LAW OFFICES OF LUCY T UNGER
MARY FLANAGAN-DEAN
1010 MARKET ST SUITE 1510
ST LOUIS, MO 63101

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Cassandra Cooper
Employee/Petitioner

v.

Land of Lincoln Legal Assistance
Employer/Respondent

Case # **17 WC 014811**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **December 16, 2019**. 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 **12/2/2019**, 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 $**38,166.44**; the average weekly wage was $**733.97**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**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 $**1,578.89** under Section 8(j) of the Act.

ORDER
Respondent Shall be given a credit of $1,578.00 for medical benefits that have been paid by group health insurance, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $857.07 to Dr. Kosit Prieb, $3.26 to Dr. Richard Hehmann, $30,689.93 to Orthopedic Ambulatory Surgery Center of Chesterfield, $25,638.90 to Dr. Nathan Mall and reimburse $40.00 to Petitioner for bills paid to Belleville Family Medical Association as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $489.31/week for 8 & 5/7 weeks, commencing 6/1/2017 through 7/31/2017, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $440.38/week for 91.6 weeks, because the injuries sustained caused the 10% loss of the right hand, 10% loss of the left hand, 10% loss of the right arm and 10% loss of the left arm, as provided in Section 8(e) of the Act.

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

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

Carl Lee 3/3/20

Signature of Arbitrator Date

MAR 3 - 2020

D/A: 12/2/2016

FINDINGS OF FACT

Cassandra Cooper, hereinafter "Petitioner", was 46 years old at the time of the injury. [T. 8]. She worked as an Administrative Secretary for Land of Lincoln Legal Assistance, hereinafter "Respondent" for 8 years leading up to the date of injury of 12/2/2016. [T. 9]. Petitioner had symptoms in her hands off and on prior to the date of accident. [P. Ex. 5, p. 2]. She had a prior left trigger thumb in which workers' compensation covered the medical treatment, but she did not receive a "settlement". [T. 65-66, 70]. She did not recall any other prior claims or injuries to her hands under worker's compensation in Missouri or Illinois but thought she may have had something for tendinitis in the nineties. [T. 67-68]. No evidence was offered of either prior medical treatment, prior settlements or prior awards regarding Petitioner's hands or arms. [T. 68-69].

As a legal secretary, Petitioner testified she typed letters from templates, approximately 30 a day, answered phones, filed, carried files, pulled fact sheets for each file, folded letters, stuffed envelopes, stamped signatures along with other infrequently performed miscellaneous duties. [T.11-15]. As part of her typing duties she typed into the letters the descriptions of all the fact sheets she was including. [T. 51-52, 58]. She testified she would pull "at least three to four sheets for each letter." [T. 51-52, 58]. Petitioner estimated that typing/keyboarding was the majority of her work and she spent more than 50% of her time, or approximately 4-6 hours daily performing this activity. [T.14] Respondent offered Petitioner's Managing Attorney, at the time of the injury, Beverly Allen's description of Petitioner's job. The job description was written on September 27, 2018. [R. Ex. 1, Depo Ex. 5]. Ms. Allen described Petitioner's duties as answering the phones 15-30 minutes per hour, 7 hours per day, type letters approximately 2.5 hours per day, stamping incoming correspondence 15 minutes per day, ordering and stocking supplies one hour once every 3-6 months, loading the printer and copier, addressing minor issues for the staff and adding postage to the postage meter 20 minutes every 3-4 weeks. [id.].

Prior to the onset of her symptoms, Petitioner testified that her department was understaffed for support staff but fully staffed for attorneys and that several months earlier the intake call center increased its hours increasing her duties. [T. 15-18, P. 11]. On August 15, 2016 the intake call hours were increased 2 ½ hours per day Monday through Thursday. [P. 10]. Petitioner testified this increased the number of calls she took and the number of letters she sent out. [T. 18]. Additionally, for at least 6 months she was the only full-time staff member responsible for the fully staffed legal department. [T. 17]. There were some temporary employees, but it wasn't until shortly before December 2016 that another full-time intake specialist was hired. [T. 16].

Petitioner offered into evidence an email in which she notified her employer of her injury. Her December 5, 2019 email to her supervisor Beverly Allen states as follows:

> *"It appears that the carpal tunnel has returned in both hands, arms and elbows. The pain started earlier last week. I have been in excruciating pain. I've been nursing it with pain medication, ibuprofen, and numbing cream to no avail. My workload has been overwhelming, especially since LARC has not been properly staffed with intake specialist, and fully staffed with attorneys (which produce more work for me). Oveta, the one intake specialists that we do have, has been unable to fully assist me because she has to attend to her duties (which usually last to the end of her shift). I have not made a doctor's appointment yet, I wanted to notify you first. What do you suggest?"* [P. Ex. 11].

Beverly Allen told her to make the doctor's appointment and to report it to Human Resources if the doctor felt it was work related. She expressed her recognition of Petitioner's increase workload stating *"[t]his is one of the things that I was afraid of when we went to extended hours. All of my concerns about extending our hours are coming to fruition."* [P. Ex. 11].

Petitioner scheduled an appointment with Dr. Wallace Abel 12/8/2016. He reports that "*Patient has history of CTS in past treated conservatively. Her CTS flared up both wrist because she had to do more office work because of people on vacation. She has been unable to work this week due to wrist pain. Pain better since off work and using ibuprofen.*" He diagnosed mild carpal tunnel syndrome, took her off work from 12/6/16-12/9/16, prescribed prednisone and wrist splints. [P. Ex. 2, pp. 12-14].

A First Report of Injury was filed on 12/15/2016 reporting Carpal Tunnel – pain in wrists and lower arms from typing and using the computer. [P. Ex. 9].

Petitioner returned to Dr. Abel 12/21/2016 complaining of worsening hand pain. He referred for to Dr. Kosit Prieb for ultrasound and emg/nerve conduction studies of the right hand. The 12/22/2016 ultrasound findings showed bilateral median nerve compression at the carpal tunnel area. The 1/6/2017 right-handed emg/nerve conduction study findings showed moderate right carpal tunnel syndrome and mild, sensory only, right ulnar neuropathy at the wrist. [P. Ex. 2, pp. 17-19 & P. Ex. 3 p. 4].

She was sent to Dr. Richard J. Hehmann 1/12/2017. He noted a history of "*bilateral hand numbness and pain, present on and off for several years, recently been severe since Thanksgiving, nocturnal symptoms noted, had positive emg/ncv on right hand.*" He diagnosed carpal tunnel syndrome and ordered nerve conduction studies on the left hand. [P. Ex. 5, pp 2-3]. The 2/1/2017 nerve conduction test was consistent with mild left carpal tunnel syndrome. [P. Ex. 4].

The employer sent Petitioner for an IME with Dr. James Stiehl on 3/13/2017. He diagnosed right carpal tunnel syndrome but did not believe it was related to her work activities. [R. Ex. 1, Depo Ex. 2.]. Based upon this, the employer denied further medical care for carpal tunnel syndrome.

Dr. Abel examined Petitioner again 4/13/2019 and referred her for orthopedic care. [P. Ex. 2, pp. 46-48].

She was examined by Dr. Nathan Mall, orthopedic surgeon on 4/21/2017. She described "*numbness and tingling in both of her hands, which began around November 2016. She started feeling this numbness while working. She works at Land of Lincoln Legal Assistance Foundation as an Administrative Secretary. She must type, answer phones, file and shred documents. She describes her job as typing about six hours per day and carrying files approximately one hour per day. She denies any secondary jobs. She has had a prior left trigger thumb that was deemed work related. She has had a Medrol Dosepak prescribed and some wrist braces since December.*" [P. Ex. 1, Depo Ex. 2].

He further noted that "*She has not had an ergonomic assessment. She does have an adjustable-height chair. She has a standard keyboard and a standard wireless mouse but no ergonomic mouse or keyboard.*" [id].

On examination he noted a positive flexion compression test and positive Tinel's at bilateral elbows. She had pain to palpation over the ulnar nerve within the condylar groove. There was some mild Tinel's in the left wrist. The right wrist had a negative Tinel's on that day. Flexion compression test was positive on the left wrist and negative on the right. [id].

Dr. Mall diagnosed bilateral wrist carpal tunnel and cubital tunnel. Since she had not had any treatment for the cubital tunnel, he ordered a right ulnar nerve brace. He recommended bilateral carpal tunnel surgery but wanted to see if the ulnar nerve braces would help her elbows before proceeding, so if necessary, both procedures could be performed at the same time. [P. Ex. 1, p. 11].

Dr. Mall on 5/17/2017 determined that the splints mildly improved the right elbow, but substantial problems continued with the left elbow. He recommended surgery for both carpal and cubital tunnels and an injection into the right thumb for the triggering problems. [id].
Dr. Mall performed a left carpal tunnel release and ulnar nerve transposition with cubital tunnel compression on 6/1/2017. [P. Ex. 1, p. 11].

Dr. Mall performed a right carpal tunnel release and right ulnar nerve transposition and a right CMC injection on 6/29/2017. [P. Ex. 1, p. 12].

Dr. Mall either took petitioner off work or placed her on light duty restrictions from 6/1/2017 until 8/2/2017. [P. Ex. 1, Depo Ex. 2]. Petitioner testified that she was off work from 6/1/2017 until she returned to full duty on 8/1/2017. [T. 32].

Petitioner reported doing well on her return visit of 8/2/2017. She had some complaints of soreness when she returned to her full-duty job with folding some letters and repetitive movements. Dr. Mall recommended additional physical therapy for range of motion, strengthening, and stretching of her bilateral upper extremities. He ordered an anti-inflammatory to make things easier for her return to full work duties. He released her to full duty stating *". . . I would like her to attempt to return back to her normal job duties. However, if she really cannot do this, then she will call me, and we will readdress this if needed."* [P. Ex. 1, Depo Ex. 2].

Petitioner last saw Dr. Mall for carpal tunnel and cubital on 10/25/2017. She was having scar related pain in her right elbow. She reported she was getting stronger but continued to have some mild discomfort and aching in the bilateral elbows and hands. Dr. Mall did not believe any additional medical treatment was required for her left carpal and cubital tunnel syndrome. She had some mild scar related pain to her right elbow. Dr. Mall felt would be reasonable for her to see her plastic surgeon to deal with the keloid. However, he did not feel there was a severe keloid and thought it would continue to improve with continued scar massage. She was released from care. [Id.]. Petitioner did not seek additional care for the scar.

Petitioner has returned to Dr. Mall after 10/25/2017, but for conditions unrelated to her bilateral carpal and cubital tunnel syndrome. [P. Ex. 1, pp 15-16].

Regarding causation, in his initial report of 4/21/2017 Dr. Mall opined as follows:

> *"Ms. Cooper is female. She has a BMI of 32, which does increase her risk for development of carpal tunnel syndrome. She does not have diabetes or high blood pressure or any other medical conditions that would increase her risk for development of carpal tunnel syndrome. While typing in and of itself is thought to be less of a risk factor for carpal tunnel than it used to be, typing in a poor ergonomic fashion with the wrist in extended or a flexed position can substantially increase the forces through the carpal tunnel and lead to median nerve dysfunction at the carpal tunnel. Similarly, keeping the elbow flexed for long periods of time, such as when typing, can cause the development of cubital tunnel syndrome. However, typically if a proper ergonomic assessment is performed, this can alleviate these risk factors for most employees. Ms. Cooper does not describe this ever happening, and therefore I do believe that her job duties could, in fact, be a factor in the development of her carpal tunnel syndrome and cubital tunnel syndrome."* [P. Ex. 1, Depo Ex. 2].

In his deposition testimony, Dr. Mall opined as follows:

"So I based my causation off of our medical research. So as I mentioned in here, she does have some other risk factors for carpal tunnel which is a BMI of thirty-two, which is a substantial risk factor for carpal tunnel. She is also female, which is also another risk factor for carpal tunnel.

What we have found in our research is that the simple act of typing alone is not necessarily a risk factor for carpal tunnel. It's when you type in a poor ergonomic position. So if your wrist is extended or flexed when you're typing that will increase the forces that go through the carpal tunnel and can lead to median nerve dysfunction.

So based on what she described to me, the fact that she hadn't had an ergonomic assessment, she didn't have an ergonomic keyboard, didn't have and ergonomic mouse, she does have and adjustable height chair which is helpful, part of it. But without those other things and sort of watching her describe how she types, I felt those - - that her job duties were at least a factor in the development of her carpal tunnel and cubital tunnel syndrome." [P. Ex. 1, pp. 9-10].

Regarding cubital tunnel he opines as follows:

". . . [M]ost people believe that cubital tunnel syndrome falls very much in line with carpal tunnel syndrome in terms of the various risk factors for that. The biggest thing with cubital tunnel syndrome is the time period of the elbow flexion. So again, if she doesn't have the appropriate positioning of her body, that can lead to additional elbow flexion when she's typing and can lead to at least a contribution of her job duties to development of those conditions. As I mentioned earlier, she has several other very significant risk factors for those conditions, but in terms of whether or not her job duties have contributed somewhat to the development of those conditions, I believe they have." [P. 1, p19].

At hearing Petitioner testified that she did undergone an ergonomic evaluation in April 2019 ordered by the employer. [T.34]. She testified the specialist made modifications to her workstation by raising up her keyboard, putting books under her screen so she would sit up straighter, and put the flaps down on the back of her keyboard to make it flatter. [T. 34-37]. She testified that these modifications *"affected [her] posture dramatically. . . . [i]t eased the pain and the pressure and the tension."* [T. 37]. She reported as well the she had purchased a wireless mouse after the injury and an ergonomic keyboard after the ergonomic evaluation. [T. 37-38].

Respondent offered into evidence the deposition testimony of Dr. James Stiehl, orthopedic surgeon. The deposition contained as exhibits his 3/1/17 report [Depo. Ex. 2], his 6/26/2019 report [Depo Ex. 3], a video of approximately 7 minutes of petitioner's job duties [Depo Ex. 4] and Beverly Allen's written job description of petitioner's job duties [Depo Ex. 5].

In his 3/1/2017 report, Dr. Stiehl reports that Petitioner reports complaints of multiple symptoms involving her hands, forearms and elbows which she attributes to her work. He notes an 8-year history of secretarial work including computer and keyboard typing, etc. She reports continued symptoms in both hands. She has pain at night and had been wearing bilateral wrist splints. She was also complaining of pain over the inner aspect of both of her elbows. She denied any prior history of arthritis, thyroid disease or diabetes. [R. Ex. 1., Depo Ex. 2].

On physical examination he records that she is 5 feet 6 inches, weight 200 pounds, BMI 32. He notes evaluation of both extremities. He finds no symptoms to palpitation over the cubital tunnel of the elbows and finds full range of motion of both elbows. He finds bilateral discomfort over the carpal tunnel of both hands, mildly positive symptoms noted with Phalen's test. Two-point discrimination is normal at 5 mm in all fingers.

The Semmes-Weinstein test is normal at 2.83 level in all fingers. She has good grip strength. Full range of motion of the thumb, fingers, and hand is noted on examination. [Id].

In his discussion he points out that the righthand nerve conduction test was consistent with right carpal tunnel syndrome. However, his diagnosis is that petitioner *"complains of a variety of symptoms in multiple areas of her elbow, forearm, and hands. These subjective complaints, in my view, are exaggerated but would be typical of a possible overuse syndrome. I am unable to correlate the symptoms of the carpal tunnel with the variety of symptoms that she offers at this time."* [Id].
In answering the question of whether her symptoms are work related he states *"No, Ms. Cooper is clearly exaggerating symptoms in her forearm and hands at this time. She does not offer obvious and direct complaints of symptoms consistent with the carpal tunnel syndrome. More likely, she offers rather global symptoms, in my view, that are hard to quantitate for a specific diagnosis."* [id].

Dr. Stiehl opined that he did not believe that any further treatment was indicated. He states: *"[b]ased on the symptom magnification that I have identified in this case. It is hard for me to state exactly what could be the problem. Ms. cooper has evidence of a right carpal tunnel syndrome. However, I do not find evidence that she does a high-repetitive factory type of job that would result in a carpal tunnel syndrome. I reference the AMA Guides to the Evaluation of Disease and Injury Causation, page 282, which clearly excludes keyboard activities and other intentional activities of secretarial work as being a potential causative factor. Therefore, I do not believe any further treatment is indicated at this time."* [id].

Dr. Stiehl then states: *"Ms. Cooper clearly has evidence of right-sided carpal tunnel syndrome."* He opined that *"Surgery could be done on the right wrist for a carpal tunnel syndrome, however, I do not believe that condition is work related at this time."* [id].

Dr. Stiehl was provided additional information and wrote second report on 6/26/2019 but did not re-examine Petitioner. [R. 1, Depo. Ex. 3]. He was provided the medical records of Dr. Nathan Mall and Dr. Mall's deposition transcript. He was provided the job requirements [R. Ex. 1 p.22 & depo ex. 5], the approximate 7-minute video [R. Ex. 1, depo Ex. 4]. He referenced his earlier report stating he diagnosed her with right carpal tunnel but did not find any other obvious conditions. He described the job requirements document as follows: *"[t]hat job has a variety of skills including doing paperwork, paper filing and I would assume there is some keyboard work indicated."* [id.].

He concludes: *"I rely on the AMA Guides to the Evaluation of Disease and Injury Causation, Second Edition 2014, that is an authority that reviews these issues. From that, I find no evidence that carpal tunnel syndrome, cubital tunnel syndrome, carpometacarpal joint disease of the thumb could be caused by an occupational exposure."* He gives no specific diagnosis of the conditions but concludes that his opinion from the March 1, 2017 exam remains the same. [R. 1, Depo Ex. 2].

Dr. Stiehl in his deposition was asked about his opinion on causation after the March examination and stated:

> *"My opinion is that using my training that I have received over the last six years by a national organization which is now named the International Academy of Independent Medical Examiners, I used the AMA Guides to the Evaluation of Disease and Injury Causation, Second Edition, published in 2014, as my authoritative reference. And I went to – I had many hours of training that they offer for a fellowship, like 175 hours, so I have done all that. And I was trained by one of the hand surgeons who gives that course that for the AMA Guides to have a carpal tunnel syndrome you have to meet the electrical standard, which you do in this case. Then you have to go and prove by Hill's criteria that that electrical change is caused by her activities. And according to this second book that I've just quoted, they state fairly categorically that computer keyboard work does not qualify as a cause compared to other causes*

which would include, obviously, age, obesity, possible rheumatic conditions or thyroid disease. But I think for her it would be age and obesity because she – her BMI is 32. So that's my opinion that is probably is not related." [R. 1. Pp 12-13].

Later in his deposition responding to whether his opinions changed after the additional information was provided to him, he states:

"My opinions are based on authoritative information that I have in this case. They are based on the fact that this patient has substantial nonoccupational risk factors including age, BMI, and gender which are positive for those conditions. And, finally, my understanding is that the legal standard is disability beyond, you know, more likely than not. I think that's the standard for this. So just – clearly, so that's my context. I can't rule out the fact that this may be a cause. If it's one percent, it's certainly one percent or three percent or ten percent, but it's not the majority of the cause." [R. 1, p. 17].

The subsequent exchange is as follows:

Q. (by Respondent's Attorney) *"So, in Illinois, the question is whether it is a cause or an aggravating factor of her carpal tunnel and cubital tunnel syndrome. So did you reach an opinion, to a reasonable degree of medical certainty as to whether her work activities caused—were a cause of her carpal tunnel and cubital tunnel syndrome.?*

A. Based on these authoritative texts, no, I do not believe they are a cause." [R. 1, p. 17].

On cross-examination Dr. Stiehl testified that he diagnosed right carpal tunnel syndrome in the March 2017 examination but that he didn't have the left carpal tunnel EMG, so he didn't offer an opinion. [R. 1, p 29-30].

Dr. Stiehl agreed that Dr. Mall's medical treatment, involving the bilateral carpal and cubital tunnel surgeries were *"effective and probably reasonable"*. [R. 1, p. 39]. Further, he testified that the fact that Dr. Mall treated her for carpal and cubital tunnel syndrome and had positive results indicates that those diagnoses were probably accurate. [R. 1, p. 39-40]. Further he believed the time she was taken off work by Dr. Mall was reasonable. [Id].

He testified that he did not believe that the typing could cause or aggravate her carpal tunnel or cubital tunnel, but when asked if he was changing his opinion regarding his earlier testimony he stated *"Well, I am not God here. I can't – I just—there can be something that might change my mind, but I don't see it in this case."* [R. 1, p. 36].

Dr. Stiehl testified that he did not have a chance to review the video or the job description with Petitioner. He did not know if the video was of her workstation or if it was her in the video. [R. 1, pp. 44-45]. Additionally, he did not know about whether an ergonomics evaluation had been performed on Petitioner's workstation or whether Petitioner had an ergonomic mouse or keyboard. [R. 1, pp. 45-46]. He spent no time with her having her describe to him how she performed the job in terms of keyboarding or any of the activities that she performed. [R. 1, p. 40].

Petitioner testified that the surgeries did help ease her symptoms but that she continues to have difficulty with both her hands and elbows as a result of the carpal and cubital tunnel. [T. 39 & 44]. She reports pain when driving for longer than an hour, with twisting activities and lifting. [T.39 & 42]. Household activities such as laundry, cleaning the tub at home, washing dishes increase her pain. [T. 39]. After typing for a few hours she will get numbness sensations in her elbows. [T. 39-40].

Petitioner further testified that her hands are weak. She has difficulty with opening jars. [T. 40]. Additionally, twisting her hair takes a long time and holding her hands above her head caused her to have pain, so she fixes her hair in intervals. [T. 40]. She avoids activities that involve vibrations such as vacuum cleaners or lawn mowers. [T. 43]. She continues to have nocturnal pain. [T. 43]

Petitioner does not take prescription pain medicine, but states that she frequently treats her symptoms with over-the-counter medication, numbing creams and bio-freeze. [T. 44-45].

Petitioner submitted medical bills with outstanding balances as follows:

Dr. Kosit Prieb	$ 857.07
Dr. Richard Hehmann	$ 3.26
Orthopedic Ambulatory Surgery Center of Chesterfield	$30,689.93
Dr. Nathan Mall	$25,638.90

Petitioner paid $40.00 out of her own pocket for Belleville Family Medical Association. Further the records show that $1,578.00 of medical benefits have been paid by group health insurance. [P. Ex. 8].

The Arbitrator Concludes:

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?**

Under Illinois law, an injury need not be the sole factor, or even the primary factor of an injury, as long as it is a causative factor. ***Sibro Inc. v. Industrial Comm.,*** 207 Ill. 2d 193, 2015, 797 N.E.2d 665 (2003). [Emphasis mine]. Even when other non-occupational factors contribute to the condition of ill-being. "[A] Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." ***Fierke v. Industrial Comm.,*** 309 Ill.App.3d 1037, 723 N.E.2d 846 (3rd Dist., 2000). [Emphasis mine.]. Allowing a petitioner to recover under such circumstances is a corollary of the principal that employment need not be the sole or primary cause of a petitioner's condition. ***Land & Lakes Co. v. Industrial Comm.,*** 834 N.E.2d 583 (2nd Dist. 2005).

Furthermore, in support of a finding of causal connection, the Arbitrator notes that the job duties performed by Petitioner, including computer keyboarding and data entry have been held to be compensable by the Commission in the very recent past. See ***Lewis Debout v. State of Illinois/Pinkneyville Correctional Center***, 14 IWCC 0167 (2014); ***Tom Osman v. State of IL/Tamms Corretional Center,*** 11 IWCC 0601 (2011); ***Cynthia Jenkins v. State of IL/Southern Illinois University, Carbondale,*** 14 IWCC 0335 (2014); ***Nancy Rambo v. State of IL/Department of Transportation,*** 12 IWCC 1020 (2012).

In this case, both doctors arrive at the same diagnosis which is bilateral carpal tunnel and cubital tunnel syndrome. Dr. Mall performed left carpal tunnel release and ulnar nerve transposition with cubital tunnel compression on 6/1/2017, and a right 6/29/2017, Dr. Mall performed a right carpal tunnel release and right ulnar nerve transposition and a right CMC injection on 6/29/2017. Petitioner acknowledge that the procedures improved her symptoms in both arms and that she returned to work. Dr. Stiehl agreed that Dr. Mall's successful

treatment of the condition is an indication that his diagnosis is accurate and that his treatment was reasonable and necessary.

However, the doctors disagree as to whether her job activities could or might cause or aggravate these conditions. I find Dr. Mall's testimony for be more credible for reasons that follow.

Dr. Stiehl in his testimony makes it clear that he is relying on literature which concludes that typing is not a factor in causing carpal tunnel syndrome. Dr. Stiehl states that her other risk factors of BMI, gender and age are greater risk factors. However, in his deposition in discussing literature he relies on he states in relevant part ". . . *according to this second book that I've just quoted, they state fairly categorically that computer keyboard work does not qualify as a cause* ***compared to other causes***. . .". [R. 1, p.13] [Emphasis mine.]. Further, he admits that there is literature which exist in the field that concludes contrary to that which he relies upon. [R. 1, p. 37]. Furthermore, he admits Petitioner's work could be a factor in the cause of carpal tunnel. He testified ". . . ***I can't rule out the fact that this may be a cause***. *If it's one percent, it's certainly one percent or three percent or ten percent, but it's not the majority of the cause."* [R. 1, p. 17] [Emphasis mine]. He only changes his opinion after Respondent's attorney informs him of the correct standard in Illinois by opining that *". . . no, I do not believe they are a cause."* [R. 1, p. 17].

Moreover, Dr. Stiehl is not consistent with his diagnosis. In his 3/1/2017 report, he says Petitioner is exaggerating her symptoms and that they are more likely global symptoms that are hard to quantitate for a specific diagnosis. [R. 1., Depo Ex. 2.]. But a few paragraphs later he states that petitioner "clearly has evidence of right-sided carpal tunnel syndrome . . . and surgery could be done on the right wrist for carpal tunnel syndrome.' [id.]. Ultimately in his deposition, he agrees with Dr. Mall's diagnosis and treatment of bilateral carpal tunnel and cubital tunnel syndrome.

On the other hand, Dr. Mall is very consistent in his opinions. He opines that:

> *"So I based my causation off of our medical research. So as I mentioned in here, she does have some other risk factors for carpal tunnel which is a BMI of thirty-two, which is a substantial risk factor for carpal tunnel. She is also female, which is also another risk factor for carpal tunnel.*
>
> *What we have found in our research is that the simple act of typing alone is not necessarily a risk factor for carpal tunnel. It's when you type in a poor ergonomic position. So if your wrist is extended or flexed when you're typing that will increase the forces that go through the carpal tunnel and can lead to median nerve dysfunction.*
>
> *So based on what she described to me, the fact that she hadn't had an ergonomic assessment, she didn't have an ergonomic keyboard, didn't have and ergonomic mouse, she does have and adjustable height chair which is helpful, part of it. But without those other things and sort of watching describe how she types, I felt those - - that her job duties were at least a factor in the development of her carpal tunnel and cubital tunnel syndrome."* [P. Ex. 1, pp. 9-10].

Regarding cubital tunnel he opines as follows:

> *". . . [M]ost people believe that cubital tunnel syndrome falls very much in line with carpal tunnel syndrome in terms of the various risk factors for that. The biggest thing with cubital tunnel syndrome is the time period of the elbow flexion. So again, if she doesn't have the appropriate positioning of her body, that can lead to additional elbow flexion when she's typing and can lead to at least a contribution of her job duties to development of those conditions. As I mentioned earlier, she has several other very*

significant risk factors for those conditions, but in terms of whether or not her job duties have contributed somewhat to the development of those conditions, I believe they have." [P. 1, p19].

The record supports Dr. Mall's conclusions that Petitioner was using poor posture and non-ergonomic positioning. While Respondent showed a video of approximately 7-8 minutes, it did not show Petitioner, and only very briefly showed the person working at her station typing. Further, Petitioner's unrebutted testimony was that an ergonomic evaluation was performed on her workstation in approximately April, 2019. The ergonomics specialist made modifications to her workstation which included raising her keyboard, flattening her keyboard by dropping the stands in the back, raising up her monitor with books to make her sit more upright. Petitioner testified that she noticed an improvement after these modifications were made. It is also significant that the Respondent did not offer into evidence the results of this evaluation. Petitioner additionally testified that after her injuries she bought an ergonomic mouse and keyboard on her own which helped.

Dr. Mall testified that he had spent time discussing with Petitioner how she performed her job duties and was aware that she was not using and ergonomic keyboard and mouse. He knew further that at that point that an ergonomic assessment had not been performed. His opinion that she was using poor posture is corroborated by the record. Conversely, while Dr. Stiehl watched the 7-8-minute video, he did not know if it was Petitioner in the video, did not verify the video or job description with her. Was unaware whether an ergonomic evaluation was performed, or whether Petitioner was using an ergonomic keyboard or mouse prior to the accident date. He also spent no time with Petitioner asking her how she performed her job duties. [R. 1, p. 40].

Other evidence also supports the conclusion that these symptoms are work related. It is clear from the evidence that just prior to the accident Petitioner's workload increased. Respondent increased the intake call time in August 2016 2 ½ hours per day. Petitioner testified that this additional call time increased her work.

Additionally, Respondent's support staffing was short for about a year and a half. Only a few months prior a second full time intake specialist was hired. Prior to that, temporary help was used sporadically and there were times Petitioner was the only support staff. On 12/5/2016 she reported the problem to her supervisor Beverly Allen in an email stating: *"[i]t appears the carpal tunnel has returned in both hands, arms and elbows. The pain started earlier last week. I have been in excruciating pain. I've been nursing it with pain medication, ibuprofen, and numbing cream to no avail. My workload has been overwhelming, especially since LARC has not been properly staffed with intake specialist, and fully staffed with attorneys (which produce more work for me). Oveta, the one intake specialist that we do have, has been unable to fully assist me because she has to attend t her duties (which usually last to the end of her shift). . . ."* [P. Ex. 11].

Beverly Allen responded by telling her to schedule a doctor's appointment and acknowledged her increase work-load stating: *"[t]his is one of the things that I was afraid of when we went to extended hours. All of my concerns about extending our hours are coming to fruition."* [P. Ex. 11].

Further, Petitioner testified that when she would have a few days off work that her symptoms would improve some, but that they would come back when she returned to work.

Petitioner testified that her position as an Administrative Secretary led to the symptoms. She noticed that her symptoms improved if she was away from the job for a few days but worsened when she returned to work. [T. 41-42]. Her job, among other duties, was typing approximately 30 letters a day from a template. This would require her to alter the template and to put into the letter descriptions of each data sheet pulled and sent with the letter. She estimated that this took approximately 4-6 hours of keyboarding per day.

Employer provided a job description prepared in 2018 that estimated the keyboarding at 2 ½ hours per day. However, even though Petitioner's current supervisor said the times seemed about correct, she admitted that she

did not know how that time was arrived at and that she had never performed that job and has never actually conducted a review of how long the job took.

For the reasons stated herein, the Arbitrator finds the causation opinion of Dr. Mall to be credible and finds that the Petitioner met her burden of proof in establishing that she sustained accidental injuries that arose out of and in the course of her employment with Respondent which are causally related to her current condition of ill-being.

Furthermore, in support of a finding of causal connection, the Arbitrator notes that the job duties performed by Petitioner, including computer keyboarding and data entry have been held to be compensable by the Commission in the very recent past. See ***Joyce Miller v. Illinois Dept. of Human Services***, 18 IWCC 0167 (2018). ***William Bates v. State of Illinois Youth Center Pere Merquette***, 17 IWCC 0106 (2017), ***Yolanda Gutierrez-Roque v. Illinois Dept. of Health & Family Services***, 18 IWCC 0027 (2018), ***Donette Martin v. State of Illinois-House of Representatives,*** 18 IWCC 0064 (2018), ***Rahshun Miller v. State of Illinois, Dept. of Transportation***, 18 IWCC 0196 (2018), ***Kathy Westerman v. State of Illinois – Menard Correctional Center***, 18 IWCC 0372, ***Janet Services v. State of Illinois CMS,*** 18 IWCC 0395 (2018), ***Vivian Wires v. Illinois Dept. of Human Services***, 18 IWCC 0532 (2018), ***Kelly Couleas v. State of Illinois-Pickneyville Correctional Center***, 18 IWCC 0732 (2018), ***Amy Price v. City of Peoria***, 17 IWCC 0095 (2017), ***Angela Young v. State of Illinois Dept. of Revenue***, 16 IWCC 0160 (2016).

Issue (J): Were the Medical Services that were provided to the Petitioner reasonable and necessary? Has the Respondent paid all the appropriate charges for all reasonable and necessary services?

The Arbitrator finds that since the Petitioner met her burden that her current condition of ill-being is related to the accident, all reasonable and necessary bills are to be paid. The Parties do not dispute the reasonable or necessity of the treatment, only causation. The Petitioner's unpaid medical bills are as follows:

Dr. Kosit Prieb	$ 857.07
Dr. Richard Hehmann	$ 3.26
Orthopedic Ambulatory Surgery Center of Chesterfield	$30,689.93
Dr. Nathan Mall	$25,638.90

Respondent is to pay these bills pursuant to the medical fee schedule. Further, Respondent shall reimburse $40.00 to Petitioner for bills paid to Belleville Family Medical Association. Further, a bill was included for MRI Partners of Chesterfield for $2,500.00 for an MRI of the lower extremity. This was clearly in error and Respondent has no responsibility for the payment of this bill.

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

Dr. Mall's records demonstrate that he had Petitioner either off work or on light duty from 6/1/2017 the date of the left arm surgery, until he released her to full duty on 8/2/2017. Petitioner testified that she was off work and allowed to return to work on 8/1/2017. Her return to work date is not disputed by Respondent.

The Respondent shall pay TTD from 6/1/2017 – 7/31/2017 at $489.31 per week for 8 5/7ths weeks as provided by section 8(b) of the Act.

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

For Accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined an 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) 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.

The Act provides that no single enumerated factor shall be the sole determinant of disability. With respect to these factors, The Arbitrator finds:

With regard to subsection (i) of Section 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. The Arbitrator finds that a permanent partial disability can and shall be awarded in the absence of an impairment rating or impairment report being introduced.

With regard to subsection (ii) of Section 8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner has returned to her prior employment. However, that employment has had ergonomic modifications performed and is currently staffed with support staff. Petitioner does report that modifications have lessoned the strain on her arms, therefore not much weight is given to this factor.

With regard to subsection (iii) of Section 8.1b(b), the Arbitrator notes that Petitioner was 46 years old at the time of the accident. Because the Arbitrator considers the petitioner to be a somewhat younger individual and concludes that Petitioner's permanent partial disability will be more extensive than that of an older individual because she will have to live with the permanent partial disability longer, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iv) of Section 8.1b(b), Petitioner's future earning capacity, the Arbitrator notes that no evidence was presented as to future earning capacity and therefore gives no weight to this factor.

With regard to subsection (v) of Section 8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that both doctors ultimately diagnosed bilateral carpal tunnel and cubital tunnel syndrome. Both doctors opined that the medical treatment was reasonable and necessary. Dr. Mall performed left carpal tunnel release and ulnar nerve transposition with cubital tunnel compression on 6/1/2017, and a right carpal tunnel release and right ulnar nerve transposition and a right CMC injection on 6/29/2017.

Petitioner credibly testified that the surgeries did help ease her symptoms that she continues to have difficulty with both her hands and elbows as a result of the carpal and cubital tunnel. [T. 39 & 44]. She reports pain when driving for longer than an hour, with twisting activities and lifting. [T.39 & 42]. Household activities such as laundry, cleaning the tub at home, washing dishes increase her pain. [T. 39]. After typing for a few hours, she will get numbness sensations in her elbows. [T. 39-40].

Petitioner further testified that her hands are weak. She has difficulty with opening jars. [T. 40]. Additionally, twisting her hair takes a long time and holding her hands above her head caused her to have pain, so she fixes

her hair in intervals. [T. 40]. She avoids activities that involve vibrations such as vacuum cleaners or lawn mowers. [T. 43].

The pain does keep her awake at night. [T. 43]. She does not take prescription pain medicine, but states that she frequently treats her symptoms with over-the-counter medication, numbing creams and bio-freeze. [T. 44-45].

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

Issue (N): Is Respondent due any credit?

Respondent is entitled to a credit of 1,578.89 for medical payments that have been paid by group health insurance. However, 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.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	14WC020611
Case Name	JAGLA, STANISLAW v. LIMOUSINE LINES, INC.
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0289
Number of Pages of Decision	8
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	
Respondent Attorney	Deborah Schaefer

DATE FILED: 6/14/2021

/s/Deborah Simpson, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STANISLAW JAGLA,
Petitioner,

vs. No: 14 WC 20611

LIMOUSINE LINES, INC.,
Respondent

DECISION AND OPINION ON REVIEW

This matter comes before the Commission on Petitioner's Review of the Arbitrator's denial of his Petition for Reinstatement of his Claim. A hearing was held on Petitioner's Petition to Reinstate before Arbitrator Mason in Chicago on March 13, 2020. Respondent was represented by counsel, Petitioner appeared *pro se*, and a record was taken.

The Commission records show the following timeline of events. Petitioner filed his Application for Adjustment of Claim on June 17, 2014 alleging an accident date of May 19, 2014. On July 17, 2015, the Commission granted Petitioner's lawyer's petition to withdraw as counsel for Petitioner. The claim was dismissed for want of prosecution on August 8, 2017. Petitioner filed his Petition to Reinstate on February 14, 2020.

In discussion of preliminary matters prior to the hearing, the Arbitrator noted that Petitioner's Motion to Reinstate indicated a mailing address in Bloomingdale, Illinois, while his Application for Adjustment of Claim indicated a mailing address in Roselle, Illinois. At the hearing, Petitioner asserted that he did not receive a copy of the order of dismissal. He also asserted that he retained the post-office box he used in the Application until June of 2018; "so if that would have been sent there [he] would have received it."

Upon questioning by the Arbitrator, Petitioner stated that he did not know that his case had been dismissed until January of 2020, when he looked up the status of his claim on the Commission website. Petitioner also claimed that when he started to represent himself, he provided his "contact information to the desk out front. So, the Commission has that information." He also alleged general and vague accusations of fraud and criminality by the employer's insurer and examining doctors.

Respondent responded that Petitioner had dismissed two previous law firms before the third withdrew. Petitioner acted as his own attorney *pro se* when he e-mailed opposing counsel and the Arbitrator about the status of his case and asked for a continuance of a May 9, 2016 status call. At that time, the matter was continued and was continued thereafter on numerous other occasions, until it was placed on final status call for August 8, 2017. Petitioner failed to appear, and the claim was dismissed for want of prosecution because the case was now more than three years old. Notice of the dismissal was sent to Petitioner's address on the Application. The address cited by Respondent as its mailing address for Petitioner correctly corresponds with the Commission records, which incidentally appears to be an actual physical address and not a post office box. Commission records do not show any notification of change of address was filed in this matter.

The Rules of the Commission provide that cases on file for more than three years are subject to dismissal for want of prosecution if the Petitioner does not appear at a status hearing. *See*, 50 Ill. Admin. Code, Section 9020.50 (D)(i). Here, the status call date of August 8, 2017 was clearly three years after Petitioner filed his Application for Adjustment of Claim (June 17, 2014) and claim was pending for more than three years. Therefore, upon Petitioner's absence from the status hearing, the Arbitrator's dismissal for want of prosecution was proper.

The Rules of the Commission also provides that upon dismissal of a claim for want of prosecution, a party has 60 days from receipt of the Order of Dismissal to file a written Petition to Reinstate. The Arbitrator is directed to assess the ground upon which the Petitioner relied and Respondent's arguments in opposition and to apply standards of fairness and equity in ruling on the Petition to Reinstate. *See*, 50 Ill. Admin. Code, Section 9020.90 (c). The Appellate Court has interpreted the Commission Rules to require the Petitioner to show due diligence in order for his Petition to Reinstate to be approved. *See, Banks v Industrial Commission*, 345 Ill. App. 3d 1138 (1st Dist. 2004).

The Commission is cognizant that Petitioner is a *pro se* litigant. As such, the Commission should ensure that Petitioner's rights are protected and provide him some leeway for any technical deficiency in pleading, *etc*. Nevertheless, we have determined that a *pro se* litigant does not have the right to flaunt Commission rules or has any less of a burden to present relevant evidence to support his contentions than a claimant who is represented by a lawyer. Here, Petitioner did not file his Petition to Reinstate until more than two and a half years after the case was dismissed; he missed the statutory filing deadline by more than two years. In addition, even though Petitioner was acting *pro se*, he clearly understood the mechanics of how to access the Commission website, how to find the status of his claim, and was actually able to electronically petition to continue the status call on May 9, 2016. Petitioner did not establish due diligence in prosecuting his claim or in submitting his petition to have it reinstated after it was dismissed.

The Commission has determined that it is the responsibility of litigants to inform the Commission of any change of address. See, *Valdez v Kap Roofing*, 15 I.W.C.C. 864. Notably, in *Ocampo v. KMW Gutterman, Inc*., 06 WC 11467, the Commission struck a Petition to Reinstate even though the claimant's lawyer withdrew, the claimant no longer lived at the address on his Application for Adjustment of Claim, the claimant did not receive timely notice of the dismissal, and filed their Petition to Reinstate more than 60 days after the case had been dismissed.

We find that the Arbitrator's denial of Petitioner's Petition to Reinstate was proper and accordingly her order denying reinstatement is affirmed, Petitioner's Petition to Reinstate is denied, and the claim is dismissed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's denial of Petitioner's Petition to Reinstate is affirmed.

IT IS FURTHER ORDERED BY THE COMMISSION, that Petitioner's Petition to Reinstate his claim is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's claim is dismissed for want of prosecution.

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.

June 14, 2021

/s/*Deborah L. Simpson*
Deborah L. Simpson

/s/*Steven J. Mathis*
Steven J. Mathis

DLS/dw
O-5/18/21
46

/s/*Deborah J. Baker*
Deborah J. Baker

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Stanislaw Jagla,

Petitioner,

vs. No. 14 WC 20611

Limousine Lines, Inc.,

Respondent.

ORDER DENYING REINSTATEMENT

This matter comes before the Arbitrator on Petitioner's Petition to Reinstate, filed on February 14, 2020. Arb Exh 2. On March 13, 2020, Respondent filed an objection to reinstatement. RX 1. The Arbitrator conducted a hearing on the petition on March 13, 2020. Petitioner, who is pro se, appeared, as did Respondent's counsel. A record was made. For the reasons set forth below, the Arbitrator finds that Petitioner failed to act with due diligence in monitoring his case and denies reinstatement.

1. Petitioner was originally represented by attorney Tony Kalogerakos. On June 17, 2014, Petitioner filed an Application for Adjustment of Claim alleging a work accident of May 19, 2014 resulting in low back and hip injuries. On the Application, Petitioner's address is listed as 1572 Brittania Way, Roselle, Illinois, 60172. RX 1, Attachment B.

2. On March 27, 2015, attorney Kalogerakos withdrew and attorney Frank Kress entered his appearance on behalf of Petitioner.

3. Attorney Kress presented a motion to withdraw to the Arbitrator on July 30, 2015. Petitioner appeared at said time, as did Respondent's counsel. Petitioner raised no objection to the motion. The Arbitrator granted the motion and recommended that Petitioner obtain representation.

4. In November 2015, the Arbitrator met with Petitioner and Respondent's counsel. Petitioner had not retained new counsel. Petitioner represented that he was injured while operating a vehicle for Respondent. Respondent's counsel acknowledged that an "incident" occurred but took the position that this incident did not amount to a compensable work accident.

5. During the months that followed, Petitioner appeared at the Arbitrator's status call on one or two occasions. On May 5, 2016, Petitioner sent an Email to the Arbitrator and Respondent's counsel indicating he would not be able to attend a status call

scheduled for May 9, 2016 and requesting a continuance. In the Email, Petitioner stated he remained under treatment and was having difficulty traveling due to his injuries. The Arbitrator responded, indicating she would return the case to the trial call, barring any objection from Respondent. RX 1, Attachment B. Respondent did not object.

6. As of August 8, 2017, Petitioner's case was sufficiently old to be categorized as a "red line" matter, meaning he was required to personally appear at the Arbitrator's 2 PM status call. Petitioner failed to appear on said date and did not otherwise communicate any request for a continuance. The Arbitrator entered a dismissal for want of prosecution. On August 10, 2017, the Commission issued a notice of the dismissal to Petitioner, using the address listed on the Application, and Respondent's counsel. RX 1, Attachment C.

7. It was not until February 14, 2020, approximately 2 ½ years after the dismissal, that Petitioner attempted to address the dismissal. On that date, Petitioner filed an Appearance (Arb Exh 1), listing a new address in Bloomingdale, Illinois, and a Petition to Reinstate and Set Trial Date (Arb Exh 2). In the petition, Petitioner alleged his contact information "was removed from Worker Comp Commission" and he never received the dismissal order. In support of his allegation that the Commission "removed" his contact information from the main frame, Petitioner attached a screen shot of the case docket view. This view correctly reflects "N.A." for Petitioner's counsel, since Petitioner did not retain new counsel after attorney Kress withdrew.

8. At the hearing, Petitioner alleged that, prior to February 14, 2020, he provided an updated address to the Commission's information department and that the Commission failed to send the dismissal notice to that address. Petitioner also alleged that it was not until January 2020, when he checked the status of his case on his home computer, that he learned of the August 10, 2017 dismissal. Petitioner also made various allegations concerning Respondent's selected Section 12 examiner and Respondent's overall conduct.

9. At the hearing, Respondent's counsel argued that Petitioner failed to act with due diligence and that reinstatement would be unfair to Respondent, given the age of the claim and the passage of significant time following the dismissal.

10. On the day of the hearing, the Arbitrator did not have access to the Commission's file. The Arbitrator subsequently obtained the file from the warehouse and examined its contents. The Arbitrator has also reviewed the information available on the Commission's main frame. The Arbitrator has been unable to find any document or notation that would support Petitioner's allegation that he provided the information department with an updated address prior to the issuance of the dismissal notice.

11. When a cause has been dismissed for want of prosecution, a party may petition to reinstate it within sixty days of receiving the dismissal order. The Arbitrator shall apply standards of fairness and equity in ruling on the petition and shall consider the grounds relied on by the claimant, any objections and the precedents set forth in Commission decisions. 50 Ill. Adm. Code 9020.90. The burden is on the claimant to allege and prove facts justifying the relief sought. Bromberg v. Industrial Commission, 97 Ill.2d 395, 401 (1983).

12. Respondent's objections to reinstatement are well-founded. This claim is fully disputed. The statute of limitations expired prior to the dismissal. The record demonstrates that, when Petitioner began representing himself, he knew how to meet, and in fact met, his obligations as a pro se litigant. Between July 2015, when attorney Kress withdrew, and the August 8, 2017 dismissal, Petitioner monitored his claim and appeared before the Arbitrator to obtain continuances. After the dismissal, however, Petitioner took no action until January 2020, despite the claim's "red line" status. At the hearing, Petitioner conceded he learned of the dismissal by taking one simple step, i.e., checking the Commission's website on his home computer. This concession undermines his argument that the Commission failed to meet his obligations to him, in terms of updating his address. A party must exercise due diligence in pursuing his claim before the Commission. See Contreras v. Industrial Commission, 306 Ill.App.3d 1071, 1076 (1st Dist. 1999) and Banks v. Industrial Commission, 345 Ill.App.3d 1138 (2004). Even if the Commission sent the dismissal order to an outdated address, as Petitioner claims, Petitioner still had a lengthy period within which to take the steps he regularly took prior to the dismissal, i.e., monitor his claim and communicate with the Arbitrator.

Wherefore, the Arbitrator denies Petitioner's Petition to Reinstate and Set Case for Trial.

This order is final and appealable.

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.

Molly C Mason

Arbitrator Molly C. Mason

April 13, 2020

APR 14 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	12WC012643
Case Name	SPAGNOLA, CURTIS v. INNOPHOS
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0290
Number of Pages of Decision	26
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Jennifer Kelly
Respondent Attorney	Kisa Sthankiya

DATE FILED: 6/14/2021

/s/Deborah Simpson, Commissioner

Signature

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

Curtis Spagnola,
Petitioner,

vs. NO: 12 WC 12643

Innophos,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary disability, permanent disability, medical and 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 14, 2020, 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.

June 14, 2021

o5/18/21
DLS/rm
046

/s/*Deborah L. Simpson*
Deborah L. Simpson

/s/*Stephen J. Mathis*
Stephen J. Mathis

/s/*Thomas J. Tyrrell*
Thomas J. Tyrrell

NOTICE OF ARBITRATOR DECISION

SPAGNOLA, CURTIS Case# **12WC012643**

Employee/Petitioner

INNOPHOS

Employer/Respondent

On 5/14/2020, 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 0.15% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0009 ANESI OZMON RODIN NOVAK KOHEN
JENNIFER J C KELLY
161 N CLARK ST SUITE 2100
CHICAGO, IL 60601

0507 RUSIN & MACIOROWSKI LTD
KISA P STHANKIYA
10 S RIVERSIDE PLZ SUITE 1925
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

Curtis Spagnola,
Employee/Petitioner

v.

Innophos,
Employer/Respondent

Case # **12** WC **12643**

Consolidated cases: **NA**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah J. Baker**, Arbitrator of the Commission, in the city of **Chicago**, on **March 11, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **October 7, 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 $**52,000.00**; the average weekly wage was $**1,000.00**.

On the date of accident, Petitioner was **58** 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 $**10,398.49** for other benefits, for a total credit of $**10,398.49**.

Respondent is entitled to a credit of $**44,783.79** under Section 8(j) of the Act.

ORDER

Petitioner sustained repetitive trauma injuries to his lower back, right shoulder, and left shoulder, which manifested on October 7, 2011. Petitioner also sustained a specific accident to the lower back on October 7, 2011.

Respondent shall pay Petitioner temporary total disability benefits of $666.67/week for 116-4/7 weeks, commencing October 7, 2011 through December 30, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $56,373.39 ($323.59 unpaid) as provided in Sections 8(a) and 8.2 of the Act and as set forth below.

The Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 30% loss of use of person-as-a-whole pursuant to §8(d)(2) of the Act.

Respondent shall pay Petitioner the compensation benefits that have accrued from October 7, 2011 through March 11, 2020 in a lump sum, 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

May 13, 2020
Date

MAY 14 2020

Spagnola v. Innophos
12 WC 12643

FINDINGS OF FACT

Testimony of Curtis Spagnola

Curtis Spagnola ("Petitioner"), was employed with Innophos ("Respondent"), as an SAPP ("sodium acid pyrophosphate") Process Operator. Petitioner testified that he had been working for the Respondent since September 1979 and worked specifically as a SAPP Process Operator for twenty-five years. (Trl. 7-8.) As an SAPP Processor, Petitioner worked seven days straight and then had days off. (Trl. 8.) His regular shifts alternated between 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7:00 a.m. (Trl. 8-9.) His normal shift length was eight hours, but he sometimes worked twelve-hour shifts, especially when other employees were on vacation, usually in the summertime. (Trl. 9-10.)

Petitioner testified that Respondent's SAPP department was responsible for producing food chemicals. (Trl. 11.) Petitioner's job duties included taking samples once per hour, making rounds to check the equipment once per hour, cleaning the ductwork, housekeeping, "making charges," and lab work. (Trl. 12-13, 17, 21.)

Petitioner testified that cleaning the "ductwork" required him to "beat" or hit a metal duct, which is similar to a pipe, with a ten-pound sledgehammer. (Trl. 12-13.) Petitioner testified that he had to clear the ducts two times per shift, and each time he cleared the ducts, he would hit the duct with the sledgehammer approximately twenty to twenty-five times and the process would take about thirty minutes. If he was working a twelve-hour shift, he would clean the duct work three or four times depending on "how bad it is." (Trl. 14-16.) On cross examination, Petitioner testified that the amount of time he had to "beat the ductwork" varied day-to-day, and depended on how often the additive got stuck in the ducts, meaning there could be some shifts where he had to do this three times and other shifts where he did not have to do it at all. (Trl. 52-54.) However, on average, cleaning the ductwork occurred two times per shift. (Trl. 54.) On redirect examination, Petitioner testified that the additive got stuck in the ducts during most shifts. (Trl. 86.) Petitioner testified that when the additive got stuck, there would be a certain smell and then he would check the duct to see if it was clogged. (Trl. 86.) Petitioner testified that cleaning the ductwork required swinging a sledgehammer overhead like a baseball bat, always over his right shoulder. (Trl. 88-90.) Petitioner testified that in the twenty-five years that he worked for Respondent, Petitioner's job duties always included clearing the ducts. (Trl. 21.)

Petitioner testified that the job duty of "housekeeping" consisted mainly of "picking up . . . piles of product off the floor" with a "cliff-digger" type of shovel. (Trl. 16-17.) Petitioner testified that the type of material he cleaned up from the floor was over-spilled product. Petitioner would shovel the product that spilled out of the tote bins from the floor and put it in a box. (Trl. 90-91.) Petitioner performed this housekeeping approximately once per shift. (Trl. 17.) The product weighed approximately twenty-five pounds. (Trl. 100.) In the twenty-five years that he worked for Respondent, Petitioner had to shovel product off the ground once in a while. (Trl. 23.) On cross examination, Petitioner testified that there was "a lot of leaking" of product at one point in time. (Trl. 56.) Petitioner testified that the housekeeping activities varied day-to-day. (Trl. 52.)

Petitioner testified that he also performed the job duty of "making a charge," which consisted of: (1) transporting fifty-pound bags of additive (ingredients) with a forklift to a tank; (2) using the forklift to lift the fifty-pound bag up to the level of the tank; (3) opening the bag with a utility knife; (4) lifting the bag off a pallet with both arms; (5) and pouring the bag into a tank. (Trl. 17-19, 57-58, 61, 80-83.) This was generally performed once per shift. (Trl.18-19.) Sometimes, Petitioner would lift the bag of additive above waist level. (Trl. 58-59.) Petitioner testified that he did not have to lift bags of additive above shoulder height. (Trl. 59.) On cross, examination, Petitioner testified that there were shifts when he did not have to add additive to a tank. (Trl. 61.) In the twenty-five years that he worked for Respondent, Petitioner's job duties always included carrying 50-pound bags. (Trl. 22.)

Petitioner testified further that he performed lab work during his shift, which included "run[ning] a pH" on material samples from tote bins. Each sample was approximately 200 milligrams and he took the samples once per hour. (Trl. 21.) The process of taking the sample, testing it, and documenting the findings took approximately ten minutes. (Trl. 49-50.)

Petitioner also testified that at the beginning of his shift, he would communicate with coworkers who had worked the previous shift and he would walk the floor to check the machines, which took about five to ten minutes. (Trl. 48.) Petitioner testified that he was responsible for administrative work that was performed in the control room, which included sitting and monitoring the computers. However, the time he spent in the control room would vary from day-to-day, and from shift-to-shift. (Trl. 51-52.)

Petitioner testified further that in the twenty-five years that he worked for Respondent as an SAPP Operator, as he performed his work activities, he noticed that he "was hurting." (Trl. 23.) Petitioner testified that he noticed both of his shoulders hurt and his lower back hurt. (Trl. 23.) Petitioner testified that he continued to work even though he felt pain in his shoulders and back because he did not want to lose any money. (Trl. 24.) Petitioner testified that as of October 7, 2011, his lower back pain got sharper and he was no longer able to work. (Trl. 24-25.) Petitioner testified that as of October 7, 2011, he could no longer pick up "very heavy stuff." (Trl. 25.) On cross examination, Petitioner testified that in addition to developing low back pain over time, on October 7, 2011, he injured his low back when he lifted an approximately 100-pound drum of sodium chlorate. (Trl. 44-45.) Petitioner clarified later that he injured his low back on October 7, 2011, when he lifted a bag of additive while adding it to a tank. (Trl. 58-59.) Petitioner stated that after he injured his low back, he stopped working because he could not move, and he went to the control room to sit down. (Trl. 59.) Petitioner testified further that he began to develop pain in both shoulders approximately three or four months before October 7, 2011. (Trl. 46.) Petitioner testified that he took aspirin for the pain before seeking medical treatment. (Trl. 46.)

Petitioner testified that he informed his supervisor, Mr. Barkhurst, about the pain he was experiencing in his low back. (Trl. 25.) Petitioner testified that he stopped working on October 7, 2011, and never returned to work for Respondent or any other employer after this date. (Trl. 26-28.) Petitioner testified that he spoke to Mr. Barkhurst about his pain on October 7, 2011. (Trl. 25, 36-37.) However, on cross examination and redirect examination, Petitioner testified that he could not remember the exact date that he spoke to Mr. Barkhurst, however, he called Mr.

Barkhurst the "next day," which he believed was October 8, 2011, to inform him of his pain and his plan to seek medical treatment. (Trl. 37-39, 94.) Petitioner could not recall if he told his employer that he intended to seek medical treatment at the time that he informed his employer about the pain he was experiencing. (Trl. 27.) Petitioner testified that he worked on October 7, 2011. (Trl. 37.) Petitioner testified that he never completed a written accident report with Respondent. (Trl. 42.)

Petitioner testified that prior to 2011, he had not injured his right shoulder or received medical treatment for his right shoulder. (Trl. 33-34.) Petitioner testified that prior to 2011, he had not injured his left shoulder or received medical treatment for his left shoulder. (Trl. 33-34.) Petitioner testified that prior to 2011, he had not injured his low back or received medical treatment for his low back. (Trl. 33-34.) Petitioner testified that prior to October 7, 2011, he was able to perform his full duty work activities as an SAPP Operator. (Trl. 34.) Petitioner testified that between October 7, 2011 and the date of the arbitration hearing, he had not sustained any new accidents involving his shoulders or his low back. (Trl. 34.)

Petitioner testified that currently, it is difficult for him to lift heavy objects and he often drops things from his hands. (Trl. 35.) Petitioner also testified that it is difficult for him to sit for long periods of time and he needs to stand up because his back starts to hurt. Petitioner testified that he is not currently treating with a doctor for his bilateral shoulder or low back. (Trl. 35.)

On cross examination, Petitioner testified that when he spoke to Mr. Barkhurst to report a work-related injury the day after his doctor's appointment, which he believed to be on October 8, 2011, he told Mr. Barkhurst that he had to see his doctor for his shoulders and it was work-related. (Trl. 36-41.) Petitioner testified that he applied for short term disability benefits on or around October 18, 2011, and subsequently, he applied for long term disability benefits. (Trl. 42-43.) Petitioner testified that on April 10, 2012, he filed an Application for Benefits in his workers' compensation claim. (Trl. 43-44.)

Petitioner testified further that he applied for Social Security disability ("SSD") benefits and on his application, he reported that he had osteoarthritis for four to five years prior to October 2011. (Trl. 64-65.) Petitioner testified that four to five years before October 2011, his low back and both shoulders first began hurting; however, he did not seek medical treatment. (Trl. 65-66.) Petitioner testified that he reported a work-related injury to the physician who conducted his SSD application physical exam. (Trl. 66.) Petitioner acknowledged that the SSD application physical examination report did not state that he had a work injury and he may not have reported that his conditions were work related. (Trl. 67, 68.)

Petitioner testified that he was eventually terminated from Respondent's employment. (Trl. 71.) Petitioner testified that his neck, left elbow, and right elbow conditions are not part of workers' compensation claim. (Trl. 72-73.) Petitioner testified that he has not conducted any job searches since October 2011. (Trl. 73.) Petitioner testified that between 2015 and 2017, he did not present light-duty restrictions to Respondent. (Trl. 74.) Petitioner testified that he did not search for work within his light duty restrictions because he was receiving SSD. (Trl. 74-

75.) Petitioner testified that after he stopped working for Respondent in October 2011, his symptoms increased. (Trl. 75.)

On redirect examination, Petitioner testified it was his understanding that he received SSD benefits for his bilateral shoulder and low back conditions, in addition to his left elbow and neck conditions. (Trl. 76.) Petitioner testified that it is difficult for him to remember specific dates and exactly what he has told doctors at times because he is autistic, which effects his ability to recall information. (Trl. 77-78.) On further redirect examination, Petitioner testified that Dr. Baig was his primary care physician and he would present to Dr. Baig for mandatory annual physical examinations that Respondent required. (Trl. 104-105.)

Testimony of James Barkhurst

James Barkhurst ("Barkhurst") testified on behalf of Respondent. (Trl. 106.) Barkhurst testified that he was employed by Respondent as a Production Supervisor and he had held that position for 20 years. (Trl. 106.) He supervised thirty-eight employees in about seven processes, including SAPP. (Trl. 107.) He supervised Petitioner in October of 2011. (Trl. 107.) He was familiar with Petitioner and the job duties in the SAPP department. (Trl. 108.) Barkhurst testified that he had not been coerced or paid to testify and he had no interest in the outcome of the hearing. (Trl. 108.) He testified that he had a good relationship with Petitioner during the time that Petitioner worked for Respondent. (Trl. 108.)

Barkhurst testified that Petitioner's job title was SAPP Operator. (Trl. 109.) There were three other people that worked in the SAPP department and two relief Operators. (Trl. 109.) The relief Operators are trained to work in multiple departments in Respondent's plant to fill in when someone goes on vacation. (Trl. 109.) The SAPP department runs 24 hours per day and 365 days a year. (Trl. 109.) In the SAPP department, there is just one person working per shift so that there is coverage 24 hours per day and seven days per week. (Trl. 110.) The shifts are 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7:00 a.m. (Trl. 110.) Everyone's day varies and there are always three Operators working and one Operator who is off work. (Trl. 110.) An employee in the SAPP department works seven days in a row, not in the same week, and then is off work for one to four days before working a different shift seven days in a row. (Trl. 111-112.) Employees work the exact same job duties on every shift. (Trl. 112.) The amount of time that each employee spends on their job duties is exactly the same on all shifts. (Trl. 112.)

Barkhurst testified that Petitioner never reported that he had a lifting injury to his low back on or around October 7, 2011. (Trl. 112.) Additionally, Petitioner never reported that he had a lifting injury to his low back prior to October 7, 2011. (Trl. 112.) Petitioner never reported that he injured both shoulders due to the repetitive nature of his work either prior to or around October 7, 2011. (Trl. 119-120.) Barkhurst testified that he believed that Petitioner reported a lifting injury to "HR" after October 7, 2011, and "HR" notified Barkhurst of Petitioner's injury. (Trl. 113.) Barkhurst testified that at some point after October 7, 2011, around October 9, 2011, Petitioner "call[ed] off" and called him to state that he would not be able to work. (Trl. 113.) Barkhurst could not remember what was said during the conversation on or around October 9, 2011. (Trl. 113.) Barkhurst testified that he thought Petitioner "called-

off" because he was sick. When asked if Petitioner reported a work-related injury at that time, Barkhurst said "No." (Trl. 113-114.)

Barkhurst testified there was a work injury reporting procedure where, if an employee reported a work injury, Barkhurst was required to fill out an incident report. (Trl. 114.) Additionally, Barkhurst would personally write an email to "HR," the plant manager, and his boss stating that an employee got hurt on the job. (Trl. 114.) Petitioner was aware of the reporting procedures. (Trl. 114.) An incident report was never generated in this case. (Trl. 114.) There was never any type of documentation that Petitioner was reporting a low back or bilateral shoulder injury on or around October 7, 2011. (Trl. 115.) Barkhurst testified that when Petitioner was off work, it was his understanding that Petitioner was off work because "he had gotten hurt at the plant." (Trl. 115.) Barkhurst learned about this the following Monday but he did not complete an incident report at that time because "We would not fill an incident report out if it did not happen at the plant." (Trl. 115.) Barkhurst testified that in October 2011, he knew Petitioner claimed to have sustained an injury at work, however, he disputed that it happened at work. (Trl. 115-116.) Barkhurst disputed it because Petitioner never reported the injury to him. (Trl. 116.)

Barkhurst testified that based on the work schedules in Respondent's Exhibit One, Petitioner did not work on October 7, 2011. (Trl. 116.) In reviewing the schedule for October 8, 2011, Barkhurst testified that "D" meant Petitioner was scheduled to work from 7:00 a.m. to 7:00 p.m. Barkhurst could not recall if Petitioner worked that shift on October 8, 2011. Petitioner would only work on a scheduled day off if he was called-in to work. Barkhurst could not recall if he called Petitioner to work on October 7, 2011, however, he testified that he would not have called him in. (Trl. 119.) Barkhurst testified that "Med" meant that Petitioner started to receive short term disability payments as of that day. (Trl. 119.)

Barkhurst testified that the SAPP job description (RX2) is a true and accurate copy of the job description for a SAPP Operator and he believed that the job description was still the same. (Trl. 120.) Barkhurst testified that the job description accurately outlined Petitioner's job duties. (Trl. 120.) Reviewing the document, specifically looking at paragraph one of the Job Functions on page three of RX2, he noted that it took about ten minutes for an Operator to walk through the entire department and discuss with the previous shift Operator any problems that may have occurred. (RX2, Trl. 121.) Petitioner would then walk the floor which took approximately twenty minutes, depending on what he was looking at as there were four floors of the SAPP process. (Trl. 121-122.) Additionally, Barkhurst testified that an Operator would then take a sample, approximately 200 milligrams, and test it once per hour. (Trl. 122.) It would take approximately ten minutes to get the sample and approximately ten minutes to test the sample, and another five minutes to log the results. (Trl. 123.)

With respect to paragraph three on page three of RX2, Barkhurst testified further that to "make a charge" was to add the additive to the tank. (Trl. 123.) There were two tanks in the facility: one was a "charge" tank, and one was a "feed" tank. (Trl. 123.) Respondent makes four different baking products: (1) the first product requires no additives; (2) the second product requires "minimal additives," maybe four bags of additive; (3) the third product requires more additive than the second product; and (4) the fourth product requires approximately eight bags of

additive. (Tr1. 123-124.) There is a possibility that a SAPP Operator will not have to add additive to a tank at all during his shift (this happens approximately three days per month) because the "charges" last fourteen hours and there is only one "charge" tank. (Tr1. 124, 126.) The second tank, the "feed" tank, only requires an Operator to scoop in sodium chlorate. (Tr1. 124.) Generally, an Operator will only have to add additive to the "charge" tank one time in a shift, however, approximately once every twelve days, an Operator may have to add additive to the "charge" tank two times in a shift. (Tr1. 125.)

Barkhurst testified that with respect to how the additive is added to the charge tank, the bags of additive are stacked on a pallet and the Operator drives the forklift to the "charge" tank. (Tr1. 126.) While there is a mechanism for a forklift to lift the bags of additive up while the Operator is working on the pallet, it was "against the rules" to use the forklift to do this. (Tr1. 127.) The additive remains on the pallet. (Tr1. 127.) The top of the tank is about two and a half feet high. (Tr1. 127.) The pallets, when fully stacked with fifty-pound bags of additive, are about four feet high, and as bags of additive are removed from the pallet, the height of the pallet goes down to about twelve inches in height. (Tr1. 127-128.) He testified the work of adding additive to the charge tank is below waist level. (Tr1. 128.) When asked how the additive is added to the tank, Barkhurst testified:

> What they would do is they would walk to the pallet, which is generally three feet away from the tank, pick up the bag, turn around and walk it to the tank, lay it on the tank, and then open it with a knife and then pick the bag up and shake the material out of it.

He testified that the Operator would take the bag of additive, rest it on the tank, and let gravity pull the material into the tank. (RX2, Tr1. 129.) Operators did not have to hold the bag of additive while the material poured into the tank. (Tr1. 129- 130.) The additive is added to the tank incrementally and the more additive required, the longer it would take to add the additive. (Tr1. 130.) Operators add the additive in two-to-three-hour increments while the additive mixes into the product. The additive is not added all at once. (Tr1. 130.) For example, an Operator will add half a bag of additive into the tank, allow it to mix in, and then about two to three hours later, add the rest of the additive to the tank. (Tr1. 130.) The job is self-paced but the Operator does have to work within the timing of the machines throughout the day. (Tr1. 130-131.) In regard to a chart on page five of RX2, Barkhurst agreed that Operators, and specifically Petitioner, are required to lift a fifty-pound bag of additive one to ten times maximum per day. (Tr1. 141-142.) Barkhurst testified that if the Operator was making a "charge" to a product using the greatest amount of additive, an Operator would be required to lift the additive eight times per day. (Tr1. 142.) Barkhurst also testified that an Operator would be required to carry a fifty-pound bag of additive by hand, one to ten times per day, approximately three to five feet, depending on where the Operator placed the additive pallet. (Tr1. 144.) Carrying the bags of additive would take approximately twenty minutes maximum (twenty minutes for eight bags, approximately ten minutes for four bags, and zero minutes for zero bags). (Tr1. 145.)

Barkhurst also testified, with respect to paragraph four on page four of RX2, that Operators are responsible for moving tote bins with a forklift and transporting them to the staging area approximately seven to eight times per shift. It takes approximately ten minutes per

bin to complete this activity. (RX2; Tr1. 131.) No hand lifting is required for this activity. (Tr1. 131.)

Barkhurst testified further that with respect to paragraph five on page four of RX2, Operators use a "standard issued sledgehammer in the plant" that is three-to-five-pounds. (Tr1. 132.) The number of times that an Operator was required to use the sledgehammer to unclog the chute (the "duct') depended on how the process was running, but generally, it was a couple of times per shift. (Tr1. 133.) There were some shifts when Operators would not have to use the sledgehammer. (Tr1. 133.) The chutes ran throughout the entire area, starting on the first floor and running up to the fourth floor. Thus, the chutes would sometimes be at ankle height, and other times they would be overhead. (Tr1. 133-134.) Depending on where the chute was clogged, an Operator would be required to work above, below, or at waist level. (Tr1. 134-135.) The chutes were like pipes that ran both horizontally and vertically. (Tr1. 134.) Unclogging a chute usually took about fifteen to twenty minutes. (Tr1. 136.) The number of times that a chute became clogged depended on the product that was being made. (Tr1. 136-137.) Looking at a chart at the top of page five of RX2, Barkhurst testified that at times, an Operator would have to lift a sledgehammer to unclog the chutes more than eleven times per day and it varied by shift. (Tr1. 143.) It was possible that an Operator could work a couple of shifts without doing overhead work to unclog the chutes. (Tr1. 143.) Barkhurst testified that the amount of time Operators spend carrying the three-to-five-pound sledgehammer varied day-to-day and depended on the "pluggage." (Tr1. 146.)

Barkhurst testified further that with respect to paragraph six on page four of RX2, Operators are required to clean the blades with a three-to-five-pound sledgehammer approximately once per shift. (Tr1. 137-138.) Cleaning the blades could take up to thirty minutes. (Tr1. 138.) This work is performed at and below waist level. (Tr1. 138.)

Barkhurst testified further that with respect to paragraph seven on page four of RX2, shoveling and using a hot water spray is what you would do to clean up "over-spillage" (product "failures" or "leaks"). (Tr1. 139.) Barkhurst testified that all Operators perform housekeeping daily, however, shoveling is usually only required a couple of times per week. (Tr1. 139.) The weight of over-spillage depended on the severity of the "failure," however, it could weigh anywhere between fifty pounds and 1,000 pounds. (Tr1. 140.) Approximately once per month, a failure occurs that weighs 1,000 pounds. (Tr1. 140.) There are some shifts where there is no over-spillage to clean up. (Tr1. 140.) Barkhurst testified that on the upper-floors, Operators could push the over-spilled product into holes in the floor instead of shoveling the product but it depended on the type and location of the spill. (Tr1. 151.)

Barkhurst testified further that Operators are also required to sit at a desk in the control room and monitor the computers and charge tanks. Approximately half of an Operator's shift, (three to four non-consecutive hours) is spent sitting at a desk and monitoring the computers and charge tanks. (Tr1. 141.)

Barkhurst testified that Operators worked twelve-hour shifts throughout the year, not just in the summer months. When Petitioner worked, Operators would work twelve-hour shifts a total of two months per year approximately. (Tr1. 146.) Petitioner was guaranteed two, ten to

thirty-minute breaks, but depending on how the department was running, an Operator could take either fewer or more breaks. (Tr1. 147.) Barkhurst testified he had observed Petitioner prior to October 2011 and Petitioner was able to do his full job duties. (Tr1. 149.) He did not notice whether Petitioner had any limitations with his low back and bilateral shoulders. (Tr1. 149.)

On cross-examination, Mr. Barkhurst clarified that he was Petitioner's supervisor from 1999 to 2011. (Tr2. 5.) Barkhurst testified that he works from 5:30 a.m. to 3:00 p.m. (Tr2. 6.) Barkhurst walks the plant floor and visits various areas of the job site when he works and there are approximately fourteen or fifteen employees working during the hours that he works. (Tr2. 7.) He is not present for the duration of every employee's shift but he works the hours that he does so that he can at least meet with each shift. (Tr2. 6-9.) His office is directly in the center of the plant. (Tr2. 7.) He averages about three hours of work which he is required to complete in his office. (Tr2. 8.)

Barkhurst testified that Petitioner regularly and adequately performed his work duties. (Tr2. 10.) He testified that it was possible, in the beginning years, that Petitioner used a 10-pound sledgehammer to clean the ducts. (Tr2. 11-12.) Barkhurst could not remember when the Operators switched from a ten-pound sledgehammer to a three-to-five-pound sledgehammer. (Tr2. 12-13.) Petitioner would have to swing the sledgehammer overhead to clear the ducts only if he did not use the stepladder he was given. (Tr2. 13.) He did not regularly see operators swinging a sledgehammer to clear the ducts. (Tr2. 14.)

With respect to over-spillage ("leaks" or "failures") where product ended up on the ground, this would occur regularly throughout the day. (Tr2. 15.) The larger failures would require voluntary overtime to clean up and the smaller failures could be done in a regular shift. (Tr2. 15-17.) Approximately twenty-five pounds of product was one or two shovels. (Tr2. 18.) The larger failures could occur every week or every month and it was hard to say. (Tr2. 18.) The smaller failures occurred at least two times per week. (Tr2. 18) There could be weeks where a failure occurred every day. (Tr2. 18-19.)

On redirect examination, Mr. Barkhurst testified that Respondent switched from a ten-pound sledgehammer to a three-pound sledgehammer sometime before 2007. (Tr2. 34.)

Exhibits

Petitioner's personnel record indicates that Petitioner began working for Respondent in 1979. Personnel records also show that Petitioner was off work on October 7, 2011. Petitioner was scheduled to work on October 8, 2011, from 7:00 a.m. to 7:00 p.m., however, Petitioner was categorized as "STD" that day, which stands for short term disability. Petitioner's short term disability application, which is dated October 18, 2011, shows that Petitioner reported back pain that "went to [his] legs," which he first noticed on October 11, 2011. However, the same application also states that Petitioner first treated with a physician for the injury on October 7, 2011 and the last day he worked was October 6, 2011. Petitioner indicated that the injury occurred at work and was work-related. Petitioner's FMLA paperwork is dated October 18, 2011, and was completed by Petitioner's primary care physician, Dr. Mirza Kalid Baig with WellGroup Health Partners. The FMLA paperwork indicates that Petitioner's condition

commenced on October 7, 2011. The Short Term Disability Attending Physician's Statement, which was completed by Dr. Baig on October 18, 2011, indicates that October 7, 2011 is either the date when Petitioner's symptoms first appeared or the date of accident, and Petitioner was first unable to work as of this date. (Resp.'s Ex. 1 – 1-12.)

A job description for the position of "SAPP 'A' Operator," which was updated in June 2006, states that an Operator in "Area 1" works rotating shifts and is responsible for the overall operation of the SAPP area. An Operator's job duties include operation of various equipment, statistical process control, and in-process testing. An Operator is also responsible for safety, housekeeping, record keeping, sampling and analysis of product stream, making acid charges and making salt solution. The job description indicates that the activities of climbing, standing, bending, and operating mobile equipment (lift truck) were required frequently, with frequently being defined as 60 – 70 percent of the time. Lifting (fifty pounds), squatting, and sitting were required seldomly, with seldom being defined as 30 to 60 percent of the time. (Resp.'s Ex. 2.)

A job analysis report for the position of "SAPP 'A' Operator," which is dated August 10, 2007, states that it is a seven-day-per-week operation and there are three shifts. An operator works forty hours per week and overtime as needed. Under the heading "Job Description," it states: "Monitors the equipment used in the production of SAPP product that is within the specifications to ensure consistent quality. The company produces four different products, each requiring the Operator keep the product within the specified parameters [sic]." (Resp.'s Ex. 2.)

The essential job functions for a SAPP Operator consisted of: (1) walking through the entire department checking the chutes; (2) taking samples from the "blender" and the "tote" to test in the lab; (3) entering test results in a computer and on a log; (4) "mak[ing] a charge" to the tank by adding the necessary amount of acid and additives (fifty pound bags of additives are lifted from a pallet, cut open, and the specified amount is added to a tank); (5) pulling out a full "tote bin" using a forklift and transporting it to a staging area (approximately five to nine totes per shift depending on the product); (6) using a three-to-five-pound hammer to "pound on the chute," if it becomes clogged which can be overhead (Operators previously used a ten-pound sledge hammer and the amount of times this occurs depends on the product); (7) cleaning the blades on the "blender" by using a hammer to reach down in the blender to "pound the blades;" and (8) performing housekeeping which can entail shoveling, mopping, and using a hot water spray hose. (Resp.'s Ex. 2.)

Additionally, the job analysis report indicates that occasional lifting of fifty pounds is required one to ten times per day from floor to waist level with respect to lifting a full bag of additive. Frequent lifting of ten to eighteen pounds is required eleven or more times per day from floor to overhead level, with respect to lifting a sledgehammer and a five-gallon bucket. Occasional carrying of fifty pounds is required one to ten times per day with respect to carrying a full bag of additive. Frequent carrying of ten to eighteen pounds is required eleven or more times per day with respect to a sledgehammer and a five-gallon bucket. The job analysis report also indicates that an Operator may "occasionally need to reach up to pull rod to lift up the fill spout [sic]." (Resp.'s Ex. 2.)

On April 14, 2011, Petitioner sought treatment from his primary care physician, Dr. Mirza Kalid Baig with WellGroup Health Partners. A handwritten progress note states "Physical" and indicates that Petitioner complained of bilateral shoulder pain for six months. (Resp.'s Ex. 10 p. 8.)

A handwritten progress note which appears to be dated October 7, 2011, indicates that Petitioner treated at WellGroup Health Partners and complained of left leg pain and numbness for the past two days. The note appears to say "Pt lifted weight. & feels Lt side back pain & pain radiates to Lt lower ext." Petitioner also reported having mild soreness in the back. Under "Provisional Diagnosis," the note states: "R/o nerve pinching myalgia." Petitioner was prescribed Motrin and instructed to follow up with his PCP if no improvement in two days. (Pet.'s Ex. 4.)

On October 12, 2011, Petitioner sought treatment from Dr. Baig. Petitioner complained of lower back pain that radiated down the left leg with numbness. Petitioner reported that the pain had started without injury. Petitioner also complained of cervical pain and numbness in the right upper extremity. Dr. Baig diagnosed Petitioner with cervical pain and numbness in the right upper extremity and low back pain. Dr. Baig recommended that Petitioner undergo X-rays of the lumbar and cervical spine. (Pet.'s Ex. 4.)

On October 18, 2011, Petitioner followed-up with Dr. Baig. Petitioner complained of worsening neck and lower back pain that he had experienced on and off for a prolonged period of time. Dr. Baig noted that the cervical and lumbar spine X-rays showed degenerative changes and noted that he completed "disability papers." Dr. Baig recommended that Petitioner undergo physical therapy and referred Petitioner to the orthopedics department for evaluation. (Pet.'s Ex. 4.)

On November 8, 2011, Petitioner sought treatment from Dr. William Payne with Specialty Physicians of Illinois (WellGroup Health Partners). A handwritten note with the same date indicates that Petitioner worked as an "Operator" and was right hand dominant. Petitioner complained of bilateral shoulder pain, left leg pain, and numbness and tingling in the right small finger for the past year. Petitioner reported that his pain traveled down the right arm sometimes and he heard "cracking sounds" from his right shoulder. Petitioner also reported that he experienced pain in the left leg with walking and he stated that sitting was his best position. A form that appears to have been completed by Petitioner with the same date indicates that he reported having pain in both arms and shoulders for the past two months. Dr. Payne assessed that Petitioner had low back pain, carpal tunnel, and right shoulder pain. Dr. Payne recommended that Petitioner undergo MRIs of the lumbar spine and left shoulder [sic], physical therapy for the back and shoulder, and occupational therapy for the wrist. Dr. Payne prescribed vitamin B6, a wrist brace, and an EMG. (Pet.'s Ex. 1.)

On November 14, 2011, Petitioner underwent an MRI of the right shoulder. The right shoulder MRI showed a full thickness tear of the supraspinatus tendon. The MRI also showed thickening and heterogeneity of the subscapularis and infraspinatus tendons, suggestive of tendinosis; and mild degenerative changes. The same day, Petitioner underwent an MRI of the lumbar spine. The lumbar spine MRI showed degenerative changes, most notably at the L4-L5

level; and at the L5-S1 level, a mild, diffuse disc bulge with a focus of increased T2 signal, suggestive of an annular tear. (Pet.'s Ex. 1, 2, 4.)

On December 13, 2011, Petitioner followed-up with Dr. Payne and reported continued lower back pain that radiated down the left leg in addition to numbness in the right back. Petitioner also reported continued pain in the right shoulder. Dr. Payne recommended that Petitioner undergo a right rotator cuff repair and an epidural steroid injection ("ESI") for the lower back. Dr. Payne also recommended that Petitioner continue physical therapy. (Pet.'s Ex. 1.)

On December 16, 2011, at Dr. Payne's recommendation, Petitioner was evaluated by a nurse practitioner in Dr. Albert DeRubertis' office who was another physician with Specialty Physicians of Illinois. The note indicates that Dr. Payne was "CC'd" on the note. Petitioner reported that he had low back pain and discomfort in the left side for approximately two months. Petitioner stated that his back pain started when he lifted a fifty-pound box. Petitioner stated that he took Meloxicam daily. The nurse practitioner concurred with Dr. Payne's recommendation for an ESI and identified the appropriate level for the ESI as L4-L5. Petitioner did not undergo the ESI that day as his blood pressure was elevated. (Pet.'s Ex. 1 & 2.)

On January 13, 2012, Petitioner underwent a right shoulder arthroscopy, subacromial decompression, and rotator cuff repair at St. James Hospital Surgery Center. (Pet.'s Ex. 1 & 2.)

On January 17, 2012, Petitioner followed-up with Dr. Payne post-right shoulder surgery. Petitioner complained of pain in the left shoulder with a positive drop-arm test, in addition to pain in the right shoulder. Dr. Payne recommended that Petitioner undergo an MRI of the left shoulder and begin physical therapy for the right shoulder in two weeks. (Pet.'s Ex. 1.)

Petitioner attended outpatient physical therapy at St. James Hospital (METT Therapy Services) beginning on January 25, 2012. (Pet.'s Ex. 3.)

On January 30, 2012, Petitioner underwent an MRI of the left shoulder. The left shoulder MRI revealed a full-thickness tear involving the anterior fibers of the distal supraspinatus, tendinosis versus partial tear of the distal infraspinatus tendon, mild degenerative changes of the acromioclavicular and glenohumeral joints, and small joint effusion. (Pet.'s Ex. 1.)

On February 14, 2012, Petitioner returned to Dr. Payne and complained of left shoulder pain, clicking, and popping. Dr. Payne reviewed the left shoulder MRI and recommended that Petitioner undergo a left rotator cuff repair. (Pet.'s Ex. 1.)

On March 21, 2012, Petitioner underwent an ESI to the L4-L5 level for the diagnosis of a disc herniation. On April 10, 2012, Petitioner returned to Dr. Payne and reported that the ESI had not helped. Dr. Payne reiterated his recommendation that Petitioner undergo a left shoulder rotator cuff repair and undergo another ESI at L4-L5. (Pet.'s Ex. 1.)

On December 7, 2012, Petitioner underwent a left shoulder arthroscopy with rotator cuff repair, acromioplasty, and labral debridement. Petitioner began physical therapy for the left shoulder in January 2013. (Pet.'s Ex. 1.)

On February 11, 2013, Petitioner was examined with respect to his bilateral shoulder conditions by Dr. Nikhil Verma, a physician with Midwest Orthopaedics at Rush, pursuant to section twelve of the Workers' Compensation Act. The report indicates that Petitioner reported an onset of bilateral shoulder pain that began in approximately 2009. Petitioner reported that he first sought treatment for his shoulders in 2011 but the pain in his shoulders was persistent two years prior to this. Petitioner denied any history of specific injury or trauma to the shoulders but reported that the symptoms began gradually over time. Petitioner reported that his job required him to lift bags weighing up to fifty pounds, which he described as lifting below shoulder level up to waist level. Petitioner reported that he performed this activity repetitively 200 to 300 times per day during the initial ten to fifteen years of work. Petitioner also stated that he had to use a sledgehammer overhead occasionally. The section twelve examination report indicates that Dr. Verma received medical records from Dr. Baig, Dr. Payne, and other medical professionals with WellGroup Health Partners. Dr. Verma opined that Petitioner was status post right and left shoulder rotator cuff repairs. Dr. Verma indicated that he was unable to provide an opinion as to whether Petitioner's bilateral shoulder conditions were related to his work. Dr. Verma requested a formal job description for Petitioner's position. Dr. Verma opined that the treatment for Petitioner's bilateral shoulders appeared to be reasonable and Petitioner had reached maximum medical improvement ("MMI") with respect to the right shoulder only. Dr. Verma opined that Petitioner could return to full duty work with respect to the right shoulder only. Dr. Verma opined that Petitioner should reach MMI with respect to the left shoulder six to eight months after the date of surgery. (Resp.'s Ex. 6.)

On March 14, 2013, Dr. Verma authored an addendum report to the February 11, 2013 section twelve examination report. Dr. Verma indicated that he received a job description for a "SAPP 'A' Operator." Dr. Verma opined that based on the job description, Petitioner's bilateral rotator cuff tears were not work related. Dr. Verma opined further that the job description did not demonstrate significant, defined as a greater than 50 percent of the workday, overhead work or frequent overhead lifting. Additionally, Dr. Verma opined that Petitioner had an insidious onset of symptoms with no history of work injury or trauma. (Resp.'s Ex. 7.)

An EMG report dated May 23, 2013, was authored by Dr. DeRubertis. The note indicates that Petitioner presented for an EMG at Dr. Payne's recommendation and Dr. Payne was "CC'd" on the note. Petitioner reported having numbness and discomfort in the right arm along the ulnar nerve distribution. Petitioner gave a history of working repetitive activities, which included using a sledgehammer at work. Petitioner underwent an EMG and nerve conduction study. Dr. DeRubertis assessed that Petitioner had significant cubital tunnel syndrome on the right. Additionally, Dr. DeRubertis assessed that Petitioner had early cubital tunnel syndrome on the left. (Pet.'s Ex. 1.)

On June 10, 2013, Petitioner underwent a lumbar spine ESI at L4-L5. On July 2, 2013, Petitioner returned to Dr. Payne. Petitioner reported that he had experienced some relief after the ESI, however, he continued to have numbness on the top of the left thigh. Petitioner also

reported that he continued to have lumbar spine pain and stiffness, which had gradually improved since onset. Petitioner reported further that he continued to have some moderate pain in both shoulders and weakness in the right arm. Dr. Payne noted that he had not received the EMG report yet. Dr. Payne recommended that Petitioner wear a tennis elbow brace, undergo occupational therapy for lateral epicondylitis, and undergo another ESI at the L4-L5 level. (Pet.'s Ex. 1.)

On July 29, 2013, Petitioner followed-up with Dr. Yvonne Jimenez, who was now his primary care physician, and requested that Dr. Jimenez complete disability paperwork. Dr. Jimenez noted that Petitioner was limited in his ability to take pain medications due to their side effects and Petitioner's risk of GI hemorrhage. (Pet.'s Ex. 4.)

On September 10, 2013, Dr. Payne noted that the EMG showed cubital tunnel syndrome on the right and left. Dr. Payne reiterated his recommendation that Petitioner wear a tennis elbow brace and undergo occupational therapy for lateral epicondylitis. (Pet.'s Ex. 1.)

On November 13, 2013, Petitioner was examined with respect to his lumbar spine condition by Dr. Edward Goldberg, a physician with Midwest Orthopaedics at Rush, pursuant to section twelve of the Workers' Compensation Act. The report indicates Petitioner stated that he developed low back pain approximately ten years before while at work. Petitioner also reported that his pain resolved afterward, but in October 2011, the pain returned absent a specific accident. The section twelve examination report indicates that Dr. Goldberg received medical records from Dr. Baig, Dr. Payne, and other medical professionals with WellGroup Health Partners. Dr. Goldberg noted that he needed to see the MRI of the lumbar spine to ascertain a definitive diagnosis. Dr. Goldberg opined that he did not believe that Petitioner's lumbar condition was due to the "the accident 02/07/2011." Dr. Goldberg opined further that based on the medical records, Petitioner did not report a specific injury on or about "10/07/2011," and Dr. Goldberg did not believe that Petitioner's lumbar spine condition was due to an "accident October 2001" based on Petitioner's history of an injury ten years before. (Resp.'s Ex. 3.)

On December 4, 2013, Petitioner presented to Dr. Rajive Adlaka with St. James Hospital and underwent an ESI at the L4-L5 level at Dr. Payne's recommendation. (Pet.'s Ex. 1.)

On December 30, 2013, Dr. Goldberg authored an addendum report to the November 13, 2013 section twelve examination report. The addendum report indicates that Dr. Goldberg reviewed X-rays of the lumbar spine dated October 12, 2011, and an MRI of the lumbar spine dated November 14, 2011. Dr. Goldberg opined that the X-rays were normal. Dr. Goldberg opined further that the MRI showed no herniation but showed some mild disc dehydration at L4-L5. Dr. Goldberg saw no evidence of nerve compression. Dr. Goldberg opined that Petitioner had mild disc degeneration at L4-L5 with some lumbar radiculitis which caused his left leg pain. Dr. Goldberg reiterated his opinion that he did not believe that Petitioner's lumbar condition was due to "the accident of 02/07/2011." Dr. Goldberg opined that Petitioner could return to full duty work. (Resp.'s Ex. 4.)

On June 17, 2014, Petitioner followed-up with Dr. Payne and complained of moderate lumbar spine pain with occasional right leg pain and numbness in the left thigh. Dr. Payne

recommended that Petitioner undergo physical therapy and an ESI for the lower back. (Pet.'s Ex. 1.)

On August 28, 2014, Petitioner returned to Dr. Payne. Petitioner reported that his back seemed to be getting better. Petitioner reported that his most recent ESI did not help much, however, physical therapy for the back was helping. Petitioner also complained of right-hand symptoms. Dr. Payne recommended that Petitioner continue physical therapy for the back and continue occupational therapy for the right elbow. Dr. Payne prescribed a back brace and a TENS unit. (Pet.'s Ex. 1.)

On June 25, 2015, Petitioner followed-up with Dr. Payne and complained of lower back pain, right arm numbness, and intermittent neck pain. Dr. Payne prescribed Medrol Dosepak and Tramadol. Dr. Payne recommended that Petitioner undergo an MRI of the cervical spine and lumbar spine, physical therapy for the neck and back, occupational therapy for the right arm, and an ESI after the MRIs were complete. (Pet.'s Ex. 1.)

That day, Petitioner underwent an X-ray of the lumbar spine. The lumbar spine X-ray showed no acute osseous finding and mild multilevel facet joint arthropathy, most significant at L4-L5 and L5-S1. The X-ray of the cervical spine showed mild progression in degenerative changes and neural foraminal narrowing bilaterally at the C3-C4 and C4-C5 levels. (Pet.'s Ex. 1.)

On October 17, 2017, Petitioner returned to Dr. Payne. Petitioner complained of persistent right arm numbness and tingling, in addition to left thigh numbness, which had persisted for two years. Petitioner reported that he did not have neck or back pain. Dr. Payne recommended that Petitioner undergo an MRI of the cervical spine and lumbar spine. (Pet.'s Ex. 1.)

That day, Petitioner underwent an X-ray of the lumbar spine. The lumbar spine X-ray showed mild multilevel facet arthropathy that had not significantly progressed since 2015. Petitioner underwent an X-ray of the cervical spine also. (Pet.'s Ex. 1.)

On November 14, 2017, Petitioner underwent an MRI of the lumbar spine. The lumbar spine MRI showed degenerative changes throughout, most prominent at L5-S1 where there was a central annular tear and moderate right and moderate to severe left foraminal stenosis due to disc bulge and facet arthropathy. Petitioner also underwent an MRI of the cervical spine. (Pet.'s Ex. 1.)

On December 7, 2017, Petitioner returned to Dr. Payne. Dr. Payne reviewed the MRI results and recommended that Petitioner undergo physical therapy for the lower back. Dr. Payne also recommended that Petitioner undergo a right cubital tunnel release. Petitioner indicated that he wanted to think about the recommendation for a right cubital tunnel release. (Pet.'s Ex. 1.)

At his July 16, 2018, deposition, Dr. Payne testified that he is a board-certified orthopedic physician. Dr. Payne testified that at some point, WellGroup Health Partners changed its name to Specialty Physicians of Illinois. Dr. Payne did not have an independent recollection of

Petitioner. He referred to his medical notes and records throughout the deposition. Dr. Payne testified that he first became aware that Petitioner worked as a machine operator on November 8, 2011. Dr. Payne testified that he was not aware of the job duties of a machine operator. Dr. Payne opined that overhead work, microtrauma, and heavy lifting could lead to the development of a rotator cuff tear. Dr. Payne opined that he considered lifting up to fifty pounds to be heavy lifting. Dr. Payne opined that if an individual had a rotator cuff tear, heavy lifting, overhead work, and sledgehammer work could potentially worsen or accelerate the rotator cuff tear. Dr. Payne opined that Petitioner's treatment, specifically the rotator cuff surgeries and the lumbar ESIs, was reasonable and medically necessary. Dr. Payne opined further that the bilateral rotator cuff repairs were causally related to Petitioner's work activities as a machine operator. Dr. Payne opined that the need for the lumbar spine ESIs was causally related to Petitioner's work activities as a machine operator. (Pet.'s Ex. 5.)

On cross examination, Dr. Payne testified that he never reviewed a job description for Petitioner, however, if he had reviewed a job description for Petitioner, he would not have documented this in his notes. Dr. Payne testified that he never reviewed a video of Petitioner's job duties. Dr. Payne testified that Dr. DeRubertis was affiliated with his practice group in 2011. Dr. Payne testified that he has not treated Petitioner since December 17, 2017. On redirect examination, Dr. Payne testified that the nurse practitioner who authored the December 16, 2011 note, nurse Debra Madden, worked with Dr. DeRubertis who was a physician in his practice group at the time. Dr. Payne testified that he would have had access to Dr. DeRubertis' medical records and notes most of the time. (Pet.'s Ex. 5.)

At his August 29, 2018, deposition, Dr. Verma testified that he is a board-certified orthopedic surgeon. Dr. Verma testified that he did not have an independent recollection of Petitioner. Dr. Verma relied on his section twelve examination report and addendum report throughout the deposition. Dr. Verma testified that Petitioner reported sustaining a repetitive use type-of-injury at the section twelve examination. Dr. Verma's testimony was consistent with his section twelve examination report and addendum report and he opined that Petitioner's bilateral shoulder conditions were not causally related to Petitioner's job activities. Dr. Verma testified that his opinion was based on his review of Petitioner's job description and job analysis report that indicated light to medium lifting activities and occasional overhead lifting, which "would not be consistent with the repetitive use development of rotator cuff tears which have been associated with frequent overhead use, i.e., more than 50 percent of the workday." Dr. Verma testified that if someone had to perform light to medium lifting and overhead lifting eleven to twenty times per day over thirty-two years, it would not change his mind. (Resp.'s Ex. 9.)

On cross examination, Dr. Verma testified that a specific trauma event is not necessary to cause a rotator cuff tear and repetitive activities can lead to the development of rotator cuff tears. Dr. Verma testified further that overhead work could make symptomatic an underlying degenerative rotator cuff tear if done frequently, but not heavy lifting. Dr. Verma testified that repetitive use of a sledgehammer being swung overhead could cause a rotator cuff tear over time "[i]f it was done as a significant portion of the work, i.e., more than 50 percent of the workday, potentially." In reviewing the job description, Dr. Verma testified that he would consider 50 to 60 percent to be within the frequent range and not seldom. Dr. Verma testified that Petitioner

had bilateral rotator cuff tears that required surgical repair and that the medical treatment rendered was reasonable and necessary. (Resp.'s Ex. 9.)

On redirect examination, Dr. Verma testified that 50 percent of the workday meant "50 percent of a full workday defined as a minimum of eight hours." Dr. Verma testified that the activity did not have to be the same activity, but the arms would have to be in an overhead position or lifting in an overhead position, which is defined as above shoulder level. In reviewing page three of the job analysis report, Dr. Verma testified that Petitioner's job did not require him to have his arms above shoulder level for four hours of the day. Dr. Verma testified that Petitioner's description of having had to lift below shoulder level up to his waist 200 to 300 times per day for the first ten to fifteen years of his work did not change his opinion because Petitioner did not develop symptoms during that time. (Resp.'s Ex. 9.)

On September 7, 2018, Petitioner was examined by Dr. Edward Goldberg with respect to the lumbar and cervical conditions pursuant to section twelve of the Workers' Compensation Act. The report indicates that Petitioner reported continued lower back pain but denied having radicular pain in any lower extremities. Petitioner reported further that he developed posterior neck pain a few years before but he did not state that there was a specific injury. Petitioner also reported that he did not take medication for his neck and lower back pain. The section twelve examination report indicates that Dr. Goldberg received the job description for an "operator" that showed Petitioner "seldom lifts 50 pounds and seldom squats and sits. He does have to operate equipment." Dr. Goldberg also reviewed medical records from Dr. Payne, Dr. DeRubertis, and other medical professionals with WellGroup Health Partners. Further, Dr. Goldberg reviewed Dr. Verma's February 11, 2013 section twelve examination report and addendum report. On examination, Petitioner had cervical range of motion that was 80 percent normal and he did not complain of pain. Petitioner's lumbar flexion was 70 degrees and Petitioner complained of pain. Dr. Goldberg also noted a significantly positive right cubital tunnel Tinel's sign. (Resp.'s Ex. 5.)

Dr. Goldberg opined that Petitioner had discogenic low back pain, however, Dr. Goldberg noted that he only had the 2011 MRI from his November 13, 2013 section twelve examination, and he did not have the MRI from 2017 to review. Dr. Goldberg opined further that Petitioner had degenerative disc disease in the cervical spine which was a competent cause for his neck pain. Dr. Goldberg opined that he did not believe that the degenerative disc disease of the lumbar and cervical spines was secondary to the "accident of 10/07/2011." Additionally, Dr. Goldberg opined that Petitioner's treatment for the lumbar spine, which included physical therapy and ESIs, was appropriate. Dr. Goldberg believed that Petitioner did not require additional treatment for the lumbar spine. Dr. Goldberg recommended that Petitioner undergo a home exercise program for the preexisting degenerative disc disease in the cervical spine and opined that Petitioner's right upper extremity symptoms were due to right cubital tunnel syndrome. Dr. Goldberg opined further that Petitioner could return to full duty work but noted that Petitioner's ability to return to work would depend on his bilateral shoulder conditions. (Resp.'s Ex. 5.)

At his May 24, 2019, deposition, Dr. Goldberg testified that he is a board-certified orthopedic surgeon. Dr. Goldberg testified further that he did not have an independent recollection of Petitioner. Dr. Goldberg relied on his section twelve examination reports and

addendum report throughout the deposition. Dr. Goldberg testified consistently with his section twelve reports and addendum report. Referring to his addendum to the November 13, 2013 section twelve report, Dr. Goldberg testified that the accident date of February 7, 2011 was a typo, however, his opinion did not change. After being asked whether Petitioner's job would be considered a medium physical demand level job, Dr. Goldberg testified that Petitioner's job would be at a medium physical demand level at most. Dr. Goldberg testified that he only reviewed the MRI reports, and not the images, for the November 2017 lumbar and cervical spine MRIs. (Resp.'s Ex. 8.)

On cross examination, Dr. Goldberg testified that the treatment Petitioner received for his cervical and lumbar spine conditions was reasonable and necessary. Dr. Goldberg testified that the recurrence of Petitioner's low back pain in October 2011 after having back pain ten years before, would correlate with the history provided by Petitioner. Dr. Goldberg testified that the medical records dated October 7, 2011 and December 16, 2011 mention a specific lifting event. Dr. Goldberg testified that hypothetically and in general, lifting a fifty -pound box is a competent cause for an onset of low back pain and radiating lower extremity symptoms. Dr. Goldberg also testified that hypothetically, lifting a fifty-pound box could worsen or accelerate preexisting degenerative disk disease in the lumbar spine. Dr. Goldberg testified that hypothetically, lifting a heavy box could have caused Petitioner's low back and left leg symptoms and could have aggravated an underlying lumbar spine degenerative disc disease. Dr. Goldberg testified that lifting fifty pounds is moderate or medium lifting. Dr. Goldberg testified that the frequency at which someone lifts fifty pounds would not make it heavy lifting. Dr. Goldberg testified that "seldom" means less than one-third of the time. Dr. Goldberg testified that hypothetically, repetitive lifting of fifty pounds could cause low back pain and could aggravate and make symptomatic an underlying lumbar spine degenerative disk disease. Dr. Goldberg testified that the definition of "seldom" in the job description was inconsistent with his understanding of "seldom." Dr. Goldberg testified that he considered sixty percent of the time to be frequent. Dr. Goldberg testified that based on his interpretation of the words seldom and frequent, Petitioner was lifting fifty pounds frequently. On redirect examination, Dr. Goldberg testified that Petitioner never reported sustaining a specific injury or repetitive injury. (Resp.'s Ex. 8.)

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

I. Issue C - Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent? (Did Petitioner sustain a repetitive trauma injury to his low back, right shoulder, and left shoulder that manifested on October 7, 2011?)
Issue E - Was timely notice of the accident given to Respondent?
Issue F - Are Petitioner's current low back, right shoulder, and left shoulder conditions of ill-being causally related to the injury?

"The phrase 'repetitive trauma' was developed in order to establish a date of accidental injury for purposes of determining when limitations statutes, and notice requirements, begin to run." *Edward Hines Precision Components v. Industrial Comm'n*, 356 Ill. App. 3d 186,

194 (2d Dist. 2005). "The categorization of an injury as due to repetitive trauma and the corresponding establishment of an injury date are necessary to fulfill the purpose of the Act to compensate workers who have been injured as a result of their employment." *Edward Hines*, 356 Ill. App. 3d at 194. The recognition of an injury date allows an employee to be compensated for injuries that develop gradually, without requiring an employee to push his body to the point of collapse. *Edward Hines*, 356 Ill. App. 3d at 194. An employee who suffers from a repetitive-trauma injury must meet the same standard of proof as an employee who suffers a sudden injury. *Durand v. Industrial Comm'n*, 224 Ill. 2d 53, 64 (2006). An employee suffering from a repetitive-trauma injury must point to a date on which both the injury and its causal link to his employment would have become plainly apparent (would have manifest itself) to a reasonable person. *Durand*, 224 Ill. 2d at 65.

"Manifests itself" signifies the date on which both the fact of the injury and the causal relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person. *Peoria County Belwood Nursing Home v. Industrial Comm'n*, 115 Ill. 2d 524, 531 (1987). However, this does not mean, necessarily the date the employee became aware of the physical condition and its clear relationship to his employment. *See Oscar Mayer & Co. v. Industrial Comm'n*, 176 Ill. App. 3d 607, 610 (4th Dist. 1988). A date based purely on discovery would penalize those employees who continue to work without significant medical complications when the eventual breakdown of the physical structure occurs beyond the statute of limitations period. *Oscar Mayer*, 176 Ill. App. 3d at 611. In short, courts considering various factors have typically set the manifestation date on either the date on which the employee requires medical treatment; or the date on which the employee can no longer perform work activities. *Durand*, 224 Ill. 2d at 71-72. The manifestation date in a repetitive-trauma injury is a question of fact for the Commission to determine (*Oscar Mayer*, 176 Ill. App. 3d at 611), and "the Commission should weigh many factors in deciding when a repetitive-trauma injury manifests itself." *Durand*, 224 Ill. 2d at 71.

At the outset, the Arbitrator finds that Petitioner's testimony was credible concerning his low back, right shoulder, and left shoulder conditions; concerning his job duties; and concerning what he notices about his current conditions. The Arbitrator notes that Petitioner appeared confused about specific information and dates numerous times throughout the arbitration hearing. The Arbitrator finds credible Petitioner's testimony that he has difficulty remembering specific dates and exactly what he has told physicians previously because he is autistic. Further, the Arbitrator notes that the medical treatment and incidents at issue occurred between three and nine years ago. The Arbitrator acknowledges that the various histories in the medical records, the histories contained in the section twelve reports, and Petitioner's testimony do not completely "mesh," however, based on the totality of the facts and circumstances in the instant case, the Arbitrator finds that Petitioner's testimony was generally credible.

The Arbitrator finds that Petitioner sustained a repetitive trauma (overuse) injury to his low back that manifested on October 7, 2011, which is the date when Petitioner required medical treatment for his low back and the date when Petitioner could no longer perform his work activities. Additionally, the Arbitrator finds that Petitioner also sustained a specific injury to the low back around October 7, 2011 while lifting a bag of additive. Petitioner testified credibly that in addition to his low back hurting throughout the twenty-five years that he worked for

Respondent, on October 7, 2011, his low back pain got sharper and he was no longer able to work. Petitioner testified credibly that even though he experienced pain in his low back, he continued to work because he did not want to lose money. Both Petitioner and Barkhurst testified that Petitioner was able to perform his full work duties before October 7, 2011. Further, there is no evidence that Petitioner sought medical treatment for his low back prior to October 7, 2011.

Further, the Arbitrator finds that Petitioner sustained repetitive trauma (overuse) injuries to his right and left shoulders that manifested on October 7, 2011, which is the date Petitioner could no longer perform his work activities. Petitioner testified credibly that during the twenty-five years that he worked for Respondent, he noticed that both shoulders were hurting. Petitioner testified that even though he experienced pain in both shoulders, he continued to work because he did not want to lose money. Although Petitioner presented to his PCP on April 14, 2011, with complaints of bilateral shoulder pain for six months, it was a singular office visit to a general practitioner at which time he did not receive any specific treatment for the shoulders. Petitioner continued to work full duty until October 7, 2011. In April 2011, Petitioner's bilateral shoulder conditions were merely a *potential* disability. *See Oscar Mayer & Co. v. Industrial Comm'n.*, 176 Ill. App. 3d 607, 611 (4th Dist. 1988) (finding that requiring notice of only a *potential* disability is a useless act since it is not until the employee actually becomes disabled that the employer is adversely affected in the absence of notice of the accident).

With respect to notice, both Petitioner's and Barkhurst's testimonies establish that Respondent received timely notice pursuant to section 6(c) of the Act. Petitioner testified that he informed Barkhurst of his low back pain on or around October 8, 2011. Petitioner also testified that on the same day, he told Barkhurst that he had to see the doctor for his shoulders and it was work-related. Barkhurst testified that Petitioner reported a work injury to "HR," and the Monday after October 7, 2011, "HR" notified Barkhurst of Petitioner's injury. Barkhurst testified further that he knew Petitioner was off work due to an injury at the plant. Further, Petitioner's STD application, although it contains some confusing dates, indicates that Petitioner treated with a physician for a work injury on October 7, 2011, which is corroborated by the medical records. (Resp.'s Ex. 1 – 1-12.)

The employee has the burden of establishing a causal relationship between his injury and employment. *Levkovitz v. Industrial Comm'n,* 256 Ill. App. 3d 1075, 1082 (1st Dist. 1993). A gradual injury stemming from repeated trauma is clearly compensable under the Act as long as the employee establishes that the injury is work-related and not the result of a normal degenerative process. *Zion-Benton Township High Sch. Dist. 126 v. Industrial Comm'n,* 242 Ill. App. 3d 109, 113 (1993). It is axiomatic that employers take their employees as they find them, thus, even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also *a* causative factor. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 205 (2003).

The Arbitrator finds that Petitioner's low back, right shoulder, and left shoulder conditions of ill-being are causally related to his repetitive job duties as a SAPP Operator. The Arbitrator finds Dr. Payne's opinion to be credible and more persuasive than Dr. Verma and Dr.

Goldberg's opinions as to Petitioner's low back and bilateral shoulder conditions. During his deposition, Dr. Payne opined that the Petitioner's rotator cuff repairs and need for the lumbar spine ESIs were causally related to Petitioner's repetitive work activities. Additionally, Dr. Payne opined that he would consider lifting fifty pounds to be heavy lifting, and activities such as heavy lifting and overhead work could lead to the development of a rotator cuff tear. Dr. Payne also opined that the performance of overhead work, using a sledgehammer, and heavy lifting could potentially worsen or accelerate a rotator cuff tear. The Arbitrator notes that the Job Analysis Report for a SAPP Operator states that frequent lifting of ten to eighteen pounds is required eleven or more times per day, from floor to overhead level, with respect to lifting a sledgehammer and a five-gallon bucket. The Arbitrator notes further Barkhurst's testimony that from 1979 to sometime before 2007, Petitioner used a ten-pound sledgehammer; and from 2007 to 2011, Petitioner used a three-to-five-pound sledgehammer while performing his job duties. (Resp.'s Ex. 2.) Petitioner testified that his job duties also required him to clean the ducts at least two times per shift in an eight-hour shift and three to four times per shift in a twelve-hour shift. Cleaning the ducts required him to beat a metal duct with a sledgehammer for twenty to twenty-five minutes. Barkhurst testified that at times, an Operator would have to lift a sledgehammer to unclog a chute more than eleven times per day but it varied by shift. Petitioner testified that cleaning the ducts required swinging a sledgehammer like a baseball bat overhead.

II. 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?

Based on the above findings of accident, causal connection, and notice, Respondent is required to pay the below listed reasonable and necessary medical bills pursuant to section 8(a) and section 8.2 of the Workers' Compensation Act:

Provider: WellGroup Partners/Specialty Physicians of Illinois
Dates of Service: October 7, 2011 to December 7, 2017
Amount: $12,669.87 ($63.59 unpaid)

Provider: Franciscan Alliance/St. James Hospital
Dates of Service: May 23, 2013 to November 21, 2017
Amount: $43,703.52 ($260.00 unpaid)

III. Issue K - What temporary benefits are in dispute?

The Arbitrator has found in Petitioner's favor on the issues of accident, causal connection, and notice. In the absence of work release documentation from Petitioner's treating physicians, the Arbitrator relies on the opinions of Dr. Verma and Dr. Goldberg in determining when Petitioner could return to full duty work. The Arbitrator finds that Petitioner is entitled to temporary total disability benefits from October 7, 2011, to December 30, 2013.

IV. Issue L - What is the nature and extent of the injury?

Pursuant to §8.1b of the Workers' Compensation 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:

1. Reported Level of Impairment

The Arbitrator notes that neither party offered an impairment rating as evidence. Thus, the Arbitrator gives this factor no weight.

2. Occupation

Petitioner has worked as a SAPP Operator since 1979. The Arbitrator gives this factor some weight.

3. Age at the Time of Injury

On the day of the accident, Petitioner was fifty-eight years old. The Arbitrator gives this factor some weight.

4. Future Earning Capacity

Petitioner has not worked since October 7, 2011 and is no longer employed with Respondent. Petitioner has not looked for employment since that time. Since October 7, 2011, Petitioner has received various disability benefits, including short term disability, long-term disability, and Social Security disability.

5. Evidence of Disability

In January 2012, Petitioner underwent a right shoulder arthroscopy, subacromial decompression, and rotator cuff repair. In December 2012, Petitioner underwent a left shoulder arthroscopy with rotator cuff repair, acromioplasty, and labral debridement. Petitioner has undergone at least three ESIs for the lumbar spine. Petitioner is limited in his ability to take pain medications due to the side effects and Petitioner's risk of GI hemorrhage. In December 2017, Petitioner saw Dr. Payne and reported continued lower back pain and Dr. Payne recommended that Petitioner undergo physical therapy. Petitioner testified that currently, he is not treating with a physician for his lower back and bilateral shoulder conditions. Petitioner testified that it is difficult for him to lift heavy objects and it is difficult for him to sit for long periods of time. The Arbitrator gives this factor significant weight.

Accordingly, after a review of the factors set out in section 8.1(b) of the Workers' Compensation Act, the Arbitrator finds that Petitioner's conditions have resulted in permanent disability to the extent of five percent (5%) of the person-as-a-whole (lower back), twelve-and-a-half percent (12.5%) of the person as a whole (right shoulder), and twelve-and-a-half percent (12.5%) of the person as-a-whole (left shoulder), pursuant to section 8(d)(2) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	06WC039961
Case Name	GRILLIER, JAMES v. STATE OF IL DEPARTMENT OF TRANSPORTATION
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0291
Number of Pages of Decision	17
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Domenic Maciariello
Respondent Attorney	Dan Kallio

DATE FILED: 6/14/2021

/s/Kathryn Doerries, Commissioner
Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES GRILLIER,

Petitioner,

vs. NO: 06 WC 39961

STATE OF ILLINOIS,
ILLINOIS DEPARTMENT
OF TRANSPORTATION,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 28, 2019 is hereby affirmed and adopted.

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

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

Pursuant to Section 19(f)(1) of the Act, this decision is not subject to judicial review. *820 ILCS 305/19(f)(1) (West 2013)*.

June 14, 2021

o-6/8/21
KAD/jsf

/s/*Kathryn A. Doerries*
Kathryn A. Doerries

/s/*Maria E. Portela*
Maria E. Portela

/s/*Thomas J. Tyrrell*
Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0291

GRILLIER, JAMES
Employee/Petitioner

Case# **06WC039961**

ILLINOIS DEPT OF TRANSPORTATION
Employer/Respondent

On 10/28/2019, 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:

1315 DWORKIN AND MACIARIELLO
DOMENIC C MACIARIELLO
134 N LASALLE ST SUITE 650
CHICAGO, IL 60602

4971 ASSISTANT ATTORNEY GENERAL
DANIEL KALLIO
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

OCT 28 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JAMES GRILLIER
Employee/Petitioner

v.

ILLINOIS DEPARTMENT OF TRANSPORTATION
Employer/Respondent

Case # **06** WC **39961**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Chicago**, on **May 15, 2019**. 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 _____

Grillier v. IDOT, 06 WC 39961

FINDINGS

On **June 14, 2005**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**51,114.00**; the average weekly wage was $**982.96**.

On the date of accident, Petitioner was **47** years of age, ***single*** with **1** dependent child.

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

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

Respondent shall be given a credit of $**293,118.47** for TTD, $**0** for TPD, $**114,029.16** for maintenance, and $**0** for other benefits, for a total credit of $**407,147.63**.

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

ORDER

The Petitioner's left groin condition resulting from a left inguinal hernia and two subsequent surgeries is causally related to the June 14, 2005 accident.

Petitioner has failed to prove entitlement to payment of any submitted unpaid medical expenses.

Respondent shall pay Petitioner temporary total disability benefits of **$655.31 per week** for **448-1/7 weeks**, commencing **June 15, 2005 through January 15, 2014**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of **$655.31 per week** for **174 weeks**, commencing **January 16, 2014 through May 17, 2017**, as provided in Section 8(a) of the Act.

Respondent shall be given a credit of **$407,147.63** for temporary total disability and/or maintenance benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of **$589.78 per week** for **100 weeks**, because the injuries sustained caused the **20% loss of the person as a whole**, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from **June 14, 2005** through **May 15, 2019**, and shall pay the remainder of the award, if any, in weekly payments.

Grillier v. IDOT, 06 WC 39961

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

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

Signature of Arbitrator

October 24, 2019
Date

OCT 28 2019

STATEMENT OF FACTS

Petitioner, a 6-year employee, testified that he worked for Respondent as a Highway Maintainer and was a member of Teamsters Local 726 (now Teamsters Local 700). In this job he ran heavy equipment, performed street demolition and asphalt paving in the summer and plowed snow in the winter. Petitioner testified he was feeling fine when he started work on 6/14/05 and was working on a grass cutting crew. He was helping a mechanic change a flat tractor tire. He testified this was a 5' tire and he was lifting it from the top. He heard something and had pain in the left groin. He testified he felt burning and told the mechanic he was not doing okay so he was taken back to the facility yard. He reported the incident to his supervisor and sought treatment the next day at the Loyola Hospital emergency room. He indicated he provided a consistent history of the incident and also complained of low back pain.

At the Loyola ER on 6/15/05 Petitioner reported he was lifting a heavy tire at work and felt burning left groin pain with a protruding bulge that was reducible. Examination noted a clearly apparent hernia and Petitioner was advised to follow up with Dr. Silver in the surgical clinic. On 6/20/05, Dr. Holt noted Petitioner had developed a left inguinal hernia and a surgical repair was planned. The history was of Petitioner lifting a tractor tire and feeling a burning sensation in the left groin, noticing a reducible bulge that evening. The surgery took place on 7/1/05 with Dr. Holt. The report states that repair was performed with a Marlex mesh plug and patch. The history from an anesthesia report notes Petitioner developed left pain after lifting a tire at work, and additional histories of a 2001 mild concussion with cervical neck strain after a car accident and prior umbilical and inguinal hernia repairs as a child without complications. Petitioner was discharged the next day with instructions to avoid heavy lifting (over 75 pounds) for 4 weeks and no driving while taking prescribed Vicodin. (Px1).

At his 8/30/05 follow-up, Petitioner was complaining of intermittent burning sensation, about twice a day, around his incision that radiated to his thigh and lasted for 15 to 20 seconds. He remained disabled from work due to his inability to lift as a construction worker. Exam was essentially normal and it was indicated that Ibuprofen was to continue with consideration of Neurontin if the pain remained persistent. A separate page states Petitioner did not feel he could lift 60 pounds and therefore did not want to work. The attending doctor stated: "No medical reason not to return to work. Wound healing well." A note was issued releasing Petitioner to return to work as of 10/1/05. (Px1).

Petitioner testified he returned to work with Respondent for one day in 2005 but was unable to perform his job.

The Arbitrator did not locate any pre-surgery progress notes in the record of evidence, but Petitioner underwent a second surgery on 5/10/06, this time with Dr. Millikan, involving left groin exploration with nerve track transection of the ilioinguinal, iliohypogastric and genital branch of the genitofemoral nerve. The report notes Petitioner had developed disabling post-surgical pain and had failed multiple conservative measures including pain management, steroid injection and radiofrequency ablation of the ilioinguinal nerve. Pre-operative diagnosis was ilioinguinal nerve syndrome, and post-operative diagnosis was entrapment of nerves in the groin. The report notes the surgeon found a patch of mesh that was adherent to "what we think was the ilioinguinal nerve." The noted nerves were transected as far as possible and as much mesh as possible was dissected and excised. A subsequent pathology report notes that within the removed fragments of tissue was evidence of fibrosis, acute and chronic inflammation, abscess formation and foreign body giant cell reaction and perivascular chronic inflammation. (Px2). No records of Petitioner following up with Dr. Millikan after this second surgery were submitted into evidence at trial. There are references in other records (Respondent's Section 12 examiner, Dr. Mitsos) which indicate Petitioner underwent a nerve block on 9/26/05 and subsequent nerve ablation procedure, but there is no record of these procedures in the presented evidence.

On 1/12/07, Petitioner was examined by surgeon Dr. Mitsos at Respondent's request pursuant to Section 12 of the Act. Petitioner reported no improvement with Dr. Millikan's surgery and that he had left anterior thigh and scrotum numbness as well as medial thigh pain. Following his review of the Petitioner's medical records and examination of the Petitioner, Dr. Mitsos diagnosed a possible mesh abscess in the remaining mesh product with possible neuroma of the transected nerves, acknowledging that this condition was causally related to the work accident. He concluded that Petitioner could be suffering from an infection from the remaining inguinal mesh and recommended that Petitioner undergo an exploration of the left groin and possible excision of any remaining mesh and infection, indicating this would be both diagnostic and therapeutic. Dr. Mitsos further opined that Petitioner had not reached maximum medical improvement and that he currently could not return to his regular job but was capable of sedentary work. (Rx3).

Petitioner testified that he discussed the surgery with Dr. Millikan and declined to undergo the procedure. On cross examination, Petitioner testified that Dr. Millikan indicated that if he underwent the surgery he would not be able to walk anymore. No record of this visit or conversation with Dr. Millikan was submitted into evidence.

Petitioner testified he then started seeing Dr. Peoples in 2012 with the same complaints in the left groin area and continued to see Dr. Peoples into 2014. However, the next medical visit indicated in the evidentiary record did not occur until after an approximate six year gap, on 7/29/13, when he saw his general practitioner Dr. Peoples. He presented with complaints of pain in the left wrist and elbow at that time, as well as pain in his left inguinal area. The notes indicate that "disability forms" were completed on this date, but the forms are not included in the evidentiary record part of the exhibit and the basis for their preparation was not recorded. Dr. Peoples wrote in her report that Petitioner was permanently disabled from his job with Respondent, but it is unclear if this was information that was communicated to her or if it was her medical opinion, and if so what that opinion was based on. (Px3).

On 1/30/14, Petitioner was evaluated by Dr. Peoples for his yearly physical and declined referral to a specialist for his groin pain "as he has seen many in the past." Petitioner underwent a CT scan of his abdomen and pelvis on 6/18/14. The results did not reveal any new hernias and was essentially unremarkable. Petitioner continued to visit Dr. Peoples for both groin pain as well as unrelated health issues. The office visit notes from 3/31/14 indicate that Petitioner had undergone three prior back surgeries due to a fall, as well as the noted prior hernia surgeries. (Px3; Px4). A June 2017 progress note indicates that Petitioner was suffering from the following issues: malignant mast cell tumor, systemic mast cell disease, vitamin D deficiency, dysthymia, acute stress

disorder, chronic pain, chronic pain syndrome, mononeuritis of the lower limb, mononeuropathy, disorder of skin, elbow joint pain, joint pain in ankle and foot, Achilles tendinitis, synovitis, abdominal pain, inflammatory disorder, mast cell malignancy, and degeneration of intervertebral discs. All of these diagnoses had been rendered within the preceding four years. (Px3).

On 3/1/18, Dr. Mitsos performed a records review at the request of Respondent pursuant to Section 12 of the Act. He reported that Petitioner underwent work hardening following his surgery with Dr. Millikan, but the Arbitrator notes there are no documents reflecting this in the evidentiary record. Dr. Mitsos also described a 1/25/07 Millikan report where "he appeared to disagree with my conclusions of 1/3/07" and did not believe a third surgery was warranted. Dr. Mitsos noted that Dr. Millikan stated that the inguinal mesh was not infected but was inflamed, that as much mesh as possible had been removed at surgery without threatening the loss of the left lower leg due to the mesh being close to the iliac vein, that the remainder of the nerves were cut and that "Dr. Millikan had nothing to offer except to state that this individual could not work." The Arbitrator notes this 1/25/07 report was also not submitted into evidence. Dr. Mitsos indicated that the only nerve Dr. Millikan did not cut was the lateral femoral cutaneous nerve which supplies the left outer thigh, where Petitioner had some complaints, and that Petitioner may have suffered a meralgia paresthetica secondary to the surgery, which is very difficult to diagnose and treat. However, he also stated that "this point at the current time is moot as it pertains to this claim." Dr. Mitsos noted there was a gap in the medical records after 1/25/07 until 2016 and that that Petitioner had undergone treatment for a number of unrelated medical issues including a malignant mast cell tumor, systemic mast cell disease, acute stress disorder, chronic pain syndrome, left elbow pain, and a number of other diagnoses. He noted that these conditions are all unrelated to the instant work injury. Dr. Mitsos opined that Petitioner had reached maximum medical improvement sometime between 1/25/07 and 6/5/14, and that Petitioner's claim for a left inguinal hernia had resolved and he was no longer being treated for a condition secondary to the work accident. (Rx4). No further medical records were found within the evidentiary record.

Petitioner testified the Respondent could not accommodate the sedentary restrictions recommended by Dr. Mitsos on 1/12/07 and that he thereafter continued to receive weekly benefits. He received TTD from 6/22/05 to 1/15/14, with Petitioner indicating he received $655.31 per week. Petitioner testified that at that point he began to receive maintenance benefits totaling $589.78 per week, which he continued to receive through 5/17/17. It is unclear why there may have been a change in the amount he was receiving, but the Arbitrator notes that based on the stipulated average weekly wage the proper benefit amount for TTD would have been $655.31 per week.

Petitioner testified he has a high school diploma and no college experience, though he did obtain a culinary arts degree from Triton College in 2011 after two years of classes, which was paid for via some type of State program that was not described in any detail. A document was submitted into evidence which appears to verify Petitioner obtained an Associates' degree in applied science for Hospitality Industry Administration Culinary Arts in May 2011. (Px5).

Petitioner testified he has been performing a self-directed job search in his geographic area and at his skill level. Petitioner testified he continued a job search from 2012 through 2018, and that this is documented in the job search logs he submitted into evidence as Px6. He testified he has not found a job. He did not find a job as a cook but testified that a friend let him work in his restaurant as a sous chef for three days in 2012, indicating that he was unable to do the work due to the prolonged standing involved. He testified that he has a standing and climbing restriction from Rush as well as from Dr. Peoples.

As to the job search logs entered into evidence, an initial group of these records were undated and included only the name and location of the employer and the job title and included laboring and installer positions. The searched positions began including dates in December 2014, with three prior entries from 2013. There were a

reasonable number of contacts indicated in December 2014 and January 2015, but after that they become much more sparse through September 2016. Significantly more information is included in these entries, however, again, they are often targeted to jobs which appear to be outside of what the Petitioner indicates he can do. No contacts are listed from mid-November 2016 through early January 2017, after which there are a limited number of entries through March 2017. The contacts then again pick up from December 2017 through February 2018, and again in July and August 2018. With regard to noting a "contact person", many state only a job position and not a name, and the vast majority of the positions involved simply applying online and waiting for a response. Again, many positions appear to go beyond sedentary work, sometimes significantly so. (Px6).

Petitioner testified that he underwent a Section 12 examination in March 2018 and was worse by then. The Arbitrator notes that the report of Dr. Mitsos indicated he had only performed a record review at that time and did not examine the Petitioner. Petitioner testified he continued to have left groin pain that felt like a knife piercing into the groin, and that this occurs without warning.

Respondent submitted a report from vendor Genex which purports to be a 3/30/07 labor market survey (LMS). The report noted Petitioner's job as a highway maintainer is in the "heavy" work category, and the LMS is based on Petitioner being limited to the sedentary work level. This report states: "The present survey examined several entry-level occupations which are typically found in the Chicago metropolitan area. The employers are located with a one-hour drive of the claimant's home in Maywood, Illinois. The occupations are Security, Light Assembly and Parking Garage Cashier. All generally offer work situations where the worker can sit for extended periods with minimal if any lifting. Security guard companies, for example, often have Gate Guard sites where the guard can stand on an as-needed basis." The handler contacted 31 potential employers, 10 of which provided information regarding requirements, physical demands, availability of openings and compensation. Security guard and parking garage employers indicate a lot of turnover in these professions. The wage rates ranged from $7.75 to $10.00 per hour at the garages, and $9.50 per hour to $12.00 per hour at the security guard companies: "The average wage for all Respondents was $9.94 per hour." (Rx5).

Petitioner underwent a vocational evaluation at The Eval Center at Respondent's request on 4/12/12. Physically, it was noted that Petitioner had last been seen by Dr. Millikan 2 years prior, that he had a course of physical therapy followed by a functional capacity evaluation (FCE), and that he since had been seeing Dr. Peoples. The Arbitrator notes that the results of the FCE are not indicated in the report, and that no FCE report was located in the evidentiary record. He self-reported ongoing nerve pain in the left leg into the groin, no feeling in the upper left thigh and occasional pain down to the left ankle. He reported he was worse depending on weather, that he wore surgical stockings and that he took Hydrocodone daily. He self-reported that he only felt capable of part-time work, a maximum of 2 hours sitting and 1 to 1.5 hours standing at a time, the ability to walk 10 to 20 blocks and the inability to lift over 50 pounds. He reported having applied for Social Security Disability (SSDI) benefits, with no indication of whether he was awarded such benefits or not. He was a high school graduate and had obtained a culinary arts degree at Triton in 2012, which he reported took him "longer than expected" to complete due to his limited physical endurance. His prior work experience included mailroom supervisor at a law firm and a FedEx package handler prior to working for Respondent. Following various vocational testing protocols, Petitioner was noted to have a number of vocational assets: good reading and vocabulary skills, average nonverbal and above average visual perception skills, slow but accurate clerical perception, average auditory comprehension, average finger dexterity, the ability to quickly and accurately make visual comparisons to find/record errors and an associate's degree in culinary arts. Vocational liabilities were a 7th grade math computation level, no work history going back to 2005, limited keyboarding skills and his physical limitations. Vocational evaluator Sherman determined that, based on his aptitudes, interests and physical capacities, Petitioner was compatible with various occupations, which were noted not to be all-inclusive, and that each job should be viewed selectively depending on specific job demands. The jobs include various clerking positions as

well as assistant pastry cook, gate guard, cashier, customer service representative and street and service order dispatchers. Ms. Sherman also listed recommendations which included a medical consultation to verify the Petitioner's current status, prognosis and work restrictions, including review of the FCE. It also recommends Petitioner start working in a part-time status given how long he had been completely off work, that Petitioner would benefit from vocational counseling and exploration and job seeking skills training, a detailed description of any job being considered, computer and software training. The report also notes that the culinary arts program assistant at Triton indicated an entry-level bakery/pastry work position wouldn't require the amount of standing as other food service positions, and thus that Petitioner might want to meet with the program assistant for more detailed information. (Rx6). It is unclear if Petitioner ever underwent the noted medical consultation.

Respondent performed an updated Transferrable Skills Analysis/LMS via Creative Case Management on 3/6/14. A 50-mile radius from Petitioner's home was utilized. The summary indicated Petitioner's outlook for returning to work was "guarded", and that there was a limited job market for Petitioner in the noted area for jobs which were both medically appropriate and utilize his current skills. Thirty-three (33) potential jobs were identified for a one week period in March 2014, with wages ranging up from $8.25 per hour. These included: food service, dietary aide, prep cook, light delivery driver, light maintenance, cashier, customer service and retail sales associate. This list was not exhaustive. For the jobs which included wage rates, the hourly wage was up to $10.75 per hour, while yearly wages ranged from $20,758 to $34,899. It was noted that employer willingness to accommodate his restrictions may be highly variable, and that reasonable accommodations per the Americans with Disabilities Act (ADA) may need to be requested. The report states that Petitioner may need to obtain a part time job to "get his foot in the door" with a goal of full-time work, and that a graduated return to work would also help to condition him for the full time demands of a workplace. Positives for Petitioner were his long work history with Respondent, his culinary arts degree, his documented ability to learn new skills, a reasonable work history, and a prior job where he was a supervisor of a mail room. Negatives included the fact that most of the possible job opportunities offered lower wages than what Petitioner had been earning, his age, his significant ongoing pain with sitting, Norco usage, lack of knowledge of basic office software and any need for heavier lifting requirements. The restrictions that were utilized were noted to be that of Dr. Mitsos ("sedentary/clerical/not heavy work"), Dr. Millikan (From 1/25/07: "Disabled from manual labor. . . sedentary or clerical work.") and Dr. Peoples (possible permanent hypersensitivity in the left groin and thigh areas). (Rx7).

On 7/9/18, Petitioner was interviewed by vocational counselor Carl Triebold at the request of his attorney. Counselor Triebold noted Petitioner had not worked since June 2005 and that Dr. Peoples had issued a 10/4/17 letter indicating Petitioner still had significant pain following his groin surgeries, hadn't been able to return to work due to pain and medication side effects and that she considered the Petitioner permanently disabled. The 4/12/12 vocational evaluation from the Eval Center (see Rx6) was noted to reference a prior FCE that had been performed in 2009 or 2010, but not the results. Petitioner reported at that that time that he felt he could perform a part time job, but Counselor Triebold indicated that this, his job duties and his physical capacity at that time were vague and not sufficiently explained. Petitioner reported to Triebold that his job had involved operating endloaders and skidsteers, that he would use jackhammers and shovels to repair roads, that he would lift over 50 pounds occasionally and when he was not driving he would perform prolonged periods of standing and walking, as well as working in extreme temperatures. Counselor Triebold noted that while Petitioner had undergone several aptitude tests at the Eval Center and several sedentary and light work level occupations were listed as "job goals" in the report, Petitioner's ability to perform any of these jobs was not indicated and the report itself stated Petitioner's "tolerance for work is unknown at this time." Counselor Triebold notes the report also indicates most of the listed job titles would require either keyboarding and knowledge of basic computer software or would require additional training. The only vocational history the report noted was Petitioner's job with Respondent, which Triebold indicated was heavy (over 50 pounds) and unskilled. Counselor Triebold

indicated Petitioner's culinary arts degree would generally be associated with direct entry into semi-skilled or skilled work assuming he had a functional capacity for this type of work. It was further noted that Petitioner had not yet been released to return to work as of April 2012. Counselor Triebold concluded that "given Petitioner's age, education, past relevant work experience and the absence of functional capacity for work activity, a return to work is not warranted at this time." (Px4). It does not appear that Triebold reviewed any of the records of Dr. Millikan or Dr. Mitsos.

Petitioner submitted a document titled "Joint Committee on Administrative Rules Administrative Code", which purports to show what a Highway Maintainer makes per contract. The document initially lists this position as "Snowbirds", defined as "all seasonal, full-time Highway Maintainers whose primary function is snow removal." They earn $4375 per month as of 7/1/14. Then there is a list of numerous types of positions, where the Petitioner's counsel highlighted "Highway Maintainer – Regular", which reflects earnings as of 7/1/15 of $35.56 per hour at full scale. Several other Highway Maintainer positions are also listed which range up to $37.67 per hour, and the Regular position is the lowest of these hourly wages (Px8).

Petitioner testified that he has not worked since initially going off work following the 6/14/05 accident other than the one day he tried to return to work with Respondent and the three days he worked as a sous chef. He testified that he currently has no job prospects. He continued to experience left groin pain. He indicated that his present hernia pain is so bad that his grinding of teeth resulted in their cracking. Petitioner testified he continues to take Norco, and that this is being prescribed by Dr. Robinson, who took over when Peoples retired.

On cross examination, the Petitioner testified he underwent two prior hernia repairs when he was 8 years old but has had no other prior groin treatment and had no groin problems leading up to the accident date. As to complaints of left thigh pain in January 2005, Petitioner testified he did not recall any such complaints prior to 6/14/05.

With regard to the vocational evaluation he participated in in 2012, he testified that the vocational counselor believed the jobs listed in the report would have been suitable for him: "They told me that they thought it would be suitable for me."

Petitioner agreed he has a high school diploma and obtained the culinary associates degree. His employment had been continuous prior to the work accident. Petitioner acknowledged that he has a valid CDL driver's license and that he last renewed it approximately 6 years prior to the hearing date.

Petitioner testified that he submitted some job logs while off work, but could not state exactly when, and testified that he lost approximately two years of job logs around 2009 when his home flooded. He started compiling job logs when his attorney advised him to do so. He testified he has applied for hundreds of jobs, from truck driving to cooking and more. He testified he followed up on the job contacts as much as he could. He had an account on Indeed.com, indicating he could check if he received a contact from a potential employer. He has not had any job interviews since the accident. As he indicated he has never turned down a job offer, the Arbitrator assumes this means he has not received any job offers. He testified he does have a current resume but did not bring a copy to the hearing. He last applied for work about four months prior to the hearing, testifying he had been looking for a full-time job so he could obtain insurance. He is able to drive a car and he does not use a cane. His daughter dropped him off at the hearing site. He agreed he has stairs in his home and he does use them but tries to limit how often he does so. He continues to take Norco twice a day. He has completed treatment for his hernia. Since 2007, Petitioner believed he had treated with four different pain clinics.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Petitioner's left-sided inguinal hernia and left groin condition are causally related to the 6/14/05 accident.

The parties have stipulated that Petitioner was injured in a 6/14/05 accident which arose out of and in the course of the Petitioner's employment with Respondent. His testimony that he developed left groin pain while helping to move and lift a very large tractor tire while it was being changed is consistent with the records of Loyola Hospital and the histories noted in his subsequent most contemporaneous medical visits. He ultimately underwent two surgeries to try to remedy the condition, one with Dr. Holt and the second with Dr. Millikan.

The records of this treatment are relatively clear through the time Petitioner was released by Dr. Holt as of 8/30/05. At that time the Petitioner continued to complain of an intermittent burning sensation that was radiating to his left thigh a couple times a day. It was noted that Petitioner did not feel he could return to heavy lifting at work but that, based on a normal examination and the doctor's statement that the Petitioner did not want to work, he was released to full duty. The Petitioner testified he returned to work for one day and was unable to perform his work duties due to his ongoing symptoms.

The problem at this point becomes a paucity of medical records upon which the Arbitrator can rely. No further records in evidence reflect treatment until a 5/10/06 surgery with Dr. Millikan. No records of Dr. Millikan which predate this surgery were located by the Arbitrator in the evidentiary record, so there is no record of what his diagnosis was or how he came to the determination that he did. The Arbitrator also found no records of Dr. Millikan in evidence post-surgically.

Other than the 1/12/07 report of Section 12 examiner Dr. Mitsos, the Arbitrator saw no records in evidence which cover the period from 5/11/06 until 7/29/13, a period of over seven years. Dr. Mitsos' 1/12/07 report indicates that he reviewed post-surgical records of Dr. Millikan which indicate that the doctor performed both a nerve block in September 2005 and a radiofrequency ablation procedure on some unknown date after the 5/10/06 surgery. Dr. Mitsos' diagnosis was a possible mesh abscess and possible neuroma of the transected nerves and he recommended a third surgery to try to remedy this. In the meantime, he opined the Petitioner was capable of working sedentary work duties.

The Petitioner testified that Dr. Millikan told him at that point that he would not be able to walk anymore if he underwent the surgery. Unfortunately, there are no records of Dr. Millikan to review to determine if he indeed indicated this to Petitioner and what the basis of such opinion would be. The Arbitrator does note that Dr. Mitsos' 3/1/18 record review indicates that he reviewed records of Dr. Millikan which stated that Petitioner's inguinal mesh was not infected but was inflamed and that Millikan had removed as much of the mesh as he could without threatening the loss of the left lower leg due to the mesh being close to the iliac vein, and that he had nothing else to offer other than that Petitioner was unable to work. Again, there are no records of Dr. Millikan in evidence to support either his conclusions or the bases for how he may have come to such conclusions.

In Dr. Mitsos' 3/1/18 record review he indicated the Petitioner may have suffered a meralgia paresthetica as a result of the surgery, which is very hard to diagnose and treat, but that this was moot as to the workers'

compensation claim as there was a large gap in treatment after 1/25/07 until 2016, and that the Petitioner had treated for a number of unrelated but significant medical conditions in this time period. He opined that Petitioner's left hernia condition had resolved and he was no longer being treated for a condition that would be considered secondary to the work accident. He also opined that Petitioner had reached maximum medical improvement sometime between 2007 and 2014.

The significant number of missing medical records in this case, including those of Dr. Millikan and pain management records, some of which are referenced in the reports of Dr. Mitsos and some of the vocational evaluations, creates a significant amount of difficulty for the Arbitrator in trying to come to conclusions regarding the issues in dispute in this matter, particularly since there are no treating records whatsoever to review for a period of over seven years between May 2006 and July 2013. In particular, the records of Dr. Millikan would be highly relevant and important in this matter. The Arbitrator also notes with interest that the Petitioner rejected a third surgery recommended by Dr. Mitsos, despite his ongoing complaints, as well as a specialist referral from Dr. Peoples in January 2014. The key thing to understand here is that the Petitioner bears the burden of proof in this case, and thus it was his burden to produce the evidence necessary to support his case.

Based on the evidence available in the record, the Arbitrator finds that the Petitioner reached MMI sometime between May 2006 and July 2013. The evidence in the record makes it virtually impossible to determine a specific date in this period. The only "treatment" referenced for the Petitioner in the record of evidence after July 2013 would be a prescription for Norco from his primary care provider. The Arbitrator also notes that Petitioner was treating with Dr. Peoples for multiple unrelated health issues as well.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

The only claimed unpaid medical expenses submitted into evidence by Petitioner are from Dr. Peoples. (Px3). The invoice documentation references dates of service from 7/29/13 through 2/15/17 (21 visits) with an outstanding balance totaling $16.15. This invoice also notes payments by BlueCross/BlueShield, adjustments and bad debt credits, but no total for this, other than that the balance listed is from a 2/11/13 visit. After reviewing the bill, the Arbitrator finds that Petitioner has failed to prove, beyond a preponderance of the evidence, that this date of service is causally related or medically necessary to the instant claim. Petitioner has been treating with Dr. Peoples for both related and unrelated health issues and the Arbitrator did not locate a medical report from 2/11/13 in evidence, so there is no way to tell what the purpose of that visit was or if it had anything to do with the left groin condition. Moreover, some of the balance has previously been paid by insurance or has been written off as bad debt. This bill is denied.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

According to Arbitrator's Exhibit 1, the parties have stipulated that the Petitioner is entitled to temporary total disability from 6/15/05 through 1/15/14. The parties have also stipulated that the Petitioner is entitled to maintenance benefits from 1/16/14 through 5/17/17, and that the Respondent has paid a total of $293,118.47 in TTD benefits and $114,029.16 in maintenance benefits.

With respect to allegedly unpaid benefits, Petitioner is seeking maintenance benefits from 5/18/17 through the 5/15/19 hearing date. The payment ledger submitted at trial by Respondent establishes that Petitioner was paid either TTD or maintenance benefits from the time of the injury until benefits were terminated on 5/17/17. (Rx2).

Petitioner testified he had applied for SSDI benefits by the time of his vocational evaluation in 2012. There is no evidence which would support whether he is receiving or is not receiving such disability benefits. If he is receiving them, there has been no evidence produced which would indicate whether such disability benefits are based on the left groin injury in whole or in part, or whether the award of such benefits is related to Petitioner's multiple comorbidities. The Petitioner has submitted a number of job logs into evidence, but many have a paucity of information in them, and there are multiple gaps in time in these logs. Most importantly, there simply is no evidence in the record which would support a valid determination of what the Petitioner's actual physical abilities have been since 5/10/06 or what they currently are beyond Petitioner's subjective symptomatic complaints.

Ultimately, the Arbitrator has not been provided with sufficient evidence to make any determinations with regard to this issue beyond what the parties have stipulated to. Therefore, the Arbitrator finds that, per stipulation of the parties, the Petitioner is entitled to TTD benefits from 6/15/05 through 1/15/14 and to maintenance benefits from 1/16/14 through 5/17/17. The Petitioner has failed to prove entitlement to further lost time benefits after 5/17/17.

The Respondent is entitled to a stipulated credit against this award totaling $407,147.63 based on payments of TTD and maintenance made by Respondent to Petitioner prior to hearing.

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, five criteria/factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after 9/1/11. As the accident in this case occurred prior to 9/1/11, §8.1b of the Act is not applicable in this case.

As noted above, the Arbitrator finds that the Petitioner sustained a left inguinal hernia as a result of the 6/14/05 accident. This led to two separate surgeries, the first to repair the hernia with the use of mesh, and the second being exploratory to try to determine a basis for Petitioner's ongoing complaints. No records were submitted into evidence reflecting Dr. Millikan's diagnosis or why he determined that such surgery was reasonable to perform at that time. This is particularly problematic since this was after the Petitioner had been released by Dr. Holt, the original surgeon, along with his statement that there was no medical reason for the Petitioner not to return to work. The 5/10/06 surgery did indicate that a patch of the implanted mesh was adherent to a nerve, which Dr. Millikan stated "we think" was the ilioinguinal nerve, and this provides a reasonable inference that the surgery was reasonable and necessary. Pathology determined that removed fragments of tissue showed evidence of fibrosis, acute and chronic inflammation and abscess formation. Also noted was foreign body giant cell reaction and perivascular chronic inflammation. Unfortunately, there are no records in evidence which explain what these processes are, how they may have occurred and impacted Petitioner at that time or how they might impact him in the future.

There then was an examination by Dr. Mitsos at the Respondent's request in January 2007, at which time he opined that Petitioner could be suffering from infection and recommended an additional surgery. Again, there are no subsequent records in evidence from Dr. Millikan for the Arbitrator to review, though a later record review by Dr. Mitsos noted that Millikan apparently had indicated further impact to the noted nerve could cause

Petitioner to "lose" his left lower leg. Again, the lack of evidence in the records leads to a lack of clarity as to how such a conclusion would have been reached, as there are no records or depositions by which to understand how Dr. Millikan may have come to such conclusion.

Only from the record review of Dr. Mitsos is it understood that Dr. Millikan at some point believed the Petitioner could not work. However, the Arbitrator would be hard pressed to give this determination any significant weight without the records of the doctor who is making such an opinion in evidence for review. Dr. Mitsos then indicates that he believed Petitioner reached MMI sometime between 2007 and 2014, and that his left groin condition had resolved long prior to the March 2018 record review and that he was no longer being treated for such condition. While Dr. Mitsos had previously opined in 2007 that the Petitioner was restricted to sedentary duty, this was his determination pending the surgery he recommended.

There are multiple subsequent vocational reports which attempt to determine what the Petitioner's prospects are for re-employment, as well as what he might be able to earn in such position. The Arbitrator cannot put any significant weight on these reports either as there has been no true determination of the Petitioner's work abilities, which is a key factor in any vocational evaluation. Of great importance in this regard, in the Arbitrator's view, is that Dr. Mitsos indicated that an FCE had been performed, however the FCE report was not included in the evidentiary record. Thus, it cannot be determined from the evidence what may have been found in terms of the Petitioner's functional physical abilities, nor whether it was a valid or invalid test. Additionally, the Petitioner has a valid CDL at this time, which necessarily either requires him to have undergone and passed a physical or at minimum provide his own certification that he was physically capable of driving a truck. He also has obtained a culinary arts degree in 2012. It is unclear why he would have obtained this degree if he was unable to perform the jobs associated with such degree. Following the 4/12/12 vocational evaluation, there were some reasonable recommendations that Petitioner was advised to follow up on, and there is no evidence indicating that he did so with any of the noted recommendations, including obtaining an updated medical evaluation and discussing job opportunities with the culinary arts program assistant at Triton College.

Ultimately, the burden is on the Petitioner to prove up the elements necessary to support a determination of either a permanent total disability, a wage differential or a percentage of a person in this case. The lack of relevant and necessary evidence in this case, as outlined in detail throughout this decision, leaves the Arbitrator unable to find that the Petitioner is either permanently and totally disabled or that he was unable to return to his regular job, whether the Respondent may have had any ability to accommodate validly determined work restrictions, or what Petitioner might be able to earn currently. The determination of Dr. Peoples, a general practitioner, that the Petitioner is unable to work without any explanation of the basis for this opinion does not carry much weight here. It is entirely possible that her statements are just a parroting of what the Petitioner may have told her, as there is no indication in the records of Dr. Peoples that she determined such a conclusion on any examination or test results. Therefore, the Arbitrator finds that the evidence supports only a finding regarding a percentage of loss in this case.

The Arbitrator believes the Petitioner sustained what typically would have been a relatively minor repairable injury, an inguinal hernia, which then appears to have gone on to involve a nerve or nerves in the inguinal area. The Petitioner then had an opportunity to seek a third surgery, which he declined. He may have had valid reasons for declining this, but without medical records to explain the situation, it is impossible for the Arbitrator to make any findings in this regard. It does appear that the injury may have significantly impacted the Petitioner's ability to work, but he has not produced sufficient evidence to make any factually supported conclusions. Based on the above factors, the record taken as a whole and a review of prior Commission awards with similar injuries similar outcomes, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of the loss of use of 20% of the person as a whole pursuant to §8(d)2 of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	14WC019027
Case Name	TAYLOR, ROBERT L v. NORTHWESTERN MEMORIAL HOSPITAL
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0292
Number of Pages of Decision	23
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Hayley Graham
Respondent Attorney	Christine Jagodzinski

DATE FILED: 6/14/2021

/s/Deborah Simpson, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT TAYLOR,

Petitioner,

vs. NO: 14 WC 19027

NORTHWESTERN MEMORIAL HOSPITAL,

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, PPD, and medical expenses both current and prospective, and being advised of the facts and law, changes the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner worked for Respondent as a registered nurse. As a requirement of his employment, Petitioner was directed to take an MMR vaccine, which protects against measles, mumps, and rubella. Petitioner testified to "allergic breakouts" after the injection, sought treatment, and was diagnosed with Fibromyalgia. In this claim, Petitioner alleges taking the vaccine resulted in his developing chronic urticaria (hives) and angioedema (swelling), for which he seeks compensation.

The Arbitrator found that Petitioner did not sustain his burden of proving his current conditions of ill-being of urticaria and angioedema were caused by administering the vaccine. The Commission agrees with the Arbitrator's analysis and conclusions in this regard. Therefore, we affirm and adopt those aspects of the Decision of the Arbitrator.

The Arbitrator also found that Petitioner did not provide adequate notice of his alleged accident/injury. Petitioner received the vaccine on January 25, 2014. He saw an allergist, Dr. Ghani, on February 25, 2014, who first posited that there could be a relationship between the vaccine and the conditions of ill-being. He sent that note to Respondent on March 12, 2014. His note indicated that since Petitioner received the vaccine he developed these symptoms. The Arbitrator stressed that the notice was clearly past the 45-day statutory limit and that the note was too vague as to actually put Respondent on notice that Petitioner may have a WC claim.

The Commission agrees with the Arbitrator that Petitioner did not prove accident or causation to a condition of ill-being. However, the Commission is not so convinced concerning the Arbitrator's finding on notice. The Act requires notice within 45 days of the time a claimant knew, or should have known, of a possible causal connection between a condition of ill-being and work-related activities. There is no evidence that Petitioner had any knowledge of any possible connection between his ongoing symptoms and receiving the vaccine until his initial visit with Dr. Ghani on February 25, 2014. The March 12th notification was 47 days after the accident but is was clearly within 45 days of the time Petitioner became aware of the possible connection. In addition, the Commission is required to construe the notice requirement liberally on behalf of the claimant and Respondent should show some prejudice due to the delay in notice.

Respondent has not alleged prejudice from delay in notification, and the Commission does not see how it could have been prejudiced by the delay. This is not a case in which a claimant claimed a physical accident resulting in an acute injury, where the employer could seek witnesses and conduct possible other investigations. This claim involves a scientific/medical assessment and not any on-the-ground investigation. In addition, we do not see how Petitioner could have affected his condition, and therefore his claim, between the date of his becoming aware of the possible work-connection and the date of his notice. The Commission concludes that even though Petitioner's notice was not perfect, it would not bar Petitioner's claim if he had been able to prove accident and causation.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated March 31, 2020 is affirmed and adopted, except as noted above.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner has failed to prove accident or causation to a current condition of ill-being and compensation is denied.

June 14, 2021

/s/*Deborah L. Simpson*
Deborah L. Simpson
/s/*Steven J. Mathis*
Steven J. Mathis
/s/*Deborah J. Baker*
Deborah J. Baker

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DLS/dw
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ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0292
NOTICE OF ARBITRATOR DECISION

TAYLOR, ROBERT L
Employee/Petitioner

Case# **14WC019027**

NORTHWESTERN MEMORIAL HOSPITAL
Employer/Respondent

On 3/31/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0009 ANESI OZMON RODIN NOVAK ET AL
HAYLEY K GRAHAM SLEFO
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

2461 NYHAN BAMBRICK KINZIE & LOWRY
CHRISTINE M JAGODZINSKI
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602-4195

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

Robert L. Taylor
Employee/Petitioner

Case # **14 WC 019027**

v.

Consolidated cases: ____

Northwestern Memorial Hospital
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 **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **April 30, 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 **12/27/2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$45,380.11**; the average weekly wage was **$872.69**.

On the date of accident, Petitioner was **48** years of age, ***married*** with **1** dependent child.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

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

Respondent is entitled to a credit of **$1,537.33** under §8(j) of the Act.

ORDER

Given that Petitioner failed to prove that sustained an accident that arose out of his employment by Respondent and that he failed to prove that he gave timely notice of his claimed accident to Respondent and that he failed to prove that his current condition of ill-being is causally related to his claimed accident, Petitioner's claim is denied.

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

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

Signature of Arbitrator

March 25, 2020
Date

MAR 3 1 2020

Robert L. Taylor v. Northwestern Memorial Hospital
14 WC 19027

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***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 accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services; ***K:*** What temporary benefits are in dispute? *TTD*; ***L:*** What is the nature and extent of the injury?

FINDINGS OF FACT

Petitioner Robert Taylor testified that he was employed by Respondent Northwestern Memorial Hospital as a registered nurse. Petitioner had worked for Respondent for approximately 14 years prior to his accident. He worked part-time: two 12-hour shifts per week since 2002. He had a measles, mumps, and rubella (MMR) vaccination at Respondent's Employee Wellness Center on December 27, 2013. Petitioner testified that he was required to receive the vaccination as part of his employment with Respondent. Petitioner testified that he worked the overnight shifts and sometimes confused dates, which is why some records indicated that he had the vaccination on December 26, 2013 rather than December 27.

Petitioner testified that the next day, December 28, he noticed swelling on his upper lip and left hand. He also had hives and an itchy rash. He iced the swelling and drank cold water and took Benadryl to minimize the symptoms. He worked his next scheduled shift despite his symptoms.

Petitioner testified that he consulted Respondent's internal research system, which contains information on side effects from different procedures or conditions. The research system is used to inform patients when they are being discharged. He looked up side effects of the MMR vaccine. Petitioner stated that the research noted that swelling and itching were listed as side effects that could last a few days.

Petitioner's symptoms progressed over the next few weeks to swelling in his abdomen, upper and lower lips, testicles, and throat. He continued to work, but had a couple of "call-offs" over the following weeks. He eventually sought medical treatment as the symptoms progressed. He testified that he called an allergist, Dr. Mohammad

Ghani, in January 2014 to schedule the next available appointment, which was February 17, 2014.

Petitioner presented to Dr. Ghani for an initial visit February 17, 2014. He gave a history of swelling, itchiness on his lips, chin, eyes, as well as swelling of his tongue and hives since having the MMR vaccine on December 27 (PX #1).

Petitioner testified he had hives in early November 2013 after he purchased a wool coat. He had a red rash and took Benadryl. He testified he stopped wearing the coat around Thanksgiving and his symptoms went away. Mr. Taylor stated he told Dr. Ghani about the wool coat when he first saw him. Petitioner was unable to undergo scratch testing to determine the cause or confirm his allergies as he could not stop taking antihistamines for 7 days. According to the records Dr. Ghani ordered a lab workup and prescribed Pepcid, prednisone, Zyrtec, steroids, and Benadryl. Petitioner testified that Dr. Ghani prescribed Claritin.

Petitioner returned to Dr. Ghani on February 25, 2014 to discuss the lab results. The labs were normal except a high IgE, over 300, when it was only supposed to be 0-100. Petitioner testified he understood that to mean he had been exposed to an allergen. He testified that Dr. Ghani said the MMR was the likely cause since his symptoms began right after receiving the injection. Petitioner further testified that Dr. Ghani gave him a note that detailed that he had been suffering from urticaria (hives) and angioedema (swelling) since receiving the MMR and that he should not undergo any additional vaccinations until his symptoms resolved. Dr. Ghani also recommended continued Zyrtec and Pepcid.

Petitioner testified on cross-examination that he never had a workers' compensation claim before or been injured on the job before. He further testified that he did not ask for a workers' compensation claim to be set up and continued putting his treatment through his group health insurance because at the time, he did not really know what was going on or where his symptoms were coming from.

Petitioner further testified that he was not aware of the procedure for reporting a work-related injury. He did not research what he was supposed to do. Petitioner also stated that he was still able to continue going to work and thought the symptoms would just eventually pass. He also acknowledged that he did not report his MMR reaction to his supervisor Cynthia Wolpert or that he completed an employee incident report.

Petitioner testified that he faxed the February 25, 2014 letter from Dr. Ghani (PX #7) to Brian Nathe, a Safety Officer in the Human Resources Department, on March 12,

2014. Petitioner testified he sent a follow-up email to Mr. Nathe advising of same and received an email back from Mr. Nathe acknowledging receipt on March 14, 2014 (PX #8). Petitioner testified he sent the letter to advise Respondent that he had been suffering from the urticaria and angioedema since the MMR vaccination and would not be able to undergo any additional vaccinations at that time.

On redirect examination Petitioner testified that he did not connect the MMR to his symptoms until Dr. Ghani reviewed the initial lab results with him.

Petitioner testified that he continued to follow up with Dr. Ghani on a monthly basis through July 25, 2014. His symptoms waxed and waned over that time. He testified that he had fairly regular outbreaks, approximately 5 per month. He described his outbreaks as swelling along his face, throat, colon, and genitals. He also had hives along his trunk, legs, and neck. He received a DepoMedrol injection March 31, 2014.

Around July 2014, Petitioner began to have pain in his shoulders, hips, and ankles. He was authorized off work as of August 14, 2014. He had persistent joint pain and Dr. Ghani prescribed Mobic on October 20, 2014. The Mobic caused rectal bleeding, so he stopped taking the medication.

Petitioner testified that the he continued to see Dr. Ghani with persistent hives and swelling, but that he also continued to have the joint pain and swelling. Petitioner testified that Dr. Ghani suggested he see a rheumatologist. He further testified that Dr. Ghani had restricted him from working from October 23, 2014 through December 1, 2014. He last worked on October 23, 2014.

Petitioner saw Dr. Lynn Meisles, a rheumatologist, November 10, 2014, complaining of joint and muscle pain since August 2014 (PX #5). Petitioner complained of pain in both feet and ankles, right worse than left, as well as bilateral knee pain. Petitioner also complained of pain in both shoulders, right worse than left. He had a history of urticaria and angioedema since December 2013. Petitioner did not give a history of the December 2013 MMR vaccination. She did a work-up for arthritis and dehydration. X-rays of the right shoulder, ankle, and foot were negative for arthritis. He continued to treat with Dr. Ghani and Dr. Meisles simultaneously.

On December 15, 2014, Petitioner returned to Dr. Meisles, who reviewed the lab tests, which were unremarkable. Petitioner complained of difficulty sleeping and staying asleep as well as difficulty staying focused. He also complained of pain around his hips, pelvis, neck, bilateral shoulders, bilateral trapezius, elbows, and wrists. Dr. Meisles administered a left shoulder/subacromial bursa cortisone injection. She restricted him from working through December 24, 2014.

Dr. Meisles administered a Depo-Medrol injection December 31, 2014. The injection relieved the joint pain. On January 12, 2015, Petitioner returned to Dr. Meisles complaining of pain across his chest, back, neck, and headaches. He also reported fatigue and difficulty sleeping. Dr. Meisles noted multiple positive tender points, including bilateral trapezius, bilateral costochondral joints, bilateral elbows, bilateral hips, and bilateral knees. Dr. Meisles diagnosed fibromyalgia. She recommended physical therapy and prescribed Cymbalta. She restricted him from working through January 30, 2015.

Petitioner underwent an initial evaluation for physical therapy at Midwest Physical Therapy January 26, 2015 (PX #4). He reported pain in his thighs and hips, low back, midback, neck shoulders, and headaches. His ranges of motion were decreased due to pain. The physical therapist noted that Petitioner's symptoms were consistent with fibromyalgia. There was no note of the date of onset of the complaints or any reference to an MMR vaccination. Therapy was recommended to continue 3 times per week for 4 weeks.

Petitioner returned to Dr. Meisles February 9, 2015. He reported improvement with Cymbalta but still had stiffness and pain. Dr. Meisles continued with the diagnoses of fibromyalgia. She recommended he decrease physical therapy to once a week. Petitioner went to 4 sessions of therapy through February 17, 2015, after which he was officially discharged on May 6, 2015, with minimal progress noted.

Dr. Ghani wrote narrative reports dated February 20, 2015 (PX #2 & DepX #2) and June 20, 2016 (PX #2 & DepX #3), in which he stated Petitioner had been under his care for urticaria and angioedema. These letters were not included in Petitioner's Exhibit #1, Dr. Ghani's clinical chart. Dr. Ghani noted that Petitioner had had intermittent hives that began in November 2013 and were treated and resolved with over-the-counter medications. Dr. Ghani further noted that after Petitioner received an MMR vaccine on December 27, 2013 Petitioner developed "swelling of the lips, chin, eyelids, and tongue and were persistently requiring multiple antihistamines and steroids," (PX #2 & DepX #3). Dr. Ghani stated that he "performed a thorough history, physical, and allergy work up, but no other definite trigger of cause for his symptoms was found" aside from Petitioner receiving the MMR vaccine.

On May 21, 2015, Petitioner returned to Dr. Meisles with continued pain and generalized positive tender points. Dr. Meisles recommended Lyrica. Petitioner continued to see Dr. Ghani on a monthly basis and had persistent swelling and hives despite his prescription steroids and antihistamine regimen.

Petitioner took FMLA leave when he had been off since October of 2014. When it ran out and he could not return to work, he was terminated on June 22, 2015 (PX #12).

Petitioner testified he had never had a workers' compensation claim before nor had he been injured on the job before. He further testified that he did not ask for a workers' compensation claim to be set up immediate and continued putting his treatment through his group health insurance because at the time, he did not really know what was going on or where his symptoms were coming from.

Petitioner further testified that he was not aware of the procedure for reporting a work-related injury. He did not research what he was supposed to do. Petitioner also stated that he was still able to continue going to work and thought the symptoms would just eventually pass.

Petitioner testified that he faxed the February 25, 2014 letter from Dr. Ghani (PX #7) to Brian Nathe, a Safety Officer in the Human Resources Department, on March 12, 2014. Petitioner testified he sent a follow-up email to Mr. Nathe advising of same and received an email back from Mr. Nathe acknowledging receipt on March 14, 2014 (PX #8). Petitioner testified he sent the letter to advise Respondent that he had been suffering from the urticaria and angioedema since the MMR vaccination and would not be able to undergo any additional vaccinations at that time.

Petitioner continued to follow up with Dr. Meisles for his fibromyalgia. He last saw Dr. Meisles January 16, 2017. He continued to have pain, stiffness and fatigue. She recommended continued exercise and prescribed Lyrica and duloxetine (Cymbalta). Petitioner testified that his insurance changed, and he could no longer see Dr. Meisles through his network. He further testified his care was transferred to his primary care physician for medication management of both his fibromyalgia and chronic urticaria and angioedema.

Petitioner's last visit with Dr. Ghani was March 10, 2017. At that time, he continued to report episodes of angioedema and difficulty swallowing during the outbreaks. Dr. Ghani was prescribing Ambien, Levocetirizine, Montelukast, Meclizine, Banophen, Cymbalta, Lyrica, EpiPen, Pepcid, Vitamin D, Senokot Tablet, and Lyrica.

On December 4, 2015, Petitioner presented as a new patient to Dr. Tamajah Gibson at Austin Family Health Center/Melrose Park Family Health Center (PX #6). He complained of 4/10 "body" pain. His main issues included dizziness. He had two falls with symptoms since February 2014. He reported trouble sleeping. Petitioner reported that he had visual changes and ringing in the ears. His blood pressure was

140/92 and had a 41.19 BMI. Petitioner's medical history of current problems included vertigo, disorder of vision, unspecified fall, dizziness, fibromyalgia, unspecified allergy, and angioneurotic edema (later corrected to angioedema), and morbid obesity. No history of adverse or allergic reaction to MMR or other vaccination was noted.

Dr. Gibson diagnosed vertigo, falls, dizziness, fibromyalgia, allergies, and morbid obesity. Dr. Gibson recommended water therapy for his fibromyalgia, MRI of the brain, and an evaluation with an ENT to determine the cause of his dizziness. Petitioner's medications included Meclizine, an EpiPen, Banophen, Ambien, Famotidine, Singular, Xyzal, Duloxetine, Lyrica, and Amlodipine.

Petitioner continued with medical care at Melrose Park Family Health Center through 2016. Dr. Gibson referred Petitioner for physical therapy for his fibromyalgia. Petitioner was evaluated at Westlake Hospital February 9, 2016. In history, Petitioner reported the onset of angioedema and urticaria August 2014, which began after going on a steroid and antihistamine regimen. There was no notation of an MMR vaccination.

Petitioner was seen by behavioral health provider Cesar Madrigal on May 11, 2016 (PX #6). Petitioner was noted as socially withdrawn, having poor self-esteem and financial issues. It was noted, "Pt. worked as an RN, on a new job he obtained a year ago during the orientation, he was mandated to take an antibiotic which caused his physical symptoms which led to him being disabled." Petitioner was diagnosed with depression. There was no note regarding an MMR vaccination. There was no note regarding causation. Petitioner's care was complicated by his diagnosis of Type II diabetes.

Petitioner had a pain management assessment at APAC Groupe May 12, 2016 (PX #6). Petitioner was referred for evaluation of dizziness, vertigo, and a couple of falling episodes. He reported that he last felt well in 2013 "just prior to getting MMR vaccine." He reported that the next day he developed edema of the lips and hands and thereafter developed hives and angioedema. 5 to 6 months after that he developed joint and muscle pain and was diagnosed with fibromyalgia. Pertinent medical history included fibromyalgia, hypertension, depression, headache, chronic pain syndrome, sexually transmitted disease, sleep apnea, and gastric ulcer. Petitioner also reported 5 falls since May 2015 due to dizziness. The neurological examination was unremarkable other than mild swaying to the left with eyes closed and antalgic gait.

It was noted, "Symptoms seem to have started around the time when several pharmaceuticals where started, beginning with Cymbalta worsening with the addition of Lyrica." It was also noted that Petitioner had "an interesting progression of problems since late 2013 after having MMR vaccine (allergy, then chronic urticaria, then FMS, then dizziness)." There was no note regarding causation of any of Petitioner's symptoms or diagnoses.

Petitioner testified he had undergone an MMR vaccination on June 29, 2009 for his employment with Respondent. He had no side effects from that vaccination. Petitioner further testified that an individual can develop allergies at different stages of life.

Petitioner testified that he was healthy prior to his outbreak of hives in November 2013 that had resolved prior to the MMR vaccine. He attributed the hives to a wool coat he had purchased. After he stopped wearing the coat, the hives went away. He did not seek medical treatment and just took over-the-counter antihistamines. Petitioner further testified that the only allergic reaction he had to food was to strawberries as a child.

Petitioner testified that he had trouble sleeping prior to the MMR vaccine, but it had worsened after. He attributed his previous sleep issues to his overnight schedule for work.

Petitioner testified that he experiences side effects from his medications, including drowsiness throughout the day and after sleeping at night, unrestorative sleep and loss of focus. Petitioner further testified that he still experiences pain and discomfort in his shoulders, hips and back that he rates at a 3 - 8/10. He stated that his symptoms are exacerbated by temperature and activities.

Petitioner testified that he has not worked since October of 2014, but at this time, no doctor has him authorized him off work at this time. Petitioner further testified that he applied for and was awarded Social Security disability benefits approximately 3 months ago. Petitioner stated that he continues to suffer from allergic outbreaks with hives and swelling approximately twice per month that last for several days. Petitioner testified that the medications he has to take during the outbreaks leave him fatigued and able to do little of anything during the outbreak.

Brian Nathe testified on behalf of Respondent. He has worked for Northwestern Medicine as a Safety Officer II in the Human Resources Department. Mr. Nathe testified that his role involved Joint Commission compliance, meaning he helped keep the hospital and its employees in compliance with various regulations, as well as occupational injury reduction, meaning identifying high injury areas and developing solutions for improvement.

Mr. Nathe testified that there were 3 ways for employees to report work injuries: 1) electronically through SafetyNet; 2) directly through a supervisor; or 3) going to Corporate Health. Mr. Nathe testified that employees were provided the procedure for

reporting an injury at new employee orientation. He further testified that employees were to fill out "incident reports" if they were injured on the job. He noted that they were identified as "incident" reports rather than "injury" reports because they encouraged "over-reporting."

Mr. Nathe testified that he was not Petitioner's supervisor. Cynthia Wolpert was Petitioner's supervisor. When presented with Petitioner's Exhibit #8, he testified that he recognized his email address, but did not specifically recall the correspondence contained within the emails. He noted that he cc'd Ms. Wolpert because she was Petitioner's supervisor.

Mr. Nathe further testified that he would have reviewed the note from Dr. Ghani (PX #7) when he received it via fax from Petitioner. He testified that despite Dr. Ghani's note stating, "Robert has been suffering from urticarial and angioedema since he received the MMR vaccine," he did not request Petitioner fill out an incident report. Mr. Nathe testified that this did not raise a red flag to him as being an "incident." He further testified that he did not inquire as to how long previously Petitioner had undergone the MMR vaccine. Mr. Nathe testified that he would have forwarded the note from Dr. Ghani to one of two committees to review the in determination of whether Petitioner could have an accommodation to not undergo a TDAP vaccination. Mr. Nathe testified that he was not aware if anyone from the committee that reviewed the note had requested that Petitioner fill out an incident report.

Evidence Deposition of Dr. Mohammed Ghani, March 21, 2017 (PX #3)

Dr. Mohammad Ghani testified by evidence deposition on March 21, 2017. Dr. Ghani specializes in allergy and immunology. He is board-certified in pediatrics and allergy/immunology.

Dr. Ghani testified that he first saw Petitioner on February 17, 2014. Petitioner told him he had had hives in November 2013 that improved with Benadryl. Petitioner then had an MMR injection and he told Dr. Ghani he started getting sick with hives that did not respond to Benadryl and antihistamines. At the first examination, Petitioner did not have hives, but Petitioner then showed pictures of his angioedema of the lips and hives on his body. Dr. Ghani testified that he planned to do a work-up to determine what could have been the possible cause of the hives. He ordered bloodwork to check immune markers to see what may be triggering the hives. Dr. Ghani stated he thought Petitioner could have an allergy or a thyroid or autoimmune condition causing his hives. He saw Petitioner again on February 25, 2014 and recommended that Petitioner hold off on the Tdap immunization requested by work.

Dr. Ghani testified that Petitioner's IgE was a little bit high and he tried to switch medications, so he could run allergy tests. Dr. Ghani could not initially recall whether he performed allergy tests, but then confirmed no allergy testing was done after reviewing the electronic record.

Dr. Ghani stated Petitioner was ready to go back to work, but Petitioner needed the Tdap vaccination, so he checked his titers to see if he was immune or not. Because Petitioner was immune, Dr. Ghani stated he did not require another shot. Dr. Ghani did not mention any statement by Petitioner that he had had hives in November 2013 related to a wool coat.

Dr. Ghani testified that Petitioner began seeing a rheumatologist because his joint pains took over more of a problem than his hives at that time. On April 27, 2015, Dr. Ghani noted Petitioner was essentially stable. He was getting some hives, but they resolved on their own within 20 or 30 minutes. Dr. Ghani testified that Petitioner was tested to determine if he had a remote cause of hereditary angioedema, Dr. Ghani believes that test was negative.

Dr. Ghani testified that Petitioner's diagnoses included chronic urticaria and angioedema with the triggering factor the MMR immunization based on his history. When asked further whether the chronic urticaria and angioedema might or could be related to the MMR vaccine, Dr. Ghani stated, "it could be, or it may be, but we have no definite proof." Dr. Ghani further stated that Petitioner had no prior history of any allergies before these episodes. He based his causation opinion on a "cause and effect" relationship, which he stated was an accepted process.

On cross-examination, Dr. Ghani stated he could not say 100% whether Petitioner's hives that began in November 2013 had completely resolved before he got the MMR vaccine. Dr. Ghani also testified that hives are not a typical side effect of the MMR vaccine, but stated he does see about 4 or 5 cases a year. Dr. Ghani stated that the MMR vaccine could have caused the hives, but he had never seen anyone with hives lasting this long. Dr. Ghani admitted that sometimes children who have hives after the MMR vaccine are highly allergic to eggs and that MMR is produced in an egg embryo. Dr. Ghani further testified he has not seen any cases of angioedema resulting following the MMR vaccine. Dr. Ghani stated Petitioner does not have a history of any foods affecting him.

Dr. Ghani also testified that a person can have idiopathic urticaria which can be chronic in nature where doctors are unable to determine the cause. Dr. Ghani did not know if Petitioner had any prior MMR vaccinations. He also testified he thought Petitioner had no previous history of any allergies. This was per Petitioner's report to him, but he never had the opportunity to review any medical records to confirm that information. Dr. Ghani testified there has been no definite trigger that he could discern

while treating Petitioner. Dr. Ghani admitted there is no reference to a food diary in his records, but stated Petitioner kept very excellent records of his daily activity, everything that he did.

Dr. Ghani stated the elevated IgE exhibited by Petitioner suggested that he had some allergies. However, Dr. Ghani did not know what type of allergies Petitioner had because he was unable to perform allergy testing.

Dr. Ghani admitted that he did not know of any literature that reported a cause and effect relationship between hives and angioedema and the MMR vaccine. He further testified that idiopathic hives occur even if no cause is identified. He testified that has not found the definitive cause of Petitioner's hives.

Dr. Ghani wrote two narrative letters: February 20, 2015 and June 20, 2016 (PX #2). In both letters Dr. Ghani recited his treatment of Petitioner for urticaria and angioedema, which symptoms began after receiving MMR vaccine on December 27, 2013. Dr. Ghani stated he obtained a thorough history, physical, and allergy workup, but no other definite trigger or causes for Petitioner's symptoms were found.

Dr. James Grober Record Review (RX #4)

At the request of Respondent, rheumatologist Dr. James Grober reviewed the records of Northwestern Memorial Healthcare, Dr. Muhammad Ghani and Dr. Lynn Meisles and wrote a report, dated June 5, 2016 (RX #4). Dr. Grober opined that Petitioner's diagnosis was fibromyalgia and idiopathic urticaria and angioedema. Dr. Grober further opined that the cause of Petitioner's fibromyalgia is unknown and that the MMR vaccination on December 27, 2013 did not cause or aggravate the fibromyalgia. Dr. Grober also stated that Petitioner's urticaria and angioedema were pre-existing conditions.

Dr. Grober stated that he could not opine whether Petitioner is capable of working full duty as a registered nurse. He also noted that if Petitioner's urticarial and angioedema persisted, he would require medication and continued care under an allergist. Dr. Grober stated that if Petitioner's fibromyalgia symptoms persisted he would require medication and continued care from a rheumatologist. He also indicated Petitioner may benefit from a sleep study. Dr. Grober noted that none of his recommendations were causally related to the MMR vaccine Petitioner received on December 27, 2013.

Dr. Alan Resnick Record Review (RX #5)

On September 16, 2016, Dr. Alan Resnick reviewed records sent to him at the request of Respondent and medical literature and wrote a report (RX #5). Dr. Resnick stated, "I am unable to reference any study that indicates that the MMR vaccine is a cause for chronic urticaria and angioedema." He also noted that he had been a practicing allergist for more than 30 years and had never seen a patient who's chronic urticaria and angioedema could be traced to an MMR vaccine.

CONCLUSIONS OF LAW

C: Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
F: Is Petitioner's current condition of ill-being causally related to the accident?

The Arbitrator addresses these issues jointly due to their close factual and conceptual relation.

It is undisputed that Petitioner underwent an MMR vaccine at the request of Respondent at the Respondent's place of employment on December 27, 2013. Petitioner testified that in order to maintain his employment with Respondent he was required to undergo the MMR vaccination at Respondent's. However, it is disputed whether Petitioner was injured in an accident or incident (the MMR vaccination) that arose out of his employment by Respondent. It is further disputed whether Petitioner's current condition of ill-being was causally related to the MMR vaccination.

Petitioner's medical records confirm that following the MMR vaccination on December 27, 2013 Petitioner developed swelling (angioedema) and hives (urticaria). Petitioner's symptoms progressed to the point where he consulted an allergist, Dr. Ghani, on February 17, 2014. It is notable that Petitioner continued to work as a nurse between the time of the vaccination and consultation with Dr. Mohammad Ghani. Petitioner was also treated by rheumatologist Dr. Lynn Meisles on referral from Dr. Ghani. Dr. Meisles eventually diagnosed Petitioner with fibromyalgia.

Petitioner relies on the testimony of Dr. Ghani in asserting his claims of accident and causation. Dr. Ghani testified that in his opinion Petitioner developed urticaria and angioedema from the MMR vaccination. Dr. Ghani based his causation opinion on what he called a "cause/effect relationship." Dr. Ghani did not explain the clinical basis for this opinion other than stating a cause/effect relationship is scientifically accepted. On cross-examination Dr. Ghani acknowledged that he was unaware of any published medical research which supported his causation opinion. He also testified that he was

unaware of any reported reaction to MMR comparable to Petitioner's reaction. He finally acknowledged that he had identified a triggering cause of petitioner's hives.

Respondent rebutted Petitioner's claims with the records reviews from Drs. James Grober and Alan Resnick, RX #4 & RX #5. Dr. Grober opined that Petitioner had fibromyalgia and idiopathic urticarial and angioedema. However, he opined that Petitioner's fibromyalgia was neither caused by nor aggravated by the MMR vaccination. Dr. Resnick, after review of Petitioner's medical records and medical research, found no relation between MMR vaccinations and urticarial and angioedema.

The greater number of witnesses in support of a proposition is not necessarily persuasive if the testimony or opinions of a lesser number of witnesses is more persuasive. Here, the Arbitrator finds the greater number of witnesses on the issue of causation to be more persuasive. Further, the Arbitrator particularly finds the cause/effect basis relied on by Dr. Ghani unpersuasive. Dr. Ghani relied on the concept of *post hoc, propter hoc* (after this, therefore because of this). Dr. Ghani confuses correlation with causation. Also, there is no indication in the medical records that Dr. Meisles related any of Petitioner's medical conditions, particularly fibromyalgia, to the MMR vaccination.

In addition, the Arbitrator notes Petitioner's doubtful credibility. The Arbitrator notes that Petitioner was a particularly poor historian for a healthcare professional. When Petitioner transferred his primary care to Melrose Park Family Health Center on numerous occasions he neglected to disclose that he had received an MMR vaccination in December 2013. These encounters were during the pendency of the present claim. If in fact, Petitioner believed the MMR vaccination was the source of his medical problems for which he sought care at Melrose Park Family Health Center one would expect that he would have reported the vaccination in his medical history.

The Arbitrator also found Petitioner's testimony about his lack of knowledge of Respondent's policies and procedures for reporting work related injuries or incidences to be disingenuous and unbelievable.

For these reasons, the Arbitrator finds that Petitioner failed to prove that he sustained an injury that arose out of his employment by Respondent and also that he failed to prove that his current condition of ill-being was causally related to any accident or incident within his employment by Respondent.

D: What was the date of the accident?

There was no genuine dispute that Petitioner had an MMR vaccination on December 27, 2013. Accordingly, the Arbitrator finds the date of claimed accident to be December 27, 2013.

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

The Arbitrator finds that Petitioner failed to give timely notice of his claimed accident to Respondent.

Petitioner testified that he and Dr. Ghani first talked about the MMR vaccine as being the possible cause of his condition at the February 25, 2014 office visit. Prior to that, Petitioner testified he was unsure as to the reason for his condition because he had expected that if it was a side effect of the vaccination that it would simply clear up after a several days. Petitioner testified that on March 12, 2014 he faxed the letter prepared by Dr. Ghani, dated February 25, 2014, that stated, "Robert has been suffering from urticarial and angioedema since he received the MMR vaccine" (PX #7).

Dr. Ghani's February 25 note does not include key words or phrases which would rise to notice of an accident or injury. The note says, "since he received the MMR vaccine." The note does not say "due to the MMR vaccine" or "because of the MMR vaccine." The content of the February 25 note does not state with any clarity whether there was a claimed accident or injury. Dr. Ghani's phrasing required speculation as to whether an injury was sustained as a result of the vaccination. Further, it invites the recipient to guess whether the vaccination was received at work or elsewhere.

Additionally, Petitioner acknowledged that he did not file an employee incident report as required by Respondent's policies and procedures. One would expect a healthcare professional to report to their employer that they believed they sustained an injury of some sort from a mandated vaccination. A registered nurse knows the value and importance of accurate reporting.

There is insufficient information in Dr. Ghani's February 25 note to permit Respondent to begin an appropriate investigation that §6(c) of the Act contemplates.

Further, Petitioner's initial symptoms began the day after the December 27 vaccination. In response, Petitioner investigated Respondent's in-house resource and identified side effects of MMR vaccinations within a few days. Clearly, Petitioner suspected some nexus between his symptoms and the MMR vaccination. This was outside the 45-day notice requirement set forth in §6(c) of the Act.

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

In light of findings stated above, the Arbitrator finds this issue is mooted and that Petitioner failed to prove that the medical care and services and the billing for those services were reasonable or necessary to treat Petitioner's claimed injuries.

K: What temporary benefits are in dispute? *TTD*

In light of findings stated above, the Arbitrator finds this issue is mooted and that Petitioner failed to prove that he is entitled to TTD benefits.

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

In light of findings stated above, the Arbitrator finds this issue is mooted and that Petitioner failed to prove that he is entitled to permanent partial disability.

Steven J. Fruth, Arbitrator

March 25, 2020
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	16WC026839
Case Name	MOTA,LUIS v. PERFORMANCE CONTRACTING INC
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0293
Number of Pages of Decision	14
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Neal Wishnick
Respondent Attorney	Jill Kastner

DATE FILED: 6/14/2021

/s/ Deborah Simpson, Commissioner
Signature

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

Luis Mota,
Petitioner,

vs. NO: 16 WC 26839

Performance Contracting,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 15, 2020, 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.

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

June 14, 2021

O 6/9/21
DLS/rm
046

/s/*Deborah L. Simpson*
Deborah L. Simpson

/s/*Stephen J. Mathis*
Stephen J. Mathis

/s/*Deborah J. Baker*
Deborah J. Baker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0293

MOTA, LUIS
Employee/Petitioner

Case# **16WC026839**

PERFORMANCE CONTRACTING INC
Employer/Respondent

On 6/15/2020, 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 0.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0491 SOSTRIN AND SOSTRIN PC
NEIL K WISKNICK
33 W MONROE ST SUITE 1510
CHICAGO, IL 60603

0766 HENNESSY & ROACH PC
JILL KASTNER
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF **Cook**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Luis Mota
Employee/Petitioner

v.

Performance Contracting, Inc.
Employer/Respondent

Case # **16** WC **26839**

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 **Tiffany Kay**, Arbitrator of the Commission, in the city of **Chicago**, on **January 14, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **July 20, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**82,070.04**; the average weekly wage was $**1,578.27**.

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

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

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $ 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 an accident arising out of and in the course of his employment with Respondent and failed to prove a causal connection between his current condition of ill-being and the alleged work accident of July 20, 2016 with the Respondent, therefore, all benefits are hereby denied.

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

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

Signature of Arbitrator

5/20/2020
Date

JUN 15 2020

PROCEDURAL HISTORY

This matter was heard before Arbitrator Kay on January 14, 2020 in Chicago, Illinois. The submitted records have been examined and the decision rendered by Arbitrator.

The parties proceeded to hearing with the following issues in dispute: whether an accident occurred while Mr. Luis Mota (hereinafter "Petitioner") worked for Performance Contracting, Inc (hereinafter "Respondent"), whether Petitioner's current condition of ill-being is casually connected to his alleged injury, whether Petitioner is entitled to temporary total disability, the nature and extent of his alleged injury and whether he is entitled to prospective care. (Arb.X1)

The parties stipulated that on July 20, 2016, Petitioner and Respondent were operating under the Illinois Workers' Act (hereinafter "Act"), that their relationship was one of employee and employer, that Petitioner provided notice to the Respondent of the accident within the time limits stated in the Act, the calculated average weekly wage pursuant to Section 10 of the Act was $1578.27, Petitioner was 34 years of age, married with 3 dependent children at the time of the accident. (Arb.X1)

STATEMENT OF FACTS AND EVIDENCE

On June 19, 2019 and January 14, 2020 this matter proceeded to hearing before Arbitrator Kay. The matter proceeded as a 19(b)/8(a) hearing, however, the parties agreed that if the Arbitrator felt Petitioner had reached MMI and did not award prospective medical an award could be rendered addressing all issues. At the time of hearing, all medical bills had been satisfied.

Petitioner testified that in May of 2015 he began working for the Respondent, PCI Construction. Petitioner began his career as a carpenter in 2007 and would work through the Union, his duties included lifting drywall weighing up to 80 pounds, sometimes needing to lift more than one piece of drywall at a time. (T11-12) In order to hang the drywall, he would pick up the sheet and then lift up the drywall and screw it onto the wall. (T13)

Prior to working for the Respondent, Petitioner received a settlement for $241,000.00 from Thorne Associates on October 15, 2014. (RX2) According to the contract, the settlement number represented a negotiated wage differential/permanent total based on permanent light/medium duty restrictions. (RX2) The amount of $2,500.00 of the settlement was allocated to future medical and was to be held by Petitioner in a self-administered MSA trust. (RX2) The restrictions were outlined by Dr. Goldberg, on March 7, 2014, of maximum occasional lifting of 40 pounds, maximum frequent lifting of 38 pounds and limit bending of the waist to occasional. (RX5)

On July 20, 2016, Petitioner began his normal workday for the Respondent at approximately 6:00 a.m. At that point, he was working with his supervisor, Sergio. The job was located in Chicago. At that time, Sergio was handing over a drywall sheet and as he was holding it, it slipped off his hands. Petitioner testified he was not able to hold it. He felt he hurt his back and got a *"big lump."* (T15-16) He did not see a doctor that date. He was seen at Concentra on July 26, 2016 and gave a history of lifting something *"similar to drywall"* when he felt pain. (PX4) Upon physical exam, there was no deformity and no swelling observed. (PX4)

Petitioner then began a course of treatment with Dr. Goldberg, he had been seen by Dr. Goldberg for a prior accident in 2013. On September 6, 2013 Petitioner underwent surgery with Dr. Goldberg for a herniation at L4-5. At the time of surgery, it was noted that he also had a herniation at L5-S1, but it was felt the L4-5 disc was responsible

for his symptoms. (PX5) He was ultimately released from care by Dr. Goldberg, following work conditioning, pursuant to a functional discharge summary in March of 2014. (T30) At that time, he spent some time without work and noticed back pain but eventually it went away. (T31) Petitioner agreed that between March of 2014 and July 20, 2016 he did not return to Dr. Goldberg and did not see any other physicians with regard to his back. (T75) He returned to work as a drywall carpenter and from May 2015 forward, he worked in that capacity. (T41-42).

He was first seen by Dr. Goldberg on August 31, 2016. On that date, an MRI and physical therapy was recommended.

Petitioner testified that he did work light duty for the Respondent through October 13, 2016. During that time, he agreed he was offered work 8 hours per day 5 days per week. (T85) He worked the same hours every day and understood the hours he was expected to work. Petitioner denied arriving late and denied that his signature was on a disciplinary notice. He disputed and denied signing the disciplinary notice on August 2, 2016 as he had *"only arrived 2 minutes late."* (T86-87) He testified on rebuttal that he had therapy that morning and that was why he was late. The records from Concentra note Petitioner had therapy on August 1, 2016, and August 3, 2016 but there is no record of therapy from August 1, 2016. (PX4)

Petitioner understood that when he arrived late there was work for him to do and when he left early there was work for him to do. (T89) He further understood that every time he left his light duty assignment there was work he could have been doing. (T90) Petitioner admitted requesting a change in work restrictions from Concentra on numerous occasions stating that he was working light duty but was unhappy about the drive to the work site. (T109-110)

Subsequent to working for the Respondent, he worked at a restaurant and helped his brother in laws. (T50) Petitioner testified that he would work 2 to 3 days a month for just a few days. He would do things like paint panels and *"light things."* (T50)

In 2017, he worked for a restaurant called Gallo. (T58) He worked there for approximately 10 months as a driver/utility person doing deliveries and whatever they needed him to do. (T62). Between July 20, 2016 and the date of hearing, Petitioner had traveled to Mexico 5 times by car, 25 hours each time. (T63)

Petitioner also buys and sells cars at an auction, but he has no idea how much money he has made. (T92) He believes it to be approximately $10,000.00, he began in 2016. (T93)

Petitioner also admitted to working for Nemec Enterprises in 2017. There he would put up a material on the wall to keep the grease off the walls. (T95-96; RX10) He was paid for that work. In addition, he was paid $500.00 by check from Nemec Enterprises to put up a door and install a bathroom sink made from stainless steel. (T97; RX11) In addition, he received a check for $650.00 from Nemec Enterprises to install a bathroom floor. This required him to be on his hands and knees. (T98-99; RX12) He admitted to several cash deposits in his account at TCF Bank, $1,000.00 on September 11, 2017; $3,300.00 on October 16, 2017; $1,700.00 on November 27, 2017 which he claimed was from selling cars. (T101-102; RX13) Petitioner testified that despite listing *"homemaker"* on his 2017 tax return, his wife would work cleaning houses and on January 23, 2018 she deposited $1,000.00 cash. (T103) On December 18, 2018, $200.00 in cash was deposited. (T104) He further testified that he would also paint old houses and would paint the entire wall. (T133)

Petitioner testified on cross examination that he did work for his brother and in laws over the prior year, approximately 3 days per week, following that time for 8 hours per day. He was working in construction making

$200.00 per day. (T54-55) The jobs he would perform would be moving electrical panels weighing approximately 10 to 12 pounds and placing ceiling panels. In order to do so, he would hold the panel up over his head. (T56-57) Petitioner admitted that he did not report his cash payments to the IRS. (T58)

Petitioner was seen by Dr. Jesse Butler for an independent medical evaluation on October 17, 2016. At the time of that examination, Petitioner completed a questionnaire regarding physical capabilities. (T106-108; RX4) According to the questionnaire, Petitioner advised Dr. Butler he could not sit for longer than 30 minutes, that pain prevented him from traveling anywhere except to the doctor and home and that he had no social life due to pain. (RX4)

Petitioner admitted that part of his prior settlement contract was to be used for payment of future medical, in the amount of $2,500.00. (T118; RX2) He further admitted that he did not spend all of the money for treatment of back pain, he started to spend the money after he was discharged. (T132) He testified that he had group medical insurance through the Respondent, PCI. (T134-135 At the time of trial, Petitioner complained of leg pain that goes into his lower back. (T49).

Mr. Matt Taormina testified on behalf of the Respondent. (T136) Mr. Taormina was employed for the Respondent as purchasing manager and warehouse manager. In addition to overseeing warehouse management and various contracts for suppliers he would assist in light duty accommodations. (T138) During the time of petitioner's light duty assignment, from July of 2016 through October 13, 2016 Petitioner was employed sweeping, tagging tools, filing paperwork, and helping to maintain and organize the shop. His assigned job hours were 7:00 a.m. to 3:30 p.m., the same every day. (T140) Petitioner did not always work those scheduled hours as there were times when he had doctor's appointments or physical therapy appointments which he would be allowed to attend. There were also instances where he showed up late and left early or when he would take excessive breaks. (T140)

Mr. Taormina testified that Petitioner was not employed any longer due to excessive breaks, arriving late, leaving early without notice and loss of productivity. (T145) At all times, when Petitioner was working for him with restrictions, there was work available. (T145) Petitioner was disciplined on August 2, 2016 for arriving well after 7am. (RX6) He was again disciplined on August 15, 2016 for leaving early on August 9, 2016 without permission and arriving late on August 10, 2016 without notice or explanation. (RX7) On October 13, 2016 he signed a Separation of Service Notice for an involuntary separation due to taking excessive personal time during paid work hours. (RX8)

Petitioner was seen by his treating physician on October 14, 2016 and stated that he was laid off as he needed frequent trips to the bathroom to *"check"*. He was referred to his primary care physician to address this complaint as it was not related to his back condition. On that same date, due to ongoing symptoms, surgery was recommended. (PX5)

Respondent presented the testimony of Jae An. Mr. An is employed as a private investigator for G4S Compliance & Investigations. (T178) Mr. An has worked as a private investigator for over 25 years. He was asked to perform surveillance on November 28, 2016 of petitioner. (T179) On that date, he personally observed Petitioner go to a Jewel Osco, walking in and out of a building, standing up while completing a banking transaction and driving to an auto parts store. (T183) The video was played in court and observed by all parties. Petitioner was seen leaving the vehicle on November 28, 2016 with a child. He was seen walking back to his vehicle and walking through a Jewel Osco parking lot. Mr. An testified that the video that was shown in court was the same video and accurately depicted the events of November 28, 2016. (RX14)

Respondent then called Mr. Nathan Lopez. Mr. Lopez is employed as a private investigator for Frasco Investigative Services. (T190) He has worked as a private investigator for 27 years and was asked to perform surveillance on petitioner. (T191-192) Prior to using the Sony video camera, he tested the camera and it was in proper working order. (T192-193) Mr. Lopez personally conducted 3 days of surveillance. On June 1, 2019 he observed Petitioner and his two children proceed to a ball field. On June 1, 2019 he observed Petitioner climb over a fence at 11:22 a.m. to enter the ballfield. (T198; RX15) He further observed Petitioner in various body positions including crouching, while playing catch with his son.

Petitioner testified on rebuttal that he did not climb over a fence but instead it was a puddle of water that he had to jump so he would not get wet. (T225) He testified there was a cinderblock in the middle of a puddle approximately 4 feet across. (T229) During the baseball game he was in pain but he did not go to an emergency room or call his doctor.

Dr. Edward Goldberg testified via evidence deposition on November 27, 2017. Dr. Goldberg testified regarding his treatment of Petitioner prior to July 2016. He testified that as of March 7, 2014 he was released from care with permanent restrictions, the purpose of the permanent restriction was to avoid reinjury. (PX1) He further testified that between March of 2014 and August of 2016, he did not have any correspondence with Petitioner or change his permanent restrictions. (PX1) He compared the MRI films from prior to 2016 with those after 2016 and agreed the disc herniation was anatomically the same, the only change was Petitioner's subjective complaints. (PX1) Subsequent to October 14, 2016 he has received no correspondence of any kind from Petitioner, he has not contacted his office for pain medication and has not scheduled any follow up visits. He has no knowledge of the condition of Petitioner's back subsequent to that date. (PX1)

Dr. Jesse Butler testified via evidence deposition on December 7, 2017. (RX1). Dr. Butler performed an Independent Medical Examination on behalf of the Respondent on October 17, 2016. At the time of Dr. Butler's examination, he found inconsistencies in Petitioner's subjective complaints and objective findings. He opined that prior to the July 20, 2016 injury Petitioner was to be working with a permanent restriction preventing him from returning to work as a drywaller. The purpose of a permanent restriction was to *"avoid reinjury"*. (RX1 at 8). Dr. Butler further opined that upon comparing the MRI film from August 28, 2013, before the July incident, to August 31, 2016, after the alleged incident, there was no structural change. He relied on Petitioner's subjective complaints and believed there may have been an exacerbation, or a flare of symptoms that did not alter the natural history of the underlying condition. (RX1 at 11)

When discussing surgery, Dr. Butler did not believe it was necessary as not only was it early on, but his physical exam findings did not correlate. He testified that an individual with a disc herniation, managed conservatively, would reach MMI, and likely return to baseline at approximately one year. (RX1). He also believed he could return to work within the confines of his prior permanent restriction. (RX1)

CONCLUSIONS OF LAW

RESERVED RULING:

At the time of trial, the Arbitrator reserved ruling on admission of Respondent's Exhibit 15, a surveillance video from June 1, 2019 and June 2, 2019. Petitioner objected to admission of the video stating that due to an

error in the date stamp, the video was defective. The Arbitrator notes that this is not a proper basis for an objection under the Rules of Evidence, and overrules the objection, allowing admission of the video.

In further support of admission, the Arbitrator has reviewed the testimony surrounding the video. Mr. Lopez was present in court and testified that he was the investigator who performed surveillance on those dates. His independent observations matched those recorded on the video and the video shows one continuous day. Petitioner is seen wearing the same clothing and the background images remain fluid. As such, it is apparent that the video was taken on the same date. Further, the Petitioner testified on rebuttal and did not dispute that the video was him, nor that it was taken on the date in question. In addition to the investigator, Petitioner himself, laid the foundation for the video when he admitted he was at a ball game on that date. Finding that a proper foundation was laid for admission of the video, it is hereby admitted into evidence as Respondent's Exhibit 15.

With respect to issue (c) whether the Petitioner sustained an accident that arose out of and in the course of his employment with Respondent, the Arbitrator finds as follows:

Petitioner bears the burden of proving every aspect of his claim by a preponderance of the evidence. Hutson v. Industrial Commission, 223 Ill.App.3d 706 (1992). *"Liability under the Workman's Compensation Act may not be based on imagination, speculation or conjecture, but must have a foundation of facts established by a preponderance of the evidence."* Shell Petroleum Corp. v. Industrial Commission, 10 N.E. 2d 352 (1937). The burden of proof is on a Claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment there is no right to recover. Revere Paint and Varnish Corp. v. Industrial Commission, 41 Ill.2d 59. Preponderance of the evidence means greater weight of the evidence in merit and worth that which has more evidence for it than against it. Spankroy v. Aleksy, 45 Ill.App.3d 432 (1st Dist. 1977).

The Arbitrator finds that petitioner is not credible. In Rosemary Parro v. The Industrial Commission, 167 Ill.2d 385; 657 N.E.2d 882 (1995), the Illinois Supreme Court agreed that if a petitioner lies on a particular issue, the court can find Petitioner not credible as to other issues.

Here, Petitioner alleges an injury on July 20, 2016 but did not seek immediate medical treatment. The Arbitrator finds this troubling due to his prior, related, claim. Petitioner was well aware of how to seek medical treatment in connection with a work-related injury based upon the prior injury. In addition, the Arbitrator questions petitioner's credibility based on multiple inconsistencies throughout his testimony. The Arbitrator notes the medical records admitted by petitioner's counsel show that in connection with petitioner's 2013 incident he sought medical treatment on the date of accident. In connection with this claim, petitioner, having a known history of back problems, did not seek immediate medical treatment despite testifying that he noted a significant lump in his back. It is inconsistent that an individual who had undergone back surgery within the past few years, would ignore a *"significant lump"* and not seek immediate medical treatment. Further, the records from Concentra do not support any deformity on examination.

The Arbitrator also notes that Petitioner testified that he worked several odd jobs for cash and yet is seeking TTD benefits throughout the same timeframe. He further admitted on cross-examination that he does not report his income to the IRS and is not paying taxes on it. The Arbitrator finds this significantly diminishes his credibility. In addition, he testified that while he had money from the prior settlement set aside for future medical he spent it on various other issues, not all pertaining to back treatment, and therefore, this does give Petitioner motive to seek a new payor for further medical treatment that may have been related to the initial claim. According

to the settlement contract, he was to place that money in a trust for future back treatment, which he obviously did not do.

In addition, Petitioner's credibility is seriously called into question based upon the indication that he accepted a prior wage differential settlement for permanent restrictions which prevented him from returning to work as a drywaller and then, within one year of accepting said settlement, applied for the very position he asserted he could not perform.

Petitioner's credibility is further called into question concerning his light duty accommodation. Petitioner testified that he disagreed with the disciplinary note of August 2, as he was only two minutes late and was late due to attendance at physical therapy. He testified that his therapy that day was at 8:14am. However, according to the testimony of Mr. Taormina his typical workday started at 7am and he worked the same hours every day. Furthermore, the records from Concentra do not support that Petitioner had therapy on August 2, 2016. He also disputed that his signature was on the notice of August 2, 2016, but when compared to the other documents admitted, his signature is very similar.

In regard to the surveillance videos the Arbitrator finds additional credibility issues. The Arbitrator has reviewed the surveillance video and finds it to be inconsistent with petitioner's trial testimony and medical records. When Petitioner presented to Dr. Butler he stated he could not leave the house for issues other than doctor's appointments. The surveillance video from November 28, 2016, approximately one month later, shows Petitioner moving about freely and taking his child to a cell phone store, as well as, the Jewel Osco. He is seen walking normally in the parking lot at a brisk speed. As such, the Arbitrator cannot rely on statements made by Petitioner to any of his treating physicians as they are inconsistent with the surveillance video.

Further surveillance depicts Petitioner jumping over a fence to get to a softball field. He testified on rebuttal that he did not climb over a fence, but instead jumped over a puddle. First, the Arbitrator notes that the field conditions appeared dry. Further, if Petitioner's story were accurate, his head would rise twice, as he stated he had to jump on a cinder block in the middle of the puddle and then jump off the cinder block to the other side of the puddle. The versions of this moment are significantly different from the testimony of the investigator, Petitioner and what can be seen on the surveillance video. Therefore, the Arbitrator finds it difficult to rely on Petitioner's testimony regarding the surveillance video footage.

Petitioner has multiple instances where his sworn testimony is inconsistent with the records. His statements made at trial and made to his treating physicians cannot be relied upon. Therefore, his version of events on July 20, 2016 cannot be relied upon. Based on this, the Arbitrator finds Petitioner failed to prove by a preponderance of the evidence that he had an accident arising out and in the course of his employment with Respondent. Therefore, all demands for benefits are hereby denied.

With respect to issue (F) whether Petitioner's current condition of ill-being is causally connected to a work accident, the Arbitrator finds as follows:

Based on the Arbitrator's decision denying accident, the Arbitrator finds Petitioner's current condition of ill-being is not causally related.

With respect to issue (K) whether Petitioner is entitled to TTD Benefits, the Arbitrator finds as follows:

Based on the Arbitrator's decision that Petitioner failed to prove an accident arising out of his employment, Petitioner is not entitled to TTD benefits. Furthermore, Petitioner testified that he worked multiple jobs, many for cash, while he was demanding TTD benefits. In order to be awarded TTD benefits, he must prove that he was not able to work. As he was clearly working, he cannot also claim he could not work and is entitled to TTD benefits. Finally, the Respondent offered Petitioner light duty work that he turned down by arriving late, leaving early and refusing to work when taking excessive personal time. He understood work was available for him when he was not working it and therefore, he chose not to accept the light duty accommodation and is not entitled to TTD benefits. In addition, the Arbitrator relies on records from Concentra which note he was not happy with the light duty and attempted to have his restrictions changed on multiple occasions to prevent him from working.

With respect to issue (L), the nature and extent of the injury of the Petitioner, the Arbitrator finds as follows:

Based on the Arbitrator's decision that Petitioner failed to prove an accident arising out of his employment, therefore issue (L) is moot.

With respect to issue (O), whether Petitioner is entitled to prospective medical treatment, the Arbitrator finds as follows:

The Arbitrator notes Petitioner has not been seen by any physician since October of 2016. As such, there is no current prescription for any ongoing medical treatment. In addition, the arbitrator questions petitioner's need for additional medical treatment as he has been able to work in various capacities for the past 3 years without the need to seek medical treatment. At the time of trial, he was not taking any prescription medication.

According to Dr. Goldberg's testimony, the disc was anatomically the same pre and post injury. As such, an award for future treatment would require a finding that Petitioner's subjective complaints are reliable. Based on multiple credibility issues described above, the Arbitrator cannot rely on Petitioner's subjective complaints. In addition, the Petitioner is engaged in activities on the surveillance video, including climbing a fence, crouching to play catch and coaching his son, these activities are not consistent with an individual who requires back surgery. As such, the petitioner's demand for medical benefits is hereby denied.

Signature of Arbitrator

5/20/2020
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	11WC024037
Case Name	BERRI,ELIDRISSIYA v. RENAISSANCE HOTEL/
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0294
Number of Pages of Decision	28
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	W. Britt Isaly
Respondent Attorney	Christine Jagodzinski

DATE FILED: 6/14/2021

/s/Deborah Simpson, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ELIDRISSIYA BERRI,

Petitioner,

vs. NO: 11 WC 24037

RENAISSANCE/MARRIOT HOTEL,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Arbitrator found that Petitioner sustained a compensable injury to her lower back on February 4, 2011 when she carried a case of soda at work as a bartender. She treated extensively through March of 2019 with physical therapy, medication, and three injections. The Arbitrator found that Petitioner suffered no more than a lumbar strain in the accident and awarded her medical expenses provided by Concentra and 25 weeks of PPD representing loss of the use of 5% of the person-as-a-whole. He also noted that Respondent paid the bills from Concentra, which was the only medical treatment to which Petitioner was entitled to treat her work-related condition of ill-being and that Respondent paid $3,573.85 in short-term disability benefits. The Arbitrator also awarded Respondent credit of $15,256.56 in paid medical expenses, denied any additional medical expenses, and denied any additional TTD.

In arriving at his decision, the Arbitrator relied heavily on the opinions of Respondent's Section 12 medical examiner, Dr. Lanoff. He viewed Petitioner's MRI and disagreed with Petitioner's treating doctor, Dr. Song that the MRI showed disc herniations. Dr. Lanoff appreciated no herniations in the MRI and even if the MRI displayed herniations, those herniations did not correspond to Petitioner's subjective symptoms. Finally, Dr. Lanoff noted that Petitioner exhibited five out of five positive Waddell signs connoting substantial inorganic findings and symptom magnification. The Arbitrator also found Petitioner to be a not credible witness based on inconsistent testimony and reports to treating doctors.

The Commission generally agrees with the Arbitrator on his analysis in this case. We find no reason to disturb his determination of Petitioner's credibility because he was able to personally observe her testify and his conclusion about her lack of credibility is corroborated by the record. We also agree that Dr. Lanoff's finding five out of five positive Waddell signs further erodes her credibility as well as putting into question the severity of her alleged condition of ill-being. We also agree with the Arbitrator's analysis and conclusion that Petitioner did not sustain her burden of proving that she was entitled to temporary total disability benefits.

However, the Commission notes that the Arbitrator discounted the report of another of Respondent's Section 12 medical examiners, Dr. Yapor. He interpreted an MRI as showing "L5-S1 disc collapse, modic changes foraminal stenosis, far lateral left L4-5-disc herniation and foraminal disc herniation not mentioned in report." His diagnoses were lumbar disc herniation, foraminal stenosis of lumbosacral region, back pain, and radiculopathy. He opined that the condition was related to her accident because she had no back complaints until after the injury, her back complaints correlated with her MRI findings and she was neurologically intact. He recommended L4-5 fusion surgery. The Arbitrator took issue with Dr. Yapor's failure to designate which MRI he was referring to. We believe that the Arbitrator may have been too dismissive of that report.

The Arbitrator only awarded medical bills from Concentra, which Respondent paid. He also awarded Respondent credit in the amount of $15,256.56 for paid medical. Based on Dr. Yapor's and Dr. Song's interpretation of MRI results, the Commission concludes that Petitioner may have sustained some disc herniations in the work accident on February 4, 2011. Therefore, we believe the Arbitrator should have awarded more of the medical expenses Petitioner incurred. We conclude that Respondent is liable for medical expenses through January 30, 2014. At that time, Dr. Song noted that a new MRI showed that her herniations had resolved and that she had severe degenerative disc disease. The Commission finds that after that date her treatment was incurred to treat her underlying degenerative condition and not the effects of the work injury.

Because we acknowledge that Petitioner may have sustained disc herniations in her work accident, the Commission believes that permanent partial disability award should be increased. However, based on her symptom magnification, her ability to work after the accident, and the fact that her treating doctor found that any herniations she may have had had resolved, we find the award should be increased only slightly.

In looking at the entire record we believe that a permanent partial disability award of 37.5 weeks of benefits representing loss of the use of 7.5% of the person-as-a-whole is appropriate in this matter. Accordingly, we modify the Decision of the Arbitrator to award additional medical benefits and increase permanent partial disability benefits.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated May 26, 2020 is hereby modified as noted above and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay medical expenses incurred by Petitioner to treat her work-related injuries through January 30, 2014, under §8(a) of the Act.

IT IS FURTER ORDERED BY THE COMMISSION that Respondent pay Petitioner permanent partial disability benefits in the sum of 290.01 for a period of 37.5 weeks, because the injuries sustained caused the loss of the use of 7.5% of the person-as-a-whole, pursuant to §8(d)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 $50,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

June 14, 2021

/s/*Deborah L. Simpson*
Deborah L. Simpson

/s/*Steven J. Mathis*
Steven J. Mathis

DLS/dw
O-4/20/21
46

/s/*Deborah J. Baker*
Deborah J. Baker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0294

BERRI, ELIDRISSIYA
Employee/Petitioner

Case# **11WC024037**

RENAISSANCE HOTEL/MARRIOTT HOTEL
Employer/Respondent

On 5/26/2020, 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 0.15% 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:

0863 ANCEL GLINK
W BRITT ISALY
140 S DEARBORN ST 6TH FL
CHICAGO, IL 60603

2461 NYHAN BAMBRICK KINZIE & LOWRY
CHRISTINE M JAGODZINSKI
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

ELIDRISSIYA BERRI,
Employee/Petitioner

Case #**11 WC 24037**

v.

Consolidated cases:

RENAISSANCE HOTEL/MARRIOTT HOTEL,
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 **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **9/30/2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD

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

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

N. ☒ Is Respondent due any credit?

O. ☐ Other

FINDINGS

On **2/4/2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$25,134.06**; the average weekly wage was **$483.35**.

On the date of accident, Petitioner was **34** years of age, ***married*** with **1** dependent child.

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

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

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

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

ORDER

Respondent shall be given a credit of **$15,256.56** for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act.

No temporary total disability benefits are awarded pursuant to §8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$290.01** /week for **25** weeks, because the injuries sustained caused the **5%** loss of a person-as-a-whole, as provided in §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

May 19, 2020
Date

MAY 26 2020

Elidrissiya Berri v. Renaissance Hotel/Marriott Hotel

11 WC 24037

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?;***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** What temporary benefits are in dispute? TTD; ***L:*** What is the nature and extent of the injury?; ***N:*** Is Respondent due any credit?

STATEMENT OF FACTS

Testimony

Petitioner Elidrissiya Berri worked for Respondent Renaissance Hotel/Marriott Hotel since June 4, 2004 as a barista and cashier attendant. Petitioner's formal title is Specialty Food Service Attendant. She testified that her job duties include preparing coffee, providing sandwiches, and cleaning machines. She lifts coffee canisters that weigh 10 pounds and she used to lift cases of soda.

On February 4, 2011, Petitioner testified that she cleaned the cooler from expired soda and took a full case of soda from the cooler. She placed the soda on top of a table and switched to the other side when she heard a "pop in her back". She felt pain. She estimated the case weighed around 25 to 30 pounds. She testified she lifted the soda to waist level and turned to put it on a higher shelf. Her accident occurred between 11:00 a.m. and 12:00 p.m. or 12:30 p.m.

Petitioner notified Patricia, her manager, that she had hurt her back. She testified that Patricia asked her to take the case of soda to the second floor, even so she thought she was okay. Petitioner testified she could not move after she took the case to the second floor. She pain in her back and into her left leg that traveled all the way to her toe. Petitioner denied any pain in her back or leg before February 4, 2011. She stated she never saw a medical provider for back pain before February 4, 2011. She also denied any injuries to her low back after February 4, 2011.

Petitioner also reported her injury to Brandon, the manager of loss prevention. She testified that Brandon called a cab and was transported to Concentra. Petitioner initially testified this occurred the following day when she came back and told them.

However, when asked whether she had any reason to dispute that her first visit at Concentra occurred on February 10, 2011, Ms. Berri stated she did not remember. She then testified she went to Concentra after February 10.

Petitioner testified she told Concentra staff how her accident happened. She had MRI studies of her low back on April 11, 2011. She received physical therapy at Concentra. Petitioner saw Dr. Heller at Concentra, who suggested she take off work. She stated she remained off work from around May 25, 2011 through October 7, 2011. Petitioner testified her condition improved while off work because therapy helped her pain.

Petitioner consulted Dr. Robert Piotrowski, her primary care doctor, on June 9, 2011. Dr. Piotrowski referred her to Dr. John Song, a neurologist. Petitioner testified that Dr. Song recommended an anterior lumbar interbody fusion at L5-S1. Petitioner did not undergo surgery, instead she had lumbar epidural steroid injections (ESI) at Advocate Medical Center on September 19 and November 14, 2011. The injections helped her pain.

Petitioner testified she had a baby on September 28, 2013. After her delivery, she did not seek treatment until January 2, 2014. Dr. Piotrowski then referred her to Dr. Ricardo Kohn. She saw Dr. Kohn on April 7, 2016. She had another MRI of her low back on July 18, 2016. Dr. Kohn prescribed therapy on October 6, 2016. She testified she attended 4 visits at Athletico beginning on November 28, 2016. Dr. Kohn also referred her for pain management.

On April 25, 2017, Ms. Berri sought treatment with Dr. Antony Tharian. Dr. Tharian diagnosed spinal stenosis and radiculopathy. He recommended a lumbar ESI. Petitioner testified she had that injection on May 1, 2017. She testified that she did not get any relief with the first injection, so she had a second injection (which was not documented). With the second injection, she could do her work and manage her pain. But when asked how it helped her, Petitioner testified when she was pain, she "cannot even stand. I cannot even do my work. I cannot even do my life; but when they give me the second shot, I was able to manage my pain with like this shot and Tylenol or like another medication that I used to take." She testified she continued treating with Dr. Tharian in 2017 and 2018. He also prescribed physical therapy and aqua therapy.

Petitioner attended therapy at Athletico beginning June 26, 2018. Her leg pain improved after therapy. She admitted she did not have medical treatment from June 2018 until she saw Dr. Song again January 4, 2019. She had X-rays and a repeat lumbar MRI February 1, 2019. She last sought treatment on February 25, 2019 with Dr. Song. She testified that he recommended a fusion surgery at L5-S1.

Petitioner testified she has not had back surgery due to her family concern as she has two kids and her husband just had surgery for his eye. She does not have relatives or family around her to help her. She testified her children are 11 and 6 years old. She is their primary caretaker and her husband is employed. Petitioner testified that she will have surgery one day as soon as she has the ability and when her husband can take care of the kids and her too.

Petitioner testified that she does 30 minutes of back exercises when she wakes up and about 15 to 20 minutes at night before she goes to sleep. When asked whether her back pain has gotten worse, better, or stayed the same since February 4, 2011, she testified her pain is getting worse.

Petitioner works 3 days a week, for a total of 24 hours. Before her work injury, she testified she worked 5 days a week. She now avoids lifting more than 10 pounds. The heaviest thing she lifts at work is a canister of coffee.

Petitioner testified she has not paid a bill from Concentra. She did not recall missing an IME appointment in 2013. She testified she never would miss an appointment.

On cross-examination, Petitioner testified Dr. Song has not restricted the number of days she is able to work. It is her choice to work 3 days a week. Petitioner testified she used to take Gabapentin, but lately she started taking like "extra stronger Motrin or Tylenol." She wears a brace at work for her back. She stated Dr. Song prescribed the brace in 2011. She has a brace she bought for herself and one that work gave her.

On further cross-examination petitioner testified Loss Prevention gave her an ice pack for her back on the day of her accident. She acknowledged that did not see her doctor between February 4 and February 10, 2011. She stated she did not make an appointment with Dr. Piotrowski until February 10, 2011 because the pain improved when she used an ice pack and over-the-counter medication.

Petitioner testified that that when she went to Concentra she told them all of her complaints. Petitioner testified the Concentra records are incorrect if the records do not mention she had leg pain after the accident. Petitioner also testified that she gave full effort in physical therapy in February and March of 2011 at Concentra. She last saw Dr. Heller April 29, 2011 when she recommended an epidural steroid injection.

Petitioner acknowledged that she presented for an IME at the request of her employer with Dr. Martin Lanoff on May 26, 2011. She thought she lost time from May 25, 2011 through October 7, 2011. She did not think she applied for a leave of absence from work during that period. Petitioner admitted that she received short-term disability benefits in the net amount of $3,573.85 for a period of time in 2011, but she could not remember when. She testified that she notified Marriott Human Resources about her leave of absence, but could not recall if she applied for a leave of absence to get the short-term disability benefits. She then recalled completing paperwork to get the short-term disability benefits.

Petitioner testified she did not have treatment from October 4, 2012 until she saw Dr. Song on July 30, 2013. She reviewed Respondent's Exhibit # 5B and did not recognize the letter advising her she had an IME scheduled with Dr. Wesley Yapor on February 7, 2013. She agreed that her address on the letter was correct, but she did not know why she could not attend the appointment. She stated her attorney had all of her papers and sent her everything. She did not think she missed anything because he would call her if she did not answer emails. Petitioner could not recall if she saw Dr. Yapor in 2014 or 2013.

Petitioner acknowledged that she did not have treatment from January 30, 2014 until February 24, 2016. When she felt better with therapy, she would not go to the doctor. She testified her husband shops on the weekends, doing the heavy shopping. She admitted she never received a copy of the bill referenced by her attorney from Concentra.

When questioned about her course of therapy at Athletico in November 2016, Petitioner recalled attending therapy. She reviewed Respondent's Exhibit #6, which she agreed was paperwork she completed in her own handwriting at Athletico on November 28, 2016. She acknowledged that she did not write that her leg was bothering her.

When she attended therapy on November 28, 2016, Petitioner agreed the therapist obtained a history from her. She reviewed the history in the Athletico records under subjective complaints (PX #4). Petitioner was asked to confirm the history in the Athletico records states, "Patient reports that many years ago, she tried to pick up one end of a couch and twisted her back ever since she has suffered from left leg and low back pain." Petitioner denied she said this to the therapist, stating she never said anything about a couch and she never had that conversation.

Petitioner admitted that, if the Athletico records show she called on November 15, 2016 to make her appointment on November 28, 2016, she called on that date. However, she disagreed that she told the person at Athletico that this treatment was not for an on-

the-job injury, as all therapy was for her work injury.

Medical Treatment

Petitioner first presented for medical treatment at Concentra on February 10, 2011, when she was seen by Dr. George Bridgeforth (PX #1). She reported that she had picked up a case of soda when she felt pain in her back on February 4, 2011. She complained of severe soreness in her lower back and stated her pain is non-radiating in nature. She did not exhibit focal tenderness to palpation or spasms. Waddell signs were negative. Flexion was to 35° and extension was to 10°. Straight-leg raise produced no pain. Motor strength was 4+/5. Dr. Bridgeforth prescribed Ibuprofen 600 mg, released her to modified activity of no lifting more than 10 pounds, and no bending more than 10 times an hour. The doctor also recommended physical therapy 3 times a week for one to three weeks.

Petitioner returned to Concentra on February 15, 2011, complaining of non-radiating pain which increased with bending and lifting. She reported relief of her pain a few hours after taking her medications. She denied numbness or weakness. Cyclobenzaprine was prescribed. Dr. Bridgeforth issued light duty restrictions.

Petitioner attended physical therapy at Concentra on February 18, 2011. She denied tingling or numbness and had been working modified duty with acceptable tolerance. Her exam was essentially normal, though she was guarded due to low back pain. She reported radiating pain at L5-S1 into her left buttock. The therapist recommended therapy 3 times a week until her goals were met.

On February 22, 2011, Dr. Bridgeforth noted Petitioner's pain was improved. She exhibited flexion from 0 to 50° and extension from 0 to 10°. Her light duty restrictions remained in place, as did her of lumbar strain. At therapy on February 22, Petitioner reported a little improvement, but complained of pain in the morning after her shift. The therapist noted restricted range of motion. Two days later, Petitioner reported moderate low back pain at therapy.

At her next physical therapy visit on March 3, 2011, Petitioner's symptoms remained unchanged. The therapist discussed her status with her physician because she had not attended therapy or seen the physician in nearly 2 weeks. Petitioner denied any change in injury status and continued with moderate left central low back pain. She reported tolerance with modified duty work. Her restrictions included no lifting over 20 pounds and no pushing or pulling over 20 pounds.

Petitioner reported improvement of about 70% of 100% normal function at physical therapy on March 10, 2011. She had less pain getting out of bed that morning. On March 15, 2011, she reported that she had been on vacation from work for a week. She felt sore getting out of bed that morning as she did her home exercise program all day yesterday. On March 18, 2011, Ms. Berri returned to physical therapy. She self-limited with flexion, but her range of motion was otherwise normal.

Dr. Barbara Heller examined Petitioner on April 1, 2011 (PX #1). Petitioner reported that she had 2 months of therapy, although the records show she had only had 8 sessions with no improvement. Petitioner reported numbness to her left leg when sitting for a while. Flexion was limited to less than 50% and she had decreased extension. Straight-leg raise test was positive in the sitting and supine positions on the left and negative on the right. Dr. Heller prescribed prednisone and an MRI to rule out a L4-5 central disc herniation to the left. Her restrictions included no lifting over 10 pounds, no bending, and no pushing or pulling over 10 pounds. Dr. Heller put physical therapy on hold.

The April 11, 2011 MRI indicated left-central disc herniations at L4-5 and L5-S1 with no stenosis or foraminal compromise.

Dr. Heller reexamined Petitioner on April 15, 2011. Dr. Heller reviewed the MRI and noted that the disc herniation at L4-5 was small and that that the L5-S1 disc was significantly narrowed and degenerative. Petitioner reported continued pain in her left buttock. She worked light duty and took a high dose of Ibuprofen for pain. Dr. Heller brought the therapist in to make sure Petitioner understood proper body mechanics. Dr. Heller recommended additional therapy to strengthen Petitioner's buttock and hamstring muscles, as well as her core. Dr. Heller recommended a lumbar epidural injection, additional therapy, and light duty restrictions.

On April 22, 2011, Petitioner presented to Dr. Heller with complaints of increased left low back pain radiating to the left knee. She worked modified duty throughout the month of April. She attended therapy on April 22, April 27, and April 29, 2011. The therapist documented poor effort and inconsistencies.

Dr. Heller reexamined Petitioner April 29, 2011. Dr. Heller noted the physical therapist's notes of inconsistent objective findings and poor effort. When questioned at trial about these inconsistencies, Petitioner stated she tried as hard as she could, but she is very anxious and very worried about her situation. Dr. Heller recommended a lumbar epidural injection and light duty restrictions.

On May 25, 2011, Petitioner sought treatment with Dr. Robert Piotrowski (PX #2A). She gave a history of a back injury with left leg numbness on February 4, 2011 after lifting a case of soda at work. She saw the work doctor and had an MRI, which showed herniated discs at L4-5 and L5-S1. Physical therapy did not help. Petitioner was not happy with her care.

On examination Dr. Piotrowski noted diminished range of motion due to pain. Straight-leg raise was positive at 15° on the left. The doctor diagnosed low back pain with L4-5 and L5-S1 disc herniations related to an injury on the job.

Dr. Martin Lanoff examined Petitioner on May 26, 2011 for an §12 IME (RX #3). Dr. Lanoff specializes in Physical Medicine and Rehabilitation. In addition to the clinical examination, Dr. Lanoff reviewed Petitioner's records from Concentra Occupational Health without physical therapy notes and imaging and reports of X-rays and the lumbar MRI on April 11, 2011 . Dr. Lanoff noted the MRI demonstrated disc desiccation with modic degenerative changes at L5-S1 and a "hint" of the disc protrusion at L4-5. Dr. Lanoff found no evidence of any lateral recess, central canal, or neural foraminal compression. He did not see any left-sided disc protrusion, noting the tiny protrusion at L4-5 tended toward the right. He also noted that Petitioner's initial complaints were limited to low back pain only and that radiating pain was first noted by Dr. Heller on April 1, 2011.

Petitioner stated that she had a right knee injury 3 years earlier, but did not claim workers' compensation. She has worked as a cashier in the coffee shop for 7 years at the Renaissance Hotel. She had not missed any time off work and was performing most of her job duties, except for heavy lifting. She reported she stands quite a bit at work and was not bending voluntarily. Petitioner complained of weakness and heaviness in both legs. She was afraid to move her back and did not want to bend at work. She was not restricted from bending but felt she could not do so. She held herself very stiffly throughout the entire examination. Petitioner stated she used to walk for exercise and take care of her child, but she cannot do so anymore. She complained that she had pain in the low back, left buttock, and down the back of the leg into the foot, as well as numbness in entirety of the left leg, which Dr. Lanoff noted was obviously non-dermatomal. Dr. Lanoff noted that Petitioner became tearful during the examination.

On examination Dr. Lanoff noted significant withdrawal pain behaviors, which was the 1st Waddell finding of overreaction. Lumbar range of motion was limited to 0° of extension and 5° of flexion, noted as an overreaction. Straight-leg raise was negative in the seated position but positive in the supine position for low back pain at 60° on the right and 45° on the left. There was a positive flip test or the 2nd Waddell non-organic finding

of distraction. Dr. Lanoff noted distraction with internal femoral head rotation in the seated position to 45° was without pain. However, in the supine position at 10° bilaterally, she complained of pain in the iliolumbar regions bilaterally, the 3rd Waddell finding of simulation (axial loading) which was negative, but positive for simulated lumbar rotation. Petitioner was also quite positive for the 4th Waddell's finding of superficial non-anatomic tenderness present in the entire iliolumbar region, much more so on the left than right. Dr. Lanoff noted a positive 5th Waddell finding with regional disturbance based on her complaints of numbness to the left lower extremity. He concluded Petitioner had 5/5 Waddell findings. He further noted that he was also unable to perform FABER, FADIR, Gaenslen's, or Patrick tests because of pain complaints.

Dr. Lanoff concluded her MRI was overread by the radiologist and there was no neural element compression whatsoever. He added that if there was any type of issue, it was toward the right as opposed to the left. Dr. Lanoff diagnosed kinesiophobia and fear avoidance behaviors and significant discomfort because she guarded her lumbar spine and would not move it. Dr. Lanoff could not state that Petitioner had any post traumatic disc herniation. He noted that if there were a disc herniation it did not correlate with her symptoms. He further noted, that if Petitioner had had a posttraumatic radiculopathy from a disc herniation with neural compromise she should have had the onset of radiating lower extremity symptoms within a short time after the accident. In fact, Petitioner's first complaints of radicular pain were noted 2 months after the accident.

Dr. Lanoff did not see any physical malady or objective findings. He opined that Petitioner was at MMI and did not have any permanent partial disability. He noted that Petitioner should be able to function with tools she was taught in physical therapy. Her work-related soft tissue injury should have resolved. He would release Petitioner to unrestricted. He finally noted that any current symptomology was not due to any work related scenario.

On May 26, 2011, Petitioner returned to Dr. Piotrowski. She saw an orthopedic doctor, who was not named, but no plan was discussed. Petitioner complained that she could not sleep at night due to pain and that she is unable to bend. She denied any improvement with medications. He referred Petitioner to neurosurgery (Dr. Song) and authorized her off work for 2 weeks.

Petitioner returned to Dr. Piotrowski on June 8, 2011. Dr. Piotrowski recommended she remain off work due to increased low back pain radiating down her left leg, rest, and take high dose of anti-inflammatories. Petitioner reported that she was unable to perform lifting and working caused pain. She was referred for a neurosurgical consult once again. She was taking vicoprofen, ibuprofen 800 mg, and Pepcid. Dr. Piotrowski authorized her off work until June 24, 2011.

On June 9, 2011, Petitioner presented to Dr John Song (PX #2A). She reported a back injury after lifting a case of soda on February 4, 2011. She complained of low back and left leg pain. She exhibited severely limited range of motion of her lumbar spine, especially with flexion. Straight-leg raise was negative. Dr. Song diagnosed a herniated disc at L5-S1 with left S1 radiculopathy. He prescribed Norco and lumbar epidural injections. He noted that if she failed treatment, she may be a candidate for a fusion at L5-S1.

Petitioner returned to Dr. Piotrowski on June 21, 2011. She reported improvement while off work, but complained of left leg weakness and numbness and took ibuprofen. She was scheduled for an epidural injection and authorized off work until July 11, 2011.

Dr. Piotrowski re-examined Petitioner on July 11, 2011. She sought treatment for her back as well as diarrhea and abdominal cramping. He authorized her off work for her back until September 12, 2011 and completed short-term disability paperwork as well as FMLA paperwork. In the paperwork, Dr. Piotrowski noted that, beginning as of May 25, 2011, she may require time off work due to episodic flare-ups of her low back pain through September 12, 2011.

Petitioner returned to Dr. Song on August 16, 2011. She did not have the epidural steroid injection due to a tooth infection. She exhibited very limited range of motion, but reported her left leg was a little better.

On August 30, 2011, Petitioner had a physical therapy evaluation at Advocate Illinois Masonic Medical Center [Illinois Masonic] (PX #2). She stated her back pain started on February 2, 2011 while lifting a case of soda. Originally, her pain radiated into her left lower extremity, but that had resolved. Her range of motion was limited. Therapy was recommended one to two times a week for 4 to 6 weeks.

On September 19, 2011, Dr. Maunak Rana examined Petitioner pursuant to a referral by Dr. Song (PX #2). Dr. Rana noted her complaints of low back pain radiating from the left leg to the toes. She stated she lifted a heavy pack of 24 cans of soda at work and twisted. She said she was unable to care for her three-year-old son. She exhibited a positive straight-leg raise on the left at 45° with a negative cross straight-leg raising on the left. She had a negative FABER test bilaterally and negative S1 tenderness bilaterally. Dr. Rana noted tenderness at L4-5 and limitation with flexion to 30°. Petitioner had 5/5 strength and normal sensation in all muscles of her lower extremities. Dr. Rana diagnosed low back pain and left radiculopathy due to a disc herniation at L4-5. The doctor administered an epidural injection at L4-5 with reported improvement of pain.

She was instructed to follow-up in 3 weeks.

Dr. Piotrowski reexamined Petitioner September 24, 2011. She reported significant relief from the epidural injection with less pain and better range of motion. She reported some numbness in her left thigh. Dr. Piotrowski recommended 2 additional weeks of therapy. He released her to return to work on October 8, 2011. On October 13, 2011, Petitioner reported good improvement after attending 5 sessions of physical therapy. She reported significantly decreased pain after an epidural injection but had pain once she returned to work.

On November 14, 2011, Dr. Rana administered epidural injections at the L4-5 nerve root and the L5-S1 nerve root on the left

Petitioner was discharged from therapy at Illinois Masonic on November 25, 2011 after she failed to return for a scheduled follow-up on November 17, 2011 (PX #2). The therapist noted poor compliance with multiple cancellations/no shows.

On December 6, 2011, Dr. Song saw Petitioner again. He was not sure if a third epidural steroid injection will help. He prescribed Gabapentin and suggested she consider a simple lumbar discectomy. Petitioner was hesitant about surgery. She returned to Dr. Song on October 4, 2012, complaining of new symptoms in her left anterior thigh. Dr. Song thought this could be L3 radiculopathy. He discussed proceeding with a L5-S1 discectomy and ordered an MRI.

On May 20, 2013, Petitioner presented to Illinois Masonic for physical therapy pursuant to a referral from Dr. Megan Gruber, whom Petitioner did not mention in her trial testimony. Her diagnoses included muscle spasms and coccydynia and she presented for a female pelvic floor evaluation. She reported worsening back pain since becoming pregnant. Her pain was 6/10, but could be 10/10 depending on activity.

Petitioner saw Dr. Song again on July 30, 2013 and reported back and left leg pain. She was 28 weeks pregnant. Dr. Song recommended physical therapy/water therapy. He would treat her following her delivery.

The Illinois Masonic therapist discharged Petitioner from therapy on August 30, 2013, noting she had not been seen since June 26, 2013 (PX #2).

Petitioner delivered her baby September 28, 2013 at Illinois Masonic.

Petitioner returned to Dr. Song November 14, 2013. She delivered her baby and felt better, although she had some left posterior leg pain. Dr. Song diagnosed spondylosis

at L5-S1 and a herniated disc with left S1 radiculopathy. He recommended a new lumbar MRI. He prescribed Gabapentin, provided that this was appropriate to take while breastfeeding. Dr. Song saw her again on January 2, 2014, but she had not had the MRI.

Petitioner had a lumbar MRI on January 22, 2014 (PX #5). The findings included a minimal posterior disc bulge with mild facet degenerative changes at L4-5 and L5-S1 without associated central canal stenosis. There was bilateral foraminal narrowing at L5-S1 and loss of disc space height with endplate changes at L5-S1.

Petitioner returned to Dr. Song on January 30, 2014 with low back pain with some left posterior thigh pain. She reported 50% improvement with therapy and Gabapentin, as well as her back brace. Dr. Song noted that the new MRI revealed that her herniated disc had resolved, but she has severe degeneration at the L5-S1 disc space with modic changes. Dr. Song planned to defer surgery and continue her current treatment regimen. A follow-up visit was scheduled in 4 to 6 weeks. If she did plan to undergo surgery, he would obtain a CT scan first.

Petitioner presented for second IME on April 3, 2014 with neurosurgeon Dr. Wesley Yapor (RX #4). An appointment with Dr. Yapor was originally scheduled on February 7, 2013, but Petitioner did not attend (RX #5B). Dr. Yapor noted Petitioner had many months of therapy, 2 lumbar epidural steroid injections with significant improvement from the second shot, and daily pain since she lifted a case of soda in 2011 at work. Straight-leg raise was negative bilaterally. She exhibited 5/5 strength, equal and symmetric reflexes, and intact sensation to light touch. Dr. Yapor noted the MRI of her lumbar spine showed disc collapse at L5-S1 with modic changes and foraminal stenosis and a far lateral left L4-L5 disc herniation and foraminal disc herniation note mentioned in the report. Dr. Yapor did not note which of Petitioner's MRIs he reviewed. He opined that Petitioner was not at MMI and recommended fusion surgery from L4-S1.

Dr. Ricardo Kohn evaluated Petitioner on April 7, 2016 (PX #3). He took over her care from Dr. Song. She reported that she was told that she needed surgery. Her history was significant for low back pain since 2011 after a work-related injury while lifting a case of soda. Upon examination, bending backwards exacerbated pain, with no pain bending to either side and minimal pain bending forward. Dr. Kohn recommended EMG studies of her lower extremity and a new MRI. Prior MRI studies showed mild degeneration at L4-5 and L5-S1 with mild foraminal stenosis at L5-S1. Dr. Kohn wanted to rule out left L5 and S1 radiculopathy. Prescribed medication included Gabapentin.

Petitioner had the lumbar MRI on July 18, 2016 (PX #5). The findings included minimal disc bulging and early facet arthropathy, greater on the left, at L4-5 and a

minimal disc bulge with endplate spurring and mild facet arthropathy and with mild left and slight right foraminal narrowing at L5-S1. The impression was moderate degenerative disc disease at L5-S1 without focal disc herniation. She underwent EMG/NVC studies on July 22, 2016. Sensory nerve and motor conduction were normal. The EMG indicated left L5-S1 radiculopathy (PX #9).

Petitioner returned to Dr. Kohn on October 6, 2016. She reported on and off pain which was exacerbated with walking and physical activity. She continued to take Gabapentin and Ibuprofen as needed. Dr. Kohn commented that her lumbar spine MRI from July 18, 2016 revealed disc degeneration at L5-S1 with mild to moderate left neuroforaminal stenosis and no significant lumbar spine stenosis. EMG studies from July 22, 2016 revealed chronic left L5-S1 radiculopathy. Bending backwards exacerbated her pain. Dr. Kohn referred her for physical therapy for her chronic L5-S1 radiculopathy and left piriformis syndrome. He renewed her prescription for Gabapentin. She was instructed to follow up in 2-3 months.

On November 15, 2016, Petitioner contacted Athletico to make an appointment for therapy. The intake form reflects her reported problems were not due to an injury on the job (PX # 6 & RX #6). She did provide information for her group insurance, Cigna.

During her initial intake at Athletico on November 28, 2016, Petitioner reported issues with her low back and radiculopathy (PX #6). The records documented Petitioner's that many years earlier, she tried to pick up one end of a couch and twisted her back. She reported that ever since that time, she suffered from left leg and low back pain. She has tried therapy in the past, but her pain always comes back. The therapist noted decreased active range of motion, pain with lumbar extension and left side bending, decreased hip and core strength, as well as a positive extension rotation test on the left. She is a cashier and is expected to stand for long periods during the day, which she is unable to do currently. Physical therapy was recommended 2 times a week for 6 weeks.

Petitioner returned to Athletico on December 5, 2016 (PX #4). She reported success with her home exercise program. Her back pain increased after standing for long periods. The therapist noted soft tissue restrictions throughout the left gluteus muscle and piriformis. On December 9, 2016, Petitioner reported that she had less pain down her leg and her pain was now concentrated in her low back. She participated in therapy. Her last visit was December 12, 2016. She reported increased symptoms down her leg while standing at work. She had attended 4 sessions.

Petitioner returned to Dr. Kohn on January 23, 2017. She reported on and off back pain and days when she is completely asymptomatic. She used a lumbar support at times.

When present, her left low back pain radiated to the knee. She reported improvement with 2epidurals in 2012. She was referred for pain management to possibly undergo an epidural steroid injection.

On April 25, 2017, Petitioner presented to Dr. Antony Tharian for the first time as she was a former patient of Dr. Rana (PX #5). She had 2 lumbar epidural steroid injections in 2012, with 70% improvement for 2 years. Dr. Tharian reviewed her MRIs from 2014, noting a minimal disc bulges at L4-5 and L5-S1 without associated central canal stenosis. She reported she had bowel and bladder incontinence prior to lumbar epidurals in 2012. She had an MRI in 2016 but did not bring it with her. Dr. Tharian recommended a lumbar epidural injection.

Dr. Tharian administered a lumbar epidural injection on May 1, 2017 at L5-S1. At a follow-up visit on June 5, 2017, she reported 50% improvement and denied any radiating pain down her left lower extremity. She still had back pain and decreased her Gabapentin dose due to side effects. Straight-leg raise was negative, and her strength was 5/5. There was tenderness to palpation on the left.

On August 21, 2017, Petitioner told Dr. Tharian she could not tolerate Gabapentin and that lidoderm patches fall off. The doctor recommended physical therapy. At a follow-up visit on December 11, 2017, Dr. Tharian noted she had not had physical therapy.

Petitioner attended therapy at Athletico with visits scheduled in February 2018 (PX #6) She attended 16 sessions: with 2 in February, 6 in March, one in April, 3 in May, and 4 in June. The therapy records noted a history of a work injury with symptoms starting on February 20, 2011.

Petitioner saw Dr. Tharian on March 5, 2018. His notes reflect that she never went to physical therapy but reported she does aqua therapy on her own. She asked for a surgical consultation, even though she saw Dr. Muro, whom she did not mention in her trial testimony, in the past who did not consider her to be a surgical candidate. Dr. Tharian gave her names of doctors.

On January 4, 2019, Petitioner returned to Dr. Song. He noted she saw several doctors since he last saw her, and one doctor recommended surgery. He ordered a new MRI and X-rays. She reported ongoing low back pain and leg pain similar to a L5 or S1 radiculopathy.

The February 1, 2019 lumbar MRI and X-rays demonstrated moderate degenerative disc disease at L5-S1 with no focal disc herniation (PX #8).

Petitioner returned to Dr. Song on February 25, 2019. He noted severe degeneration at L5-S1 on the MRI. Petitioner had back pain and some pain down her left posterior thigh. Dr. Song noted Petitioner had not improved over the last 8 years and that she is a candidate for an anterior fusion at L5-S1. Dr. Song noted that Petitioner wished to proceed with surgery.

CONCLUSIONS OF LAW

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

It is undisputed that Petitioner sustained a work-related injury to her low back on February 4, 2011. Petitioner claims that she developed a condition of ill-being in her low back pain radiating into her left leg that was causally related to her accident. A series of lumbar MRIs demonstrated degenerative changes with disc bulging at Petitioner's L4-5 and L5-S1. Certain of the MRIs indicated herniated discs at these levels, findings that were adopted by various of Petitioner's treating physicians.

The Arbitrator notes that none of Petitioner's treating physicians opined that her work accident caused bulging or herniated discs. None opined that the degenerative changes were where a pre-existing and were exacerbated or aggravated by the accident. On the other hand, Respondent's examining physician, Dr. Lanoff, opined that petitioner sustained a lumbar sprain/strain from which she should have recovered by the time of his IME on May 26, 2011.

The key to Petitioner's claim of ill-being is based on the credibility her history that she had not had similar complaints or symptoms before her December 4, 2011 work accident. After reviewing all of the evidence the Arbitrator finds that petitioner was not a credible witness in her testimony at trial and was not credible in reporting her history and symptoms to her treating physicians.

Petitioner testified at trial and reported to her treating physicians that she developed low back pain which radiated into her left leg immediately following her work accident. It is noteworthy that petitioner testified at trial that she sought medical care immediate care for these complaints at Concentra, when in fact she did not present for medical care until February 10, 2011. Petitioner testified at trial that she reported low back pain that radiated into her left leg. The chart notes from Concentra do not document a complaint of radiating pain until April 1, 2011. In fact, there were specific denials of radiating pain or lower extremity numbness or weakness prior to April 1.

In addition, Petitioner had a history of inconsistent symptomatic complaints as well as poor effort in compliance documented by her physical therapists. Moreover, petitioner continued to work full time, albeit with lifting restrictions, from the day of her accident through May 25, 2011. Petitioner was apparently able to tolerate a job that required her to be on her feet all day while serving coffee and sundries, along with the required lifting and carrying of coffee bar dispensers and beverage bottles. Petitioner testified that she limited herself from lifting the cases of soda bottles or cans which led to but offered no evidence of how she was able to stock the coffee bar without lifting or carrying cases of soda or other beverages.

Petitioner's credibility was challenged by certain histories noted by her healthcare providers. Petitioner testified at trial that the Concentra chart notes documenting her initial denial of radiating pain were incorrect. She also testified at trial that she never reported to a therapist at Athletico that years before that she had developed continuing low back and left leg pain when attempting to lift a couch. The Arbitrator acknowledges that certain matters may be omitted or overlooked in a patient's report of history by a healthcare provider. That may indeed explain the claimed discrepancy in the Concentra history but the details of the couch episode within the Athletico history are such that they have the ring of truth. The Athletico note also documented that Petitioner had received therapy for her low back and left leg pain which had not helped relieve her complaints.

Petitioner's credibility was also challenged by her failure to testify at trial about physicians mentioned in her medical records, Drs. Muro and Gruber, who apparently engaged in her care.

It is noteworthy that in January 2014 Dr. Song, upon review of the most recent lumbar MRI, noted that Petitioner's herniated discs had resolved.

It is equally noteworthy that over the years Petitioner continued to work for Respondent at her regular job during her medical care and during significant gaps in her medical care: October 2011 through December 2012 and over 2 years between 2014 and 2016.

Respondent's examining physician, Dr. Lanoff, noted the most compelling inconsistencies within Petitioner's case. Dr. Lanoff noted 5 of 5 positive Waddell signs. He noted the contradiction of a positive straight-leg while supine and a negative while seated. He noted the non-anatomic, non-dermatomal complaint of numbness throughout the entire left leg. While Dr. Lanoff did not opine specifically, his examination clearly demonstrated Petitioner's symptom magnification. Dr. Lanoff did note that even if there were a disc herniation, that did not correlate to Petitioner's subjective complaints. It is noteworthy that Petitioner did not give you a history to Dr. Lanoff of chronic low back

and left leg pain that preexisted her work accident, a history she withheld from her treating physicians and at the trial of this matter. The Arbitrator finds Dr. Lanoff's thorough review of Petitioner's case persuasive and adopts his opinions.

The Arbitrator notes the findings of Dr. Yapor on his IME were based on his interpretation of an MRI. Dr. Yapor did not note which of Petitioner's MRIs he reviewed, an important point given the number of MRIs she had, as well as the varying assessments of those MRIs by various physicians, most noteworthy being Dr. Song's assessment in January 2014 that the disc herniations had resolved. Given this gap and Petitioner's poor reliability and credibility as a historian, the Arbitrator does not find Dr. Yapor's opinions persuasive.

After review of all the evidence, the Arbitrator finds that Petitioner failed to prove that her claimed current condition of ill-being, namely low back and left leg pain from bulging or herniated discs lumbar spine, is causally related to her work accident on December 4, 2011. The Arbitrator does find the Petitioner proved that she sustained a soft tissue sprain/strain to her lumbar spine, as opined by Dr. Lanoff.

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

K: What temporary benefits are in dispute? TTD; ***L:*** What is the nature and extent of the injury?; ***N:*** Is Respondent due any credit?

Petitioner submitted a statement from Concentra from February 23, 2017 showing total charges of $5,097.42 with payments of $4,748.41 and adjustments of $349.01 (PX #1A). She testified that she has never received a bill from Concentra. Respondent's medical payment summary shows total payments of $4,748.41 to Concentra with the vendor names listed as Occupational Health and Occspecialists, PC (RX #1).

The Arbitrator notes that the Concentra bill reflects a balance of $0.00. The Arbitrator therefore finds that Respondent paid all appropriate charges for all reasonable and necessary medical expenses and no additional medical expenses are awarded.

K: What temporary benefits are in dispute? TTD

Petitioner claims temporary total disability benefits from May 25, 2011 through October 7, 2011 (19 & 3/7 weeks). Dr. Lanoff concluded Petitioner was able to work full duty as of his exam May 26, 2011. Petitioner continued to work with light duty restrictions

until she saw her primary care doctor on May 26, 2011, who then authorized her off work due to her subjective complaints. However, Petitioner did not testify about how the light duty restrictions were accommodated.

The parties stipulated that Petitioner received short term disability benefits while she was off work in the net amount of $3,573.85 (ArbX #1).

The Arbitrator finds that Petitioner failed to prove that she is entitled to temporary total disability benefits for the period of time from May 25, 2011 through October 7, 2011, given her questionable credibility with regard to her history and her subjective complaints and given Dr. Lanoff's persuasive opinion that she was capable of full duty work during that period of time.

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

Petitioner's permanent partial disability was evaluated in accord with §8.1b(b) of the Act:

i) No AMA Impairment Rating was offered in evidence. The Arbitrator cannot give any weight to this factor.

ii) Petitioner's job title was Specialty Food Service Attendant. She was a cashier at a hotel lobby stand, a job which required her to be on her feet the entire workday in which she was also required bending and stooping to stock product, as well as occasionally lifting and carrying cases of bottled beverages. The Arbitrator gives great weight to this factor.

iii) Petitioner was 34 years old at the time of her accident. She had a statistical life expectancy of approximately 48 years. The Arbitrator gives moderate weight to this factor.

iv) Petitioner continued to work the great majority that time since her accident. It was no evidence that her earning capacity was adversely affected by her injuries. The Arbitrator gives great weight to this factor.

v) Petitioner received extensive medical care for her claimed injuries, although there were 2 significant gaps in that care, one of which was more than 2 years. Her medical care included several regimens of epidural spinal injections and several courses of physical therapy. The evidence showed that Petitioner did not consistently attend or put forth full effort in her therapy. Petitioner consulted an impressive array of physicians, some of whom diagnosed herniated lumbar discs. Petitioner displayed significant inconsistencies and symptom magnification in an IME with Dr. Martin Lanoff. Petitioner's medical records also revealed a significant history of chronic low back and left leg pain which she did not disclose to her treating physicians or Respondent's examining's physicians. The medical evidence

tends to prove that Petitioner did not sustained dramatically caused bulging or herniated discs but rather sustained a sprain/strain of her lumbar spine. The Arbitrator gives great weight to this factor.

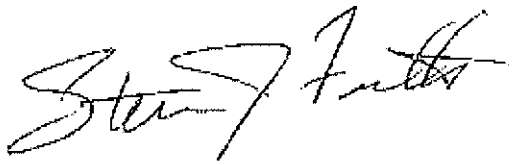
Based on all of the evidence, including the above five factors, the Arbitrator finds that Petitioner sustained a permanent partial disability from her injuries to the extent of 5% loss of a person-as-a-whole, 25 weeks, pursuant to §8(d)(2) of the Act.

N: Is Respondent due any credit?

It is undisputed that petitioner was scheduled for an IME with Dr. Wesley Yapor on February 7, 2013, for which she did not appear. Petitioner's counsel did not notify respondent's counsel of Petitioner's inability to attend the IME until February 6, 2013. Respondent was charged a $1,000.00 fee by Dr. Yapor in accord with the doctor's cancellation policy (RX #5A). Petitioner testified that she had been notified of the scheduled IME. Accordingly, Respondent argues that it is entitled to a credit for Dr. Yapor's $1,000.00 fee for late cancellation.

The Arbitrator finds no statutory authority to award respond to a credit for cancellation fees relating to a missed IME, see *Lee v. University of Illinois*, 10 WC 24293, 13 IWCC 692 and *Phillips, Jr. v. Michael Nicholas Contractors*, 03 WC 37182, 8 IWCC 937. See also *O'Neil v. Illinois Workers' Compensation Com'n*, 2020 ILApp(2d) 190427WC, where the appellate court held that there was no statutory authority working penalties and attorney's fees when the respondent withdrew authorization for medical care.

Petitioner applied for and received short-term disability benefits totaling $3,573.85, for which respondent would have been entitled to a credit had temporary total disability benefits been awarded. Inasmuch as temporary total disability benefits were not awarded, this issue is moot.



Steven J. Fruth, Arbitrator

May 19, 2020
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC003076
Case Name	WILSON,PEARLINE v. PALMER HOUSE HILTON
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0295
Number of Pages of Decision	21
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Ian Elfenbaum
Respondent Attorney	Tiana Muntner

DATE FILED: 6/14/2021

/s/ Deborah Simpson, Commissioner

Signature

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

Pearline Wilson,

Petitioner,

vs. NO: 19 WC 3076

Palmer House Hilton Hotel,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §§19(b) and 8(a) having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical, prospective medical and temporary disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 15, 2020, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $50,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

June 14, 2021

O-6/9/21
DLS/rm
046

/s/*Deborah L. Simpson*
Deborah L. Simpson

/s/*Stephen J. Mathis*
Stephen J. Mathis

/s/*Deborah J. Baker*
Deborah J. Baker

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0295
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

WILSON, PEARLINE
Employee/Petitioner

Case# **19WC003076**
17WC013189

PALMER HOUSE HILTON HOTEL
Employer/Respondent

On 9/15/2020, 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 0.12% 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:

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WARRENVILLE, IL 60565

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

19B/8A ARBITRATION DECISION

Pearline Wilson
Employee/Petitioner,

Case # **19** WC **03076 (severed for hearing by agreement of the parties)**

v.

Consolidated cases: **17 WC 13189**

Palmer House Hilton Hotel
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 **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **August 18, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **01/28/2019**, 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 **$29,464.52**, the average weekly wage was **$755.50**.

On the date of accident, Petitioner was **55** years of age, ***single*** with **0** dependent children.

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

Respondent ***has in part*** paid 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 **$4,877.59** for other benefits, for a total credit of **$4,877.59**.

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 $503.66 per week for 30 4/7 weeks, commencing January 29, 2019 through August 30, 2019, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner's medical bills totaling $4,890.24 (PX 1-4), per fee schedule directly to Petitioner as provided in Section 8(a) of the Act. Respondent shall be given a credit of $4,877.59 for medical benefits that have been paid as detailed in Respondent's Exhibit 7.

Respondent shall authorize and pay for the left knee surgery recommended by Dr. Sompalli.

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

9/11/20
Date

SEP 15 2020

Pearline Wilson v. Palmer House Hilton Hotel
19 WC 3076 (severed from 17 WC 13169 for hearing, by agreement of the parties)

Summary of Disputed Issues

Petitioner has worked as a housekeeper at Respondent hotel since 2011. She claims a left knee injury occurring January 28, 2019. She testified she was working in one of her assigned guest rooms when she noticed a cockroach in the bathtub. She stepped into the tub with her right foot and put a towel over the cockroach. The cockroach continued to move. She struck her left knee on the side of the tub as she turned and attempted to back out. She immediately reported the accident to her supervisor and went to the security area, where she completed a report. She acknowledged she did not mention twisting her knee in this report.

Petitioner began a course of treatment at Concentra the following day. The Concentra records also reflect that Petitioner struck her left knee against the tub. The Concentra physician, Dr. Taiwo, imposed significant restrictions. Respondent offered Petitioner "light duty" beginning at 10 PM the next day, January 30th. Respondent offered into evidence Emails reflecting that Petitioner called in, after learning of the offer, and indicated "she could not work on the third shift." RX 5. On January 30, 2019, Petitioner retained an attorney and went to AMCI, where she saw a chiropractor who took her off work. AMCI subsequently referred her to an orthopedic surgeon, Dr. Sompalli, who diagnosed a meniscal tear and recommended surgery. Dr. Sompalli relied on the history Petitioner provided to him, i.e., that she twisted her left knee while backing out of the tub, in finding causation. Respondent's examiner, Dr. Karlsson did not find causation, based on the varying histories, but agreed that Petitioner has a meniscal tear and the proposed surgery is reasonable and necessary.

The disputed issues include accident, causal connection, average weekly wage, medical expenses, temporary total disability and prospective care. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified she has worked as a housekeeper at Respondent hotel for nine years. Her duties include cleaning guest rooms, including bathrooms, and changing beds. She cleans sixteen rooms during an eight-hour shift. Prior to her claimed accident, she typically worked forty hours per week. If she worked fewer hours, it was due to a lower house count. When she left Respondent, she was earning $20.42 per hour. She previously earned $19.72 per hour.

Petitioner acknowledged seeing her primary care physician due to left knee swelling about two years before her claimed accident. The physician drained her knee. Petitioner denied being subject to any knee-related work restrictions prior to the accident.

Petitioner testified she injured her knee at work on January 28, 2019. Prior to the injury, she went to an assigned guest room and began pulling used linen. She noticed a

cockroach inside the bathtub. She testified it was not uncommon to encounter cockroaches in guest rooms. She was supposed to kill any insect she found. If she failed to do so, she would get written up. She placed a towel over the cockroach and put her right foot inside the tub. At that point, she was facing a wall. The bathroom door was behind her. The cockroach started to move. She tried to back out, striking her left knee against the side of the tub in the process. She managed to kill the cockroach after she struck her knee. She went out to the hall and asked a female co-worker to use the house phone to alert her boss, Maria.

Petitioner testified that Maria came to the guest room and asked what had happened. Petitioner explained how she had gotten hurt and complained of her leg. She asked Maria whether she wanted to see the cockroach but Maria declined, saying "I know we have them." Petitioner identified PX 6 as a photograph she took of the dead cockroach lying on the towel. Maria sent her to the hotel's security department, where she met with a manager named Tommy. Petitioner identified page 2/10 of RX 3 as an "Employee Accident Report" she completed. She also identified her handwriting on page 3/10 and her signature on page 4/10.

The "Employee Accident Report" (RX 3, p. 2/10) sets forth the following narrative, written by Petitioner: "Hit left knee against the tub in Room 21258 trying to kill a large cockroach that was in the tub in a guest room." The report reflects that Petitioner was injured at 12:42 PM on January 28, 2019. The following page, also labeled "Employee Accident Report," sets forth the following description of Petitioner's injury: "inner knee swollen on left leg." Petitioner rated her pain at 7/10 and answered "no" in response to a question asking whether she had previously injured the same body part. RX 3, p. 3/10. Petitioner marked the inside of her left knee on a diagram on the next page and signed this page at the bottom. RX 3, p. 4/10. Petitioner also signed a form authorizing release of her medical records to Respondent and its workers' compensation carrier. RX 3, p. 5/10. Pages 7/10 through 10/10 of RX 3 consist of forms ["Refusal of Medical Care", "Witness Statement Form" and "Accident Investigation"] that are not completed. Petitioner, among others, signed the last page, 10/10, which consists of a set of instructions concerning same-day accident reporting, etc.

Petitioner testified that a "top sheet," consisting of a statement she wrote concerning the accident, is missing from the exhibit marked as RX 3.

Petitioner testified that, while she was in the security area, she spoke with a nurse via telephone. The nurse told her to return if her knee became swollen, indicating she would be sent to Concentra.

Petitioner testified she did not resume her usual job duties after she left the security area. At Maria's direction, she sat in Respondent's linen room with her leg up, waiting for her ride home.

Petitioner testified she went to work the following day, January 29, 2019, and was sent to Concentra. The Concentra records (PX 1) reflect that Dr. Taiwo saw Petitioner that day and recorded the following history and complaints:

> "Patient reports she hit her left knee on the tub while stepping on a roach while cleaning tub, yesterday about 12:30 PM. She notes intermittent sharp pain to the medial left knee. The swelling [h]as improved. She walks with a limp. No give away. No prior knee injury."

On examination, Dr. Taiwo noted swelling over the medial aspect of the left knee, tenderness over the medial collateral ligament and diffusely over the medial knee, normal strength and negative anterior drawer testing. Dr. Taiwo obtained left knee X-rays which showed no acute abnormalities on preliminary reading. The doctor diagnosed a left knee contusion. He prescribed Ibuprofen and physical therapy. He provided Petitioner with an Ace wrap and hot/cold compresses. He released Petitioner to light duty, indicating she should be sitting 95% of the time, should stand and walk only occasionally and should avoid kneeling, squatting and climbing. He directed Petitioner to return in two days. PX 1, pp. 1-4. Petitioner attended a therapy session at Concentra the same day. The therapist noted a pain rating of 7/10. He also noted that Petitioner denied any functional restrictions prior to the accident. PX 1, p. 5.

Petitioner testified that her knee hurt so much the following day that she decided she needed a second opinion. She retained an attorney who gave her a list of physicians to choose from. She selected AMCI because it was close to her home.

Records in PX 2 reflect that Petitioner saw Dr. Ashley Daliege, a chiropractor, at AMCI on January 30, 2019. The doctor noted a complaint of left knee pain following a work accident on January 28, 2019. She indicated that Petitioner, a housekeeper, "was cleaning a bathtub when she struck her left knee against the tub" and experienced an immediate onset of pain. She also noted that Petitioner was initially given an ice pack and a brief period of rest but, after twenty minutes, was "instructed to finish the remainder of her shift." She described Petitioner as completing "the remaining 4 hours of her shift with difficulty" and undergoing care at Concentra the following day. She noted that Petitioner denied any previous left knee injuries. On left knee examination, she noted Grade 1+ edema of the distal third of the medial thigh and medial knee, tenderness and hypertonicity over the distal third of the adductor magnus, tenderness over the medial knee, 5/5 strength and no instability. She diagnosed a left knee/lower leg sprain and a left knee contusion. She prescribed home exercises, took Petitioner off work and directed Petitioner to see Dr. Foreman on February 5, 2019. PX 2, p. 1.

Petitioner testified that the doctor at AMCI gave her an "off work" note (PX 2, p. 3) and that AMCI sent this note to Respondent via Email. Petitioner testified she did not hear anything from Respondent. Respondent's human resources department was closed for four days due to bad weather.

Petitioner returned to AMCI on February 1 and 4, 2019 and underwent therapy sessions with Dr. Daliege. The doctor again noted Grade 1+ edema of the left knee. She indicated that Petitioner reported no change in her symptoms. PX 2, pp. 5.

On February 5, 2019, Petitioner saw Dr. Foreman at AMCI. The doctor noted continued left knee pain, rated up to a 7, along with swelling, stiffness, locking and weakness with walking. On left knee examination, he noted edema, medial tenderness and positive McMurray's. He indicated he had difficulty assessing laxity and strength due to Petitioner's pain. He obtained left knee X-rays which showed degenerative disease and no acute abnormalities. He agreed with Dr. Daliege's diagnoses and indicated Petitioner could have a "possible exacerbation of previously asymptomatic degenerative disease." He related Petitioner's symptoms "to the incident noted in the initial visit." He recommended additional therapy and provided Petitioner with a cane and hinged knee brace. PX 2, p. 7. He prescribed various medications and directed Petitioner to limit weight bearing and remain off work pending re-evaluation on February 26th. PX 2, p. 11.

Petitioner continued undergoing therapy with Dr. Daliege thereafter. PX 2, pp. 12-18. On February 20, 2019, Dr. Daliege noted that Petitioner remained symptomatic after ten therapy sessions and was unable to see Dr. Foreman for follow-up on February 25th. She indicated she discussed Petitioner's situation with Dr. Foreman, noting he placed therapy on hold, ordered a left knee MRI and continued to keep Petitioner off work. PX 2, p. 19.

The left knee MRI, performed without contrast on February 28, 2019, showed a small effusion, chondromalacia of the patella with mild tricompartmental osteoarthritis and a horizontal tear of the posterior horn of the medial meniscus. PX 4, pp. 1-2.

On March 5, 2019, Dr. Foreman reviewed the MRI with Petitioner. He put therapy on hold and recommended that Petitioner see an orthopedic surgeon. PX 2, p. 21.

Petitioner saw Dr. Sompalli at Elite Orthopaedics on March 15, 2019. Dr. Sompalli noted a complaint of 7-8/10 left knee pain and associated weakness. He described Petitioner as limping and relying on a cane. He recorded the following account of the accident:

> "Patient states on 1/28/19 she went into [a] room to start cleaning and as she went into the washroom she noticed a cockroach in the tub. Patient grabbed a towel and placed it on top of the roach. She put her right leg into the tub and stepped onto the towel. The roach then tried to crawl up the patient's leg. The patient got scared and quickly took right leg out of the tub and, as doing so, her left leg that was on the outside of the tub twisted and banged against the tub. Patient states she felt a 'pop' at her left knee. Patient states she experienced severe pain and swelling."

The doctor also noted that Petitioner reported having had her left knee drained due to swelling a year earlier but described herself as fully functional and pain free up to the time of the accident.

On initial left knee examination, Dr. Sompalli noted a small effusion, medial joint line tenderness, patellofemoral grind and 0 to 120 degrees of motion. After reviewing the MRI, he diagnosed a medial meniscus tear, effusion, chondromalacia of the patella and arthritis "secondary to work injury 1/28/19." He administered a cortisone injection. He prescribed Mobic and physical therapy. He directed Petitioner to remain off work and return in four weeks. PX 3, pp. 1-7.

Petitioner restarted therapy with Dr. Daliege on March 19, 2019. Petitioner continued attending therapy thereafter through April 3, 2019. PX 2, p. 31.

Petitioner returned to Dr. Sompalli on April 12, 2019. The doctor noted that Petitioner reported some improvement following the injection and nine weeks of therapy but "did not complete the new PT order from last visit due to no transportation." His examination findings were unchanged. He described Petitioner as having failed conservative care. He recommended a left knee arthroscopy and debridement. He directed Petitioner to remain off work, undergo left knee X-rays and return on May 24, 2019. PX 3, pp. 8-14.

The left knee X-rays, performed on April 16, 2019, showed no acute fracture or dislocation and "changes compatible with osteoarthritis." PX 2, p. 34.

Petitioner next saw Dr. Sompalli on May 31, 2019. The doctor noted that Petitioner remained symptomatic and was scheduled to undergo a Section 12 examination on July 22nd. His examination findings were unchanged. He reviewed the X-ray results with Petitioner and again recommended surgery. He directed Petitioner to remain off work and return on August 30, 2019. PX 3, pp. 14-21.

Petitioner did not return to Dr. Sompalli after May 31, 2019.

At Respondent's request, Dr. Karlsson conducted a Section 12 examination of Petitioner on July 22, 2019. In his report of that date, Dr. Karlsson recorded the following account of the accident:

> "The examinee is a 54-year-old female who reports injuring her left knee while working as a hotel room attendant for HLT Palmer, LLC. At the time, she was cleaning a room and there was a large cockroach in the tub. She put a towel over the cockroach and went back to get something to get rid of the cockroach with. When she came back toward the tub, the cockroach had crawled out from under the towel, was flailing around and she tried to quickly turn toward her right and banged her left knee against the tub. She felt as though something popped in her knee and she twisted back again. Her leg started swelling but she finished her workday."

Dr. Karlsson noted that Petitioner denied any history of prior treatment to her knee but acknowledged experiencing "some occasional arthritis pain that would come and go." He indicated that Petitioner complained of pain on the inner side of the knee and occasional locking of the knee.

Dr. Karlsson described Petitioner as cooperative throughout the examination. He described Petitioner's gait as antalgic, noting cane usage. On left knee examination, he noted a range of motion of 0 to 150 degrees, no effusion or erythema, 5/5 quadriceps and hamstring strength, 1+ medial joint line tenderness, pain but no clicking with McMurray testing and trace medial facet patellar pain. He noted no abnormalities on right knee examination.

Dr. Karlsson indicated he reviewed the treatment records along with the MRI report and images. He interpreted the images as revealing minimal effusion, mild tricompartmental arthritis, no fractures, dislocations or loose bodies and a horizontal high signal throughout the posterior horn of the medial meniscus, consistent with a tear of the posterior horn of the medial meniscus.

Dr. Karlsson opined that Petitioner has "objective findings on MRI of a medial meniscus tear and medial arthritis," "objective findings on plain X-ray of arthritis" and "objective findings on physical exam of slight atrophy of the left leg from disuse." He described these findings as "consistent with some subjective complaints" but indicated that Petitioner's complaints were greater than would be expected from the findings. He did not link her complaints or the findings to the work accident, based on the "widely varying histories." He noted that Petitioner originally reported merely hitting her left knee, later reported stepping into the tub with her right leg and twisting and striking her left knee and then, to him, indicated she became startled by the roach's movement when she returned to the tub and twisted and struck her knee. He concluded that "the earliest history is the most accurate" and that he would not expect the mechanism of just striking the knee against a tub to cause a meniscal tear. He opined that the arthritis was not caused by the injury but was a longstanding condition. He conceded that the mechanism Petitioner described to him could have caused a meniscal tear but that this description differed from Petitioner's earlier accounts. He opined that Petitioner's conditions would cause some knee pain but "not enough to require the use of a cane every day and use of a brace at all times when out of bed." He described the recommended left knee arthroscopy with partial medial meniscectomy and debridement as reasonable and necessary. He found Petitioner to be at maximum medical improvement for her work injury, "which was a contusion of the knee." He saw no need for work restrictions and found Petitioner capable of full duty. RX 1.

Dr. Sompalli testified by way of evidence deposition on October 31, 2019. PX 5. The doctor's CV (Sompalli Dep Exh 1) reflects he attended medical school at Loyola.

Dr. Sompalli testified that about 40% of his practice involves knee conditions. He performs between 100 and 150 knee surgeries annually. He performs knee replacements, arthroscopies, reconstructions and meniscal repairs. PX 5, p. 5.

Dr. Sompalli testified he first saw Petitioner on March 15, 2019, at Dr. Foreman's referral. He did not review records from Concentra or Dr. Foreman prior to this visit. He does not recall whether he ever reviewed these records. PX 5, p. 6. He did review the February 28, 2019 MRI. He interpreted this study as showing a medial meniscal tear, chondromalacia of the patella and mild arthritic changes. His interpretation is consistent with that of the radiologist. PX 5, p. 7. Petitioner provided a history of the work accident to him. Petitioner told him she put her right leg into a bathtub, placed a towel on top of a cockroach and stepped onto the towel. When the cockroach tried to crawl up her leg, she became scared and quickly moved her right leg out of the tub, twisting and banging her left leg in the process. PX 5, p. 7.

Dr. Sompalli testified that a person with a torn meniscus may experience swelling, pain, instability and sometimes locking. Based on Petitioner's MRI, he recommended a left knee arthroscopy, a partial medial meniscectomy and a possible debridement. He last saw Petitioner on May 31, 2019, at which point he was still recommending this surgery. PX 5, pp. 8-9.

Dr. Sompalli testified that a meniscal tear can result from a sports-related injury or in a "normal everyday life setting." About 40% of such tears happen to people who are not involved in sports. One of the main mechanisms of injury described in the literature is a twisting injury to the knee while the foot is planted. The medial meniscus is "tethered more" than the lateral meniscus and thus a twisting injury pulls on it and tears it. PX 5, p. 9. Petitioner has mild arthritis in her knee but that condition is not associated with her meniscal tear. Severe arthritis can cause meniscal tearing but "you don't see them in early arthritis." PX 5, p. 10. He opined that Petitioner's work accident caused her meniscal tear. The work accident may have also aggravated her underlying arthritis. The surgery he is recommending is to treat the tear, not the arthritis. PX 5, pp. 10-11. The treatment that Petitioner underwent at Dr. Foreman's office was reasonable, necessary and related to the work accident. PX 5, pp. 12-13. He is still recommending surgery. Since Petitioner is a hotel housekeeper, she would likely require eight to twelve weeks off work following the surgery. She might be able to perform some seated work prior to that. PX 5, p. 13. Petitioner will require physical therapy and possibly work conditioning postoperatively. PX 5, pp. 13-14. He also recommends that post-operative patients use a cold therapy system to decrease pain and swelling. The treatment he is recommending is reasonable, necessary and related to the work accident. PX 5, pp. 13-14.

Under cross-examination, Dr. Sompalli acknowledged he has not seen Petitioner since May 31, 2019. If she continues to have the same symptoms she had on that date, he would recommend surgery. PX 5, pp. 15-16. His opinion that Petitioner has mild arthritis is based on his review of the MRI along with the radiologist's interpretation. He typically gives depositions at attorneys' offices because his own facility is too small. He is being paid a standard deposition fee. The pre-accident knee swelling that Petitioner described to him could have been due to arthritis or a pre-existing injury. PX 5, pp. 16-17. He did not ask Petitioner why she experienced the swelling. He does not know where the swelling-related treatment took place. PX 5, p. 17. He does not believe he necessarily had to review the pre-accident records because he was seeing Petitioner for a work injury and not a chronic problem. PX 5, p. 17. He does not believe

he needed to review those records before addressing causation. PX 5, p. 18. He has no idea why Petitioner had her knee drained. Swelling of the knee could be caused by arthritis or trauma. A meniscal tear can cause swelling, as can severe arthritis. He relied on the history that Petitioner provided in addressing causation. PX 5, pp. 18-19. He was not skeptical about Petitioner's story. PX 5, p. 20. He is not aware that, when Petitioner first reported the injury, she indicated she struck her left knee and did not report twisting the knee. PX 5, p. 20. He is not aware that Petitioner first described twisting her knee when she saw him on March 15, 2019. PX 5, p. 21. If Petitioner had not told him she twisted her knee, his causation opinion could possibly be different. If Petitioner had told him she merely bumped her knee, he would probably not have found causation. PX 5, p. 23. In his note of March 15, 2019, he indicated that meniscal injuries occur with a twisting motion. PX 5, p. 23. He also noted that swelling can be a common finding and that conservative care can be effective for many patients. PX 5, p. 24. He recommended surgery on April 12, 2019. A month earlier, he had recommended twelve physical therapy sessions. Petitioner did not complete those sessions. PX 5, p. 25. It would not be fair to say that Petitioner did not fail therapy because she failed to complete therapy. Petitioner had already attended therapy for nine weeks before he recommended the twelve sessions. PX 5, p. 25. Petitioner reported improvement secondary to that therapy. He ordered surgery because Petitioner failed nine weeks of therapy and a cortisone injection. PX 5, p. 26.

On redirect, Dr. Sompalli testified that therapy does not repair a meniscal tear. PX 5, p. 27.

Dr. Karlsson issued an addendum on January 24, 2020, after reviewing Dr. Sompalli's deposition. He again agreed with Dr. Sompalli's surgical recommendation but did not link the need for surgery to the accident. He reiterated that Petitioner provided "three distinct different histories" of how her injury occurred. He indicated that, "with widely varying histories, the earliest is usually the most accurate." He also indicated that, when varying histories are offered, a question arises as to whether there was an actual injury. He agreed, to some extent, with Dr. Sompalli's statement that "it is not necessary to know the full prior history or causation of an injury for treatment at all times." He disagreed, however, with the doctor's statement that "it is not important to know the full prior history when issuing a causation opinion." After noting that Petitioner did not complete the additional therapy that Dr. Sompalli recommended, he indicated it was unlikely, in Petitioner's case, that additional therapy would lead to significant improvement. He anticipated that Petitioner would need six weeks of therapy postoperatively. He saw no need for a cold therapy unit. RX 2.

Petitioner testified she has not received any temporary total disability benefits. The surgery that Dr. Sompalli recommended has not been authorized. If the Arbitrator awards the surgery, she wants to undergo it. Dr. Karlsson spent five minutes with her on July 22, 2019. He asked her to stand up, walk and sit. He lifted her leg and moved it. She is currently experiencing 8/10 pain in her left knee. She uses the brace and cane prescribed by AMCI. Her bones ache. She experiences numbness and a "ripping" sensation in her leg. She takes over the counter Ibuprofen to address her symptoms. Standing, walking and sitting in certain positions causes her pain to increase. She feels better when her leg is elevated. She provided

the same account of the accident to AMCI, Dr. Sompalli and Dr. Karlsson. Before the accident, she experienced left knee swelling. She would apply an ice pack to her knee. About two years before the accident she saw a doctor for the swelling. This doctor drained fluid from her knee. She was never subject to knee-related work restrictions prior to the accident. She was able to perform her job duties before the accident.

Under cross-examination, Petitioner reiterated that a "more descriptive" page is missing from RX 3, the documents relating to the accident. In the report that appears in RX 3, she indicated she "hit it," referring to her left knee. She did not mention twisting her knee. It was at Respondent's security department that they iced her knee. She then went to the linen room, where she sat with her leg elevated. The guest room where the accident occurred was the last room she was supposed to clean that day. She did not finish cleaning that room after the accident. Another employee finished cleaning the room. She acknowledged that Respondent left her a telephone message offering her light duty but the light duty was scheduled for midnight on January 30th. She did not call back to decline the offer. She wanted a second opinion. She took January 30th off. Her leg was so sore she could not stand on it. The doctor at Concentra said her leg was swollen. He said she could take two to three days off but he did not write this down. Respondent left a message telling her that light duty was available at midnight on January 30th, not on January 29th. At Concentra, she "probably" said she twisted her leg but she does not know what the doctor wrote down. She told the doctor at Concentra exactly what happened. She told him she turned backward, with her leg turning with her body. She did not use the word "twist." Both the turn and the striking caused her injury. She went to AMCI after consulting with an attorney. The attorney showed her a list of doctors she could see. The list included AMCI. She chose this facility because it is closer to her home. She told the doctors at AMCI "the same scenario," i.e., that her body and leg turned while she was backing out of the tub. She did not tell the doctor at AMCI that she twisted her leg. The doctor at AMCI automatically took her off work. She was referred to Dr. Sompalli because therapy was not helping. She described the work accident to Dr. Sompalli. This was not the first time she mentioned twisting her knee. She told Dr. Sompalli the same story, i.e., that when she turned her body, her leg also turned. She told Dr. Sompalli she had previously had her left knee drained. She had the knee drained by a technician at a place in Chicago called "Quest." She had previously seen a doctor at a hospital but she cannot recall the name of the hospital. The doctor told her she needed to have her knee drained. She told this doctor her knee was hurting a little. She had not previously injured her knee. She last saw Dr. Sompalli on May 31, 2019. She went to Rush the week before the hearing. At Rush, she underwent knee X-rays and was given pain medication. She did not go to Rush because of any new injury. She went there because she has waited too long to undergo surgery. [Petitioner did not offer the Rush records into evidence.] She has not reinjured her knee since the work accident.

On redirect, Petitioner testified that, as she lifted her right leg out of the bathtub, she put weight on her left leg. She turned to her right, backwards, to get her right leg out. That is when she hit her left knee. She went to Concentra on January 29, 2019, the day after the accident. Respondent offered her an overnight shift on January 30th. She went to AMCI during the day on January 30th. She did not take a day off in order to go to AMCI.

Tommy Hardin testified on behalf of Respondent. Hardin testified he has worked as a security manager for Respondent for two years. He is chairman of the safety committee at Respondent. His duties include filing workers' compensation claims. If an employee is injured on the job, that person comes to the security area to complete paperwork. The injured employee also speaks with a nurse via a hotline.

Hardin testified he independently recalls Petitioner reporting an accident. Petitioner reported that she was cleaning a room when she bumped her knee while trying to kill an insect. He recalls Petitioner saying she injured her right knee. Petitioner did not report twisting her knee. He cannot recall which part of the knee was painful.

Hardin identified an Email in RX 3 as a communication he sent to Singer in human resources. In the Email, he indicated that Petitioner bumped her knee. If Petitioner had reported twisting her knee he would have made a note of that. Petitioner completed the "Employee Accident Report" that is marked page 2/10. This report has not been altered. No pages are missing from the collection of accident-related documents. He completed page 6/10 and signed page 10. Petitioner did not produce any photograph when she reported the accident. If Petitioner had given him a photograph he would have noted that.

Under cross-examination, Hardin acknowledged that no page 5/9 appears in the collection of documents that comprise RX 3. Petitioner told him about the cockroach. The hotel is older and Petitioner's job involved the removal of bugs. Petitioner initially spoke with a nurse on the telephone hotline and then spoke with him. He sent an Email after reviewing the accident report.

On redirect, Hardin testified that the pages in RX 3 have two sets of numbering.

Under re-cross, Hardin testified that the packet of forms relating to work accidents has been re-done over the years. The packet may have consisted of only eight pages originally.

In addition to Dr. Karlsson's reports, Respondent offered into evidence a series of Emails dated Tuesday, January 29, 2019. In the earliest Email, sent at 2:44 PM, Randall Singer (who is identified as Respondent's assistant director of human resources) notified several individuals, including Mark Celestin, of Petitioner's restrictions. Celestin responded to Singer at 4:14 PM, indicating that Respondent could offer Petitioner "overnight shifts, 10 PM to 6 AM" and that Petitioner was due to work the next day. At 4:46 PM, Singer Emailed the same individuals again, indicating he had called Petitioner at 4:20 PM and left a message for her to call him. At 5:44 PM, Singer indicated he called Petitioner again at 5:42 PM and told her she would be working light duty on January 30th on the overnight shift, from 10 PM to 6 AM, "and to call the department to let them know if she accepts the light duty." At 8:07 PM, Lenny Vanna, who is identified as Respondent's night housekeeping manager, Emailed Singer, Celestin and others, indicating that Petitioner called "and said she could not work on the third shift." Vanna went on to say that she "told [Petitioner] she would not get paid for it and then she had more

questions and comments." Vanna indicated he told Petitioner to call human resources on Thursday. RX 5.

Respondent also offered into evidence a medical payment ledger (RX 7) and documents concerning Petitioner's hours and wages (RX 8).

Petitioner was recalled in rebuttal. She listened to Hardin's testimony. When she first went to the security area, after the accident, she met with an older white man. Hardin, who is Black, arrived later. She did not make any statements to Hardin.

Arbitrator's Credibility Assessment

The fact that Petitioner has worked for Respondent for eight years weighs in her favor, credibility-wise.

Much has been made about the variances in Petitioner's account of the accident. While the accident report and Concentra records do not document any twisting mechanism, they reflect that Petitioner injured her left knee while attempting to deal with a cockroach that she found in a guest room bathtub. It makes sense to the Arbitrator that Petitioner, at least initially, was more focused on the unsavory nature of the work task than on the precise mechanism of injury. From a logistical point of view, it also makes sense that Petitioner would have twisted her left knee while stepping out of the bathtub. Petitioner was trying to take evasive action while in an awkward position, i.e., with her left leg on the exterior of the tub and her right leg inside it.

Respondent maintains that the delayed production of a photograph of the cockroach also undermines Petitioner's credibility. Respondent appears to suggest that Petitioner's entire account is fictitious. Respondent's witness, however, freely acknowledged that the hotel where he and Petitioner work is old and that one of Petitioner's housekeeping duties is to dispose of insects.

Overall, the Arbitrator found Petitioner's treating surgeon, Dr. Sompalli, more persuasive than Respondent's examiner, Dr. Karlsson. Dr. Sompalli saw Petitioner on several occasions while Dr. Karlsson examined her once. Dr. Karlsson invaded the province of the Arbitrator and concluded, without explanation, that a patient's earliest history is the most reliable.

Arbitrator's Conclusions of Law

<u>Did Petitioner sustain an accident arising out of and in the course of her employment?</u>

The Arbitrator finds that Petitioner sustained an accident on January 28, 2019 arising out of and in the course of her employment. Petitioner satisfied both prongs of the accident "test." The accident occurred "in the course of" her employment in that it took place on

Respondent's premises during her regular shift. The accident "arose out of" the employment in that Petitioner was performing a work-related task, i.e., attempting to remove an insect from a bathtub in a guest room, when she was injured. Respondent's witness acknowledged that one of Petitioner's housekeeping duties was to dispose of any insects she found in the hotel.

Did Petitioner establish causal connection?

The Arbitrator finds that Petitioner established a causal connection between the accident of January 28, 2019 and her current left knee condition of ill-being. In so finding, the Arbitrator relies on the following: 1) Petitioner's testimony concerning the nature of the left knee treatment she underwent a year or two before the accident; 2) Petitioner's testimony that the accident occurred after she had already completed much of her shift; 3) Respondent's wage records, which reflect that Petitioner worked five and a half hours on January 27, 2019, the day before the accident; 4) Petitioner's testimony concerning the physical nature of her housekeeper duties; 5) the fact that Dr. Taiwo noted left medial knee swelling and tenderness over the medial collateral ligament and medial knee when he examined Petitioner on January 29, 2019, the day after the accident; 6) Dr. Sompalli's causation opinion; and 7) Dr. Karlsson's concession that the mechanism of injury Petitioner described to him could have caused a meniscal tear. With respect to the second and third factors, the Arbitrator finds it unlikely Petitioner could have successfully performed her housekeeper duties on January 27th and 28th, up until the accident, had she torn her meniscus at some point prior to the 27th.

What were Petitioner's earnings? What is Petitioner's average weekly wage?

Petitioner claims earnings of $33,277.49 and an average weekly wage of $799.54. Respondent claims an average weekly wage of $601.75. Arb Exh 1.

Petitioner testified she typically worked 40 hours per week but conceded she worked fewer hours when the "house count" was low. She testified she earned $20.42 per hour as of the accident and $19.72 per hour earlier in time. [According to PX 7, the raise went into effect at the end of September 2018.] She did not address the issue of overtime.

Respondent's witness did not testify as to Petitioner's schedule or pay.

Both parties offered documents concerning Petitioner's hours and earnings during the year preceding the accident. The Arbitrator notes that the $33,277.49 earnings total claimed by Petitioner includes vacation and sick pay as well as some overtime wages. Petitioner's "regular pay" during the year before the accident totaled $29,464.52. The documents reflect that Petitioner worked 429 regular hours from January 29, 2018 through April 28, 2018 and 1,129.75 regular hours from April 29, 2018 through January 27, 2019 (the day before the accident). The combined hours total 1,558.75. Based on Petitioner's testimony concerning her schedule, the Arbitrator finds that Petitioner made herself available to work 40 hours per week but was not always required to do so. When fewer guests were at the hotel, Petitioner worked fewer hours. In this sense, Petitioner is not unlike the construction worker whose schedule the Court

analyzed in Sylvester v. Industrial Commission, 197 Ill.2d 225 (2001). The Arbitrator divides 1,558.75 by 40 and arrives at 38.97. For ease of calculation, the Arbitrator rounds 38.97 up to 39. The Arbitrator divides the $29,464.52 in earnings by 39 to arrive at an average weekly wage of $755.50.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims medical expenses from Concentra, ACMI, Elite Orthopedics and Preferred Open MRI. PX 1-4. Respondent disputes this claim, based on its accident and causation defenses. Respondent offered into evidence a ledger reflecting that its carrier, Sedgwick, made payments totaling $4,877.59 to various medical providers. RX 7. [At the hearing, Respondent claimed Section 8(j) credit in the amount of $4,877.59. After the hearing, the parties stipulated that Respondent was entitled to credit in this amount but not under Section 8(j), since the payments were not made by a group carrier.]

The Arbitrator has previously found in Petitioner's favor on the issues of accident and causation. Dr. Sompalli testified that the care he and Dr. Foreman provided was reasonable and necessary. Respondent's examiner, Dr. Karlsson, did not characterize any aspect of Petitioner's treatment as unreasonable or excessive. He agreed that Petitioner has a meniscal tear that requires surgery, although he did not link the tear to the work accident.

The Arbitrator finds that the treatment underlying the claimed medical expenses was reasonable, necessary and causally related to the work accident. The Arbitrator awards the claimed expenses (PX 1-4), subject to the fee schedule and with Respondent receiving credit for the $4,877.59 in payments it made. RX 7.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims she was temporarily totally disabled from January 29, 2019 through the hearing of August 18, 2020. Respondent primarily relies on its accident and causation defenses in arguing that Petitioner is not entitled to temporary total disability benefits. Respondent alternatively argues that no benefits are owed because Petitioner declined its offer of light duty on January 29, 2019. The parties agree no benefits have been paid to date.

The Arbitrator has previously found in Petitioner's favor on the issues of accident and causation. The available evidence does not support the conclusion that Petitioner declined a bona fide offer of light duty on January 29, 2019. At most, the Emails in RX 5 establish that Respondent, via telephone, offered Petitioner undefined "light duty" beginning "on the overnight shift" (i.e., 10 PM to 6 AM) on January 30, 2019 and that Petitioner responded to the offer by saying she "could not work on the third shift." Respondent produced no evidence indicating that the work it offered was within the stringent restrictions [95% seated work, etc.] imposed by Dr. Taiwo, a physician affiliated with its chosen provider, Concentra. Moreover, by the time the offered shift would have started, at 10 PM on January 30, 2019, Petitioner had seen a physician of her own choice, with that physician taking her off work. Section 8(a) of the

Act afforded Petitioner this right. Petitioner was subsequently referred to an orthopedic surgeon, Dr. Sompalli, who has recommended knee surgery. Respondent's examiner, Dr. Karlsson, did not find causation, but conceded Petitioner has a meniscal tear that requires surgical repair.

Petitioner claims a lengthy period of temporary total disability but acknowledged she last saw Dr. Sompalli on May 31, 2019, more than a year before the hearing. On that date, the doctor directed Petitioner to remain off work and return to him on August 30, 2019. PX 3, p. 20. Petitioner offered no explanation as to why she failed to return on that date. Nor did she specifically deny working in any capacity after May 31, 2019. The last record in evidence that describes Petitioner as "off work" is Dr. Karlsson's examination report of July 22, 2019. RX 1. Petitioner testified she sought treatment for her knee at Rush shortly before the hearing but she did not offer any records concerning this treatment.

On this record, the Arbitrator finds it appropriate to award temporary total disability benefits from January 29, 2019 through August 30, 2019, a period of 30 4/7 weeks. The Arbitrator awards those benefits at the rate of $503.66 per week, having previously found Petitioner's average weekly wage to be $755.50.

Is Petitioner entitled to prospective care?

Petitioner seeks prospective care in the form of the left knee surgery recommended by Dr. Sompalli. Respondent asserts Petitioner is not entitled to this care, based on its various defenses. The Arbitrator has previously found in Petitioner's favor on the issues of accident and causation. Respondent's examiner conceded that the recommended surgery is reasonable and necessary. The Arbitrator awards prospective care in the form of the left knee surgery recommended by Dr. Sompalli.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC028252
Case Name	HILL, FELICIA v. CHICAGO TRANSIT AUTHORITY
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) & 8a
Decision Type	Commission Decision
Commission Decision Number	21IWCC0296
Number of Pages of Decision	15
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Marc Stookal
Respondent Attorney	Elizabeth Meyer

DATE FILED: 6/15/2021

/s/Deborah Baker, Commissioner

Signature

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

FELICIA HILL,

Petitioner,

vs. NO: 18 WC 28252

CHICAGO TRANSIT AUTHORITY,

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 whether Petitioner's left knee condition of ill-being remains causally related to her undisputed accidental injury, entitlement to Temporary Total Disability benefits, and necessity of the incurred medical expenses as well as the prospective treatment recommended by Dr. Chaudri, and being advised of the facts and law, provides additional analysis as set forth below, but otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

The Commission, like the Arbitrator, finds Petitioner's current left knee condition of ill-being is causally related to her undisputed May 19, 2018 accidental injury. We write separately to address Respondent's arguments on Review.

Respondent argues the mechanism of injury could not have resulted in the claimed pathology. Respondent emphasizes the records consistently reflect Petitioner struck the outside front part of her knee and Dr. Forsythe opined this mechanism of injury is inconsistent with a meniscus tear, which if it existed was on the inside and back of the left knee. Respondent further notes Dr. Chaudri did not offer a contrary opinion.

While it is certainly true Dr. Chaudri did not offer specific testimony as to how a blow to the anterolateral aspect caused a tear of the posterior horn of the medial meniscus, the Commission notes the doctor was never asked to do so. Rather, the doctor's causation opinion is predicated on Petitioner's history of an acute injury with immediate onset of symptoms which thereafter persisted, as well as her clinical presentation. Further, Dr. Chaudri explained the MR arthrogram ultimately confirmed his conclusion that Petitioner had sustained a meniscal tear: "Again, so she was having joint line tenderness. She would from time to time have a positive McMurray's and Apley's compression test. The way she was describing mechanical issues all confirm that she had a tear of the meniscus." Pet.'s Ex. 4, August 26, 2019 Dep., p. 17.

In contrast, Dr. Forsythe concluded Petitioner sustained a mere knee contusion. Dr. Forsythe opined Petitioner had no meniscal pathology, either on physical exam or diagnostic imaging, and even if such meniscal pathology did exist, her mechanism of injury was inconsistent with the pathology identified by the radiologist and Dr. Chaudri. Notably, Dr. Forsythe testified Petitioner had none of the three characteristics of meniscal pathology: 1) medial or lateral joint line tenderness, 2) positive McMurray test, and 3) effusion. Resp.'s Ex. 2, p. 18. The Commission does not find Dr. Forsythe's opinions to be persuasive. We observe Dr. Forsythe testified that most contusions such as he diagnosed would fully resolve within three months with physical therapy (Resp.'s Ex. 2, p. 45), yet Petitioner's symptoms persisted for several months despite undergoing a two-month course of physical therapy. We further observe the treating records repeatedly document the presence of the same meniscal pathology indicators identified by Dr. Forsythe. Specifically, Dr. Chaudri's examination findings included a positive McMurray test on May 30, 2018, along with the presence of both medial joint line tenderness and a positive McMurray test on April 29, 2019; May 23, 2019; June 20, 2019; and August 1, 2019. Pet.'s Ex. 4, Dep. Ex. 1. While Petitioner's McMurray test was not always positive, Dr. Chaudri acknowledged the intermittent nature of that finding and nonetheless concluded that her overall clinical picture was consistent with a meniscal tear. The Commission finds the chain of events, coupled with Petitioner's credible complaints and Dr. Chaudri's conclusions as corroborated by the radiologist, establish Petitioner's current condition of ill-being remains related to her accidental injury.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 28, 2020, as amended above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $870.84 per week for a period of 73 6/7 weeks, representing August 31, 2018 through January 29, 2020, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b), 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. Resp onent shall be given a credit of $31,350.24 for temporary total disability benefits that have been paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $3,645.16 for medical expenses, as provided in §8(a), subject to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Responent shall provide and pay for the left knee treatment recommended by Dr. Chaudri as provided in §8(a) of the Act.

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

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

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.

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.

June 15, 2021

/s/ *Deborah J. Baker*

DJB/mck

O: 5/5/21

/s/ *Stephen Mathis*

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/s/ *Deborah L. Simpson*

NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

HILL, FELICIA
Employee/Petitioner

Case# **18WC028252**

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

On 4/28/2020, 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 0.15% 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:

1544 NILSON STOOKAL GLEASON CAPUTO
MARC B STOOKAL
205 W RANDOLPH ST SUITE 440
CHICAGO, IL 60606

0515 CHICAGO TRANSIT AUTHORITY
ELIZABETH MEYER
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

21IWCC0296

STATE OF ILLINOIS)
)SS.
COUNTY OF **COOK**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

FELICIA HILL
Employee/Petitioner

v.

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

Case # **18** WC **28252**

Consolidated cases: **n/a**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **JANUARY 29, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **May 19, 2018**, 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 $**67,925.52**; the average weekly wage was $**1,306.26**.

On the date of accident, Petitioner was **50** 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 $**31,350.24** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**31,350.24**.

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

ORDER

As detailed in the attached memorandum discussing the *Findings of Fact and Conclusions of Law:*

- The Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$3,645.16**, to ADCO Billing Solutions, as provided in Sections 8(a) and 8.2 of the Act. (*See* PX 6).; and,

- The Petitioner is entitled to reasonable and necessary prospective medical care as recommended by Dr. Chaudri.; and,

- The Respondent shall pay Petitioner temporary total disability benefits of **$870.84/week** for **73.86 weeks**, commencing **August 31, 2018 through January 29, 2020**, as provided in Section 8(b) of the Act.; and,

- Furthermore, 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

APRIL 24, 2020
Date

APR 2 8 2020

FELICIA HILL v. CHICAGO TRANSIT AUTHORITY

18 WC 28252

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried on Petitioner's Section 19(b)/8(a) Petition before Arbitrator Steffenson on January 29, 2020. The issues in dispute were causal connection, medical bills, prospective medical care, and Temporary Total Disability (TTD) benefits. (Arbitrator's Exhibit 1). The parties agreed to receipt of this Arbitration Decision via e-mail and requested a written decision, including findings of fact and conclusions of law, pursuant to Section 19(b) of the Act. (Arbitrator's Exhibit (*hereinafter*, AX) 1) and Transcript at 6).

FINDINGS OF FACT

The Petitioner was employed as a public bus driver for the Respondent, Chicago Transit Authority. She began her employment with the Respondent in 2012. She testified that during the entire period of her employment with the Respondent she worked as a bus driver.

The Petitioner described her work duties as including a daily pre-route safety check of the bus she was assigned to drive. The inspection included making sure the bus was working properly by walking the entire exterior of the bus, checking the tires, the lights and the various turn and stop signals. She next testified that she would go inside the bus and inspect that all items were working properly. Once the inspection process was completed, she would begin her route, picking up and dropping off passengers. The Petitioner testified that her normal workday consisted of eight (8) to nine (9) hours of driving. The Petitioner testified that approximately 40 to 50 passengers could be accommodated in seats on the busses that she would drive.

The Petitioner reported she was assigned the 79th Street route on May 19, 2018. She described this route as travelling on 79th Street from the Chicago lakefront to the Ford City Mall. The Petitioner testified this is a circular route and she drove this route back and forth during her work shift. She noted the route takes approximately one hour and ten minutes to complete depending on traffic and the number of passengers coming on and off the bus.

The Petitioner testified that on May 19, 2018, at approximately 8:00 a.m., while heading eastbound on her route, there was a passenger she suspected might have been intoxicated, boarded her bus. Later, she appreciated this passenger had fallen asleep in the back of the bus. She then stopped and parked her bus at 79th Street and Jeffrey to check on the sleeping passenger because she was coming toward the end of her route and did not want to take this passenger to the end.

The Petitioner testified as she moved from her driver's seat to check on the passenger, she struck her left knee on a metal panel located under the steering wheel. (Transcript (*hereinafter*, T.) at 14). The Petitioner further stated: "so I got up, I hit my knee; but it stung, and then I just keep going on with the procedure." (T. at 15). She reported this metal panel is "under there to hold the steering wheel. Like we have metal stuff under there." (T. at 15). She then approached the sleeping passenger and engaged that individual in conversation before returning to her driver's seat to continue her 79th Street route. However, she admitted she did not recall whether the passenger exited the bus immediately after their conversation or at some other time.

The Petitioner testified that her left knee was hurting but not to a degree where she could not continue her route. She then drove the bus to the west end of the route at Ford City, where she noticed her left knee was swollen and throbbing and it was becoming painful for her to drive the bus. The Petitioner then called the Respondent to report the accident. (T. at 17). A City of Chicago Fire Department ambulance was dispatched to her location and took the Petitioner to the Holy Cross Hospital emergency room.

The Petitioner provided her accident history to the medical staff at Holy Cross, was examined by a physician, underwent an x-ray of her left knee, and was discharged with medication and a crutch to ambulate. Later that day, she then visited Concentra Medical Center pursuant to instructions from the Respondent. She again provided her accident history and received medical care from the staff at Concentra. At the end of this visit, she was given a modified work order indicating that she was medically disabled from driving a bus. (T. at 20). The Petitioner then returned to work with these restrictions on May 23, 2018 and was tasked with performing paperwork and cleaning jobs at one of the Respondent's garages. (T. at 20).

The Petitioner sought further medical care for her left knee from Dr. Salman Chaudri, an orthopedic physician, on May 30, 2018. She provided her accident history to Dr. Chaudri and reported her left knee continued to be swollen on the left side of the knee towards the back and remained painful. Dr. Chaudri conducted a physical examination of the Petitioner's left knee, recommended an MRI examination of the joint, and prescribed a knee brace and

medications for her symptoms. (T. at 21). The left knee MRI took place on July 7, 2018, and the Petitioner returned for follow-up care with Dr. Chaudri on July 25, 2018. During this appointment, she continued to report her pain and swelling symptoms and, after a physical examination of the left knee and review of the MRI, Dr. Chaudri provided the Petitioner with two (2) injections for the knee. (T. at 22). Dr. Chaudri also recommended Petitioner continue with her work restrictions and begin a course of physical therapy. (T. at 22-23).

Upon returning to Dr. Chaudri on August 29, 2018, the Petitioner reported she did not obtain relief in her left knee after the injections and had yet to begin physical therapy due to pending approval of the same. During this visit, Dr. Chaudri continued Petitioner's work restrictions and recommended physical therapy and supplemented these with the suggestion of a viscosupplementation injection for her left knee. (T. at 23-24). She continued to follow-up with Dr. Chaudri on September 27 and October 29 with her ongoing symptoms and reported to him the viscosupplementation prescription had not been authorized. In response, Dr. Chaudri continued her work restrictions, physical therapy order, medication program, and recommendation for the injection. He also suggested an MRI arthrogram and that diagnostic study took place on January 9, 2019. (T. at 25-26).

The Petitioner returned to Dr. Chaudri on January 10, 2019 noting her ongoing complaints of swelling on the side and in the back of her knee. Dr. Chaudri reviewed the MRI arthrogram with the Petitioner and recommended she undergo a left knee surgical procedure. The Petitioner agreed with this medical plan and Dr. Chaudri continued her work restrictions. (T. at 27-28).

After another such visit with Dr. Chaudri on February 7, 2019, the Petitioner then met with Dr. Brian Forsythe on April 18, 2019, pursuant to the Respondent's Section 12 request. The Petitioner asserted Dr. Forsythe's examination was brief, lasting approximately five (5) minutes. (T. at 29). Thereafter, on April 29, 2019, the Petitioner returned to Dr. Chaudri with her ongoing left knee complaints and he restated his surgical recommendation and work restrictions at the end of the appointment.

Subsequently, the Petitioner's TTD benefits were suspended on May 12, 2019 and she testified it was her understanding this was done in response to Dr. Forsythe's Section 12 report. (T. at 30-31). The Petitioner reviewed the Section 12 report with Dr. Chaudri during a May 23, 2019 appointment and he continued his surgical recommendation, Petitioner's work restrictions, and medication program. (T. at 32). Dr. Chaudri also continued these recommendations after appointments on June 20, August 1, September 23, November 4, and December 2, 2019. In addition, he revised the Petitioner's work restrictions to a "no work"

status during this period. (Petitioner's Exhibit 5). The Petitioner last saw Dr. Chaudri in January of 2020 where he again continued with his recommended medical action plan. (T. at 34). She continues with her desire to proceed with Dr. Chaudri's left knee surgical suggestion. (T. at 34-35).

The Petitioner confirmed the Respondent has not offered any sort of work since August 30, 2018. She testified she doubted her ability to safely operate one of the Respondent's buses because of her ongoing left knee difficulties and her ultimate responsibility to the passengers on a bus. She also highlighted a bus driver's need to use the left leg and foot to operate the bus turn signal system, a task she reported would be hindered by her ongoing left knee symptoms. (T. at 35-37). The Petitioner stated she does wish to return to work for the Respondent. (T. at 38-39). However, her left knee continues to bother her with constant pain and swelling that she tries to alleviate with ibuprofen, ice, and resting. (T. at 37-38). The Petitioner also confirmed she received TTD benefits from September 2, 2018 through May 11, 2019. (T. at 40).

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

Issue F: *Causal connection*

To obtain compensation under the Act, a claimant must prove that some act or phase of his or her employment was a causative factor in his ensuing injuries. *Land & Lakes Co. v. Industrial Comm'n*, 359 Ill. App. 3d 582, 592 (2005). In resolving disputed issues of fact, including issues related to causation, it is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675 (2009).

A causal connection between a condition of ill-being and a work-related accident can be established by showing a chain of events wherein an employee has a history of prior good health, and, following a work-related accident, the employee is unable to carry out his duties because of a physical or mental condition. *Kawa v. Illinois Workers' Compensation Comm'n*, 245 Ill. App. 3d 359, 265 (1993).

Following a careful review of the testimony and documentary evidence in the record, the Arbitrator gives greater weight to the opinions and recommendations of the Petitioner's treating physician, Dr. Chaudri, over those of the Respondent's Section 12 examiner, Dr. Forsythe. In doing so, the Arbitrator also finds the Petitioner's testimony as to her work accident and her current left knee symptoms to be credible.

During his medical care for the Petitioner, Dr. Chaudri was provided consistent accident histories by the Petitioner and found several positive test results, including a positive McMurray's test. (Petitioner's Exhibit (*hereinafter*, PX) 4 at 7). Based upon his examination, Dr. Chaudri reasonably opined Petitioner to be suffering a tear of the left medial meniscus, commenced a course of conservative medical care to treat the Petitioner's symptoms, and ordered a diagnostic MRI of her left knee. (PX 4 at 8-9). He thoughtfully continued these conservative measures even though the MRI study revealed no meniscal tear and provided the Petitioner with a more direct form of treatment via injection therapy. (PX 4 at 10).

Dr. Chaudri then carefully ramped up the Petitioner's medical care plan by suggesting she receive a viscosupplementation injection because her symptoms continued unabated into August of 2018. (PX 4 at 11-12). As the Petitioner's medical condition failed to improve and the viscosupplementation treatment option was rebuffed, Dr. Chaudri reasonably prescribed an MRI arthrogram, stating:

> "So again I think she - - we had kind of changed directions with the negative MRI and done conservative measures for, you know, going on 4-½ months by then, and she had not had any improvement. As stated before, MRI's are not 100 percent sensitive. So I wanted to get a better test that would better evaluate the meniscus because her symptoms were still the same and had not resolved since the initial injury." (PX 4 at 15).

After the January 9, 2019 left knee MRI arthrogram, Dr. Chaudri reported it confirmed his clinical findings stating "again, she was having joint line tenderness. She would from time to time have a positive McMurray's and Apley's compression test. The way she was describing mechanical issues all confirmed that she had a tear of the meniscus." (PX 4 at 17). He then recommended a left knee arthroscopic procedure, noting the Petitioner would be a good candidate for such an operation. (PX 4 at 19).

Dr. Chaudri was asked at his September 30, 2019 deposition whether he had an opinion within a reasonable degree of medical and surgical certainty whether the Petitioner's current

condition of ill-being and her need for surgery is related to her accident of May 19, 2018. The doctor testified: "Yes, I believe it's directly related to her accident which happened on May 19, 2018 while working as a CTA bus driver." (PX 4 (*September 30, 2019*) at 5). He then expanded on his opinion by stating:

> "So going back to my initial evaluation of May 30, 2018 and her subjective findings she stated that she was a bus driver, and she had an injury on May 19, 2018. She stated that she injured herself when she was getting up from the driver's chair and hit her knee.
>
> She stated that it swelled up and was painful at that time; and that when I saw her, she had cognitive clinical findings associated with that. The patient stated that she never had pain prior to that and that her pain has not resolved since then. So I would say that it is related to that." (PX 4 (*September 30, 2019*) at 5-6).

Dr. Chaudri opined the Petitioner could be expected to return to work in a light-duty capacity four (4) to eight (8) weeks post-surgery, with a return to regular duty in two (2) to four (4) months. He further testified if there was a full meniscal repair, Petitioner would be at maximum medical improvement (MMI) in four (4) to six (6) months post-surgery. (PX 4 (*August 26, 2019*) at 25).

Dr. Forsythe, the Respondent's Section 12 examining physician, reported the Petitioner complained of a pain level of 5.5 out of 10 and that her left knee was functionally 30 percent of normal. (Respondent's Exhibit 2 at 12). He cited a series of negative findings, including a negative McMurray test at the time of his examination. (Respondent's Exhibit (hereinafter, RX) 2 at 13). He confirmed he reviewed both the MRI and the MR arthrogram and noted no significant meniscal pathology on either study, despite the reports of Dr. Chaudri and the radiologist. (*Compare* RX 2 at 15-16 *and* PX 4 at 16-17). He opined Petitioner was coping with a resolved left knee contusion. (RX 2 at 17).

In response to a query concerning the most frequent area for meniscus tear to appear, Dr. Forsythe stated:

> "A: In the knee? Posterior horn, in the back.
> Q: Posterior horn of the medial meniscus?
> A: Yes, it is a very common location.

Q: And the MR arthrogram, where does this doctor find the Grade III tears at?

A: This doctor describes a tear of the inferior surface of the posterior horn of the medial meniscus.

Q: And that's the most frequent area that meniscus tears or meniscal tears occur in?

A: Usually." (RX 2 at 32).

Dr. Forsythe stated while he could not see a Grade III tear on the MR arthrogram, it is an abnormal condition and can cause pain in an individual. (RX 2 at 36). He then confirmed treatment for a Grade III tear can involve an injection and physical therapy. (RX 2 at 36).

The record reveals Dr. Chaudri initially began a conservative course of treatment consisting of injections, medication and physical therapy. When the Petitioner's symptomology did not improve, Dr. Chaudri ordered more detailed diagnostic testing in the form of an MRI arthrogram that revealed the medial meniscus tear and resulted in his surgical recommendation. Accordingly, after a careful review of the evidence, both testimonial and documentary, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the injury.

Issue J: *Medical bills*

Petitioner's Exhibit 6 was admitted into evidence without objection. (T. at 52). It is a billing statement from ADCO Billing Solutions in the amount of $3,645.16 for medication ordered on May 30, 2018, September 27, 2018, and September 27, 2018 ordered by Dr. Chaudri. (PX 6). The Petitioner identified these bills, testifying that to the best of her knowledge these bills were not paid by the Respondent. (T. at 35). These medications all were ordered by Dr. Chaudri during his treatment of the Petitioner. (PX 6).

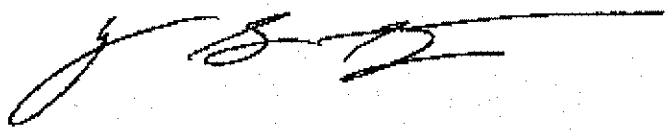
Based upon the findings concerning **Issue F**:, above, and after a careful review of all the evidence, both testimonial and documentary, the Arbitrator finds Respondent shall pay these reasonable and necessary medical services, pursuant to the medical fee schedule, of $3,645.16 to ADCO Billing Solutions, as provided in Sections 8(a) and 8.2 of the Act.

Issue K: *Prospective medical care*

Having found that the Petitioner's current condition of ill-being is related to the injury in question, the Arbitrator further finds that the Petitioner is entitled to reasonable and necessary prospective medical care as recommended by Dr. Chaudri, subject to Section 8(a) of the Act.

Issue L: *TTD*

The Arbitrator finds Petitioner is entitled to TTD benefits from August 31, 2018 through the trial date of this matter on January 29, 2020. This period amounts to 73.86 weeks and, when calculated with Petitioner's TTD rate of $870.84 per week, equals $64,320.24. Additionally, Respondent is entitled to a credit of $31,350.24 for paid TTD benefits. (AX 1).



Signature of Arbitrator

APRIL 24, 2020
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	14WC018703
Case Name	ROBINSON, MCHENRY S v. STATE OF ILLINOIS, DEPARTMENT OF AGRICULTURE
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0297
Number of Pages of Decision	16
Decision Issued By	Barbara Flores, Commissioner

Petitioner Attorney	V. Andrew Marzal
Respondent Attorney	Thomas Owen

DATE FILED: 6/15/2021

/s/ Barbara Flores, Commissioner

Signature

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

McHenry Robinson,

Petitioner,

vs. NO: 14 WC 18703

State of Illinois, Department of Agriculture

Respondent.

DECISION AND OPINION ON REVIEW

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

The Decision of the Arbitrator delineates the facts of the case in detail. As relevant to the issues on review, the Commission writes additionally to address the issues of causal connection and temporary total disability ("TTD").

A. Causal Connection

The Arbitrator found that Petitioner did suffer an accident on May 22, 2014, but that his current cervical vertigo condition of ill-being was not causally related to said accident. The Arbitrator found that Petitioner suffered a head injury on the date in question with no residual effects, per the opinion of Respondent's Section 12 examiner, Dr. Kramer. The Arbitrator found that the initial St. James emergency room ("ER") records were inconsistent with any head or neck injury, and that if Petitioner had exhibited dizziness, confusion, etc., a more thorough work-up would have been done to that end. Further, the Arbitrator noted that treating chiropractor, Dr. Breitweiser, released Petitioner from care on June 23, 2014, and his records do not support

causation as to Petitioner's vertigo complaints, nor do the V.A. records. The Arbitrator found that Dr. Kramer's causation opinion finding no causal connection between said injury and Petitioner's current vertigo condition is supported by the record, whereas Dr. Neri's causation opinion was not endorsed by any other physician and was not supported by the ER records.1

The Commission disagrees with the Arbitrator's assessment, viewing the evidence differently. Thus, the Commission reverses the Arbitrator's ruling and finds that causal connection to Petitioner's current condition has been proved by a preponderance of evidence.

In order to obtain compensation under the Act, a claimant must prove that some act or phase of his employment was a causative factor in his ensuing injuries. *Land & Lakes Co. v. Industrial Comm'n*, 359 Ill. App. 3d 582, 592 (2005). Recovery will depend on the employee's ability to show that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of a preexisting condition. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 204-05 (2003). "Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was *a* causative factor in the resulting condition of ill-being." (Emphasis in original.) *Id.* at 205.

Our supreme court has held that "medical evidence is not an essential ingredient to support the conclusion of the [Commission] that an industrial accident has caused the disability," but rather, "[a] chain of events which demonstrates a previous condition of good health, an accident, and subsequent injury resulting in a disability" may be sufficient to prove a causal nexus between the accident and the employee's injury. *International Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63-64 (1982). It is well established that proof of prior good health and change immediately following after an injury may establish that an impaired condition was due to the injury. *Navistar International Transportation Corp.*, 315 Ill. App. 3d 1197, 1206 (2000). A causal connection between work duties and a condition may be established by a chain of events, including a claimant's ability to perform duties prior to the accident and inability to do the same following the accident. *Id*.

Here, the Commission finds that the evidence supports a ruling that Petitioner has met his burden of proving causal connection to his current condition by a preponderance of the evidence. On the date in question, Petitioner suffered an undisputed head injury. Prior to this date, Petitioner had worked for Respondent as a Meat Inspector for four years without being medically excused from work for head pain or any vertigo-related issues. After the accident, which caused Petitioner's head to jerk forward and sideways, Petitioner's complaints required ER treatment the same night. Just five days later, Petitioner exhibited dizziness, being dazed, light-headedness when standing from a seated position and chronic headaches. These symptoms were either wholly absent prior to the accident, or present with less severity prior to the accident. After the accident, these conditions deteriorated to a state of disability. Petitioner was diagnosed with moderate cervical, thoracic and lumbar strains, lumbar facet syndrome, and a right rib contusion. Dr. Breitweiser kept Petitioner off work through June 22, 2014, indicating that Petitioner "might" be able to return to full duty on June 23, 2014. Although he released Petitioner from care, Dr. Breitweiser also recommended Petitioner see a doctor at the Jesse Brown V.A. for his

1 Dr. Neri was Petitioner's Section 12 examiner at this Counsel's request.

dizziness. Petitioner testified that he informed Dr. Breitweiser of his headaches, but Dr. Breitweiser told him that he could not treat him for that, hence the referral.

The Arbitrator relied on Dr. Kramer's statement that contemporaneous records did not indicate a head injury, despite Dr. Kramer's opinion that Petitioner did sustain a head injury during the accident. Despite the unrebutted head injury, Dr. Kramer opined that Petitioner's gait disorder was related to his comorbidities, and that his chronic dizziness was not related to the accident. While Petitioner acknowledged his history of dizzy spells prior to the accident, he testified that they were less severe than those he now suffers from. He also testified without rebuttal that he had no dizzy spells in the months immediately pre-dating the accident, but has fallen often since the accident. He testified that when he wakes up in the morning he has to "get up in stages and focus my eyes."

Accordingly, the Commission relies on the chain of events in finding causal connection between the accident and Petitioner's current vertigo condition. Petitioner had no vertigo-related symptoms which caused him to be excused from work prior to the undisputed work accident, which was followed by increased vertigo-related complaints, headaches, off-work designation, and ongoing treatment into February of 2019. Moreover, Dr. Neri opined that it was the cervical vertigo that disabled Petitioner from work after the accident. Thus, the record belies the opinions of Dr. Kramer, rendering them unpersuasive. Based on the above, the Commission reverses the Arbitrator's ruling and finds that Petitioner has established a causal connection between his accident and current vertigo condition.

B. Temporary Disability

The Arbitrator awarded TTD benefits from May 27, 2014 through June 23, 2014, finding no evidence that Petitioner was medically excused from work prior to May 27, 2014. The Arbitrator further found that Petitioner was released to return to work as of June 23, 2014 by Dr. Breitweiser. The Commission assesses the evidence differently than the Arbitrator.

The dispositive test for awarding TTD benefits is "whether the claimant's condition has stabilized, that is, whether the claimant has reached maximum medical improvement." *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 759 (2003). Here, Petitioner was placed off work for his accident-related condition by Dr. Breitweiser on May 27, 2014. Dr. Breitweiser later indicated that Petitioner "might" be able to return to full duty on June 23, 2014 and released Petitioner from care, but also recommended Petitioner see a doctor at the Jesse Brown VA for his dizziness. The Commission distinguishes the plain language in this medical record from the Arbitrator's finding that Petitioner was, in fact, released by Dr. Breitweiser to return to full duty work. The Commission finds that Dr. Breitweiser's opinion that Petitioner might be able to return to full duty is not tantamount to a full duty release, particularly considering his recommendation for further treatment for Petitioner's dizziness at the time. The Commission is further persuaded that Petitioner was not able to perform full duty work considering Dr. Neri's opinion. Dr. Neri opined that it would have been reasonable for Petitioner to have been off work since the accident, and that as of his examination on March 30, 2017 Petitioner was unable to work and had not yet reached maximum medical improvement.

Based on the totality of evidence, the Commission finds that Petitioner has established his entitlement to additional TTD benefits and modifies the Arbitrator's award finding that Petitioner is due TTD benefits from May 27, 2014 through March 30, 2017.

In all other respects the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE FOUND BY THE COMMISSION that causal connection shall extend to include Petitioner's current vertigo condition.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $634.78 per week from May 27, 2014 through March 30, 2017 for a period of 157 and 1/7ths 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 shall receive a credit for $2,539.24 in TTD and/or Maintenance paid and is entitled to credit for any and all amounts paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $3,537.86 for medical bills that have been paid by Petitioner's group health insurance, and shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on March 25, 2020 is hereby affirmed as modified herein.

IT IS FURTHER ORDERED BY THE COMMISSION that that Respondent pay to Petitioner the sum of $571.30 per week for a period of 25 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused a 5% loss of use of the person as a whole.

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.

June 15, 2021

/s/ *Barbara N. Flores*
Barbara N. Flores

o: 5/6/21
BNF/wde
45

/s/ *Marc Parker*
Marc Parker

/s/ *Christopher A. Harris*
Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0297
NOTICE OF ARBITRATOR DECISION

ROBINSON, McHENRY Case# **14WC018703**
Employee/Petitioner

ST OF IL-DEPT OF AGRICULTURE
Employer/Respondent

On 3/25/2020, 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 0.80% 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:

0059 BAUM RUFFOLO & MARZAL LTD
V ANDREW MARZAL
33 N LASALLE ST SUITE 1710
CHICAGO, IL 60602

6298 ASSISTANT ATTORNEY GENERAL
THOMAS GRADY OWEN
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
SPRINGFIELD, IL 62704

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

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

MAR 25 2020

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF **Cook**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

McHenry Robinson
Employee/Petitioner

v.

State of Illinois-Department of Agriculture
Employer/Respondent

Case # **14** WC **018703**

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 **8/9/2019**. 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 _____

M. Robinson v. S.O.I.-Dept. of Agriculture, 14 WC 018703

FINDINGS

On **May 22, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$46,648.00**; the average weekly wage was **$952.17**.

On the date of accident, Petitioner was **77** years of age, ***single*** with **0** dependent children.

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

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

To date, Respondent has paid **$2,539.24** in TTD and/or for maintenance benefits, and is entitled to a credit for any and all amounts paid.

Respondent is entitled to a credit of **$3,537.86** under Section 8(j) of the Act 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.

ORDER

Respondent shall pay reasonable and necessary medical services of $2,520.00, as provided in Sections 8(a) and 8.2 of the Act, and as is set forth below.

Respondent shall pay Petitioner permanent partial disability benefits of $571.30 per week for 25 weeks, because the injuries sustained caused the 5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner the compensation benefits that have accrued from 5/22/2014 through 8/9/2019 in a lump sum, 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

March 24, 2020
Date

MAR 2 5 2020

FINDINGS OF FACT

On May 22, 2014, Petitioner was employed by Respondent as a meat inspector, inspecting animals at slaughterhouses for FDA compliance. His job requires him to stand all day, stoop, bend and squat, with minimal lifting. He had been so employed since June of 2011. (RX 2) He was 77 years old.

Petitioner testified that he slipped on hog guts and fell into a metal table/platform while inspecting a meatpacking plant in Chicago Heights. Petitioner said that he struck the back of his neck, just bellow the skull. Petitioner said that his supervisor, Lawrence Jefferson told him that he lost consciousness. Petitioner was taken by ambulance to St. James Hospital. Jefferson accompanied Petitioner to the hospital.

Petitioner was treated and released at the St. James ER. Petitioner testified that at the ER he had pain in the chest and back, he was dizzy, disoriented and nauseous. His vision was off and his neck hurt. The St. James records show that Petitioner complained of right rib pain related to a slip and fall into a table at work. He denied head injury or loss of consciousness. The neurologic and musculoskeletal exams were negative. The physical exam was not consistent with a head or neck injury. Petitioner was alert and oriented times 3. There was tenderness to right rib palpation. Rib X-rays were negative. Petitioner was discharged with a diagnosis of rib contusion, right and told to follow up with his PCP. (PX 1)

Petitioner next came under the care of a chiropractor, Dr. Robert Breitweiser. At the first visit, Dr. Breitweiser diagnosed moderate cervical, thoracic, lumbar sprain/strain, lumbar facet syndrome and right sided rib contusion. Petitioner complained of trouble with balance since May 23 and being light headed when he gets up from a sitting position. Petitioner told Dr. Breitweiser that he jerked his head and neck in the fall. He did not know if his neck pain and headache got worse. He did not hit his head or have a loss of consciousness. Petitioner gave a history of a July 2010 motor vehicle accident resulting in headache and neck pain. Petitioner said his balance was not so good before the accident. There was a history of a fall at work onto his buttocks in September of 2013. Petitioner was excused off work by Dr. Breitweiser from May 27, 2014 to June 22, 2014. He was released to full duty work as of June 23, 2014. The last office visit with Dr. Breitweiser was June 23, 2014. Petitioner was instructed to follow up with his PCP regarding his previous health issues and was referred to a neurologist at the VA hospital for an evaluation. (PX 2)

Petitioner then began treatment at the Jesse Brown VA Medical Center. His PCP at Jesse Brown provided treatment for dizziness, with referrals to neurology, a brain CT and audiology consults. In August of 2016, Dr. Ryan released Petitioner to return to work with restrictions of 2 hours standing, limit bending and no squatting or stooping. Petitioner was to use a cane for stability. Petitioner did not use a cane before the accident. He did experience dizziness before the accident, but it was less severe.

Petitioner contacted respondent about returning to work after he was released to return to work with restrictions by Dr. Ryan. He was told that he would need a full duty release. Respondent did not offer Petitioner limited duty work, vocational rehabilitation, job search assistance or schooling. Petitioner apparently did not contact Respondent regarding return to work when he was given a full duty release by Dr. Breitweiser.

Respondent paid TTD from May 27, 2014 through June 23, 2014. (RX 3)

Currently, Petitioner experiences dizziness, he has pounding headaches and uses a cane. He has tried to look for work, but has been unsuccessful. He has had no subsequent neck or head injuries.

Petitioner was seen for an IME by Dr. Jeffrey Kramer at the request of Respondent on April 1, 2015. He was examined by Dr. Gene Neri on March 30, 2017. (RX 4, PX 5)
Jesse Brown VA Hospital records were submitted in two volumes by Petitioner, paginated 1 through 1255. (PX3, PX4) The records request is dated 8/7/2019 and seeks records from 2016 to present. (PX 3, page 1) The records contain numerous visits for vertigo/dizziness complaints and for neck and back issues. They do not contain off work slips or any definite causation opinions. A chart note of February 14, 2019 (P 402) shows a diagnosis of chronic vertigo, likely benign paroxysmal positional vertigo because of the patient's age and the positional component. The BPPV condition is not said to be related to any head trauma. (PX 3)

Petitioner submitted the Evidence Deposition of Dr. Neri, a board certified neurologist, taken on June 8, 2018. (PX 5) He examined Petitioner on March 30, 2017. The history was that Petitioner fell backwards and struck his torso on a metal platform. He developed significant vertigo thereafter. The physical exam was largely benign. Dr. Neri's impression was a mild cerebral concussion and severe cervical strain (whiplash type injury) as a result of the fall. This was an acceleration/deceleration injury. Petitioner has cervical vertigo and sleep disturbance secondary to the mild concussion and cervical vertigo. Petitioner was not at MMI and not able to work at the time of the exam. Dr. Neri did not testify as to the exact medical records that he reviewed, although he did say that he had reviewed the ER records. On cross examination, it was noted that Dr. Neri did not review the CT films. Dr. Neri thought that the 2010 MVA symptoms had resolved. Petitioner's symptoms could be related to Petitioner's co-morbidities. The medication Metformin could be consistent with the dizziness symptoms. (PX 5)

Respondent submitted the Evidence Deposition of Dr. Kramer, a board certified neurologist, taken on August 1, 2017. (RX 4) Dr. Kramer examined Petitioner and the medical records, including the 10/3/2014 brain CT film, the St. James ER records, Dr. Breitweiser's records and notes from Jesse Brown VA Hospital. It was noted that Petitioner had several co-morbidities, including: atrial fibrillation, pacemaker, hypertension, diabetes, dyslipidemia, heart disease, diabetic neuropathy, stroke in the brain stem and osteoarthritis. Petitioner complained of dizziness. He had light headedness, but no dizziness before the accident. The physical exam was benign, with findings consistent with diabetic neuropathy. His impression was that Petitioner had a head injury as a result of the May 22, 2014 fall by history, with no residuals. Petitioner's gait abnormality was multifactorial and unrelated to the injury. There was no causal connection regarding Petitioner's gait abnormality or regarding his complaints of dizziness. He was at MMI as of the time of exam. Dr. Kramer could not opine when MMI occurred. On cross examination, Dr. Kramer agreed that blunt trauma could be the cause of temporary vertigo symptoms but not the cause of Petitioner's vertigo complaints at the time of the exam. At the time of the examination, Petitioner was not exhibiting signs of dizziness. (RX 4)

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 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:

Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on May 22, 2014.

This finding is based upon Petitioner's testimony, Petitioner's Exhibit 6, Respondent's Exhibit 4 and the medical records. Petitioner was clearly in the course of his employment, as he was inspecting a meat plant. The injury arose out of his employment, as the risk of slipping on hog guts on a slaughterhouse floor is certainly incident to the employment of a meat inspector.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENT, THE ARBITRATOR FINDS:

Petitioner gave timely notice of the accident, in accordance with Section 6(c) of the Act.

This finding is based upon Petitioner's testimony, PX 6 and RX 2.

Petitioner testified that his supervisor, Jefferson was a post occurrence witness and accompanied Petitioner to the St. James ER.

Respondent completed a Form 45 on the date of accident. (RX 2)

Petitioner filled out a "Workers' Compensation Employee's Notice of Injury" on May 27, 2014 (three days after the accident). (PX 6)

Respondent had knowledge of the accident within 45 days of its occurrence.

WITH RESPECT TO ISSUE (F), IS PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS:

Petitioner's current condition of ill-being, to wit: status post head injury of 5/22/2014, with no residuals, per the opinion of Dr. Kramer, is causally related to the injury.

This finding is based on the persuasive opinions of Dr. Kramer and the medical records.

The records of St. James are complexly inconsistent with any head or neck injury. If Petitioner exhibited any signs of dizziness, confusion, etc., a more thorough work-up would have taken place and the complaints/findings would have been documented.

Dr. Breitweiser released Petitioner from care to full duty work as of June 23, 2014. His records do not support causation as to Petitioner's vertigo complaints. Likewise, the VA records do not support causation.

Dr. Kramer's causal connection opinion is persuasive. He reviewed the CT film and described the records that he reviewed, including the ER records which do not demonstrate any head injury. He endorsed causal connection to a resolved head injury with no residuals, based upon the patient's history.

Dr. Neri's causal connection opinion (to a diagnosis of cervical vertigo, one not endorsed by any other physician and not supported by the ER records) is not persuasive.

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:

Petitioner claimed one medical bill, $2,520.00 from Dr. Breitweiser. (PX 2) It does appear that Respondent paid the bill from Dr. Breitweiser. (RX 3)

The Dr. Breitweiser bill is awarded, pursuant to Sections 8(a) and 8.2 of the Act. Respondent is entitled to a credit for all payments made on the awarded bill.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS:

Petitioner claims TTD from May 23, 2014 through March 30, 2017, representing 147-6/7 weeks.

There is no evidence that Petitioner was medically excused from work before Dr. Breitweiser took him off work on May 27, 2014. Dr. Breitweiser released Petitioner to return to work as of June 23, 2014. Petitioner provided no medical documentation that he was excused from work thereafter. Accordingly, for this reason and based upon the Arbitrator's finding regarding the issue of causal connection above, Petitioner's claim for TTD subsequent to June 23, 2014 is denied.

TTD is awarded for the period of May 27, 2014 through June 23, 2014, a period of 3-5/7 weeks. The TTD rate is $634.78.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS:

Pursuant to Section 8.1(b) of the Illinois Workers' Compensation Act, for accidents occurring after September 1, 2011, permanent partial disability shall be established using five enumerated criteria, with no single factor being the sole determinant of disability. 820 ILCS 305/8.1(b). The criteria to be considered are: (i) the reported level of impairment pursuant to the physician's findings per the American Medical Association's "Guides to the Evaluation of Permanent Impairment"; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. *Id.*

Regarding criterion (i), no AMA Impairment Rating was rendered, and, therefore, this factor is given no weight.

Regarding criterion (ii), Petitioner was employed as a meat inspector on the date of accident. Petitioner was released to full duty work by Dr. Breitweiser, but did not return to his meat inspector job. The Arbitrator gives this factor some weight.

Regarding criterion (iii), Petitioner was 77 years old at the time of the injury. The Arbitrator acknowledges the Petitioner's age and the limitations that come with this type of injury as a result of his age. This factor is given more weight.

Regarding criterion (iv), the Arbitrator does not find that Petitioner suffered a loss of earning capacity as a result of the injury. The Arbitrator gives this factor appropriate weight in determining PPD..

Regarding criterion (v), the Arbitrator takes note of the opinion of Dr. Kramer on causation, the Arbitrator's finding on the issue of causation, above and the submitted medical records. Petitioner's current vertigo, dizziness and unsteadiness symptoms are not related to the accidental injury of May 22, 2014. The Arbitrator gives this factor great weight.

Upon consideration of all of the required factors and the Record as a whole, the Arbitrator finds that, as a result of the injuries sustained, Petitioner has suffered the 5% loss of use of the person as a whole.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	11WC031401
Case Name	MARRERO, MARIA v. OMNI HOTELS
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0298
Number of Pages of Decision	11
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Nancy Shepard
Respondent Attorney	Robert Cozzi

DATE FILED: 6/16/2021

/s/Kathryn Doerries, Commissioner

Signature

21IWCC0298

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARIA MARRERO,

Petitioner,

vs. NO: 11 WC 31401

OMNI HOTELS,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission, herein, modifies the Arbitrator's decision on page 2, last paragraph, striking the entire sentence beginning, "The records of Dr. Hsu…".

The Commission modifies the Arbitrator's decision on page 4, section (J), to read, "Respondent is liable for all reasonable, necessary, and causally related medical expenses through October 13, 2011."

The Commission reverses the Arbitrator's ruling on page 3, paragraph 3, referring to the inadmissibility of Dr. Amin's narrative report. Respondent raised no objection to its admissibility at arbitration and the report was admitted into evidence. Thus, the Commission reviews the evidence including Dr. Amin's narrative report.

The Commission, after considering Dr. Amin's report and in light of the additional evidence admitted at trial, does not find it persuasive on the issue of causation. Dr. Amin's opinion

omits a history or understanding of the accident. In addition, the Commission finds the treating medical records of Dr. Lewis more persuasive on this issue. After treating the Petitioner for the work-related injury sustained on April 7, 2011, Dr. Lewis discharged Petitioner on October 13, 2011. On exam, he noted full and pain free range of motion of the left wrist and diagnosed her condition as "resolved dysfunction of the left wrist." He released her to return to work regular duty and discharged her from medical care. In light of all the evidence adduced at trial, the Commission affirms the Arbitrator's finding on causation.

All else otherwise is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 12, 2019 is hereby affirmed and adopted with changes as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $358.07 per week for a period of 10.25 weeks, as provided in §8(e)(9) of the Act, for the reason that the injuries sustained caused the 5% loss of use of Petitioner's left hand.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

JUNE 16, 2021

o- 4/20/21
KAD/jsf

/s/*Kathryn A. Doerries*
Kathryn A. Doerries

/s/*Maria E. Portela*
Maria E. Portela

/s/*Thomas J. Tyrrell*
Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MARRERO, MARIA
Employee/Petitioner

Case# **11WC031401**

OMNI HOTELS
Employer/Respondent

On 6/12/2019, 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 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:

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CHICAGO, IL 60603

0057 LAW OFFICE EDWARD LICHTENSTEIN
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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

Maria Marrero
Employee/Petitioner

v.

Omni Hotels
Employer/Respondent

Case # **11** WC **031401**

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 **Thomas L. Ciecko**, Arbitrator of the Commission, in the city of **Chicago**, on **March 28, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 7, 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 condition of ill-being, a contusion to Petitioner's left hand and sprain injury to the left wrist ***is*** the only condition causally related to the accident.

In the year preceding the injury, Petitioner earned **$31,032.56**; the average weekly wage was **$596.78**.

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

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

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$9464.29** for other benefits, for a total credit of **$9464.29**.

Respondent is entitled to a credit of **$10,011.25** under Section 8(j) of the Act.

ORDER

Permanent Partial Disability: Schedule injury (for injuries before 9-1-11)

Respondent shall pay Petitioner permanent partial disability benefits of $358.07/week for 10.25 weeks because the injuries sustained caused the five (5) % loss of the left hand, as provided for in Section 8(e) of the Act.

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

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

Signature of Arbitrator

6/12/19
Date

JUN 12 2019

Maria Marrero v. Omni Hotels, No. 11 WC 031401

Preface

The parties proceeded to hearing March 28, 2019, eight years after Petitioner claimed she was injured at work, on a Request for Hearing indicating the following disputed issues: whether Petitioner's current condition of ill-being is causally connected to the accidental injuries sustained on April 7, 2011; whether Respondent is liable for unpaid medical bills and out of pocket expenses in the amount of $1623.96; whether Petitioner is entitled to two periods of temporary total disability; and what is the nature and extent of the injury. Maria Marrero v. Omni Hotels, No. 11 WC 031401 Transcript of Proceedings on Arbitration at 4; Arbitrator's Exhibit 1. There was no medical testimony offered by either party.

Findings of Fact

Maria Marrero (Petitioner), a 47 year old female, testified that on April 7, 2011, she was a lobby attendant for the Omni Hotel (Respondent), cleaning bathrooms, lobbies, and the pool area. She saw a guest stuck between swinging doors with a crate full of boxes, who asked if she could hold the door. As she attempted to do so, the guest pulled the crate forward and the door slammed on her wrist. She said her hand was stuck between the door and a wall. She said it was her left wrist. Petitioner testified the front desk manager helped pull the cart back and she got her wrist out. Marrero at 8-11.

Petitioner testified she first sought medical treatment a month later at Concentra. The records of Concentra indicate Petitioner was first seen May 2, 2011. An examination found she was able to move her fingers and wrist and grasp objects. There was no swelling or deformity noted of the left wrist. An x-ray of the left hand found no fracture or dislocation. She was assessed with a hand contusion, given ibuprofen, a wrist brace, and told to use an ice pack and follow up with Concentra. Petitioner returned to Concentra May 7, 2011, and reported dull intermittent pain of 2 out of 10. She said she was working regular duty. She was again assessed with a contusion of the hand. Petitioner returned to Concentra May 14, 2011, and said she had reinjured her wrist by lifting a crib with a coworker. She was simply assessed with wrist pain, given a thumb splint and restrictions on the use of her left arm, on lifting and wearing the splint. Petitioner testified these restrictions were accommodated. Petitioner returned to Concentra May 18, 2011. The records indicate she reported pain in her left hand and wrist, and noted minimal swelling. She was assessed with a hand contusion, given medicine, and referred to a hand surgeon, with no use of the left hand and wearing of a splint. Marrero at 13, 15; Petitioner's Exhibit 2 (unpaginated).

Petitioner testified she then saw Dr. Lewis. The records of Concentra indicate Dr. Nolan Lewis initially consulted with Petitioner June 6, 2011. He assessed her with blunt trauma to the left wrist and recommended occupational therapy, wearing a wrist brace at work, and limited restrictive use of the left hand. A new x-ray of the left wrist done that day found no fractures or dislocation. Petitioner's occupational therapist noted Petitioner had missed almost as many appointments as she had attended. Dr. Lewis had an MRI done of Petitioner's left wrist July 27, 2011. On August 4, 2011, Petitioner saw Lewis. He found no ligament injury on the MRI, or

any other abnormal findings, with questionable lunate osteonecrosis. Lewis assessed Petitioner with a sprain injury of the left wrist, and without explanation, de Quervain tenosynovitis. He recommended a thumb brace, and restricted work. He also recommended a steroid injection that Petitioner declined. An x-ray taken August 4, 2011, found no fracture or dislocation and no significant change from the previous x-ray. Dr. Lewis noted an MRI of July 27, 2011, was unremarkable for acute injury. Petitioner did consent to an injection of her left wrist. By September 15, 2011, Dr. Lewis noted no swelling or tenderness of the wrist, and improved symptomatology. Petitioner saw Dr. Lewis October 13, 2011, who found a full pain free range of motion of the wrist with grip strength the same on both sides. He assessed Petitioner with resolved dysfunction of the left wrist, and told Petitioner she could do her regular work. Petitioner testified Lewis released her from care, removed her restrictions, and returned her to work. Lewis noted Petitioner indicated she would follow up with her primary care physician. She did not indicate why. An x-ray of Petitioner's left wrist done October 13, 2011, showed no evidence of acute fracture or dislocation. Marrero at 16, 20; Petitioner's Exhibit 3 (unpaginated).

Petitioner submitted to an independent medical examination September 14, 2011, by Dr. Mark Cohen, Director of Hand and Elbow Section, Midwest Orthopaedics at Rush. At that time, Cohen was not provided with any medical records and took his history from Petitioner. Petitioner now said a guest closed the door on her left hand. She said she did not recall the specific mechanism of the injury. Petitioner told Cohen her wrist was getting better, and she was not in therapy. Cohen noted no obvious swelling or deformity on the wrist or hand. Petitioner had full digital and full wrist motion. Cohen noted a possible (nonorganic) functional component to Petitioner's complaints and said the primary source of pain was over listers tubercle dorsally. Cohen viewed Petitioner's MRI from July 27, 2011, and found it consistent with ulnocarpal abutment [a degenerative wrist condition]. He said Petitioner clearly has radiographic evidence of ulnocarpal abutment, but was in no way convinced the radiographic findings were consistent with her symptoms. Respondent's Exhibit 1 (unpaginated). Dr. Cohen compiled an addendum to the IME September 26, 2011, having received Petitioner's medical records. He said they did not change his opinions in the case. Respondent's Exhibit 2 (unpaginated).

Petitioner testified she saw her primary care physician, Dr. Bruce Kline, who referred her to Dr. Patricia Hsu. The records of Dr. Kline submitted into evidence are completely irrelevant to Petitioner's work injury and offer no support Kline referred her to anyone. They concern Pap smears, mammograms, venereal disease, nasal congestion, lower abdominal pain, and biometric screening. Marrero at 19; Petitioner's Exhibit 4 (unpaginated).

The records of Orthopaedic Associates of Riverside, and Dr. Patricia Hsu indicate a Patient Information form which has a "Section III (complete if work related injury)" and that is blank. A new Patient form indicates neither a worker's compensation problem, nor a no fault, but "a lawsuit Sept. 12." Dr. Hsu noted she saw Petitioner February 3, 2012, assessing her with left de Quervain's tenosynovitis, and without explanation, without current diagnostics, and without recognition of prior treatment, offered surgical release. Petitioner testified she had surgery March 20, 2012. She said surgery did not help her. The records of Dr. Hsu indicate surgery was performed March 20, 2012, a left de Quervain's release. That was followed by therapy at Accelerated Rehabilitation. By April 13, 2012, after several visits by Petitioner, Hsu

noted Petitioner was making good progress in therapy and inexplicably stated Petitioner should do no lifting with her right hand at work. It was her left that was injured and which underwent surgery. Up to this point, a year post accident, no treating physician, treating hospital, or other treating healthcare provider had indicated a causal connection between de Quervain's tenosynovitis and the injury. Yet after Petitioner's visit of April 13, 2012, without explanation or amplification, Hsu wrote an appended follow up note stating the need for surgery, presumably the left de Quervain's release, was directly related to the April 4, 2011, work incident. Petitioner however stipulated the accident occurred April 7, 2011. Petitioner's Exhibit 5 (unpaginated); Marrero at 23, 55, 24, 8; Arbitrator's Exhibit 1.

We do not know what prompted the note, it has no context or explanation. Hsu offers no rationale for the opinion. It is, of course not conclusive proof of such matters. It is an outlier in Petitioner's medical records. 820 ILCS 305/16.

During the remainder of 2012, the records of Orthopaedic Associates note Petitioner still complaining of discomfort and pain, yet not wanting any further treatment. A chart note of April 16, 2014, noted Petitioner's pain was transient and minor in nature. She had been returned to work November 5, 2012. Petitioner's Exhibit 5 (unpaginated).

Petitioner testified she saw Dr. Tanay Amin at Orthopaedic Associates, April 10, 2015, four years post accident. His letter to an attorney for Petitioner, of July 27, 2015, is clearly prepared for use in litigation and is inadmissible. Amin continued to see Petitioner until June 8, 2016, over five years post accident. Marrero at 33; Petitioner's Exhibit 5 (unpaginated); 820 ILCS 305/16.

Petitioner submitted to a follow up Independent Medical Examination April 12, 2018, with Dr. Mark Cohen. Cohen reviewed additional medical records from Petitioner, including the operative report of surgery performed May 18, 2017. As of the date Cohen saw Petitioner, she was back at work without restrictions, and receiving no treatment. He did an extensive physical examination of Petitioner. He noted Petitioner's pain in her wrist did not fit any anatomic distribution and found no findings consistent with persistent de Quervain's tenosynovitis. He noted her behavior during the examination was atypical. He found Petitioner did not have a diagnosis in which to account for rather global complaints and physical findings. He said there were multiple findings consistent with functional nonorganic component to her complaints, with symptom magnification. She was, he said, at MMI and could work without restrictions. He placed her current diagnosis at nonspecific wrist, hand and upper extremity pain without identifiable pathology or diagnosis. He noted she may have a component of symptom magnification. Respondent's Exhibit 3.

Petitioner testified she had no benefit from surgery. Marrero at 45, 55.

Conclusions of Law

Disputed issue **F**, is Petitioner's current condition of ill-being causally related to the injury. An injured employee bears the burden of proof to establish the elements of her right to compensation, including the existence of a causal connection between her condition of ill-being

and her employment. Navistar International Transportation Corporation v. Industrial Commission (Diaz), 315 Ill. App. 3d 1197, 1202-1205 (2000). A claimant must prove that some act or phase of her employment was a causative factor in the ensuing injury. Whether a causal connection exists is a question of fact. Vogel v. Illinois Workers' Compensation Commission, 354 Ill. App. 3d 780, 786 (2005).

I find as a conclusion of law, what is related to the accident of April 7, 2011, is a contusion to Petitioner's left hand and a sprain injury to the left wrist. In support of this, I rely on the records of Petitioner's treating physicians, Dr. Bahmangeig, Dr. Dyer, and Dr. Nolan Lewis. I note the lack of diagnostic evidence of acute injury in x-rays taken May 2, 2011; June 6, 2011; August 4, 2011; and October 13, 2011; as well as an MRI done July 27, 2011. There were no abnormal findings on any x-ray or MRI done from April 7, 2011, to October 13, 2011. Although Dr. Lewis assessed Petitioner with left de Quervain tenosynovitis, he did not relate that condition to the accident, and in fact indicated Petitioner's disfunction of the left wrist resolved almost eight years ago, and released her from care to regular duty.

I also rely on the finding of Dr. Mark Cohen, who noted the images on the MRI of July 27, 2011, were consistent with ulnocarpal abutment, a degenerative condition.

No other medical condition of Petitioner over the next eight years is causally connected to the accident on April 7, 2011. As Dr. Cohen indicated, Petitioner's pain has no identifiable pathology or diagnosis.

Disputed issue **J** is, is Respondent liable for unpaid medical bills and out of pocket expenses. It is not, as all the bills set forth by Petitioner are subsequent to Dr. Lewis's release of Petitioner to work on October 13, 2011. Petitioner claims a co-pay to Dr. Kline on October 4, 2011, but Petitioner's Exhibit 4, the records of Dr. Kline, do not indicate Petitioner saw him October 4, 2011, and the only October visit was on the 29th for biometric screening.

Disputed issue **K** is, is Petitioner entitled to a period of temporary total disability. To be entitled to a temporary total disability award under the Act, an injured worker must prove not only she did not work, but was unable to work. Ingalls Memorial Hospital v. Industrial Commission, 241 Ill. App. 3d 710 (1993).

Here, Petitioner worked regular duty from the accident to first seeking medical attention May 2, 2011. She was given some restrictions on May 14, 2011. She testified those restrictions were accommodated. The restrictions were lifted October 13, 2011. Petitioner testified she returned to work with no restrictions. I find as a conclusion of law Petitioner is not entitled to a period of temporary total disability.

Disputed issue **L** is, what is the nature and extent of the injury of April 7, 2011. That date of injury precedes the effective date of 820 ILCS 30518-1b, and so disability need not be established using those criteria.

Petitioner sustained a soft tissue injury that resolved over a period of months. She wore a splint, had a period of occupational therapy, and at times declined injections. She eventually had

minimal swelling and tenderness. She had full range of motion and even at first had pain 2/10 that was dull and intermittent. She continued working the same job, with no evidence of economic disadvantage. Neither of her surgeries are related to the accident.

Based on the evidence and a consideration of the record as a whole, I find Petitioner sustained permanent partial disability to the extent of five (5) % loss of use of the left hand (10.25 weeks).

Arbitrator

6/12/19
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	11WC002393
Case Name	KRANSKY,MIKE v. COOK COUNTY JUVENILE DETENTION
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0299
Number of Pages of Decision	29
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Ardwin Boyer
Respondent Attorney	Terrence Donohue

DATE FILED: 6/16/2021

/s/ Marc Parker, Commissioner

Signature

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

Mike Kransky,

Petitioner,

vs. No. 11 WC 2393

Cook County Juvenile Detention Center,

Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner, a 32-year-old custodial worker, sustained two herniated lumbar discs and an umbilical hernia on December 14, 2010 when two steel lockers which he was unloading fell on him. He underwent two back surgeries: a microdiscectomy at L4-5 and L5-S1 on March 31, 2011, and a 2-level fusion with hardware on November 29, 2011. Petitioner also underwent hernia repair surgery in April 2011. On August 29, 2012, Petitioner underwent a functional capacity evaluation which found him capable of working jobs requiring only light to medium physical activity.

Petitioner commenced vocational rehabilitation, initially working with vocational rehabilitation counselors from Respondent, Cook County (administered by Genex), through 2014. When that vocational rehabilitation proved unsuccessful in helping Petitioner find a job, he switched counselors and began working with Ed Steffan of EPS Rehabilitation.

Ed Stefan testified that there was a stable job market for Petitioner, and that based upon his education, experience and training, Petitioner could earn between $15.00 and $20.00 per hour. The parties stipulated that at the time of Petitioner's accident, his AWW was $660.35, or $16.51 per hour for a 40-hour week. During his job search, Petitioner applied for a variety of positions, but focused on truck driving positions, for which he had prior experience.

Between 2014 and 2017, a few job offers appeared imminent but did not come to fruition. In October 2014, Petitioner was conditionally offered a $17.00/hour job as a route driver for Ecolab. That position fell through when Petitioner was informed he would need a commercial driver's license ("CDL") and would need to expunge a few traffic convictions from his driving record.

Petitioner also applied online for various positions at Albanese Confectionary. However, he was most interested in a potential truck driving position at that company which he learned about from Rich Michaelski, a friend of his ex-brother-in-law. At that time, Michaelski was a warehouse supervisor who stated he would soon be promoted to plant manager. The truck driving position would have paid Petitioner $50,000.00 per year – substantially more that the earning potential reported by his vocational rehabilitation counselors.

Over the next 18 months, Michaelski informed Petitioner and vocational counselor, Ed Steffan, that Petitioner would be hired for the truck driving position in the near future. Michaelski even gave Petitioner tentative starting dates for that position, but those dates were postponed for various reasons. Michaelski subsequently left his employment at Albanese, and the truck driving position never materialized.

At the arbitration hearing, Respondent presented the testimony of Patti Davis, a Human Resources employee of Albanese. She testified that Albanese had no records of any contact, interviews, or job applications from Petitioner.

In the Arbitrator's decision, he found Petitioner's credibility questionable, and concluded Petitioner failed to show he made a good faith job search after October 14, 2014 – the date Petitioner informed Ed Steffan of the Ecolab job offer. The Arbitrator believed Petitioner, "should have known," that he needed a CDL for that position before applying for it. The Arbitrator also criticized counselor Ed Steffan for not knowing that as well. The Arbitrator did not believe the Albanese truck driving position was legitimate, and he found that Petitioner and Ed Steffan ignored sufficient warning signs regarding it and allowed themselves to be duped by Michaelski. During the time Petitioner was waiting for finalization of the Albanese truck driver position, he passed up a few lesser paying jobs.

The Arbitrator awarded Petitioner 90-3/7 weeks of TTD (December 15, 2010 through September 10, 2012), and 109-1/7 weeks of maintenance (September 11, 2012 through October 14, 2014). In terminating Petitioner's maintenance benefits after October 14, 2014, the Arbitrator

found that after that date, Petitioner failed to cooperate in good faith with vocational rehabilitation efforts.

The Arbitrator found Petitioner's credibility questionable for other reasons as well. The Arbitrator did not find credible Petitioner testimony that he conducted over 1,000 job searches, because Petitioner did not offer documentary evidence to corroborate it. The Arbitrator believed Petitioner was neglectful for appearing at Ivy Technical Community College to take an, Interest and Aptitude Test without first verifying that it would be administered that day. The Arbitrator also found that the testimony of Albanese employee, Patti Davis, contradicted Petitioner's testimony that he applied for positions at that Albanese.

The Commission views the evidence regarding Petitioner's job search efforts differently than the Arbitrator. Although Petitioner did not offer job search records into evidence, he did testify he made at least 15 job employer contacts per week during his years-long period of unemployment. Respondent offered no evidence to contradict that testimony of Petitioner.

Regarding the Ecolab position, the Commission does not find it unreasonable that Petitioner was unaware of all the job prerequisites before applying for it. When Petitioner was informed of those prerequisites, he took steps to meet those conditions, but was unable to do so before that position was filled. The Commission does not find Petitioner's application for the position at Ecolab to have been in bad faith.

Nor does the Commission find Petitioner's pursuit of the Albanese truck driving position to have been in bad faith. Patti Davis confirmed that Michaelski was, in fact, the warehouse supervisor at Albanese. Petitioner testified credibly that he had numerous communications with Michaelski about the truck driving position, and at Michaelski's request, gave him his driver's license to begin a background check. Ed Steffan also spoke with Michaelski. Both Petitioner and Steffan believed that position was a legitimate employment prospect. The Commission finds that neither Michaelski's mistaken belief regarding his authority to hire Petitioner, nor the fact that Petitioner did not submit a written application to Albanese's H.R. Department, demonstrated bad faith on Petitioner's part.

Eventually, Petitioner accepted a position at another employer, Mullins, Inc., on May 8, 2017. Prior to that date, Petitioner participated in all prescribed vocational rehabilitation activities. Ed Steffan's testimony further supports a conclusion that Petitioner participated meaningfully in his job search. The Commission finds that Petitioner's job search activities through May 8, 2017 were in good faith, and that he is entitled to maintenance benefits for 242-6/7 weeks, for the period of September 11, 2012 through May 7, 2017.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 17, 2019, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of maintenance benefits is modified, and Respondent shall pay to Petitioner maintenance of $440.23 per week for a period of 242-6/7 weeks, for the period of September 11, 2012 through May 7, 2017, pursuant to §8(a) of the Act.

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

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

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

June 16, 2021

/s/ *Marc Parker*
Marc Parker

MP:yl
o 5/6/21
68

/s/ *Barbara N. Flores*
Barbara N. Flores

/s/ *Christopher A. Harris*
Christopher A. Harris

NOTICE OF ARBITRATOR DECISION

KRANSKY, MIKE Case# **11WC002393**

Employee/Petitioner

COOK COUNTY JUVENILE DETENTION CENTER

Employer/Respondent

On 9/17/2019, 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 1.87% 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:

0905 NEWMAN BOYER & STATHAM LTD
JAMES S HAMMAN
18400 MAPLE CREEK DR #500
TINLEY PARK, IL 60477

2337 INMAN & FITZGIBBONS LTD
TERRENCE M DONOHUE
33 N DEARBORN ST SUITE 1825
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

Mike Kransky
Employee/Petitioner

Case # **11 WC 2393**

v.

Cook County Juvenile Detention Center
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 **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **April 24, 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:** Alternatively, is Petitioner entitled to a wage differential pursuant to §8(d)1?

FINDINGS

On **December 14, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$34,338.20**; the average weekly wage was **$660.35**.

On the date of accident, Petitioner was **32** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$39,998.04** for TTD, **$10,871.58** for TPD, **$108,799.49** for maintenance, and **$0** for other benefits, for a total credit of **$159,669.11**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$440.23**/week for **90 3/7** weeks, commencing **12/15/2010** through **9/10/2012**, as provided in §8(b) of the Act.

Respondent shall be given a credit of **$39,998.04** for temporary total disability benefits that have been paid.

Petitioner failed to prove that he is entitled to TPD benefits, as provided in §8(a) of the Act.

Respondent shall be given a credit of **$10,871.58** for temporary partial disability benefits that have been paid.

Respondent shall pay Petitioner maintenance benefits of **$440.23**/week for **109 & 1/7** weeks, commencing **9/11/2012** through **10/14/2014**, as provided in §8(a) of the Act.

Respondent shall be given a credit of **$108,799.49** for maintenance benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of **$396.21/week** for **200** weeks, because the injuries sustained caused a **40% loss of a person-as-a-whole**, as provided in §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

September 16, 2019
Date

SEP 17 2019

Mike Kransky v. Cook County Juvenile Detention Center
11 WC 2393

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***K:*** What temporary benefits are in dispute? Maintenance after October 14, 2014; ***L:*** What is the nature and extent of the injury?; or ***O:*** Alternatively, is Petitioner entitled to a wage differential pursuant to §8(d)1?

FINDINGS OF FACT

Petitioner was working at Cook County Juvenile Detention Center on December 14, 2010. He had worked there for 4 months but had been an outside contractor for 7 years before. His job included emptying garbage from jail cells, sweeping and waxing floors, and removing scrap and debris.

On December 14, 2010 Petitioner was helping remove lockers when 2 lockers fell off a flatbed and landed on him causing low back pain. He went to the emergency room at St. Margaret Mercy Hospital in Dyer, Indiana on that same day (PX #4). He gave a history of feeling a pop and immediate 8/10 low back pain going into his left leg. On exam Petitioner had pain on the left with straight-leg raise but none on the right. The remainder of the exam was essentially normal. Lumbar spine X-rays were normal. Petitioner was given Toradol for pain. He was discharged with prescriptions for Vicodin and ibuprophen and directions to follow up with his "Workmen's Comp Physician."

Petitioner went to Hammond Clinic in Munster, Indiana December 15, 2010 (PX #3). Petitioner presented with complaints of severe low back pain which radiated down the left leg from an accident at work. He gave a history of catching a falling locker and felt a pop in the low back with numbness radiating down the left leg to the calf but not to the foot. On exam Petitioner had tenderness over the periumbilical area. He had a history of a prior umbilical hernia. A reducible hernia was palpated. There was also diminished range of motion. Dr. Richard Rodarte diagnosed an umbilical hernia and a herniated lumbar disc due to "classic presentation of herniated disc." Petitioner was released with light duty work restrictions. A lumbar MRI was also ordered.

Petitioner was seen again by Dr. Rodarte December 20. Petitioner complained of severe low back pain, right side greater than left. He also complained of leg numbness and weakness without specifying which leg or whether bilateral. There was left-sided spasm and equivocal straight-leg raise without specifying which side. Lumbar range of motion was still abnormal. He was referred for surgery to repair the hernia and taken off work.

The December 21, 2010 lumbar MRI demonstrated a broad-based disc protrusion with moderate encroachment of the right neuroforamen and right lateral recess with moderate encroachment of the thecal sac at L4-5 and a moderate broad-based left foraminal disc protrusion resulting in moderate encroachment of the thecal sac at L5-S1. There was also severe encroachment of the left neuroforamen due to facet arthropathy and the disc protrusion as well as moderate encroachment of the right neuroforamen. There was also disc desiccation of L4-5 and L5-S1.

Petitioner returned to the Hammond Clinic December 22, 2010 with continued complaints of abdominal pain and back pain. Dr. Rodate's exam findings were essentially the same as before, although he noted abnormal muscle strength without specifying the part of the body or muscle group. Dr. Rodarte noted his strong opinion that Petitioner's umbilical hernia was work-related, despite a denial letter. He referred Petitioner to spine service ASAP.

Petitioner saw orthopedist Dr. Dwight Tyndall of Orthopaedics Specialists of Northwest Indiana December 29, 2010 (PX #3 & PX #5). Petitioner gave a history a lifting accident at work on December 14, 2010. He had immediate low back pain which radiated into the left leg to the calf. He was not working. Petitioner reported 8/10 pain. He also complained of left "gastroc" (gastrocnemius muscle) weakness when going up and down stairs. On exam Petitioner was unable to do any toe raise on the left. Straight-leg raise on the left was positive for back pain and leg pain. Range of motion was diminished by back pain.

Dr. Tyndall reviewed the MRI and found herniated discs with collapsed discs at L4-5 and L5-S1. He noted there was no spondylosis. He noted that the MRI was consistent with the history and symptoms. Dr. Tyndall diagnosed herniated discs at L4-5 and L5-S1 and prescribed a Medrol Dosepak. He took Petitioner off work.

On January 3, 2011 Dr. Rodarte wrote a "To Whom It May Concern" letter stating his "strong" opinion that Petitioner's umbilical hernia was work-related and that treatment and repair of the hernia "be part of his Workmen's Compensation injury claim."

On January 5, 2011 Dr. Tyndall noted that Petitioner's back and leg complaints persisted. Petitioner still had a positive straight-leg on the left and diminished back range of motion. Left leg radiculopathy was added to the diagnoses of herniated discs at L4-5 and L5-S1. Dr. Tyndall released Petitioner to restricted work and was to request approval for an epidural injection.

On January 19 Petitioner presented to Dr. Tyndall with back and 8/10 right leg pain. On exam Petitioner had a right-sided list and a positive seated straight-leg raise on the right. The diagnoses were now right L4-5 and L5-S1 disc herniations with right

leg radiculopathy. Epidural injections were scheduled, and Petitioner was kept off work. Dr. Tyndall indicated that surgery might be necessary if the epidurals failed.

The copy of the January 19 note in PX #5 has a handwritten correction to the diagnoses: "L" leg radiculopathy due to L4-5 and L5-S1 disc herniations.

By March 21, 2011 Dr. Tyndall noted that conservative care had failed and scheduled Petitioner for microdiscectomy at L4-5 and L5-S1 on the left. Dr. Tyndall performed a left L4-5 and L5-S1 hemilaminectomy, partial facetectomy, and microdiscectomy March 31, 2011. Petitioner's left leg symptoms were slightly improved but were sometimes worse by April 8. Dr. Tyndall withheld physical therapy until Petitioner had his hernia repair. Dr. Tyndall opined that Petitioner would likely recover over time, "more or less."

Petitioner had umbilical hernia repair surgery on April 14, 2011 by Dr. Rawlings.

Petitioner saw Dr. Tyndall on May 6, 2011, after his hernia repair. The doctor planned to start physical therapy within 3 weeks and foresaw Petitioner's return to light duty work within a month and full duty with 6 weeks. Dr. Tyndall ordered physical therapy June 8 and still kept Petitioner off work. Dr. Tyndall ordered work conditioning July 6, 2011. MRIs with and without contrast were ordered July 27, 2011.

Petitioner's medical records and imaging were reviewed by orthopedic surgeon Alexander Ghanayem, M.D. of Loyola University Medical Center. In his October 20, 2011 report Dr. Ghanayem opined that Petitioner had a recurrent lumbar disc herniation at L4-5 causing mechanical low back pain (PX #7). He stated that a lumbar fusion at L4-5 to L5-S1 was reasonable.

On November 29, 2011 Dr. Tyndall performed an L4-5 and L5-S1 interbody fusion with allograft and instrumentation (PX #5).

Dr. Tyndall's notes document Petitioner's progression through post-operative therapy through June 13, 2012, when he noted Petitioner was 3 to 4 months "behind in his progress." Another round of physical therapy had been authorized even though Petitioner reported he was not taking pain medication and had no leg pain.

Petitioner had an FCE August 29, 2012 at Advantage Physical Therapy (PX #6). The FCE was noted as valid. Based on the job description Petitioner needed to function at the Medium demand level. Petitioner was found to capable of functioning at a Light-Medium to Medium demand level. Accordingly, Petitioner was found to be unable to demonstrate the physical capabilities and tolerance to meet the demands of the job.

On September 10, 2012 Dr. Tyndall noted that Petitioner had completed an FCE. He noted that Petitioner could not return to his prior employment due to the 40-pound lifting restriction of the FCE. According to the FCE Petitioner could work at a Light-

Medium to Medium demand level. Dr. Tyndall found Petitioner was at MMI and released Petitioner to return "as needed."

Petitioner testified that Respondent did not have jobs for him within those restrictions. He initially underwent vocational rehabilitation under the Cook County Vocational Rehabilitation Program through Genex Services, starting in December 2012. Petitioner testified that he met with the Genex representative Patrick Conway every week. He received help with his resume and cover letters, was sent to job fairs, was given prospects, and advised what jobs to look for. Petitioner said he did online job searching, went to employers in person, passed out resumes, filled out applications, and went to job fairs. During this time the only job offer he received was from Ecolab, which he got on his own. Petitioner guessed that he may have contacted "a thousand" employers in his job seeking efforts.

Petitioner testified that he met with vocational counselor Ed Steffan in his attorney's office on April 23, 2014. Mr. Steffan would give him job leads, meet with him weekly, go over leads and potential employers, review his resume and cover letter, and provide ideas for online job-search. They pursued jobs involving route sales and route driver, which he had a history of doing. While working with Ed Steffan he was required to make 15 employer contacts per week and kept track of those on "job-seeker" forms. Petitioner testified that Mr. Steffan never suggested that he pursue a CDL license. He never received a CDL, indicating he did not pass the test when he took it.

Petitioner testified he received a job offer from Ecolab as a route driver in October 2014. The job was within his restrictions. He testified that were waiting for Ecolab's vice-president's approval, but they wanted to have him start training by October 20 in Colorado. Petitioner testified they missed the training session and that he was then advised that he needed to get some traffic violations cleared off his record.

Petitioner testified he was not getting TTD benefits around this time and therefore had no money to pay an attorney to get his record expunged. He said eventually he was able to get his record cleared, but by then he was told the job was no longer available.

Respondent's Exhibit #7, a January 28, 2015 electronic note, stated that Ecolab had been contacted and that Ecolab never offered Petitioner a job.

Petitioner testified that in August 2015 he learned of a position at Albanese Candy. This was through a friend of his ex-brother-in-law, Rich Michalski, who was a manager/supervisor. Petitioner presented his Group Exhibit #1, consisting of alleged applications submitted and reviewed by Albanese. He said they were submitted through Indeed.com and Lucio Solutions. Petitioner testified he continued to search for jobs while the Albanese job offer was pending.

Petitioner testified that he received a job offer from Lurie Bros. in August 2016 driving a forklift, which paid $9.50/hour. He testified while he was waiting to hear back if he could accept the job, it no longer was available. Petitioner testified that he was offered another job with Dungarvin in April or May 2017 earning $9/hour but said that was only part-time and was a different position than what he applied for.

Petitioner ultimately obtained a job with Silver Buckle/Mullins, Inc., earning $9/hour for 40 hours per week, and he continues to work there. He does courier work and promoting for them, dropping off contracts, picking up contracts, dropping off checks, and promoting for bands.

Petitioner testified that he currently has problems with his back, arthritis, and a hip problem from not getting proper therapy after his fusion. He goes to a back doctor once a month and always has pain.

On cross-examination Petitioner acknowledged that he consulted with vocational counselor Ed Steffan on advice of his attorney. He could not recall what the salary was at the Ecolab position.

Petitioner stated that he had 2 seatbelt violations and a speeding ticket which he needed to expunge in order to get a CDL.

Petitioner testified that he was told by a supervisor at Ecolab that he would be hired pending the vice-president's approval. The only documentary evidence he has regarding the Ecolab offer was the e-mail, PX #2. Petitioner was not aware that the Workers' Compensation insurance adjuster had attempted but was unable to get any confirmation of any job offer by Ecolab.

Vocational rehabilitation with Ed Steffan was placed on hold from October 17, 2014 until April 22, 2015. Petitioner testified that during that time he performed job-search activities on his own and was paid weekly benefits.

Petitioner admitted he was offered a forklift driver position on September 19, 2016 at Lurie Bros. He testified that he was instructed by Ed Steffan to hold off on taking that position. He was not aware that the adjuster from Respondent had wanted him to take the position. Following the Lurie Bros. job rejection, Petitioner continued to be paid full weekly benefits.

Petitioner learned of the Albanese position through a friend of his ex-brother-in-law, Rich Michaelski. He said Rich was a supervisor, who told him that he was being promoted to plant manager. Petitioner said that Rich led him to believe he had the ability to hire people. Petitioner said that during his efforts to secure the Albanese position he met with Mr. Michaelski and 2 others whose names he could not recall. He believed the other 2 were supervisors. Petitioner did not know whether these other individuals had any authority to hire. He testified he personally met with these people.

Petitioner then clarified that his "meetings" were actually only for a minute or so. One of these meetings with other supervisors occurred in the Albanese parking lot; the other occurred during a lunch with Rich Michaelski. Petitioner testified that during his entire pursuit of the Albanese job he never even went inside the Albanese building.

Petitioner testified that he told Ed Steffan on September 23, 2016 that Mr. Michaelski would provide an exact date of hire on October 16, 2016 for a truck driver position. Petitioner told Mr. Steffan that Mr. Michalski was the plant manager because suggested Michalski told him he was going to be promoted and that Michalski considered himself a plant manager. Rich Michalski was Petitioner's one and only contact at Albanese.

Petitioner acknowledged that he told Ed Steffan around October 17, 2016 that after he passed a background check for Albanese, he would get a start date, and that this information came from Rich Michaelski. Petitioner further clarified that the process involved him giving Michalski a copy of his driver's license.

Petitioner testified he was then given a specific start date of November 28, 2016 by Rich Michaelski of November 28, 2016. Petitioner clarified that Michaelski said this is when Albanese was looking to hire again. There was no documentation regarding the November 28 start date.

Petitioner asked Michaelski if his scheduled honeymoon in December 2016 would interfere with the November 28 start date. Petitioner testified that Michaelski told him the honeymoon would not be a problem. Petitioner said there was no documentation regarding any of these hiring details, such as job offer, start date, background check, or passing a drug test. He never actually took a drug test for Albanese.

Petitioner said he was then told of a new start date of January 16, 2017 due to a Christmas break, and Albanese being closed between January 2 and January 9. He testified that Rich Michaelski told them he would get an official job offer letter on January 9, 2017, that his salary would be $51,900 with the possibility of a $2,000 raise in 60-90 days.

Petitioner disputed the accuracy of the Ed Steffan December 12, 2016 report, which indicated that Petitioner had said he was told by 3 separate individuals in management at Albanese that January 16 was a firm start date.

Petitioner was cross-examined regarding the vocational report which indicated that on May 11, 2016 he was offered a job at Wilkins Foods. He testified that the job required a class C driver's license. Petitioner disputed the vocational report which indicated he was offered a job at Wilkins Foods for $13.50/hour because of his concern over the training and a 2-year contract, and the Albanese position being so close. Petitioner felt the job would not comply with the FCE restrictions and was more

physical. Petitioner denied ever telling Mr. Steffan he was concerned over the training or the fact that it was a 2-year contract.

Petitioner's Exhibit #1 was offered to document Petitioner's job search efforts: Lucio Solutions had received his application for a job at Albanese, a document from Indeed.com confirming an application for a material handler, forklift operator position for which he applied around December 6, 2016, the next application for an Albanese position dated January 23, 2017, also through Indeed.com, but for a material handler position, another application with Albanese for a packaging operator position, and a January 24, 2017 application through Indeed.com for a building and grounds technician at Albanese. Petitioner conceded these were not for the truck driver position which occupied so much of his focus, but said he just wanted to get into Albanese and go from there.

Petitioner testified he has not done any job searches since beginning with Silver Buckle/Mullins on May 8, 2017. His job at Silver Buckle/Mullins is courier work, dropping off contracts, picking up paychecks, dropping off paychecks, dropping off flyers, doing inventory.

Petitioner told Ed Steffan he wanted to get a CDL and tried to get it, but the County wouldn't pay for his classes. He testified that he went to get the CDL license for the Wilkins Service job but did not pass. He subsequently determined the job was too physical and he never pursued it further. He never did get a CDL. Petitioner testified that he never told Mr. Steffan he had in fact obtained a CDL. Petitioner testified that the August 5, 2016 Mr. Steffan's report indicating claimant had obtained a Class C CDL was simply wrong. He also testified it was not true that he had a chauffeur's license, as the August 5, 2016 Steffan report indicated.

Petitioner did not take a recommended interest and aptitude testing at Ivy Technical Community College was that he went down there to take the test, but the test was not offered on the day he went.

Petitioner disagreed that the majority of his job contacts were done online, testifying that only about 50% were online. He claimed that he spent 40-50 hours per week in job-search activities. He testified that of the 15 contacts he would be given for the week, 7 would be applications online and the rest would be in-person contact.

Evidence Deposition of Ed Steffan (PX #8)

Ed Steffan of EPS Vocational Rehabilitation testified regarding vocational rehabilitation efforts on behalf of Petitioner. Mr. Steffan opined that Petitioner could not return to work for Cook County and that the County had not offered him a position of employment. As part of the initial evaluation process, Petitioner agreed to fully cooperate with Mr. Steffan's efforts to obtain replacement employment for him. EPS

provided information on potential employers to Petitioner and that Petitioner followed up with those potential employers.

Mr. Steffan further testified that Petitioner actively pursued alternative employment options and said that Petitioner, compared to most individuals he's seen, was a very active participant in the self-directed job search program. He explained the job seeker forms that Petitioner filled out concerning the potential employers he contacted and stated that they totaled in the hundreds. He added that the potential number of prospective employers that Petitioner contacted was a substantial, in the hundreds.

Mr. Steffan and EPS worked with Petitioner over a period of approximately 3 years, from April 2014 through April 2017. When questioned regarding Petitioner's cooperation with his vocational rehabilitation efforts, Mr. Steffan testified that he has over 30 years of experience assisting individuals with disabilities to find employment. As he reviewed all the people he had worked with, he believed Petitioner to be one of the more active and involved participants on his own behalf.

Mr. Steffan further testified that Petitioner lost the position with Ecolab because of a blemish on his driving record, that Petitioner retained an attorney to clear his driving record, but he did not get the position. Mr. Steffan also testified concerning Petitioner's attempt to obtain a position Albanese Candies, a potential employer that was identified by Petitioner through a friend by networking. He also stated that Petitioner followed their instructions very well, that being the number-one way people get employed. Mr. Steffan further testified that he was aware of a number of reasons the potential position of employment had been delayed from his discussion with Petitioner and he spoke directly with a representative of that company, Rich Michaelski. Petitioner wanted that position and anticipated being hired by Albanese. Mr. Steffan testified that he recalled talking with Mr. Michaelski several times regarding the movement of the job and that he, Michaelski, actually expressed some frustration related to needing drivers and drivers not being hired.

Mr. Steffan further testified to correspondence between EPS and Suyon Flowers at Cook County regarding delays in the position of employment with Albanese Candies, his contacts with the representative of Albanese in that regard, and his confirming that Respondent did not want Petitioner to pursue a job that was being offered to the petitioner to drive a forklift earning $9/hour, but would rather have him continue to pursue the higher paying position at Albanese. He also stated that the position with Albanese Candies never materialized and that Petitioner did nothing to prevent him from being hired by Albanese. Mr. Steffan also testified that Petitioner was willing to accept the job at Lurie Brothers, but that he had wanted to pursue the much higher paying job at Albanese.

Although Mr. Steffan testified that Petitioner was capable of earning $15 to $20 per hour in readily available employment. He also testified that Petitioner had done nothing or failed to do something in not obtaining those positions of employment. He acknowledged that he was unable to obtain such a position of employment for Petitioner. He further testified to Petitioner's good faith efforts to obtain the best paying job that he could get, stating that Petitioner was active in what he produced as material that was given to him regarding his activities. Mr. Steffan testified Petitioner's inability in obtaining a CDL likely had something to do with his physical restrictions.

Mr. Steffan was contacted by Petitioner's attorney on March 25, 2014, requesting vocational assistance. He first met with Petitioner on April 23, 2014 at Petitioner's attorney's office. Following that meeting Mr. Steffan forwarded an Initial Evaluation and Rehabilitation Plan on April 30, 2014. (DepX #4). Mr. Steffan testified he believed Petitioner followed the general recommendations they provided to him to facilitate the job-search process. They met approximately 2 times per month. He testified that Petitioner followed up with most of the leads provided regarding potential employers and did some on his own. He stated Petitioner was a very active participant in a self-directed job search program. Mr. Steffan provided Petitioner with job seeker forms and the Petitioner was to indicate the employer, whether they inquired in person, completed an application online, or called. Steffan indicated EPS worked with the Petitioner from the initial meeting until approximately April 11, 2017. Mr. Steffan characterized Petitioner as being one of the more active and involved participants on his own behalf. Mr. Steffan testified regarding the Ecolab position, that after the job offer was made at over $17/hour, it was learned claimant had a "blemish" on his driving record, which Petitioner then tried to get cleared.

Mr. Steffan testified that great effort was expended to achieve the job with Albanese Candy. He recounted that the position to Petitioner was pushed back or delayed for a variety of reasons including a delay in construction of an addition at the site. Mr. Steffan testified Petitioner was excited about the Albanese position because of the significant wage and that it was within his physical capacities. Mr. Steffan stated that Petitioner first learned of this position from Rich Michaelski, who he described as the plant manager at Albanese. He spoke with Mr. Michaelski a number of times, although he was unable to point to his notes her documentation to verify the same. Mr. Steffan reviewed his correspondence to counsel for Respondent dated November 14, December 13, and December 23, 2016. He testified that he believed that it was at Respondent's direction that claimant was told not to take the Lurie Brothers job and to pursue the Albanese position. Petitioner was willing to accept the Lurie's position, but his primary focus was the Albanese higher paying job.

On cross-examination Mr. Steffan affirmed that Petitioner first came to him as a referral from his attorney in April 2014. He testified that from the beginning until his

final opinions in February 2017, his overall opinion did not change. He agreed that as of his last opinion on February 10, 2017, that despite Petitioner's restrictions, he had the available physical capacities which allowed access to a wide range of readily available jobs in a stable labor market. Specifically, Mr. Steffan felt that Petitioner was capable of earning $15-$20 per hour, assuming Petitioner performs a full-time good-faith effort. This remains his opinion today.

Mr. Steffan testified that positions in the $15-$20 per hour range are readily available to Petitioner even with his restrictions. He added that Petitioner were to land a position at about $17 per hour or above, he would essentially have no wage loss. Mr. Steffan agreed that the Petitioner is underemployed at his position at Silver Buckle earning $9 per hour, given his potential earning capacity of $15-$20 per hour.

Mr. Steffan testified that he does not know Petitioner spent on his job-search activities, and that there is really no way to keep track of that time. He agreed that in person contact is better than online. He also agreed that if all a claimant did was post his resume and complete applications online for the majority of his effort, that would not represent a diligent job-search and he would have little chance of securing employment. Mr. Steffan agreed that the true evidence as to whether Petitioner was diligent or not in his job seeking responsibilities would be found in the job seeker forms. He felt Petitioner did an above average job-search

Mr. Steffan agreed that having a CDL would improve Petitioner's job prospects. He recalled asking the County to pay for a CDL, but he had no documentation confirming this ever happened. Petitioner had told him about the steps it would take to get his driving record expunged for the Ecolab position. He accepted that as true, with no independent verification. Mr. Steffan indicated, as with the Albanese job, that he never verified the many specific details provided by Petitioner regarding Ecolab interviews, drug test details, tour of the facility, measurements for uniform, or travel to Minnesota for a week of training. He allowed that it is possible that the Petitioner could have made all of those details up with respect to the position. Mr. Steffan testified that any evidence that the Petitioner engaged in a job search during that time would only be found in job seeker forms.

Mr. Steffan did not disagree that when his company calls in verification/follow-up to the Petitioner's submitted job seeker forms that most, if not 95% of the time, the person answering simply advises they are not hiring, or they don't have anything from Petitioner. He agreed they were usually not able to get any confirmation if claimant had contacted them or if he dropped off a resume or submitted it online.

Mr. Steffan further testified from his August 4, 2015 report that EPS was advised by Petitioner of a lunch interview with an individual named Rich from Albanese who had his resume and that when it gets closer to the plant opening they will have him fill

out an application for a delivery driver position paying $45,000-$50,000. Petitioner then advised EPS as documented in the August 17, 2015 report, that his interview with Michalski went very well and that he expected to be hired within a month and a half. Petitioner was more specific on August 31, 2015 indicating he got a text from Michalski on August 24 saying his route with Albanese would be a Naperville to Indiana route and it may begin in 4 weeks.

Petitioner had further advised EPS that he would be doing a walk around at the Albanese factory on September 25, 2015. Petitioner cancelled a plan vocational meeting which was scheduled for that day, so he could participate in the claimed Albanese walk around. Additionally, he told EPS after the plant construction is completed, he would be hired as a route sales delivery driver. Mr. Steffan recalled being told there was going to be an addition to the plant, and that construction was delayed, and the job offer also delayed. Petitioner provided further details to EPS that this was a family company, that there are going to be getting into gummy vitamins, that there is free health care, and that there will be a 401(k) program, that they should be hiring two drivers on November 1, 2015 and he will be one of them.

Mr. Steffan stated that initially he did not contact Albanese to confirm any of this. He confirmed that Petitioner also told them in October 2015 that there were construction delays and that the opening of the new facility had been pushed back until early December 2015, but that they did give him a benefits packet of information. He further confirmed that Petitioner told them around September 22, 2015 he went to a job fair at Albanese and that Rich Michalski took him to lunch to further discuss the job. Mr. Steffan further confirmed the Petitioner said Michalski told them they had to tear up cement to add on something to the warehouse and therefore hiring was going to be pushed back and now would be January 16, 2016 at best but may be later. Petitioner told Steffan that in March 2016 he was talking to supervisors at Albanese almost every week. Mr. Steffan testified Petitioner told him he was going to meet with Michalski at 11:00 AM on April 15, 2016 to tour the plant and then go to lunch, and therefore Petitioner was not available for his scheduled vocational rehabilitation meeting with EPS.

Mr. Steffan agreed that in May 2016 Petitioner was offered a job at Wilkins food paying $13.50 per hour, but said Petitioner was concerned that there was a 6-8 month training and that he would then have to sign a two-year contract for $14 an hour, and with the Albanese position so close he didn't want to do it.

Mr. Steffan agreed that in 2016 Petitioner told him that Albanese was doing their warehouse this week and may finally start hiring drivers in June 2016. He testified that in June 2016 Petitioner said Albanese should be calling for interview soon and he hopes to hear by the end of the month, that Albanese will be hiring one driver, which will not be posted because Petitioner is the one to be hired and he speaks to the hiring person

daily. Mr. Steffan confirmed that Petitioner advised him on July 5, 2016 that his Albanese position could be starting in mid-August and that he had met with Rich Michalski last week who will be back from vacation July 18 and that the job is $45,000-$50,000 a year and insurance will begin after 30 days.

Mr. Steffan acknowledged that in the August 5, 2016 EPS report Petitioner reported that he had passed the class C license test. Mr. Steffan further acknowledged that around August 2016 Petitioner further advised that he has a chauffeur's license, which allows him to carry up to 15 people, but that he had no further information about that.

Steffan testified again that if Petitioner actually had the CDL it could have increased the prospects that he could find employment in the $15-$20 per hour range.

Mr. Steffan acknowledged that Petitioner advised them around August 30, 2016 that his start with Albanese as a truck driver could be October and he was unsure what to do. The Albanese job allegedly paid $40,000-$45,000 per year, but he had a job offer from Lurie Bros. at $9 per hour as a forklift operator going up to $10-$10.50 per hour after 90 days. Petitioner then advised that his computer got "hacked" and that he lost all of his emails and documentation regarding his applications.

Mr. Steffan acknowledged that in September 2016 Petitioner had advised that he had decided not to accept the Lurie Brothers job because he will be leaving in 3-4 weeks to take the Albanese job and that Rich Michalski will provide him an exact date of hire on October 16, 2016.

Petitioner told Steffan on October 17, 2016 he was personally delivering a copy of his identification to Albanese to complete a background check, and that after passing the background check he will get his start date.

Mr. Steffan further testified that the Petitioner related in November 2016 he was waiting for a letter for instructions from Albanese to take a physical and a drug testing examination, which would have been done last week, but the HR person was out. Petitioner further advised that he would start on December 12, 2016, after his honeymoon. Mr. Steffan further acknowledged in November 2016 that Petitioner told them he would be hired at Albanese, but that the hire date was fluid.

Mr. Steffan acknowledged that as late as January 13, 2017 Petitioner was saying he should have more paperwork about his Albanese job in a week.

Mr. Steffan testified that he actually spoke with Rich Michaelski in January 2017, and that Michalski told them that until production is up he does not know a hiring date but that Kransky is the number one candidate and will be hired to drive, and that construction delays and logistical concerns have interfered with the process.

Mr. Steffan testified that other than the phone call with Michaelski, he did not recall speaking with anyone else from Albanese. He testified it was his understanding that Rich Michaelski was the plant manager, and that he was not aware that he was only a supervisor not involved in any hiring. He believed it was Petitioner who led him to believe Michalski was a plant manager. Mr. Steffan indicated that he was aware that Michalski had been terminated from Albanese. He said he had no independent knowledge whether Albanese employed truck drivers, or how many they might employ or what their salaries would be.

When confronted with the possibility that Petitioner simply made up the whole Albanese job situation and with information that Albanese had no records regarding Petitioner despite multiple searches, Mr. Steffan replied it is simply not his responsibility. He testified "I'm certainly not waiving his flag . . . But the records he produced could all be falsified for all I know I don't have any way—I have to deal with people on what they tell me, and no employer gave me any information that would lead me to believe that things were fictitious like you're showing me Albanese is." Regarding the phone call with Rich Michaelski, he stated "So for all I know it's his neighbor and best friend, and they scam to me. I don't want to believe that, but anything is possible."

Mr. Steffan testified that the only evidence that exists of the level of participation and veracity of the claimant's job search would be contained in Petitioner's job seeker forms.

Mr. Steffan concluded that his opinion from the start of his involvement up until April 2017 is that Petitioner is employable in the $15-$20 per hour job range within his restrictions and has access to a wide range of readily available jobs in a stable labor market at that salary.

Evidence Deposition of Patti Davis, Albanese Candy (RX #2)

Patti Davis testified at evidence deposition February 22, 2018, on behalf of Respondent. Ms. Davis is the payroll and benefit specialists for Albanese Confectionery Group, having worked there for 27 years. Her responsibilities included payroll, health insurance benefits, recordkeeping. This included records regarding job applicants or scheduling of interviews, background checks, drug testing, and job offers.

Ms. Davis testified that she received a subpoena for records relating to Petitioner but could not locate any records. She testified she was then contacted by Respondent's counsel to look again to make sure whether or not there were any records regarding Petitioner, but again found that there were none. Ms. Davis testified that she first checked regarding any background screening, indicating they use a company called Choice, which maintains a record of everybody that had been offered a job, who would then take the background screening and drug test, but Petitioner's name was not listed. She also said that offer letters for all job offers are sent to prospective employees and are

saved in the system. There were no offer letters for Petitioner. She testified that those letters are kept whether or not the applicant accepts the job.

Ms. Davis also testified that there is a "careers" feature on the Albanese website where applicants can apply online, but there was no record of Petitioner ever applying through the website. Ms. Davis further testified there was no record of Petitioner being scheduled for an interview. She testified that if someone had gotten to the point where they had drug testing, there would be a record of that individual.

Ms. Davis further testified that Albanese was not hiring drivers in October 2016 and not for the claimed salary of $50,000 per year. Further, she testified that from that time through the present, the company still only has one driver for a box truck who has worked there for a very long time and was "not going anywhere." She explained that the company does not have any fleet of trucks of its own. Freight companies come and pick up the customers' orders to ship and vendors deliver products through these freight companies.

Ms. Davis further testified that there was no construction going on at Albanese in October 2016. The company had already expanded and added on and was only ramping up to hire more manufacturing jobs. She was unaware that there was any type of hiring freeze in October 2016.

Ms. Davis summarized that knowing everything and having searched all of the records, she did not believe it is possible that Petitioner had applied and interviewed and been scheduled for testing for a job at Albanese.

Ms. Davis testified that Rich Michaelski was just a supervisor in the warehouse, and not the plant director, and he was not someone who would hire or interview anyone to be a driver.

On cross-examination Ms. Davis testified that any applications received would be kept in the system for at least a year. She further clarified that the prior expansion started in 2014 up until around 2016 and involved putting in new machinery and another line in order to make the gummies. She said there was a lot of hiring going on at that time. She testified that there is only one truck driver, which is in the warehouse position, and there is a box truck for the retail store that goes back and forth from the two retail stores with supplies.

On further cross-examination she testified that Shane Houlihan would be the one who would interview anyone after the recruiter had brought the application to him, and that he would be the one to hire or not hire someone. She added that Shane Houlihan was Rich Michalski's boss.

Ms. Davis reviewed correspondence from Ed Steffan detailing the claimed contacts between Petitioner and Albanese, including information regarding a start date

after passing a background check, an updated start date, a further amended start date based upon his honeymoon, scheduled drug testing, a date for an official job offer letter, and information regarding a $51,900 per year position. She testified there was no record of any of this in the company's records. She further testified that the $51,900 salary was higher than salaries for new hires. Ms. Davis further testified that her investigation revealed that Petitioner was never given a firm start date and no offer letter was ever created nor any communications at all regarding the potential hiring of Petitioner. Ms. Davis further testified that there were no construction delays or other logistical concerns around October 2016, as was indicated in Mr. Steffan's correspondence.

CONCLUSIONS OF LAW

K: What temporary benefits are in dispute? Maintenance after October 14, 2014?

The Arbitrator finds that Petitioner failed to prove that he is entitled to maintenance benefits after October 14, 2014. A claimant is entitled to maintenance benefits when he or she expends a good faith effort cooperate with rehabilitation and vocational efforts. Failure cooperate in good faith with rehabilitation and vocational efforts can lead to suspension all benefits.

It is Petitioner's burden of proof to prove his good-faith cooperation with rehabilitation and vocational efforts. Due to Petitioner's questionable credibility, the Arbitrator finds that Petitioner failed to prove faith operation rehabilitation and vocational efforts.

The Arbitrator first questioned Petitioner's credibility when he testified that he had made close to a thousand contacts in seeking employment once he had reached MMI. Normally, such a statement would be tempted as hyperbole and puffery but for other evidence detracting from Petitioner's credibility.

Petitioner testified that he had received an offer of employment from Ecolab as a route driver. Petitioner submitted evidence of that offer in the form of an e-mail exchange as Petitioner's Exhibit #2. PX #2 included a message to petitioner from Eric Sullivan, Ecolab District Manager, dated November 5, 2014, collaborating Petitioner's testimony that the decision to hire was awaiting approval from the VP of operations. However, Respondent's Exhibit #7, an electronic memo dated January 28, 2015, noted no offer of employment had ever been made Petitioner.

Petitioner had acknowledged that he had unresolved traffic violations which prevented him from getting a CDL (commercial driver's license). Petitioner testified that the Ecolab job involved transporting pesticides "and stuff like that." It seems unlikely that Petitioner's for such a job without a clean driving record and without a CDL. Attempting to obtain employment driving in commercial vehicle hauling hazardous materials without a CDL is not, in the mind of the Arbitrator, a good-faith effort in seeking employment.

Petitioner had been recommended to take interest and aptitude testing. He showed up for the testing at Ivy Technical Community College, but on a day when there was no testing. Petitioner was neglectful in not determining an actual day for scheduled interest and aptitude testing and did not follow up for testing.

Petitioner further failed to sustain his burden for entitlement to maintenance benefits after October 14, 2014. Petitioner has offered none of the routine and standard job-search records or job seeker forms or vocational reports from Ed Steffan at EPS, even though Mr. Steffan and EPS were ostensibly conducting vocational placement efforts from March 2014 to April 2017.

A substantial part of Petitioner's claim rested on his efforts to obtain employment with Albanese Confectionery Group. Petitioner testified to extensive contacts with a Rich Michaelski, a purported plant manager at Albanese, as well as formally applying for a job at Albanese. Petitioner testified that he had been offered a job as a driver for $50,000. Petitioner testified to luncheon and parking-lot meetings with Mr. Michaelski. According to Petitioner, Mr. Michaelski made numerous and repeated promises of employment, all of which changed with Michaelski's explanations of delays in construction or a hiring freeze. Petitioner's vocational counselor Ed Steffan has at least one conversation Mr. Michaelski regarding Petitioner's potential employment with Albanese.

In fact, although Rich Michaelski was an employee of Albanese Confectionery, he was not a plant manager or director. According to Respondent's witness Patti Davis, Albanese's payroll and benefits specialist, Mr. Michaelski was a warehouse supervisor who had no authority to hire any workers. Ms. Davis further testified that there are no records that Petitioner had applied for employment with Albanese or had been scheduled for background screening or a drug test, contrary to Petitioner's trial testimony.

It appears the both Petitioner and Ed Steffan were misled about any possibility of Petitioner being hired by Albanese Confectionary. The Arbitrator does not believe that either Petitioner or Ed Steffan engaged in any misconduct of their own. However, there were ample signs that a job offer from Albanese was not genuine.

Petitioner's and Ed Steffan's contacts with Albanese Confectionery was limited to contact Rich Michaelski. There was no contact with Albanese human resources. No copy of a purported application for employment at Albanese was offered in evidence. There were no meetings between Petitioner and Rich Michaelski in any of Albanese's corporate or business offices. The Arbitrator finds it dubious that a prospective employer would postpone a hire date for an applicant's honeymoon. Such a consideration might be plausible or an applicant possessing greater skill set than Petitioner possessed. None of standard preemployment screening, such as background check and drug testing, was ever performed.

While Petitioner and Ed Steffan may have been duped by Rich Michaelski, there were sufficient warning signs ignored by Petitioner and Mr. Steffan, who without critical thinking, allowed themselves to be duped. Such behavior does not meet Petitioner's burden to demonstrate good-faith efforts to gain employment.

The date of October 14, 2014 was the date that Petitioner advised his vocational counselor that he had a job offer at Ecolab earning approximately $17/hour, and that he was to undergo a drug test and a physical exam that same week. He provided very specific details including that he was to start training in Colorado on October 20. However, as stated above, the Ecolab job required a CDL. Petitioner was not eligible for a CDL at the time of the purported job offer, a fact Petitioner ought to have known at that time. Further, Petitioner's vocational counselor Ed Steffan should also have known Petitioner was not eligible for the Ecolab job due to the lack of a CDL. This neglect shows a lack of good-faith effort to obtain employment.

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

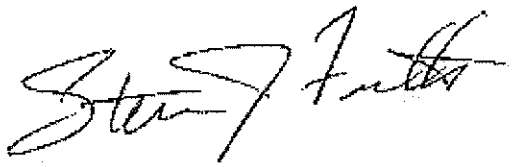
O: Alternatively, is Petitioner entitled to a wage differential pursuant to §8(d)1?

Petitioner, as with a claim for entitlement to maintenance benefits, also has the burden of proving entitlement to wage differential benefits. Based on the opinion of Petitioner's own vocational expert that he has not sustained a loss in earning capacity, the Arbitrator finds that Petitioner failed to prove that he is entitled to a wage differential.

The Arbitrator does find that Petitioner sustained a permanent partial disability of 40% loss of a person-as-a-whole.

Petitioner sustained two separate injuries as a result of his work accident on December 14, 2010: herniated discs at L4-5 and L5-S1 as well as an umbilical hernia. The hernia required surgical repair on April 14, 2011. Petitioner went through a course of conservative care for his lumbar injury which failed to relieve his condition. He had a left L4-5 and L5-S1 hemilaminectomy, partial facetectomy, and microdiscectomy performed March 31, 2011. Petitioner's lumbar symptoms persisted, and he was later diagnosed with a re-herniation at L4-5. On November 29, 2011 Dr. Tyndall performed an L4-5 and L5-S1 interbody fusion with allograft and instrumentation.

Petitioner did attain MMI and was released to return to work with restrictions that Respondent could not accommodate. He has continuing complaints of low back pain which affect his activities of daily living. In light of all the evidence, the Arbitrator, as stated above, finds that Petitioner sustained a partial permanent partial disability of 40% loss of a person-as-a-whole.



Steven J. Fruth, Arbitrator

September 16, 2019
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC023725
Case Name	INIQUEZ,MICHAEL A v. TOWN OF CICERO BUILDING DEPT
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remanded Arbitration
Decision Type	Commission Decision
Commission Decision Number	21IWCC0300
Number of Pages of Decision	31
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	David Kosin
Respondent Attorney	Robert Luedke

DATE FILED: 6/16/2021

/s/ Marc Parker, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael A. Iniquez,
Petitioner,

vs. No. 18 WC 023725

Town of Cicero,
Building Department,
Respondent.

DECISION AND OPINION ON REVIEW

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

The Arbitrator found Petitioner did not prove that his July 2, 2018 accident arose out of his employment and denied Petitioner all benefits. The Commission views the evidence differently and finds that Petitioner's accident arose out of and in the course of his employment with Respondent and awards benefits accordingly.

I. Findings of Fact and Procedural History

Petitioner was employed by Respondent Town of Cicero ("Town") as a blight inspector and was required to use a Town vehicle to travel to and inspect areas reported to be blighted. He obtained the list of locations to be inspected from the computer in his office on the second floor of the Town Hall. Each morning, he would use his key card to enter the South entrance and climb the South staircase to his office, where he would sync his phone with the computer to obtain his

assignments, then descend the stairs, exit the building, and drive his Town vehicle to the designated locations. From time to time during the workday, he would return to his office and repeat the process to obtain additional locations to be inspected.

On July 2, 2018, Petitioner arrived at Town Hall, used his card key to enter the South entrance, and climbed the South staircase to his office. He synced his phone with his computer and re-entered the South staircase on his way out of the building. As he was descending the stairs, his foot slipped and he fell, striking the right side of his body and head, his bilateral shoulders, neck, and back, as he fell down approximately 15 steps. Petitioner testified that he thought he slipped from moisture on the stairs. Petitioner was unable to get up and remained at the base of the stairs until discovered by a co-worker, who called an ambulance.

The ambulance transported Petitioner to the emergency room at MacNeal Hospital, where he was diagnosed with a right shoulder contusion and fracture of the thoracic spine. He was taken off work for three days.

Petitioner followed up with his primary care physician for headaches and pain in his right shoulder, right knee and lumbar spine. He was then referred to Dr. Hejna, who ordered MRIs of his right knee and bilateral shoulders. Dr. Hejna referred Petitioner to Dr. Derani for a neurological consult.

Petitioner submitted his off work slips to Respondent and was referred to its occupational clinic, Westlake, on July 16, 2018. There Petitioner repeated his complaints of right knee, lumbar spine, neck, and bilateral shoulder pain, and the clinic determined Petitioner's objective findings were consistent with his work-related etiology.

On July 24, 2018, Petitioner learned from his primary care physician that his workers' compensation benefits were being denied by Respondent. He asked for his physician to return him to work, as he required the income.

On September 19, 2018, neurologist Dr. Derani diagnosed Petitioner with post-concussion syndrome and prescribed vestibular therapy, which alleviated his dizziness but not his headaches.

Dr. Chudik of Hinsdale Orthopaedic Associates evaluated Petitioner's right knee and bilateral shoulders on August 1, 2018. Dr. Chudik suspected a left shoulder scapularis tear, right shoulder rotator cuff tear, and a right knee meniscal tear and ordered MRIs of all three areas. The MRIs confirmed his initial suspicions, and Dr. Chudik recommended bilateral surgeries to repair the shoulder tears and an injection and physical therapy for Petitioner's right knee. Petitioner completed the therapy and received the knee injection, but he testified that his unoperated shoulders remain painful when he turns a steering wheel, lifts, reaches, or moves his hands behind his back. He also continues to suffer from three or more headaches per month and from right knee pain with prolonged standing. Petitioner filed a Petition for Immediate Hearing, which took place on January 21, 2020, seeking medical expenses, prospective medical treatment, and temporary total disability.

In evaluating whether Petitioner sustained a compensable accident, the Arbitrator noted that Petitioner's accident occurred "within the time and space boundaries of the employment." *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). Petitioner had begun his workday at the time of his accident, had picked up his assignments and was heading to his Town vehicle to begin his inspections, so he was clearly in the course of his employment. However, the Arbitrator determined that Petitioner had failed to prove the second prong required for a compensable claim, that the accident arose out of his employment. *Id.*

The Arbitrator then addressed several different theories of recovery and determined that Petitioner failed to prove that he sustained an accidental injury that arose out of his employment, concluding that Petitioner failed to prove that the stairs were defective or presented any increased risk of injury. The Arbitrator also rejected Petitioner's theories that the stairs were an employment-related risk, that Petitioner was subjected to a street risk, or that Petitioner was a traveling employee whose use of the stairs was reasonably foreseeable and incidental to his job as blight inspector. Therefore, the Arbitrator denied all compensation for this accident.

II. Conclusions of Law

In reviewing the record, the Commission views the evidence differently and finds that Petitioner was a traveling employee who proved that he sustained a compensable accident that arose out of and in the course of his employment with Respondent.

A traveling employee is one for whom travel is an essential element of his employment where he must travel away from his employer's premises to perform his job. *Cox v. Illinois Workers' Comp. Comm'n,* 406 Ill. App. 3d 541, 545 (2010). In this case, there is no question that Petitioner was a traveling employee while in the field inspecting blighted premises. However, the Arbitrator concluded that Petitioner was not a traveling employee *at the time of his accident*, because he was on his employer's premises. The Arbitrator then determined that Petitioner had failed to prove that his accident arose out of his employment. The Commission concludes otherwise.

A traveling employee is deemed to be in the course of his employment from the time he leaves home until he returns home or "portal to portal." *Kertis v. Illinois Workers' Comp.* Comm'n, 2013 IL App (2d) 120252WC; *Pryor v. Illinois Workers' Comp. Comm'n*, 2015 IL App (2d) 130874WC, ¶20. Here Petitioner did not lose his status as a traveling employee merely because the accident occurred on stairs located in his employer's facility. He had begun his travel when he left his home and continued as a traveling employee while he made a stop at Town Hall to obtain his assignments. His status as traveling employee did not terminate when he stepped through the South entrance and re-emerge as he exited the parking lot. He remained a traveling employee until he returned to his home at the end of the workday. *Urban v. Industrial Comm'n*, 34 Ill. 2d 159, 162-63 (1966).

An injury sustained by a traveling employee arises out of his employment if he was injured while engaging in conduct that was reasonable and foreseeable, conduct that "might normally be anticipated or foreseen by the employer." *Robinson v. Industrial Comm'n*, 96 Ill. 2d 87, 92 (1983). Here Petitioner was in the course of his employment as a traveling employee. He had left his home and traveled to his office to retrieve his assignments. His injury occurred while he was descending

the staircase on the way from his second-floor office to the exit from which he would walk to the parking lot and then drive his Town vehicle out to make his inspections. The Illinois Supreme Court noted in *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003) that an injury arises out of the employment where it had its origin in a risk "incidental to" the employment. The Court has defined "incidental" is mean belonging or connected to what the employee has to do to fulfill his job duties. *McAllister v. Illinois Workers' Comp. Comm'n*, 2020 IL 124848, ¶36. Petitioner's job was to inspect properties that had been reported for blight conditions. In order to obtain the list of properties he was assigned to inspect, Petitioner was required to report to his office at Town Hall and sync his cell phone to his computer, then descend the stairs to the main floor and exit the building to pick up his Town vehicle and proceed with the inspections. Petitioner testified that he might return to his office several times a day to obtain additional assignments. Therefore, the Commission finds his conduct in descending the stairs was reasonably foreseeable and incidental to his job as blight inspector. Petitioner's fall down the stairs at the Town Hall occurred in the course of and arose out of his employment.

Moreover, a recent Illinois Supreme Court decision has clarified the circumstances in which an employee's alleged accident is deemed compensable when assessing employment-related risks. The Commission observes that Petitioner slipped and fell on the stairs while descending stairs on the way to his vehicle to perform his off-site blight inspection duties. Accordingly, Petitioner was exposed to a risk distinctly associated with his employment because at the time of the occurrence, he was performing acts that the employee might reasonably be expected to perform incident to his assigned duties as a blight inspector. See *McAllister v. Illinois Workers' Compensation Comm'n*, 2020 IL 124828, ¶ 46 (citing *Caterpillar Tractor v. Industrial Comm'n*, 129 Ill. 2d 52, 58 (1989)). Moreover, "[w]here the claimant's injury was sustained as a result of the condition of the employer's premises, [our supreme] court has consistently approved an award of compensation." *Archer Daniels Midland Co. v. Industrial Comm'n*, 91 Ill. 2d 210, 216 (1990); see also *Dukich v. Illinois Workers' Comp. Comm'n*, 2017 IL App (2d) 160351WC, ¶ 40 (and cases cited therein); *Mores-Harvey v. Industrial Comm'n*, 345 Ill. App. 3d 1034, 1038 (2004) (and cases cited therein); *cf. Chicago Tribune Co. v. Industrial Comm'n*, 136 Ill. App. 3d 260, 264 (1985) (affirming award of benefits for claimant who was injured while walking through a gallery owned by the employer which claimant was required to traverse in order to get to her work station even though the gallery was open to the general public, and stating that "[i]t is difficult to see how the [employer] can escape liability by exposing the public to the same risks encountered by its employees").

Like the claimant's actions in *McAllister* that were found to be incidental to his employment and reasonably foreseeable in the fulfillment of his assigned job duties, the Commission finds that Petitioner's actions descending the particular stairs for the express purpose of fulfilling his off-site blight inspector duties were incidental to his employment and reasonably foreseeable. Having determined that the accident occurred both in the course of and arose out of his employment with Respondent, the Commission finds Petitioner's accident compensable. The Arbitrator's finding to the contrary is reversed.

Because the Arbitrator found that Petitioner had failed to prove that his accident arose out of his employment, medical expenses, prospective treatment, and temporary total disability were not considered in his decision. The Commission notes that on the Request for Hearing the parties

stipulated that if any medical bills were awarded, Respondent shall pay those charges directly to the providers pursuant to the fee schedule. Attachment A to the Request for Hearing lists a total of $62,231.04 in outstanding medical bills, and the Commission finds that Respondent is liable for all reasonable and necessary medical expenses, as listed in Attachment A, at the fee schedule rate, with Respondent to receive §8(j) credit for any payments by group health insurance. Also on the Request for Hearing is the parties' agreement on the duration of Petitioner's temporary total disability, 3 and 1/7ths weeks. As the Commission has determined that Petitioner's accident is compensable, Respondent is liable for 3 and 1/7ths weeks of temporary total disability.

Additionally, Petitioner seeks prospective medical treatment. Dr. Chudik has recommended bilateral shoulder surgery to repair the tears caused by Petitioner's work accident. Respondent did not dispute the reasonableness and necessity of this treatment and based its argument solely on liability. The Commission finds that Respondent should authorize and pay for the shoulder surgeries recommended by Dr. Chudik, as well as any medications prescribed by Dr. Derani for the treatment of Petitioner's work-related headaches.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on February 3, 2020, is hereby reversed. The Commission finds Petitioner sustained an accident on July 2, 2018 that arose out of and in the course of his employment, and Petitioner proved by a preponderance of the evidence that his current condition of ill-being is causally related to the accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the reasonable and necessary medical expenses incurred for treatment and listed in Petitioner's Exhibit 8, as provided under Section 8(a) and Section 8.2 of the Act. Pursuant to the parties' stipulation at arbitration, the Respondent should pay the providers directly.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary total disability benefits in the amount of $930.11 per week for 3 and 1/7ths weeks, commencing July 3, 2018 through July 24, 2018, as provided under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the bilateral shoulder surgeries recommended by Dr. Chudik and the medications for the treatment of headaches prescribed by Dr. Derani, as provided under Section 8(a) and Section 8.2 of the Act.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that 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.

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.

July 16, 2021

/s/ *Marc Parker*
Marc Parker

MP:dk

O-05/20/21
068

/s/ *Barbara N. Flores*
Barbara N. Flores

/s/ *Christopher A. Harris*
Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC008179
Case Name	OSBORNE,JAWAUN v. COLUMBUS MANOR
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) Remanded Arbitration
Decision Type	Commission Decision
Commission Decision Number	21IWCC0301
Number of Pages of Decision	15
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Richard Victor
Respondent Attorney	ANDREA CARLSON

DATE FILED: 6/16/2021

/s/ Thomas Tyrrell, Commissioner

Signature

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

Jawaun Osborne,

Petitioner,

vs. NO: 18 WC 8179

Columbus Manor,

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 causation, temporary total disability, medical expenses and prospective medical treatment, affirms the Decision of the Arbitrator, with changes as stated herein, said decision being attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission notes a scrivener's error in the Decision of the Arbitrator at p.5, paragraph 3 wherein it was noted that "[o]n February 2018, Petitioner returned to Dr. Giannoulias …" The Commission hereby corrects this to show that "[o]n February 18, 2019, Petitioner returned to Dr. Giannoulias…"

All else is otherwise affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed 7/20/20, is hereby affirmed and adopted with changes as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $308.00 per week for a period of 83-5/7 weeks, from 3/1/18 through 10/9/19, 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 $16,027.00 for reasonable and necessary medical expenses under §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall authorize and pay for the prospective medical treatment and medical expenses associated with the arthroscopic Bankart repair surgical procedure prescribed by Dr. Giannoulias, pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons of 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 $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.

June 16, 2021

/s/ *Thomas J. Tyrrell*
Thomas J. Tyrrell

TJT: pmo
o 4/20/21
51

/s/ *Maria E. Portela*
Maria E. Portela

/s/ *Kathryn A. Doerries*
Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0301
NOTICE OF 19(b) ARBITRATOR DECISION

OSBORNE, JAWAUN Case# **18WC008179**
Employee/Petitioner

COLUMBUS MANOR
Employer/Respondent

On 7/20/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1920 BRISKMAN BRISKMAN & GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

5001 GAIDO & FINTZEN
BRITTNEY MANSFIELD
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

J. Osborne v. Columbus Manor, 18 WC 08179

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)1 8)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Jawaun Osborne
Employee/Petitioner
v.
Columbus Manor
Employer/Respondent

Case # **18** WC **08179**

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 **3/13/2020**. 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

J. Osborne v. Columbus Manor, 18 WC 08179

FINDINGS

On the date of accident, **2/28/18**, 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 **$24,024.00**; the average weekly wage was **$462.00**.

On the date of accident, Petitioner was **30** 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 **$16,671.96** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$16,671.96**.

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 $16,027.00, as provided in Sections 8(a) and 8.2 of the Act and as is set forth below.

Respondent shall pay Petitioner temporary total disability benefits of $308.00/week for 83-5/7TH weeks, commencing 3/1/18 through 10/9/19, as provided in Section 8(b) of the Act.

Respondent shall authorize and pay for the Arthroscopic Bankart Repair surgical procedure offered by Dr. Giannoulias and the associated medical expenses, pursuant to 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

July 17, 2020
Date

ICArbDec19(b)

JUL 20 2020

FINDINGS OF FACT

On March 13, 2020, the arbitration hearing was conducted pursuant to Section 19(b) of the Act with the Petitioner as the only testifying witness. Petitioner and Respondent were represented by counsel. The disputed issues were causal connection to current condition of ill-being, medical bills, temporary total disability, and prospective medical.

Petitioner testified that he had worked at Respondent's facility as a security supervisor for two and a half years. He would oversee the facility on the second shift. If a resident acts out, it was his job duty to bring the resident to the nurse's station for the required treatment.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on February 28, 2018. Petitioner was called to assist a nurse with an aggressive resident. While he was walking with the patient, the patient attacked Petitioner as they approached the nurse's station. Petitioner raised his left arm defensively to protect his face and the resident took his left wrist and pushed it back. Petitioner immediately heard and felt a pop and felt the dislocation of his left shoulder. Accident is not in dispute. [T 9-10; Arb.X 1]

Petitioner testified that he had experienced a prior dislocation of his left shoulder in June 2010, from a boxing/ horseplay incident, for which he saw a physician three times during the course of approximately three months in 2010. He did not receive physical therapy, injections nor surgery. Petitioner testified he recovered completely. He had no pain and no further dislocations, injuries, or treatment to his left shoulder from 2010 until the work accident of February 28, 2018. Petitioner testified that following the February 28, 2018 work accident, he had significant pain and instability in his left shoulder, much worse than after the 2010 incident. [T 11-13]

Petitioner was seen at Rush Oak Park Hospital within a half hour after the February 28, 2018 accident, where the mechanism of his accident, resulting symptoms, and prior dislocation were noted (PX1). On March 9, 2018, upon referral by his attorney, Petitioner then sought treatment at Illinois Orthopedic Network (ION). [T 13]

Petitioner was initially seen at ION by Dr. Sompali, who placed a total work restriction and prescribed an MRI which was done on March 16, 2018, physical therapy and medication. Petitioner was then seen by Dr. Giannoulias at ION on April 4, 2018. Dr. Giannoulias diagnosed Petitioner with an anterior torn labrum and dislocation. Petitioner received an injection on June 6, 2018, after experiencing increased pain when he inadvertently caught a ball with his left hand on May 27, 2018. [T 14, 30]

On July 18, 2018, Dr. Giannoulias prescribed a surgical repair for the dislocation. Petitioner testified that at that time, he did not want to undergo surgery [T15], as he had to care for his daughter and had no one to care of her. Petitioner was in physical therapy at ION from March 15, 2018 to June 20, 2018. On September 26, 2018, Dr. Giannoulias placed a 10-pound lifting restriction, with no overhead work[(PX2,4,5,6]. Petitioner testified that, after Dr. Giannoulias released him to return to work with restrictions, he engaged in an unsuccessful job search effort as Respondent had no work available. He memorialized the search activities on job search lists from October 23, 2018 through February 8, 2019 [PX9, T 15-17, 19]. Petitioner was paid TTD during this time period.

Petitioner testified that his left shoulder symptoms continued. He returned to Dr. Giannoulias on February 18, 2019, receiving a full-duty release as of February 27, 2019. He was still in pain and his shoulder was not "right" at that time. [T19] Petitioner testified his symptoms continued, and on March 11, 2019 he returned to

Dr. Giannoulias, again receiving work restrictions and an order for an FCE, performed on April 11, 2019, which again placed work restrictions. Petitioner testified that he experienced another dislocation to his left shoulder. While reaching above his home refrigerator, his shoulder just popped out. Petitioner then returned to Dr. Giannoulias on June 12, 2019. Dr. Giannoulias placed a total work restriction and ordered an MRI, showing a chronic Hill-Sachs lesion and Bankart tear. [PX2, T 19, T 44]

On June 27, 2019, Dr. Giannoulias, again prescribed an arthroscopy and Bankart repair, reiterating this prescription on August 22, 2019. Petitioner testified that due to the continuing severe pain and instability, he wanted the surgery prescribed by Dr. Giannoulias [T21, PX2,7].

Petitioner was authorized off work and did not work until he started working full at Invictus Security Services on October 10, 2019, as a watchman making $25.00/hour. His job does not require physical work. He merely observes, he watches. He was still working for Invictus at the time of the hearing. He has not had any other incidents, accidents or dislocations since the reaching above the refrigerator incident at home. [T 21-22]

On cross examination, Petitioner clarified that his job duties as security supervisor involved bringing only the unruly or upset residents to the nurse's station for injections and medications. Petitioner's job duties did not regularly involve lifting but he did regularly deal with handling upset, unruly and aggressive Residents. On the day of the accident, Petitioner was informed that the Resident who caused him injury was upset, not unruly. Petitioner was trained on how to handle patient/residents. The training consisted to call for a code and to pin and restrain the resident down to the floor. [T 25-26]

At the time of the hearing, Petitioner continued to experience instability, weakness and severe pain with movement of the left arm or lifting with his left arm. He avoids lifting with his left arm in order to avoid pain and because he anticipatorily fears that it will pop out again. Thus, he compensates with his left shoulder instability by using his right arm more than his left. [T 23-24]

On cross examination, Petitioner testified that he sought medical treatment at Rush University Hospital less than 30 minutes after his work injury. He was advised that he diagnosed with a left shoulder dislocation. He was ordered to be off work and see an orthopedic surgeon. When asked if Rush referred him to Illinois Orthopedic Network [ION] or if he was self-referred, Petitioner testified that his attorney referred him to ION. [T 25-26]

On cross examination, Petitioner testified that he received the recommended physical therapy. Physical therapy improved his pain but not completely. He was given restrictions. He did not recall off the top of his head exactly what the restrictions were at the time, but he thought it was no lifting over 20 pounds. His job at Columbus Manner required him to lift more than 20 pounds. His pain improved with therapy. The pain did go down but not completely down. So, Petitioner disagreed with the statement that he had made excellent improvement by May 2018 or that surgery could be avoided. [T 27-29]

Petitioner testified on cross examination that he told the physical therapist of experiencing increased pain in his left shoulder when he accidently caught a ball with his left hand while playing catch on May 27, 2018. Petitioner testified that he was not intending to play catch using his left hand. He was not using his left arm while playing catch. The ball came to him and he just reached and caught it in a reflexively. He did not fear injuring his left shoulder playing catch, because it was his intent to only use his right arm. [T 30- 32]

Petitioner testified on cross examination that he did not tell Dr. Giannoulias at his June 6, 2018 appointment that he experienced increased pain after the playing catch incident. He thought it was charted in his therapy notes

and that Dr. Giannoulias already knew when he reviewed the charted therapy notes. He assumed that Dr. Giannoulias had read his chart. [T 33-34]

Petitioner testified on cross examination that he could not have surgery in June 2018 because he was just getting custody of his daughter and had no one to take care of her. Also, he wanted to give his shoulder more physical therapy in the hope of avoiding surgery. He testified that the additional physical therapy did not help. His shoulder symptoms remained the same. [T 35

On September 26, 2018, Dr. Giannoulias' PA gave him restrictions which he believed based on his recollection to be no pushing, pulling, no over the shoulder lifting and no lifting more than 40 pounds. Petitioner testified that his shoulder felt stable. Petitioner then returned to work in October. He did not seek treatment nor receive treatment between September 26, 2018 and February 18, 2019 because he was waiting for surgery to be authorized. During that time period he did not work and was studying for another job. [T 35- 37]

On February 2018, Petitioner returned to Dr. Giannoulias after having been released to return to work by Respondent's examining physician. Petitioner wanted to get pain medication so he could work and to check up on surgery. Somehow, he got released to full duty. On March 11, 2019 he was placed on restrictions. [T 37-40]

On cross examination, Petitioner testified that the dislocated his left shoulder in June 2010 while doing horse play boxing. He did not go to physical therapy. The doctor just checked out his shoulder a couple times. He had no other accidents or dislocations from June 2010 to February 28, 2018. When asked how the February 2018 dislocation was different from the 2010 event, Petitioner testified that his shoulder was not loose after the 2010 dislocation but has remained unstable after the 2018 work accident. For example, Petitioner testified that when he is riding on a bus, he can feel his shoulder move back and forth because it is loose. [T 40-41]

On March 6, 2019, Petitioner was examined by Dr. Balaram at Respondent's request pursuant to Section 12 of the Act. Dr. Balaram informed him that he released him back to work. Petitioner informed Dr. Balaram of his June 2010 dislocation as well as Dr. Giannoulias. Petitioner did not believe that his shoulder had healed because it had not returned to the pre-accident baseline. His shoulder remained unstable. He did not return to work for the Respondent because he was informed by the Respondent that they did not have any work for him. [T 42-43]

Petitioner testified on cross examination that he experienced difficulties completing certain activities during the functional capacity evaluation. During the FCE, he had trouble with any lifting or pushing down movements with his left arm, such as getting up off the floor or crawling. [T 43]

Petitioner testified that he has been able to perform his activities of daily living such as grocery shopping, cooking, cleaning, and taking care of his daughter. He is able to pick up his daughter who weighs approximately 30 pounds. He was able to do so with the use of his right hand and avoiding lifting with his left arm. He further testified that he has not had any treatment for approximately six months, or since August of 2019 [T 44-45, 53-54]

On redirect examination, Petitioner testified he still wants to have the recommended surgery. He has continuously wanted surgery other than the first time it was recommended. [T-46-47] He testified that he wants the surgery, because although the instability and pain improved with physical therapy, it has not gone away. He still experiences pain and instability. He has not had the surgery because he does not have a way to pay for it. Petitioner has been working and performing his activities of daily living by compensating with the use of his right arm. [T 47-52]

Dr. Giannoulias testified that Petitioner's left shoulder dislocation and labrum tear as seen on multiple MRI's, suffered in the February 28, 2018 accident, was causally related to that accident as a permanent aggravation. Dr. Giannoulias testified his opinion was based on the documented eight-year gap between the 2010 incident and the February 28, 2018 accident, without any further dislocations, treatment, or symptoms in the interim. Dr. Giannoulias testified that Petitioner's young age made him more prone to subsequent dislocations, and that the dislocation suffered at home in June of 2019 did not break the causal connection link and, rather, was a consequence and sequalae to the February 28, 2018 work accident. Dr. Giannoulias testified that for these reasons he disagreed with the opinions of Respondent's examining physician, Dr. Balaram, and that Petitioner had not returned to his baseline condition. Thus, Dr. Giannoulias testified that Petitioner's condition, need for surgery, and inability to work were causally related to the February 28, 2018 accident [PX8].

Petitioner testified that he was off work from March 1, 2018 through October 9, 2019. Petitioner testified that on October 10, 2019, he found full-time employment with Invictus Security Services as a "watchman", observing only and with no lifting. Petitioner testified that he has had no other injuries to his left shoulder. Petitioner testified he continues to have severe pain instability, and weakness in his left shoulder on raising his left arm up and down or reaching overhead. Petitioner takes non-prescription medications for some relief. As a result of these symptoms, Petitioner wants the prescribed surgery, for which he has no other method to pay.

Petitioner appeared for a Section 12 Medical examination by Dr. Balaram on March 6, 2019 at Respondent's request. Dr. Balaram reviewed the MRI and medical records regarding Petitioner's left shoulder. He also completed a physical examination of Petitioner. Dr. Balaram's report noted that Petitioner's symptoms were consistent with recurrent dislocation and shoulder instability. The report further stated that Petitioner had returned to his baseline position after opting for non-surgical treatment. Dr. Balaram opined that the Petitioner experienced a temporary aggravation of his left shoulder underlying condition and any additional treatment is related to the 2010 left shoulder dislocation. Dr. Balaram noted that Petitioner was able to return to full duty work as he had healed to the same baseline position that he was in prior to the February 28, 2018 left shoulder dislocation. [RX 3]. Dr. Balaram testified that the left shoulder dislocation that occurred in February 2018 caused a temporary aggravation of the Petitioner's left shoulder condition given the recurrent dislocations. Appropriate medical treatment was rendered to date at the time of the March 6, 2019 examination. The treatment returned Petitioner to his baseline position of being prone to having further dislocations in the future as that is the natural progression of patients that have a single dislocation prior in their life. Dr. Balaram testified that Petitioner had reached his baseline, pre-injury condition of the left shoulder since he should have healed appropriately as he was one-year post incident with no additional dislocations. Any surgical recommendation would be attributed to the 2010 left shoulder dislocation, if that was the first shoulder dislocation, and the surgery would consist of left shoulder stabilization. However, Dr. Balaram refused to comment on the need for surgery in Petitioner's case. [RX 4, p. 21].

A Functional Capacity Evaluation was completed on April 2, 2019 at ION. The FCE report notes that left arm lifting should be limited to 47.5 pounds and left arm carrying should be limited to 37 pounds. There were also notations that Petitioner is limited by pain as well as weakness. On April 11, 2019, Petitioner returned to Dr. Giannoulias and permanent restrictions consistent with the FCE were imposed. The permanent restrictions consisted of no carrying, pushing, pulling, or lifting more than 50 pounds. Petitioner then returned to Dr. Giannoulias on June 12, 2019 because he was reaching for something above the refrigerator the day before and his left shoulder dislocated. It was noted that Petitioner was discharged from care on April 11, 2019. Petitioner was able to relocate the shoulder and the emergency room records confirmed that the left shoulder had been successfully reduced. An MRI of the left shoulder was ordered, and Petitioner was advised to continue wearing a sling for two weeks. Petitioner was given off work restrictions. [PX2] Petitioner testified that he was never discharged from care by Dr. Giannoulias. He was released, PRN. He understood that to mean that he may

come back. Petitioner also testified that he was not horse playing or playing catch right before the left shoulder dislocated during this incident. [T49-51]

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 or her 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)

The Arbitrator who had opportunity to view Petitioner's demeanor under direct examination and under cross-examination. The Arbitrator evaluated the testimony of the Petitioner in consideration of all the evidence in the record. The Arbitrator finds that Petitioner was a credible witness. The Arbitrator notes that Petitioner's testimony was corroborated by and consistent with the medical records.

In support of the Arbitrator's decision relating to whether Petitioner's condition of ill-being is causally connected to the accident ("F"), the Arbitrator finds:

Petitioner's current condition of ill-being is causally connected to the accidental injuries sustained on February 28, 2018. The Arbitrator does not agree with Respondent's allegation that Petitioner only sustained a temporary aggravation of a pre-existing condition; a temporary aggravation that lasted for the period of March 1, 2018 through March 25, 2019 and then returned to a pre-accident baseline. (Arb.X1)

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine the weight to give to testimony, and resolve conflicts in evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill.2d 401, 406-07 (1984); *Hostney v. Illinois Workers' Compensation Comm'n*, 397 Ill.App.3d 665, 675 (2009). Not only may the Commission decide which medical view is to be accepted, it may attach greater weight to the opinion of the treating physician. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. 3d 225 (1992).

The Arbitrator finds Petitioner's testimony, and the testimony and opinions of Dr. Giannoulias to be more persuasive than those of Respondent's examining physician Dr. Balaram. This finding is based on Petitioner's consistent clinical and diagnostic findings and the lack of any documented symptoms, treatment, or dislocations or other injuries to the left shoulder between 2010 and the February 28, 2018 work accident. Petitioner worked for the Respondent for two and half years, restraining aggressive patients without incident, until the accident of February 28, 2018. Therefore, the Arbitrator finds Petitioner's current left shoulder

condition to be causally related to the February 28, 2018 accident as a permanent aggravation in that surgery is required to repair his injured shoulder.

Dr. Giannoulias and Dr. Balaram both agree that generally a person is more prone to experience additional shoulder dislocations after the initial dislocation. The younger the person is, the more likely additional shoulder dislocations will occur. Dr. Balaram and Dr. Giannoulias both agree that the February 28, 2018 work incident was an aggravation of an underlying preexisting condition, given the previous 2010 left shoulder dislocation. Dr. Balaram does not provide a satisfactory explanation for the undisputed eight-year gap. Dr. Giannoulias does. The February 2018 accident was an aggravation of Petitioner's pre-existing asymptomatic condition. And, as Dr. Giannoulias explained, the February 2018 work accident weakened his shoulder and caused it to be unstable. Petitioner consistently complained of instability after the work-related accident. Whereas Dr. Balaram opined that Petitioner's apprehension or fear of another dislocation was subjective, it was not. The two subsequent incidents occurring while performing ordinary activities of daily living are factually juxtaposed to Dr. Balaram's view. It is well settled that when a claimant's condition is weakened by a work-related accident, a subsequent accident that aggravates the condition does not break the causal chain. *Vogel v. Ind. Comm'n*, 354 Ill.App.3d 780 (2005)

Petitioner did not wish to undergo surgery for the left shoulder until June 2019, after Petitioner playing catch and inadvertently catching the ball with his left hand. This rather insignificant event caused increased pain in May 2018. He also experienced an additional left shoulder dislocation in June 2019 while simply reaching above a refrigerator at home. His delay in agreeing to undergo surgery is understandable. Petitioner was hoping to get better with conservative treatment, a treatment plan Dr. Giannoulias found to be reasonable. Also, Petitioner frankly stated that he had just acquired custody of daughter and, thus, was not in position to conveniently undergo surgery. The Arbitrator finds Petitioner's conduct to be understandable and reasonable. The Arbitrator finds that the February 28, 2018 accident weakened his shoulder and the two subsequent incidents did not break the causal chain.

The "chain of events" legal theory also supports a finding of causation. It well established under the law that a prior condition of good health followed by a change immediately following an accident allows an inference that a subsequent condition of ill-being is the result of the accident. *Navistar International Transportation Co. v. Industrial Comm'n*, 315 Ill. App.3d 1197, 1205 (2000). An accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. *Int'l Harvester v. Indus. Comm'n*, 93 Ill. 2d 59, 63-64 (1982).

Dr Giannoulias endorsed this theory. In this case, the evidence clearly shows that Petitioner had a prior dislocation eight years before the accident. The preexisting condition was asymptomatic for eight years and did not prevent Petitioner from performing his usual work duties in an unrestricted manner. It did not prevent him from physically restraining acting out residents for the two- and one-half years in which he worked for Respondent until his February 28, 2018 accident. The evidence reflects that Petitioner had no treatment regarding his left shoulder for eight years prior to the accident. Petitioner took no pain medication for his shoulder for eight years prior to the accident. Respondent's wage statement for the year preceding the accident supports that Petitioner worked for at least one year, full-time, without missing work. (RX1).

Petitioner was in a condition of "good health" relating to his shoulder prior to February 28, 2018 as is evidenced by Petitioner's credible testimony, his ability to work full-time and full duty, and, the total absence of any credibility medical evidence to the contrary, and then followed by unstable and painful shoulder immediately following the accident.

The Parties stipulated that Petitioner sustained accidental injuries to his left shoulder on February 28, 2018. The injuries have not abated or subsided. The medical records demonstrate that Petitioner's injury resulted in medical treatment and subsequent disability. There is no credible evidence of any other trauma to Petitioner's left shoulder between the June 2010 horseplay boxing injury and his February 2, 2018 work accident.

Petitioner experienced a left shoulder dislocation in 2010. Dr. Giannoulias and Dr. Balaram have testified that a person is more prone to experience additional shoulder dislocations after the initial dislocation. The younger the person is, the more likely additional left shoulder dislocations will occur. Dr. Balaram and Dr. Giannoulias both agree that the February 28, 2018 work incident was an aggravation of an underlying preexisting condition given the previous 2010 left shoulder dislocation. Dr. Balaram opined it was just a temporary condition. Dr. Giannoulias disagrees. The evidence supports Dr. Giannoulias opinion. Petitioner did not wish to undergo surgery on his left shoulder until June 2019, after Petitioner had been playing catch which caused increased pain in May 2018 and experienced an additional left shoulder dislocation in June 2019 while reaching above a refrigerator at home. The two subsequent events support Petitioner's claims of experiencing instability in his left shoulder post-accident.

The Arbitrator finds that there has been no superseding, intervening accident to break the chain of causation. Therefore, based on the foregoing, the Arbitrator concludes that Petitioner's current condition of ill-being relative to his left shoulder is causally connected to the accidental injuries sustained on February 28, 2018.

In support of the Arbitrator's decision relating to the medical expenses ("J"), the Arbitrator finds:

Based on the Arbitrator's findings regarding causal connection and the opinion of Respondent's expert that the treatment received was appropriate, the Arbitrator awards the following medical expenses pursuant to §§8(a) and 8.2 of the Act:

PX 3	Illinois Orthopedic Network:	$2,965.30
PX 4	Midwest Specialty Pharmacy:	$6,348.00
PX 5	Berwyn Diagnostic Imaging:	$1,950.00
PX 6	Premier Healthcare Services:	$3,263.66
PX 7	Preferred Open MRI:	$1,500.00
	Total:	**$16,027.00**

Respondent is entitled to a credit for all awarded bills that it has paid or satisfied.

In support of the Arbitrator's decision relating to prospective medical care ("K"), the Arbitrator finds:

The Arbitrator places greater weight on the findings and opinions of Dr. Giannoulias as to Petitioner's need for surgery than that of Dr. Balaram, and, thus, finds him to be more persuasive than Dr. Balaram. Dr. Giannoulias' records and opinions consistent with, and corroborated by, the evidence. His findings and opinions are concise and clearly explain why the offered surgery is medically reasonable and necessary.

Conservative treatment failed to render Petitioner's left shoulder stable and pain free. Surgery would make it so. Dr. Balaram, on the other hand, declined to render an opinion on the need for surgery.

Based on the Arbitrator's finding regarding causal connection, the Arbitrator orders Respondent to authorize and pay the medical costs of the Arthroscopic Bankart Repair surgical procedure prescribed by Dr. Giannoulias and any associated medical expenses, pursuant to §§8(a) and 8.2 of the Act.

In support of the Arbitrator's decision relating to the period of temporary total disability ("L"), the Arbitrator finds:

Petitioner claims to be entitled to TTD for the period of March 1, 2018 through October 9, 2019. Respondent disagrees and claims that Petitioner was temporarily totally disabled for the period from March 1, 2018 through March 25, 2019.

The Arbitrator notes Petitioner was engaged in an unsuccessful job search from October 23, 2018 through February 8, 2019, for which he would be entitled to maintenance benefits. The Arbitrator will not disturb the Parties' stipulated classification of the undisputed temporary benefit period. It does not change the outcome of any lost time benefits to be awarded. (Arb. Exhibit 1, PX9, T 16-17, 19).

Furthermore, Respondent claims, and Petitioner agrees, that Respondent paid temporary total disability benefits for said period in the amount of $16,671.96. Thus, the temporary totally disability period at issue is from March 26, 2019 through October 9, 2019. Based on the Arbitrator's findings regarding causal connection, medical expenses, prospective medical treatment and the stipulated TTD period, the Arbitrator finds Petitioner was temporarily and totally disabled from work from from March 1, 2018 through October 9, 2019 and awards 83-5/7th weeks temporary total disability benefits.

Respondent shall pay Petitioner temporary total disability benefits of $308.00 /week for 83-5/7th weeks, commencing 03/01/2018 through 10/09/2019, as provided in §8(b) of the Act. Respondent is, of course, entitled to a credit for all compensation benefits paid.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC004816
Case Name	CHEN, MEICHANG, Widow of CHANGZHI QIU (deceased), and as Mother and Next of Kin of Celinda Qiu, Minor Child of Changzhi Qiu (deceased), and Rong Qiu, Daughter of Changzhi Qiu (deceased) v. ZHIU YI MEI, individually and dba ZHIU YI CORP dba SEE THRU CHINESE KITCHEN #21
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0302
Number of Pages of Decision	12
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Frank Sommario
Respondent Attorney	Will Dimas

DATE FILED: 6/17/2021

/s/Kathryn Doerries, Commissioner

Signature

21IWCC0302

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 Choose direction	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHEN, MEICHANG, Widow of
CHANGZHI QIU (deceased), and as
Mother and Next of Kin of Celinda Qiu,
Minor Child of Changzhi Qiu (deceased),
and Rong Qiu, Daughter of Changzhi Qiu (deceased),

Petitioner,

vs. NO: 15 WC 04816

ZHIU YI MEI, individually and
d/b/a ZHIU YI CORPORATION, d/b/a
SEE THRU CHINESE KITCHEN #21, and
STATE OF IL TREASURER and
EX-OFFICIO CUSTODIAN OF
INJURED WORKERS' BENEFIT FUND, et. al,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, benefit rates, employment, medical expenses, notice, permanent disability, penalties and attorney's fees, rate adjustment fund, and payment pursuant to §9, 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 affirms and adopts the Arbitrator's Decision in its entirety except with regard to the Decedent's marital status. The Commission views the evidence relative to Decedent's marital status differently than the Arbitrator. The Commission finds that the evidence on the death certificate and the Illinois Court of Claims Opinion filed on June 23, 2015, are

persuasive and sufficient to establish that the deceased, Changzhi Qiu, was married to Meichang Chen on the date of his death.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision filed on March 16, 2020, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner failed to prove an employee-employer relationship existed between Decedent and Respondent and failed to prove that an accident occurred that arose out of and in the course of Decedent's employment with Respondent, therefore, all benefits are denied.

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

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

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. As there are no monies due and owing, there is no bond set by the Commission 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.

June 17, 2021

/s/*Kathryn A. Doerries*
Kathryn A. Doerries

KAD/bsd
O042021
42

/s/*Thomas J. Tyrrell*
Thomas J. Tyrrell

/s/*Maria E. Portela*
Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
FATAL

21IWCC0302

MEICHANG, CHEN ET AL Case# **15WC004816**

Employee/Petitioner

ZHIU YI MEI ET AL

Employer/Respondent

On 3/16/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.40% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1993 ROMANUCCI & BLANDIN LLC
FRANK A SOMMARIO
321 N CLARK ST SUITE 900
CHICAGO, IL 60654

0000 ZHIU YI MEI INDIVIDUALLY AND
D/B/A ZHIU YI CORP
1065 W ARGYLE ST #2E
CHICAGO, IL 60640

0000 ZHIU YI CORP D/B/A SEE THRU
CHINESE KITCHEN #21
5249 W MADISON ST
CHICAGO, IL 60644

4980 ASSISTANT ATTORNEY GENERAL
COLIN KICKLIGHTER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF **Cook**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
FATAL

Meichang Chen, et al.
Employee/Petitioner
v.
Zhiu Yi Mei, et al.
Employer/Respondent

Case # **15** WC **4816**

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 **Thomas L. Ciecko**, Arbitrator of the Commission, in the City of **Chicago**, on **December 30, 2019**. 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 Decedent's employment by Respondent?

D. ☐ What was the date of the accident?

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

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

G. ☒ What were Decedent's earnings?

H. ☒ What was Decedent's age at the time of the accident?

I. ☒ What was Decedent's marital status at the time of the accident?

J. ☒ Who was dependent on Decedent at the time of death?

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

L. ☒ What compensation for permanent disability, if any, is due?

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

N. ☐ Is Respondent due any credit?

O. ☒ Other **lump sum compensation**

FINDINGS

On the date of accident, **October 31, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Decedent and Respondent.

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

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

Decedent's death ***is not*** causally related to the accident.

In the year preceding the injury, Decedent earned $**5808.00**.

On the date of accident, Decedent was **41** years of age, ***single*** with **2** dependent children.

Respondents, shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**40,000.00** for other benefits, for a total credit of $**40,000.00**.

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

The Arbitrator finds that Decedent died on **October 31, 2014**, leaving two dependent children.

ORDER

Denial of benefits
Because an employee-employer relationship did not exist and because an accident did not occur that arose out of and in the course of Decedent's employment by Respondent, all benefits are denied.

Penalties
No penalties or fees are awarded.

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

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

Signature of Arbitrator

3/16/2020
Date

MAR 16 2020

Meichang Chen, et al. v. Zhiu Yi Mei, et al., No. 15 WC 04816

Preface

This Application seeks compensation for fatal injuries from an employer Respondent and from The Injured Workers' Benefit Fund. The parties proceeded to hearing December 30, 2019, on a Request For Hearing indicating the following disputed issues: whether on October 31, 2014, Petitioner and Respondent were operating under the Illinois Workers' Compensation Act and their relationship was one of employee and employer; whether Petitioner on that date sustained accidental injuries that arose out of and in the course of employment; whether Respondent was given notice of the accident within the time limits stated in the Act; whether Petitioner's current condition of ill-being is causally connected to the injury; whether Petitioner's earnings during the year preceding the injury were $26,150.80, and the average weekly wage, calculated pursuant to Section 10 of the Act was $502.90; whether at the time of injury Petitioner was 41 years old, married with two dependent children; whether Respondent is liable for unpaid medical bills of $5269.89 to Mt. Sinai Hospital; whether Petitioner is entitled to minimum death benefits; what is the nature and extent of the injury; whether Petitioner is entitled to penalties/attorney's fees under Sections 19(k), 19(l), and 16; and whether compensation shall be paid in a lump sum pursuant to Section 9. Chen Meichang, et al., v. Zhiu Yi Mei, et al., Transcript of Proceedings on Arbitration at 5-8; Arbitrator's Exhibit 1; Petitioner's Exhibit 6. Respondent, on three specific issues, not only disputed the issue but "demanded proof." This is becoming a common error, not required or allowed anywhere in any responsive pleading or a Request for Hearing. It appears nowhere in any relevant procedure and is a nullity, of no effect.

Because of the magnitude of issues in this hearing, and the burden on Petitioner to prove all elements of the claim, it is baffling that Petitioner called no witnesses and did not testify.

During the introduction of exhibits on behalf of Petitioner, Petitioner sought to introduce a response to a FOIA request from the Chicago Police Department containing an Original Case Incident Report. Respondent objected and I took the issue under advisement. Petitioner's Exhibit 3; Chen at 22-23. Petitioner did not address the objection in its Proposed Findings of Fact and Conclusions of Law, simply citing to the exhibit as he saw fit as if the objection and concerns of the Arbitrator, or the objection never happened. Respondent likewise did not address the issue. That disregard aside, police reports are generally not admissible in Illinois. Jacobs v. Holley, 3 Ill. App. 3d 762 (1972); Ill. R. Evid. 803(a); S. Ct. Rule 236(b). However, that prohibition seemingly applies to accident reports. This is not an accident report, and so I overrule the objection to Petitioner's Exhibit 3 and it is admitted. As with all exhibits, the question is one of weight.

The only witness who testified was Zhiu Yi Mei, the owner of See Thru Chinese Kitchen, and one of the Respondents in this matter. He testified through a Chinese interpreter.

Findings of Fact

Pursuant to 50 Ill. Adm. Code 9030.90, the parties were asked if they wished to make an opening statement. Petitioner did and referred to his statement as "...the prove up of a death

case...." That term is not found in either the Act or Rules of the Commission. Presumably Petitioner was acknowledging his obligation to prove all the elements of the request for benefits. Respondent IWBF noted the Respondent employer was present. Petitioner's counsel then indicated he had no witnesses and said "...I adopt my opening statement as my proof of the case." It is a universally acknowledged axiom that anything which is said in opening statement is not evidence. This Arbitrator admonished counsel that his opening statement was not evidence, the implication being he may want to rethink what he is doing. He did not ask for a recess to secure witnesses, did not call the employer, and did not seek a recess to attempt to narrow the nearly dozen disputed issues in the case. He simply sought to introduce a number of exhibits. All were admitted except Petitioner's Exhibit 3 which has been addressed above and admitted. With that Petitioner rested. Chen at 11, 18, 18-19, 19-34, 35.

This Arbitrator then acknowledged the presence of Zhiu Yi Mei, the owner of See Thru Chinese Kitchen, and his translator. Mei wanted to testify. Because he was without counsel and obviously not familiar with how to testify, this Arbitrator began the inquiry of Mei. Chen at 35, 37, 38.

Mei testified he is the owner of See Thru Chinese Kitchen. He knew the deceased, he was a relative. [The deceased was Changzhi Qui]. Mei was not present when the accident happened. After the accident, the family of the deceased told him they had *no money* for expenses and so he took $40,000.00 from a bank and paid them cash. He testified he took all the money from the bank and borrowed from friends and family and gave it to decedent's family. Mei said it was all his savings from the 20 plus years since he came to the United States. Mei testified decedent's family asked for $100,000 *in cash* but all he could get was $40,000.00. He said he paid for the funeral expenses and family expenses. Chen at 39-41 (emphasis added); Petitioner's Exhibit 2. At this point I note that in an Opinion of the Illinois Court of Claims, filed June 23, 2015, the Court notes the claimant, Mei Chang Chen, received life insurance benefits of $300,484.93. Petitioner's Exhibit 7. I find Mei credible and a reliable witness.

On cross examination by Petitioner's counsel, Mei testified this happened a few days after the death in 2014. He said he knows decedent died at the restaurant October 31, 2014. He said it had been so long he probably did not have receipts from the withdrawals. Mei testified he gave the money to the decedent's wife. He could not say it was Meichang Chen. Mei testified he had met once or twice with Petitioner's counsel. Chen at 41, 42, 43.

On cross examination by the Attorney General, Mei testified he found out about the murder the same day, from a restaurant employee. He said he was cited by The Insurance Compliance Division and settled a citation for $20,000.00, which has been paid. This Arbitrator then asked whether the money was a loan or gift. Mei testified he was not thinking like that, the family said they needed the money for the funeral and burial. He said he had not gotten any of the money back, that after the tragedy the family did not even talk to him. He said the wife said if she had money, she would pay him back but nothing happened. He is not expecting to get the money back. Chen at 44-47.

The Respondent IWBF called no witnesses and introduced one exhibit. They rested and Petitioner offered no rebuttal. Chen at 47-49.

Conclusions of Law

Disputed issue **A** is was Respondent operating under and subject to the Illinois Workers' Compensation Act. I find, as a conclusion of law, Zhiu Yi Mei and See Thru Chinese Kitchen were operating under and subject to the Act. I rely on the Insurance Compliance Settlement Agreement entered into between the Commission and Mei, which was paid in full March 7, 2017. Respondent's Exhibit 1. Essentially, the Commission has found Mei operating under the Act and he has agreed by the terms of the Settlement.

Disputed issue **B** is was there an employee-employer relationship between the deceased and See Thru Chinese Kitchen.

The Illinois Supreme Court has set forth the path to an analysis of the issue in Roberson v. Industrial Commission (P.I&I Motor Express, Inc.), 25 Ill. 2d 159 (2007). The court stated that an employment relationship is a prerequisite for an award of benefits under the Act and the question of whether a person is an employee remains one of the most vexatious in the law of compensation. The question is a fact specific inquiry. No rule governs all cases. Factors that help to determine when person is an employee are: whether an employee may control the manner in which the person performs the work; whether the employer dictates the person's schedule; whether the employer pays the person hourly; whether the employer withholds income and social security taxes from the person's compensation; whether the employer may discharge the person at will; and whether the employer supplies the person with materials and equipment. Also, a consideration is whether the employer's general business encompasses the person's work. No single factor is determinative, and the significance of these factors will change depending on the work involved. The determination rests on the totality of the circumstances. Id. At 174-75.

Initially I note that despite the relationship being a prerequisite for an award, Petitioner's counsel failed to ask a single question of Mei, the owner of See Thru Chinese Kitchen, about whether Qiu was his employee, nor did he ask questions that would clarify the myriad of disparate documents contained in Petitioner's Exhibit 10. Neither did the Attorney General. Presumably in support of this issue, Petitioner submitted a dog's breakfast of exhibits containing: a W-2 from 2014 for Changzhi Qiu from See Thru Kitchen; a W-2 from 2014 to Chang Zhi Qiu from Long Tung Inc.; a W-2 from 2014 from China Garden Chinese Restaurant Inc. to Chang Zhi; a check dated February 27, 2014, from Long Tung Inc. to Chang Zhi Qiu in the amount of $627.16 and a duplicate of that check later in the exhibit; a check dated April 30, 2014, from Zhiu Yi Corporation to Chang Zhi Qiu in the amount of $627.16 and a duplicate of that check later in the exhibit; a check dated May 31, 2014, from Zhiu Yi Corporation to Chang Zhi Qiu in the amount of $627.16 and a duplicate of that check later in the exhibit; a check dated June 30, 2014, from Zhiu Yi Corporation to Chang Zhi Qiu in the amount of $627.16 and a duplicate of that check later in the exhibit; a check dated October 31, 2014, [the date of death] to Chang Zhi Qiu in the amount of $627.16, and a duplicate of that check later in the exhibit, and yet another duplicate of that check even later in the exhibit; a W-2 from 2013 to Chang Zhi Qiu from Long Tung Inc., and a duplicate of that W-2 later in the exhibit; a W-2 from 2013 to Chang Zhi from China Garden Chinese Restaurant Inc.; a document from Ivy Garden Learning Center dated August 1, 2014, indicating an amount due from Lam Qiu in the amount of $210.00. Petitioner's Exhibit 10. There is no indication any of the checks were given to the deceased or cashed,

certainly not the one issued on the date of death. There is no evidence of any relationship to this Application by China Garden Chinese Restaurant, or Long Tung Inc., and no testimony to support their relevance. I note Mei could have been asked any number of questions about these entities and their relation to the deceased. Moreover, Mei could simply have been asked, by either party who examined him, whether the deceased was an employee of his, what was his job, and whether he was working on the day he was killed. Without any evidence on the significance of these disparate documents, they have no weight on this issue. As an aside, the submission of so many duplicate financial documents, which appear to add bulk, or weight to the exhibit, along with the lack of context, is troubling.

Surprisingly, Mei only testified decedent was a relative who died in the restaurant. Chen at 39, 42. There was no testimony by the owner of See Thru Chinese Kitchen, and relative of the decedent, that the decedent was an employee. No one asked him. There is only a W-2 from 2014 for Chagzhi Qiu that indicates income and social security taxes were withheld. No other Roberson factor was addressed by any party. The totality of the factors leads to Petitioner's failure to sustain his burden to prove all elements of the claim, here that an employee-employer relationship existed on the date of the accident. Relying only on a single W-2 for 2014 is too thin to find a relationship. Because of the failure of Mei to identify the decedent as an employee, I give no weight to the contents of the Chicago Police Department Original Case Incident Report listing See Thru Chinese Kitchen as the employer, as the Officers did not indicate the source of that representation. I also give no weight to the notation Officers "...were informed that a worker at the restaurant had been shot...." There is no indication who informed them. Without that, there can be no indicia of reliability. The Report is poorly written and lacks complete contents and context. Again, Mei did not testify decedent was an employee. Neither party asked him. I also note the records of Mt. Sinai Hospital do not identify an employer of the then patient.

Disputed issue **C** is whether an accident occurred that arose out of and in the course of Decedent's employment by Respondent. Even if the paucity of evidence could be cobbled together to support an employee-employer relationship, the Application runs squarely into this issue.

An employee's injury is compensable under the Act only if it arises out of and in the course of the employment. Both elements must be present at the time of the claimant's injury in order to justify compensation. Injuries sustained on an employer's premises and while a claimant is at work are generally deemed to have been received in the course of employment. Arising out of the employment refers to the origin or cause of the claimant's injury. For an injury to arise out of the employment, its origin must be in some risk connected with, or incidental to the employment so as to create a causal connection between the employment and the accidental injury. There are three types of risk which an employee might be exposed to: risks distinctly associated with the employment; risks that are personal to the employee; and neutral risks which have no particular employment or personal characteristics. Potenzo v. Illinois Workers' Compensation Commission, 378 Ill. App. 3d 113, 116 (2007).

Here the only testimony as to the injury came from Mei, and it is thin. He said decedent was a relative who died in the restaurant.

The Office of the Medical Examiner of Cook County, Illinois concluded the decedent, Changzhi Qiu died of multiple gunshot wounds. Petitioner's Exhibit 5.

The Illinois Court of Claims found, in awarding compensation under the Crime Victims Compensation Act, that the decedent was the victim of a violent crime, First Degree Murder. Petitioner's Exhibit 7.

The Chicago Police Report is sparse to say the least. The little that can be gleaned from the mass of police officers at the scene after the shooting is that a witness, a female white Hispanic, stated she was picking up food at the See Thru Chinese Kitchen when she saw an unknown someone say something to the decedent, who then turn and ran. The unknown someone fired two shots at the decedent from a handgun and fled the restaurant. Police found the decedent in the back of the restaurant, unresponsive and shot in the upper left back. The offender was not identified. Petitioner's Exhibit 3. There is no evidence of a robbery, or property removed from the restaurant or decedent. There is no evidence why the decedent was shot. No evidence was offered this was a high crime area or otherwise dangerous neighborhood. Mei was not asked about any of this by either party. No one but the decedent was shot, and only after the offender spoke to him and decedent ran away. That seems circumstantial evidence that the altercation was personal between the decedent and offender. It is Petitioner's burden to show the assault was work related. Green v. Industrial Commission, 87 Ill. 2d 1, 5 (1981). The fact that an injury occurred at the place of employment (assuming an employee/employer relationship) is not sufficient to establish the injury arose out of the employment. Id. This is a neutral risk.

The Illinois Supreme Court has found in cases where the issue of compensability resulting from assaults, that injuries suffered by employees were not compensable if there was evidence the motive was personal to the victim rather than work related, or if the claimant could not demonstrate a reason for the assault. Schultheis v. Industrial Commission, 96 Ill. 2d 340 (1983).

Petitioner has failed to prove the decedent's injury arose out of his employment, essentially offering no evidence at all.

Disputed issues **E**, **F**, **L**, **K** and **O**, because of the finding there was no proof of an employee-employer relationship, nor proof an accident arose in the course of employment are resolved against Claimant. The notice issue is moot. No compensation or benefits of any kind is due. Any lump sum distribution is moot.

Disputed issue **G**, what were decedent's earning, if they somehow remained at issue, and decedent was an employee of See Thru Chinese Kitchen, can only be supported by the W-2 from 2014 indicating decedent earned 5808.00 in 2014. In any event the earnings issue is moot.

Disputed issue **H**, is what was the decedent's age at the time of the accident. I find based on the Certification of Death, it was 41 years old. Petitioner's Exhibit 2.

Disputed issue **I**, is what was decedent's marital status at the time of death. Respondent disputes decedent was married. Petitioner submits a translated Notarial Certificate (Translation) by the People's Republic of China, Taishan Notary Public Office, Guangdong Province. As to the contents, issues of credibility aside, the translation states Chen Meichang and Qui Changzhi "...registered for marriage...." The Marriage Law of the People's Republic of China is clear that the process of marriage consists of two distinct steps. First, registration is a prerequisite to marriage, and is reviewed by the Chinese government. If approved, a marriage certificate is issued. By Chinese law, a husband and wife relationship is established as soon as a man and a woman obtain a marriage certificate. Marriage Law of the People's Republic of China, Chapter II, Article 8; See www.cecc.org/resources/legal-provisions/marriage-law-of-the-people's-republic-of-china-amended; www.New York.China-Consulate.org. I find that on the day of decedent's death he was not married, certainly not to Chen.

I also note that Mei could not identify Meichang Chen as the decedent's wife and neither party followed up on that line of questioning. I also note that the records of Mt. Sinai Hospital indicate the patient, the decedent, was never married. Petitioner's Exhibit 9 at 10, 11.

In view of the findings on issues **B** and **C** the issue is moot.

Disputed issue **J** is who was dependent on decedent at the time of death. Subject to the age and circumstances limitations in Section 7(a) of the Act, a surviving child or children are conclusively presumed to be dependent on a deceased employee. Ravenswood Disposal Services v. Illinois Workers' Compensation Commission, 2019 Il App (1st) 181449 WC paragraph 23; 820 ILCS 305/7(a). There are two surviving children, Qui Rong, age 17 at the time of death, and Celinda Qiu, age 11 at the time of death. Petitioner's Exhibit 1 at 6, 9, 10.

In view of the findings on issues **B** and **C** the issue is moot.

Disputed issue **M** is should penalties or fees be imposed upon Respondent. That is Mei, who gave his life savings in cash to decedent's family and paid a hefty fine for not having insurance; and the taxpayers of the State of Illinois.

Penalties and attorney's fees pursuant to Sections 19(k) and 16 are based on deliberate delay, bad faith and improper purpose, and are discretionary. McMahan v. Industrial Commission, 183 Ill. 2d 499, 515 (1998). There is no evidence of such here. In view of the previous findings, the issue is moot. Penalties under 19(l) rely on the ability of an employer or carrier to justify delay of payment. Mechanical Devices v. Industrial Commission, 344 Ill. App. 3d 752, 763 (2003). The failure of Petitioner to sustain the burden of proof in this Application are ample justification for nonpayment. In view of previous findings, the issue is moot. This would be no case for penalties or fees.

Arbitrator

3/16/2020
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	12WC007561
Case Name	JUAREZ, MARIA v. PACTIV
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0303
Number of Pages of Decision	17
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Christopher Johnson
Respondent Attorney	William Dewyer

DATE FILED: 6/17/2021

/s/Kathryn Doerries, Commissioner
Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARIA JUAREZ,

Petitioner,

vs. NO: 12 WC 07561

PACTIV,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on May 29, 2019, 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 bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2) (West 2013)*. Based upon the denial of compensation herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

June 17, 2021

KAD/bsd
O042021
42

/s/*Kathryn A. Doerries*
Kathryn A. Doerries

/s/*Thomas J. Tyrrell*
Thomas J. Tyrrell

/s/*Maria E. Portela*
Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JUAREZ, MARIA
Employee/Petitioner

Case# **12WC007561**
12WC007563

PACTIV
Employer/Respondent

On 5/29/2019, 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 2.32% 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:

4239 LOO JOHN ELIASIK/NEAL STROM
BRIAN C HERCULE
180 N LASALLE ST SUITE 3700
CHICAGO, IL 60601

1872 SPIEGEL & CAHILL PC
MARTIN T SPIEGEL
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MARIA JUAREZ
Employee/Petitioner

Case # **12** WC **007561**

v.

Consolidated cases: **12WC007563**

PACTIV
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 **Tiffany Kay**, Arbitrator of the Commission, in the city of **Chicago**, on **11/19/2018**. 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 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 3, 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 **$25,376.00**; the average weekly wage was **$488.00**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$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 SUSTAINED A COMPENSABLE INJURY ARISING OUT OF AND IN THE COURSE OF HER EMPLOYMENT ON MARCH 3, 2011.

PETITIONER FAILED TO PROVE THAT SHE SUSTAINED ANY PERMANENT PARTIAL DISABILITY AS A RESULT OF THE COMPENSABLE 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

05/24/19
Date

MAY 29 2019

ICArbDec p. 2

PROCEDURAL HISTORY

This case has been consolidated with the following case: 12WC7563.

The matter of case # 12WC7561 was heard before Arbitrator Tiffany Kay (hereinafter "Arbitrator Kay") on October 19, 2018 in Chicago, Illinois. The submitted records have been examined and the decision rendered by Arbitrator Kay. The parties stipulated that Pactiv Corporation (hereinafter "Respondent") and Mrs. Maria Juarez (hereinafter "Petitioner") were operating under the Illinois Workers' Compensation Act (hereinafter "Act") on March 3, 2011, that their relationship was one of employer and employee, that the Petitioner did sustain accidental injuries that arose out of her employment with Respondent, and timely notice was given in accordance to the Act. (Arb.X1) In addition, Respondent agreed that it is liable for any unpaid medical bills. (Arb.x1) The stipulated average weekly wage at the time of the accident and in accordance to the Act was $488.00, the petitioner was 46 years of age with 1 dependent child. (Arb.x1)

At issue is whether Petitioner sustained an accidental injury that arose out of and in the course of her employment with Respondent, whether the Petitioner's condition of ill-being is causally connected to her injury and the nature and extent of Petitioner's injury. (Arb.X1) In addition, the parties stipulated that there is a petition for attorney's fees by a former attorney pending. (Arb.X1) Petitioner's attorney stipulated that the former attorney was notified about the hearing. (Arb.X1)

SUMMARY OF FACTS AND EVIDENCE

March 3, 2011 accident – 12WC7561

Petitioner testified that on March 3, 2011, while working for Respondent, she was on her way to her break and everything was blocked by a lot of production. (T.13) Specifically, the path she was walking through had a lot of oil on the floor that had been dropped. (T.13) Petitioner stated that when she encountered the oil on the floor she didn't notice it and when she walked through the path she slipped on the oil. (T.13) Petitioner testified that she fell backwards and seated. (T.13) Petitioner testified that after she fell she went directly to the officer of the manager/personnel in chief to give notification of her accident. (T.13) In result of the fall, she felt pain in her back, upper part of her leg, and pain running down to her foot. (T.15)

Petitioner testified that after reporting the accident, on the same day, Respondent sent her to the Concentra Occupational Health Clinic (hereinafter "Concentra"). (T.16) The Arbitrator notes that the medical records submitted into evidence reflect that Petitioner was seen on March 8, 2011 at Concentra. (R.X3) Petitioner reported to Concentra that she had slipped and fell and caught herself with the right hand, developed pain in her lower back which was exacerbated by bending, and pain in her right shoulder which was exacerbated by raising her arm. (R.X3) In addition, Petitioner complained of pain in the lower abdomen that worsened with urination. The Arbitrator notes this is inconsistent with the testimony provided by Petitioner at trial regarding her mechanism of injury. (T.13, R.X3) Concentra assessed a lumbar strain, thoracic strain and shoulder strain. (R.X3) Concentra provided Petitioner with the following restrictions: to not lift over 5lbs, no bending more than 5 times per hour, no pushing/pulling over 5lbs of force, no prolonged standing/walking longer than tolerated and that she should sit 80% of the time. (R.X3) Petitioner was told to return on March 15, 2011. Petitioner continued to receive treatment in the form of physical therapy and pain medication from the occupational health clinic. While receiving physical

therapy, Petitioner testified that she was able to return to work on light duty with accommodations from the date of the accident until she was released to return to work full duty. (T.17)

On April 19, 2011, Petitioner was released to work full duty at maximum medical improvement. (T.17, R.X3)

December 2, 2011 accident – 12WC7563

Petitioner testified that on December 2, 2011, she was working on a machine while standing on a metal step/platform. (T.18,19) In order to work on the machine, Petitioner had to constantly walk from one side of the line to the other side of the line. (T.18) Petitioner testified that while she was walking across the platform, she slipped and fell off the platform. (T.20) Petitioner stated that the fall resulted in her hitting her head and losing consciousness. (T.20) Additionally, Petitioner stated that her whole body hit the floor on her right side and she injured her ribs. Petitioner testified that when she woke up she was in an ambulance and was taken to Gottlieb Memorial Hospital (hereinafter "Gottlieb"). (T.22) Petitioner testified that none of the paramedic staff asked her what had happened to her. (T22) Petitioner further testified that no one from work escorted her to the hospital and that no one showed up from work while she was there. (T.23) The Arbitrator notes, during cross examination, Petitioner testified that while at Gottlieb she did speak with the personnel chief/boss manager/personnel staff/human resources. (T.50) The hospital records reflect that Petitioner reported that she had fallen and hit her head and loss consciousness. (R.X2) In contrast, the Arbitrator notes, that the Triage Assessment Report, states that Petitioner's subjective complaint was that she felt dizzy, had a headache with back pain. (R.X2) Petitioner also reported that she had not had breakfast or taken her diabetic medication and denied any trauma. (R.X2) Petitioner was released from the hospital that same day. (T.27)

Petitioner testified that on December 2, 2011 she was a diabetic and was taking pills with food for her condition. (T.23) Petitioner further testified that at trial she was still a diabetic. (T.23) Furthermore, on the date of the accident she had not taken her diabetic pill yet because she normally took it at 9:00am after eating her lunch. (T.24) Petitioner testified that she arrives at work at 7:00 am. (T.24) On this particular day she had not taken her pills because the accident occurred. (T.25) Petitioner further testified that on the date of the accident she had not felt dizzy, weak, or tired. (T.26)

The Arbitrator notes that Respondent submitted into evidence ambulance records also referred to as "Patient Care Reports" from the Franklin Park Department. (R.X1, R.X6) Respondent also entered into evidence unrebutted evidence depositions from the paramedic staff members Mark Stewart (hereinafter Mr. Stewart) and Kyle Shamie (hereinafter Mr. Shamie). (R.X1) Mark Stewart's report states that Petitioner was found confused and oriented with a primary impression of syncope, fainting and dizziness. (R.X1) In addition, his secondary impression was that these were due to diabetic symptoms (Hypoglycemia). (R.X1) The reports' narrative further states that Petitioner was found unconscious, lying on the ground of the factory. (R.X1) Witnesses stated that Petitioner was not feeling well and laid down and was stating that she was very thirsty. In addition, he stated that there was no trauma to Petitioner. Petitioner was placed on a stretcher and transported to Gottlieb. (R.X1)

Additionally, he testified that he and his partner arrived on the scene at 8:35am. (R.X6) He reviewed his assessment from the ambulance records and stated that they found Petitioner's airways open and she was breathing with normal aspirations. (R.X1, R.X6) Petitioner was awake when she was found, alert but confused and lethargic. (R.X6) He stated that they administered an IV of 200 cc fluids Bolus to help bring Petitioner's elevated glucose level down. (R.X6) Mr. Stewart ultimately testified that there was

no trauma at the scene because he would have marked it on the reports as a trauma call. In addition, the way their system is set up in regards to logging in, if he would have marked that that it was a trauma call he would not have been able to log off the system until he completely filled out/elaborated in the trauma section of the report. (R.X6) Mr. Stewart indicated that in the section of the ambulance report entitled Nature of the Call, the call, he indicated that the condition was syncope/unconscious. He testified that the chief complaint and nature of the call were consistent.

In the deposition of Mr. Shamie, he testified that he and his partner responded to a call on December 2, 2011, involving the Petitioner, with the nature of an individual who had fainted or was unconscious. (R.X5) Specifically, he referred to what was written in the report which stated that the individual was syncope/unconscious. Mr. Shamie went on to define syncope as when a person passes out and is unconscious. (R.X5) Furthermore, at some point, Mr. Shamie testified that they were able to communicate with Petitioner and ask her questions. (R.X5)

Petitioner was later referred by the Respondent to Advanced Occupational Medicine Specialists and was seen on December 3, 2011 by Dr. Khanna. (T.27, P.X2) Petitioner provided a history of falling at work on December 2, 2011 and landing on her right side off of a riser. (P.X2) Petitioner described a pain in her back and her right leg to knee. (P.X2) Petitioner was assessed as having a low back strain secondary to a fall at work. (P.X2) She was prescribed pain medication and a course of physical therapy which she underwent. (PX 2). According to Petitioner's medical records, she was sent for MRIs on January 4, 2012 which revealed a disc bulge at L4-L5 and a cervical disc herniation at C5-C6. (PX 4).

On April 5, 2012, Petitioner was referred to see Dr. Kevin Tu (hereinafter "Dr. Tu") at G&T Orthopedics for a surgery consultation regarding her right shoulder. The Arbitrator notes that when Petitioner saw Dr. Tu, she gave a history of going up a step at work when she slipped and landed on her right shoulder. (P.X7) Dr. Tu indicated that the mechanism of injury, as reported to him, going up a step, slipping and falling landing on her right shoulder would be a mechanism consistent with the development of cervical radiculopathy and right shoulder impingement. During Petitioner's visit on April 15, 2013, the records reflect that Petitioner requested to amend/clarify the original history she provided regarding her accident stating that she did not fall downstairs but actually fell off of scaffolding. Dr. Tu diagnosed the Petitioner with right shoulder impingement and opined that the Petitioner suffered a traumatic work-related injury, but that her shoulder symptoms were more related to her cervical spine. (PX 7). Dr. Tu did not recommend shoulder surgery (PX 7).

The petitioner testified, and her medical records reflect, that on April 19, 2012 she was referred to Dr. Harsoor for pain management. (PX 6).

On July 23, 2012, Petitioner was seen by Dr. Sean Salehi (hereinafter "Dr. Salehi") for a surgical consultation regarding her cervical spine. (PX 3, R.X7). The Petitioner gave Dr. Salehi the history of slipping backwards off of a step injuring herself at work on December 2, 2011. Dr. Salehi indicated he could not explain her low back complaints based upon the pathology. On October 16, 2012, he indicated that an FCE had been done and was unreliable. Dr. Salehi determined that the Petitioner did not need surgery and recommended work conditioning. (PX 3). The Petitioner was then released at maximum medical improvement on September 20, 2012 with no restrictions.

On November 2, 2012, Petitioner was seen by Dr. Jesse Butler (hereinafter "Dr. Butler") at Spine Consultants LLC. Petitioner complained of neck and low back pain. She stated that she injured herself while working on a stage with her foot on the edge of the stage. She stated she fell about 1 foot to the

floor, striking her head, neck, right shoulder and right hip. Additionally, she reported fainting. (R.X8) Dr. Butler assessed Petitioner and noted that she could return to work without restrictions. He also indicated that there was no structural basis for her ongoing complaints. (R.X8)

Petitioner's counsel entered into evidence an evidence deposition from Petitioner's primary doctor, Jack C. Leong, M.D (hereinafter "Dr. Leong"). He testified that he had been treating the Petitioner for diabetes for two years prior to the accident and that her blood sugar had been well controlled. (PX 8). He stated that Petitioner suffers from hyperglycemia, also known as high blood sugar. (PX 8). He stated that Petitioner had not reported to him any previous episodes of lightheadedness or dizziness before her accident of December 2, 2011. (PX 8). When asked about the medical records from Gottlieb hospital which indicated that the Petitioner's blood sugar level was elevated, Dr. Leong explained that it was likely elevated as a result of her accident and because Petitioner never got to take her diabetes medication. (PX 8). Further, Dr. Leong explained that Petitioner's elevated blood sugar would not have caused her to be dizzy. (PX 8). The Arbitrator notes that Dr. Leong stated that he had not reviewed the records from the Franklin Park Dire Department or the hospital records from Gottleib hospital prior to providing an opinion on Petitioner's condition. Dr. Leong gave the opinion that the Petitioner's diabetes did not contribute at all to her fall on December 2, 2011. (PX 8).

Respondent had the Petitioner evaluated by Dr. Kathleen Weber, M.D. (hereinafter "Dr. Weber"). Dr. Weber testified that the history provided to Gottlieb was different than the history provided to Advanced Occupational. (R.X4) Dr. Weber indicated that based upon the report from the Franklin Park Fire Department, it would suggest that her onset of symptoms was related to an underlying condition and not specifically related to a work injury. Specifically, she pointed to the notation in the Fire Department records that Petitioner wasn't feeling well, she laid down and was thirsty, without trauma to the petitioner. She also noted that the report indicated that she was suffering from syncope, fainting, dizziness, diabetic symptoms and hyperglycemia. The Arbitrator notes that Dr. Weber also admitted that from the records she reviewed, it was at least unclear whether the Petitioner's dizziness occurred before or after she fell. (RX 4). She opined that a complaint of being thirsty would be suggestive of hyperglycemia. (R.X4)

Petitioner testified that she worked with light duty restrictions until April 1, 2012, when she was laid off due to no further light duty being available. Petitioner also testified that she did not receive any TTD benefits from the point she was released at maximum medical improvement on September 20, 2012 and April 1, 2012 when she was laid off. Petitioner testified that she has not sought any treatment related to her neck, back, right shoulder, or right hip since November 2, 2012. (T.51)

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment/Summary of Testimony:

The Petitioner, Mrs. Maria Juarez, was the only witness to testify at trial regarding her alleged incident on March 3, 2011 and December 2, 2011. Petitioner was aided using an interpreter, Mr. Cristobal Azpilcueta (hereinafter "Mr. Azpilcueta") from Interprenet Services. Opposing counsel was asked whether he would like to ask the interpreter any qualifying questions and he declined to do so.

March 3, 2011 accident – 12WC7561

The Arbitrator finds Petitioner's overall testimony to be truthful and credible. The Arbitrator notes a discrepancy with Petitioner's testimony regarding her mechanism of injury and her history of the

accident to the medical providers. Specifically, Petitioner testified that in result of her slip on oil that was located on the floor she fell backwards and seated. (T.13) In contrast, Petitioner reported to Concentra that she "slipped and caught herself with her right hand; she developed pain in her lower back…". (R.X3) The Arbitrator notes this is inconsistent with the testimony provided by Petitioner at trial regarding her mechanism of injury. (T.13, R.X3) Additionally, Petitioner testified that she was seen on March 3, 2011 at Concentra. (T.13) In contrast, the medical records submitted reflect that she was seen on March 8, 2011. (R.X3)

December 2, 2011 accident – 12WC7563

The Arbitrator finds several discrepancies between the Petitioner's testimony, medical records, subjective complaints and non-rebutted exhibits entered into evidence by the Respondent. In regard to the actual accident on December 2, 2011, Petitioner testified that while she was walking across a platform, she slipped and fell off the platform. (T.20) Petitioner stated that the fall resulted in her hitting her head and losing consciousness. (T.20) Additionally, Petitioner stated that her whole body hit the floor on her right side and she injured her ribs. In contrast, the Triage Assessment Report from the hospital, states that Petitioner's subjective complaint was that she felt dizzy, had a headache with back pain. (R.X2) Petitioner also reported that she had not had breakfast or taken her diabetic medication and denied any trauma. (R.X2) Petitioner testified at trial that on the date of the accident she had not felt dizzy, weak, or tired. (T.26)

Furthermore, the Respondent entered into evidence unrebutted ambulance records also referred to as "Patient Care Reports" from the Franklin Park Department. (R.X1, R.X6) The records reflect reports and evidence depositions from the paramedic staff members Mr. Stewart and Mr. Shamie (R.X1) Mr. Stewart's report states that Petitioner was found confused and oriented with a primary impression of syncope, fainting and dizziness. (R.X1) In addition, his secondary impression was that these were due to diabetic symptoms (Hypoglycemia). (R.X1) Specifically, Mr. Stewarts' report stated that Petitioner was awake when she was found, alert but confused and lethargic. (R.X6) He stated that they administered an IV of 200 cc fluids Bolus to help bring Petitioner's elevated glucose level down. (R.X6) Mr. Stewart ultimately testified that there was no trauma at the scene because he would have marked it on the reports as a trauma call. In addition, the way their system is set up in regard to logging in, if he would have marked that that it was a trauma call he would not have been able to log off the system until he completely filled out/elaborated in the trauma section of the report. (R.X6) He testified that the chief complaint and nature of the call were consistent. Witnesses stated that Petitioner was not feeling well and laid down and was stating that she was very thirsty. That there was no trauma to Petitioner. Petitioner was placed on a stretcher and transported to Gottlieb. (R.X1)

On April 5, 2012, Petitioner was referred to see Dr. Kevin Tu (hereinafter Dr. Tu) at G&T Orthopedics for a surgery consultation regarding her right shoulder. The Arbitrator notes that when Petitioner saw Dr. Tu, she gave a history of going up a step at work when she slipped and landed on her right shoulder. (P.X7) During Petitioner's visit on April 15, 2013, the records reflect that Petitioner requested to amend/clarify the original history she provided regarding her accident stating that she did not fall downstairs but actually fell off of scaffolding.

Overall, due to the discrepancies and contradictions between the Petitioner's testimony, medical records, exhibits admitted into evidence and conflicting testimony the Arbitrator finds the Petitioner's testimony to not be credible.

With respect to issue (C) whether an accident occurred that arose out of and in the course of employment with Respondent, the Arbitrator finds as follows:

March 3, 2011 accident – 12WC7561

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. The Arbitrator finds that Petitioner has proven by a preponderance of the evidence that her accident on March 3, 2011, arose out of and in the course of her employment with Respondent. "A claimant bears the burden of proving by a preponderance of the evidence that his injury arose out of and in the course of the employment." 820 ILCS 305/2 (West 2002). Both elements must be present in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483, 137 Ill. Dec. 658, 546, N.E.2d 603 (1987).

An injury 'arises out of' one's employment if it originates from a risk connected with, or incidental to, the employment, so as to create a causal connection between the employment and the accidental injury." *Brais v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 120820WC, ¶18. Therefore, "in order to determine whether the Petitioner's injury arose out of her [his] employment, one must first categorize the risk to which he or she was exposed. Illinois recognizes three categories of risk to which an employee may be exposed: (1) risks distinctly associated with employment; (2) risks personal to the employee, such as idiopathic falls, and (3) neutral risks which have no particular employment or personal characteristics." *Illinois Consolidated Telephone Co. v. Industrial Comm'n*, 314 Ill. App.3d 347, 352, 247 Ill. Dec. 333, 732 N.E.2d 49 (2000).

The Arbitrator finds that the Petitioner proved by a preponderance of the evidence that she was exposed to a risk distinctly associated with her employment creating a causal connection between her employment and the accidental injury. In order "for an injury caused by a fall to arise out of the employment, a claimant must present evidence which supports a reasonable inference the fall stemmed from a risk associated with her [his] employment." *Builders Square, Inc. v. Industrial Comm'n,* 339 Ill.App.3d 1006, 1010, 274 Ill. Dec 897,791 N.E.2d 1308. "Employment related risks associated with injuries sustained as a consequence of a fall are those to which the general public is not exposed such as the risk of tripping on a defect at the employer's premises, falling on uneven or slippery ground at the work site, or performing some work-related task which contributes to the risk of falling." *Nabisco Brands, Inc. v. Industrial Comm'n*, 266 Ill.App.3d 1103, 1107, 204 Ill. Dec. 354, 641 N.E.2d 578 (1994). Here, Petitioner testified that on March 3, 2011, while working for Respondent, she was on her way to her break and everything was blocked by a lot of production. (T.13) Specifically, the path she was walking through had a lot of oil on the floor that had been dropped. (T.13) Petitioner stated that when she encountered the oil on the floor she didn't notice it. When Petitioner walked through the path she slipped on the oil and fell. (T.13) Petitioner testified that she fell backwards and seated. (T.13) Petitioner testified that after she fell she went directly to the officer of the manager/personnel in chief to give notification of her accident. (T.13) The Arbitrator finds that the condition of the premises was the contributing cause to Petitioner's fall. Accordingly, the Arbitrator finds there was a risk present that was distinctly associated with the Petitioner's employment.

The Arbitrator finds the Petitioner proved by a preponderance of the evidence that her injury occurred "in the course of" her employment with Respondent. Petitioner provided unrebutted testimony that the incident occurred while she was at work, during work hours, and on her way to her break. (T.13) Accordingly, the Arbitrator finds the Petitioner's accident occurred in the course of her employment with Respondent.

December 2, 2011 accident – 12WC7563

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that her accident on December 2, 2011, arose out of and in the course of her employment with Respondent. "A claimant bears the burden of proving by a preponderance of the evidence that his [her] injury arose out of and in the course of the employment." 820 ILCS 305/2 (West 2002). Both elements must be present in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483, 137 Ill. Dec. 658, 546, N.E.2d 603 (1987).

An injury 'arises out of' one's employment if it originates from a risk connected with, or incidental to, the employment, so as to create a causal connection between the employment and the accidental injury." *Brais v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 120820WC, ¶18. Therefore, "in order to determine whether the Petitioner's injury arose out of her [his] employment, one must first categorize the risk to which he or she was exposed. Illinois recognizes three categories of risk to which an employee may be exposed: (1) risks distinctly associated with employment; (2) risks personal to the employee, such as idiopathic falls, and (3) neutral risks which have no particular employment or personal characteristics." *Illinois Consolidated Telephone Co. v. Industrial Comm'n*, 314 Ill. App.3d 347, 352, 247 Ill. Dec. 333, 732 N.E.2d 49 (2000).

Here, Petitioner claims while she was walking across a platform, when she slipped and fell off the platform. (T.20) "Falls resulting from an internal, personal origin or idiopathic in nature. An injury resulting from an idiopathic fall arises out of the employment only where the employment conditions significantly contributed to the injury by increasing the risk of the fall or the effects of the fall." *Stapleton v. Industrial Commission* 282 Ill.App3d 12 (1996).

In this case, not only is it questionable, based upon the paramedics' records and their depositions whether the petitioner had a fall on the date of accident, but there is also a lack of evidence that the employment conditions significantly contributed (or in any way contributed) to the injury by increasing the risk of a fall. (R.X1, R.X6) Petitioner relies solely on her testimony that while working on a machine and having to walk from one side of the line to the other side of the line, she slipped and fell off the platform. (T. 18, 20)

Petitioner's testimony regarding the mechanism of injury has been directly contradicted in several medical reports, evidence depositions, and histories she has provided to her own treaters. The Arbitrator notes that the within the paramedic reports and depositions, witnesses stated that Petitioner wasn't feeling well and laid down and was stating that she was very thirsty. (R.X1) The Triage Assessment Report from Gottlieb, states that Petitioner's subjective complaint was that she felt dizzy, had a headache with back pain. (R.X2) Petitioner also reported that she had not had breakfast or taken her diabetic medication and denied any trauma. (R.X2) On April 5, 2012, while seeing Dr. Tu at G&T Orthopedics for a surgery consultation regarding her right shoulder, she gave a history of going up a step at work when she slipped and landed on her right shoulder. (P.X7) However, on a follow-up visit on April 15, 2013, with Dr. Tu, the records reflect that Petitioner requested to amend/clarify the original history she provided regarding her accident stating that she did not fall downstairs but actually fell off of scaffolding.

The Arbitrator finds, due to the discrepancies between Petitioner's testimony, the un-rebutted medical records submitted into evidence, evidence depositions taken from the paramedics who assisted and took Petitioner to Gottlieb, and contradicting mechanisms of injury Petitioner provided to her treaters,

Petitioner has failed to prove that she was exposed to a risk distinctly associated with her employment creating a causal connection between her employment and the accidental injury.

Petitioner established that on December 2, 2011 she was working at Respondent when the alleged accident occurred. Therefore, the issue of whether the injury was in the course of employment is moot.

With respect to issue (F), whether the Petitioner's current condition of ill-being is causally related to the Injury, the Arbitrator finds as follows:

March 3, 2011 accident – 12WC7561

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. After hearing the testimony of Petitioner and reviewing the un-rebutted exhibits submitted, the Arbitrator finds that Petitioner's current condition of ill-being with regards to her cervical spine, lumbar spine, thoracic spine, right shoulder and arm are causally related to her injury of March 3, 2011.

Causation in a workers' compensation case may be established by a chain of events showing prior good health, an accident and a subsequent injury. *Gano Electric Contracting v. Industrial Comm'n*, 260 Ill. App. 3d 92, 96-97, 631 N.E.2d 724 (1994).

Here, the Petitioner was working for Respondent prior to her injury on March 3, 2011. Petitioner testified that she was injured on March 3, 2011 at work after slipping on oil located on the floor. (T.13) The Petitioner reported her accident to Respondent right away and was sent to its occupational health clinic for treatment related to the accident. (T.14, R.X3) Petitioner testified in result of the fall, she felt pain in her back, upper part of her leg, and pain running down to her foot. (T.15) Concentra provided Petitioner with the following restrictions: to not lift over 5lbs, no bending more than 5 times per hour, no pushing/pulling over 5lbs of force, no prolonged standing/walking longer than tolerated and that she should sit 80% of the time. (R.X3) Petitioner continued to receive treatment in the form of physical therapy and pain medication from the occupational health clinic. While receiving physical therapy, Petitioner testified that she was able to return to work on light duty with accommodations from the date of the accident until she was released to return to work full duty on April 19, 2011. (T.17, R.X3) The Respondent has not provided any rebuttal evidence that the Petitioner's injuries were not related to the accident of March 3, 2011.

Based on the foregoing, the Arbitrator finds that Petitioner's condition of ill-being regarding her cervical spine, lumbar spine, thoracic spine, right shoulder and arm are causally related to her injury on March 3, 2011.

December 2, 2011 accident – 12WC7563

As a finding has been made that the Petitioner's accident did not arise out of and in the course of her employment with Respondent, the other disputed issues are moot.

With respect to issue (J), whether the Respondent paid for all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

December 2, 2011 accident – 12WC7563

As a finding has been made that the Petitioner's accident did not arise out of and in the course of her employment with Respondent, the other disputed issues are moot.

With respect to issue (L), whether the Petitioner is entitled to TTD for the period of 4/1/12 through 9/12/12, representing 23.428 weeks, the Arbitrator finds as follows:

December 2, 2011 accident – 12WC7563

As a finding has been made that the Petitioner's accident did not arise out of and in the course of her employment with Respondent, the other disputed issues are moot.

With respect to issue (L) the Nature and Extent of the injury, the Arbitrator finds as follows:

March 3, 2011 accident – 12WC7561

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. For injuries that occur before September 1, 2011, the Commission evaluates the physical impairment and the effect of the disability on the injured employee's life. Petitioner testified that while working for Respondent on March 3, 2011, she sustained an injury that resulted in injuries to her cervical spine, lumbar spine, thoracic spine, right shoulder and arm. Petitioner's alleged accident occurred prior to September 1, 2011. Therefore, the factors to be considered are the individual's age, skill, occupation, training, inability to engage in certain kinds of activities, pain, stiffness or limitation of motion.

The Petitioner testified in result of the fall, she felt pain in her back, upper part of her leg, and pain running down to her foot. (T.15) Concentra assessed a lumbar strain, thoracic strain and shoulder strain. (R.X3) On May 15, 2011, Petitioner was released to return to work on light duty with restrictions. On April 19, 2011, Petitioner was released to work full duty, without restrictions, and at maximum medical improvement. (T.17, R.X3) On cross examination, Petitioner testified that she when she was last seen by the Concentra doctors she told them that she felt better. (T.39) The Arbitrator notes that Petitioner failed to provide any evidence through medical records, exhibits, or testimony that she sustained any permanent partial disability as a result of the accident of March 3, 2011.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner failed to prove that she sustained any permanent partial disability and benefits are denied.

December 2, 2011 accident – 12WC7563

As a finding has been made that the Petitioner's accident did not arise out of and in the course of her employment with Respondent, the other disputed issues are moot.

Tiffany Kay

05/24 /2019

Signature of Arbitrator **Date**

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	12WC007563
Case Name	JUAREZ, MARIA v. PACTIV
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0304
Number of Pages of Decision	15
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Christopher Johnson
Respondent Attorney	William Dewyer

DATE FILED: 6/17/2021

/s/Kathryn Doerries, Commissioner
Signature

21IWCC0304

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 Choose direction	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARIA JUAREZ,

Petitioner,

vs. NO: 12 WC 07563

PACTIV,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on May 29, 2019, 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 bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2) (West 2013)*. Based upon the denial of compensation herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

June 17, 2021

/s/*Kathryn A. Doerries*
Kathryn A. Doerries

/s/*Thomas J. Tyrrell*
Thomas J. Tyrrell

/s/*Maria E. Portela*
Maria E. Portela

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ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0304
NOTICE OF ARBITRATOR DECISION

JUAREZ, MARIA
Employee/Petitioner

Case# **12WC007563**
12WC007561

PACTIV
Employer/Respondent

On 5/29/2019, 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 2.32% 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:

4239 LOO JOHN ELIASIK/NEAL STROM
BRIAN C HERCULE
180 N LASALLE ST SUITE 3700
CHICAGO, IL 60601

1872 SPIEGEL & CAHILL PC
MARTIN T SPIEGEL
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MARIA JUAREZ
Employee/Petitioner

v.

PACTIV
Employer/Respondent

Case # **12** WC **007563**

Consolidated cases: **12WC007561**

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 **Tiffany Kay**, Arbitrator of the Commission, in the city of **Chicago**, on **November 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **December 2, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$25,376.00**; the average weekly wage was **$488.00**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$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 SHE SUSTAINED A COMPENSABLE INJURY ARISING OUT OF AND IN THE COURSE OF HER EMPLOYMENT WITH RESPONDENT. THEREFORE, COMPENSATION IS DENIED.

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

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

Signature of Arbitrator

05/24/19
Date

MAY 29 2019

PROCEDURAL HISTORY

This case has been consolidated with the following case: 12WC7561.

The matter of case #12WC7563 was heard before Arbitrator Tiffany Kay (hereinafter "Arbitrator Kay") on October 19, 2018 in Chicago, Illinois. The submitted records have been examined and the decision rendered by Arbitrator Kay. The parties stipulated that Pactiv Corporation (hereinafter "Respondent") and Mrs. Maria Juarez (hereinafter "Petitioner") were operating under the Illinois Workers' Compensation Act (hereinafter "Act") on December 2, 2011, that their relationship was one of employer and employee, and that timely notice of the accident was given to the Respondent in accordance to the Act. (Arb.X2) The stipulated average weekly wage at the time of the accident and in accordance to the Act was $488.00, the Petitioner was 46 years of age with 1 dependent child. (Arb.X2)

At issue is whether Petitioner sustained an accidental injury that arose out of and in the course of her employment with Respondent, whether her injury was causally connected to this injury, and whether Respondent is liable for unpaid medical bills. (Arb.X2) In addition, Petitioner claims to be entitled to TTD for 4/1/12 through 9/12/12 representing 23.428 weeks and the Respondent disputes this. (Arb.X2) The nature and extent of the injury is also at issue. (Arb.X2) The Arbitrator notes that a petition for attorney's fees by a former attorney is pending and Petitioner's attorney has stipulated that the former attorney was notified of the date and proceedings.

SUMMARY OF FACTS AND EVIDENCE

March 3, 2011 accident – 12WC7561

Petitioner testified that on March 3, 2011, while working for Respondent, she was on her way to her break and everything was blocked by a lot of production. (T.13) Specifically, the path she was walking through had a lot of oil on the floor that had been dropped. (T.13) Petitioner stated that when she encountered the oil on the floor she didn't notice it and when she walked through the path she slipped on the oil. (T.13) Petitioner testified that she fell backwards and seated. (T.13) Petitioner testified that after she fell she went directly to the officer of the manager/personnel in chief to give notification of her accident. (T.13) In result of the fall, she felt pain in her back, upper part of her leg, and pain running down to her foot. (T.15)

Petitioner testified that after reporting the accident, on the same day, Respondent sent her to the Concentra Occupational Health Clinic (hereinafter "Concentra"). (T.16) The Arbitrator notes that the medical records submitted into evidence reflect that Petitioner was seen on March 8, 2011 at Concentra. (R.X3) Petitioner reported to Concentra that she had slipped and fell and caught herself with the right hand, developed pain in her lower back which was exacerbated by bending, and pain in her right shoulder which was exacerbated by raising her arm. (R.X3) In addition, Petitioner complained of pain in the lower abdomen that worsened with urination. The Arbitrator notes this is inconsistent with the testimony provided by Petitioner at trial regarding her mechanism of injury. (T.13, R.X3) Concentra assessed a lumbar strain, thoracic strain and shoulder strain. (R.X3) Concentra provided Petitioner with the following restrictions: to not lift over 5lbs, no bending more than 5 times per hour, no pushing/pulling over 5lbs of force, no prolonged standing/walking longer than tolerated and that she should sit 80% of the time. (R.X3) Petitioner was told to return on March 15, 2011. Petitioner continued to receive treatment in the form of physical therapy and pain medication from the occupational health clinic. While receiving

physical therapy, Petitioner testified that she was able to return to work on light duty with accommodations from the date of the accident until she was released to return to work full duty. (T.17)

On April 19, 2011, Petitioner was released to work full duty at maximum medical improvement. (T.17, R.X3)

December 2, 2011 accident – 12WC7563

Petitioner testified that on December 2, 2011, she was working on a machine while standing on a metal step/platform. (T.18,19) In order to work on the machine, Petitioner had to constantly walk from one side of the line to the other side of the line. (T.18) Petitioner testified that while she was walking across the platform, she slipped and fell off the platform. (T.20) Petitioner stated that the fall resulted in her hitting her head and losing consciousness. (T.20) Additionally, Petitioner stated that her whole body hit the floor on her right side and she injured her ribs. Petitioner testified that when she woke up she was in an ambulance and was taken to Gottlieb Memorial Hospital (hereinafter "Gottlieb"). (T.22) Petitioner testified that none of the paramedic staff asked her what had happened to her. (T22) Petitioner further testified that no one from work escorted her to the hospital and that no one showed up from work while she was there. (T.23) The Arbitrator notes, during cross examination, Petitioner testified that while at Gottlieb she did speak with the personnel chief/boss manager/personnel staff/human resources. (T.50) The hospital records reflect that Petitioner reported that she had fallen and hit her head and loss consciousness. (R.X2) In contrast, the Arbitrator notes, that the Triage Assessment Report, states that Petitioner's subjective complaint was that she felt dizzy, had a headache with back pain. (R.X2) Petitioner also reported that she had not had breakfast or taken her diabetic medication and denied any trauma. (R.X2) Petitioner was released from the hospital that same day. (T.27)

Petitioner testified that on December 2, 2011 she was a diabetic and was taking pills with food for her condition. (T.23) Petitioner further testified that at trial she was still a diabetic. (T.23) Furthermore, on the date of the accident she had not taken her diabetic pill yet because she normally took it at 9:00am after eating her lunch. (T.24) Petitioner testified that she arrives at work at 7:00 am. (T.24) On this particular day she had not taken her pills because the accident occurred. (T.25) Petitioner further testified that on the date of the accident she had not felt dizzy, weak, or tired. (T.26)

The Arbitrator notes that Respondent submitted into evidence ambulance records also referred to as "Patient Care Reports" from the Franklin Park Department. (R.X1, R.X6) Respondent also entered into evidence unrebutted evidence depositions from the paramedic staff members Mark Stewart (hereinafter Mr. Stewart) and Kyle Shamie (hereinafter Mr. Shamie). (R.X1) Mark Stewart's report states that Petitioner was found confused and oriented with a primary impression of syncope, fainting and dizziness. (R.X1) In addition, his secondary impression was that these were due to diabetic symptoms (Hypoglycemia). (R.X1) The reports' narrative further states that Petitioner was found unconscious, lying on the ground of the factory. (R.X1) Witnesses stated that Petitioner was not feeling well and laid down and was stating that she was very thirsty. In addition, he stated that there was no trauma to Petitioner. Petitioner was placed on a stretcher and transported to Gottlieb. (R.X1)

Additionally, he testified that he and his partner arrived on the scene at 8:35am. (R.X6) He reviewed his assessment from the ambulance records and stated that they found Petitioner's airways open and she was breathing with normal aspirations. (R.X1, R.X6) Petitioner was awake when she was found, alert but confused and lethargic. (R.X6) He stated that they administered an IV of 200 cc fluids Bolus to help bring Petitioner's elevated glucose level down. (R.X6) Mr. Stewart ultimately testified that there was

no trauma at the scene because he would have marked it on the reports as a trauma call. In addition, the way their system is set up in regard to logging in, if he would have marked that that it was a trauma call he would not have been able to log off the system until he completely filled out/elaborated in the trauma section of the report. (R.X6) Mr. Stewart indicated that in the section of the ambulance report entitled Nature of the Call, the call, he indicated that the condition was syncope/unconscious. He testified that the chief complaint and nature of the call were consistent.

In the deposition of Mr. Shamie, he testified that he and his partner responded to a call on December 2, 2011, involving the Petitioner, with the nature of an individual who had fainted or was unconscious. (R.X5) Specifically, he referred to what was written in the report which stated that the individual was syncope/unconscious. Mr. Shamie went on to define syncope as when a person passes out and is unconscious. (R.X5) Furthermore, at some point, Mr. Shamie testified that they were able to communicate with Petitioner and ask her questions. (R.X5)

Petitioner was later referred by the Respondent to Advanced Occupational Medicine Specialists and was seen on December 3, 2011 by Dr. Khanna. (T.27, P.X2) Petitioner provided a history of falling at work on December 2, 2011 and landing on her right side off of a riser. (P.X2) Petitioner described a pain in her back and her right leg to knee. (P.X2) Petitioner was assessed as having a low back strain secondary to a fall at work. (P.X2) She was prescribed pain medication and a course of physical therapy which she underwent. (PX 2). According to Petitioner's medical records, she was sent for MRIs on January 4, 2012 which revealed a disc bulge at L4-L5 and a cervical disc herniation at C5-C6. (PX 4).

On April 5, 2012, Petitioner was referred to see Dr. Kevin Tu (hereinafter "Dr. Tu") at G&T Orthopedics for a surgery consultation regarding her right shoulder. The Arbitrator notes that when Petitioner saw Dr. Tu, she gave a history of going up a step at work when she slipped and landed on her right shoulder. (P.X7) Dr. Tu indicated that the mechanism of injury, as reported to him, going up a step, slipping and falling landing on her right shoulder would be a mechanism consistent with the development of cervical radiculopathy and right shoulder impingement. During Petitioner's visit on April 15, 2013, the records reflect that Petitioner requested to amend/clarify the original history she provided regarding her accident stating that she did not fall downstairs but actually fell off of scaffolding. Dr. Tu diagnosed the Petitioner with right shoulder impingement and opined that the Petitioner suffered a traumatic work-related injury, but that her shoulder symptoms were more related to her cervical spine. (PX 7). Dr. Tu did not recommend shoulder surgery (PX 7).

The petitioner testified, and her medical records reflect, that on April 19, 2012 she was referred to Dr. Harsoor for pain management. (PX 6).

On July 23, 2012, Petitioner was seen by Dr. Sean Salehi (hereinafter "Dr. Salehi") for a surgical consultation regarding her cervical spine. (PX 3, R.X7). The Petitioner gave Dr. Salehi the history of slipping backwards off of a step injuring herself at work on December 2, 2011. Dr. Salehi indicated he could not explain her low back complaints based upon the pathology. On October 16, 2012, he indicated that an FCE had been done and was unreliable. Dr. Salehi determined that the Petitioner did not need surgery and recommended work conditioning. (PX 3). The Petitioner was then released at maximum medical improvement on September 20, 2012 with no restrictions.

On November 2, 2012, Petitioner was seen by Dr. Jesse Butler (hereinafter "Dr. Butler") at Spine Consultants LLC. Petitioner complained of neck and low back pain. She stated that she injured herself while working on a stage with her foot on the edge of the stage. She stated she fell about 1 foot to the

floor, striking her head, neck, right shoulder and right hip. Additionally, she reported fainting. (R.X8) Dr. Butler assessed Petitioner and noted that she could return to work without restrictions. He also indicated that there was no structural basis for her ongoing complaints. (R.X8)

Petitioner's counsel entered into evidence an evidence deposition from Petitioner's primary doctor, Jack C. Leong, M.D (hereinafter "Dr. Leong"). He testified that he had been treating the Petitioner for diabetes for two years prior to the accident and that her blood sugar had been well controlled. (PX 8). He stated that Petitioner suffers from hyperglycemia, also known as high blood sugar. (PX 8). He stated that Petitioner had not reported to him any previous episodes of lightheadedness or dizziness before her accident of December 2, 2011. (PX 8). When asked about the medical records from Gottlieb hospital which indicated that the Petitioner's blood sugar level was elevated, Dr. Leong explained that it was likely elevated as a result of her accident and because Petitioner never got to take her diabetes medication. (PX 8). Further, Dr. Leong explained that Petitioner's elevated blood sugar would not have caused her to be dizzy. (PX 8). The Arbitrator notes that Dr. Leong stated that he had not reviewed the records from the Franklin Park Dire Department or the hospital records from Gottleib hospital prior to providing an opinion on Petitioner's condition. Dr. Leong gave the opinion that the Petitioner's diabetes did not contribute at all to her fall on December 2, 2011. (PX 8).

Respondent had the Petitioner evaluated by Dr. Kathleen Weber, M.D. (hereinafter "Dr. Weber"). Dr. Weber testified that the history provided to Gottlieb was different than the history provided to Advanced Occupational. (R.X4) Dr. Weber indicated that based upon the report from the Franklin Park Fire Department, it would suggest that her onset of symptoms was related to an underlying condition and not specifically related to a work injury. Specifically, she pointed to the notation in the Fire Department records that Petitioner wasn't feeling well, she laid down and was thirsty, without trauma to the petitioner. She also noted that the report indicated that she was suffering from syncope, fainting, dizziness, diabetic symptoms and hyperglycemia. The Arbitrator notes that Dr. Weber also admitted that from the records she reviewed, it was at least unclear whether the Petitioner's dizziness occurred before or after she fell. (RX 4). She opined that a complaint of being thirsty would be suggestive of hyperglycemia. (R.X4)

Petitioner testified that she worked with light duty restrictions until April 1, 2012, when she was laid off due to no further light duty being available. Petitioner also testified that she did not receive any TTD benefits from the point she was released at maximum medical improvement on September 20, 2012 and April 1, 2012 when she was laid off. Petitioner testified that she has not sought any treatment related to her neck, back, right shoulder, or right hip since November 2, 2012. (T.51)

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment/Summary of Testimony:

The Petitioner, Mrs. Maria Juarez, was the only witness to testify at trial regarding her alleged incident on March 3, 2011 and December 2, 2011. Petitioner was aided using an interpreter, Mr. Cristobal Azpilcueta (hereinafter "Mr. Azpilcueta") from Interprenet Services. Opposing counsel was asked whether he would like to ask the interpreter any qualifying questions and he declined to do so.

March 3, 2011 accident – 12WC7561

The Arbitrator finds Petitioner's overall testimony to be truthful and credible. The Arbitrator notes

a discrepancy with Petitioner's testimony regarding her mechanism of injury and her history of the accident to the medical providers. Specifically, Petitioner testified that in result of her slip on oil that was located on the floor she fell backwards and seated. (T.13) In contrast, Petitioner reported to Concentra that she "slipped and caught herself with her right hand; she developed pain in her lower back…". (R.X3) The Arbitrator notes this is inconsistent with the testimony provided by Petitioner at trial regarding her mechanism of injury. (T.13, R.X3) Additionally, Petitioner testified that she was seen on March 3, 2011 at Concentra. (T.13) In contrast, the medical records submitted reflect that she was seen on March 8, 2011. (R.X3)

December 2, 2011 accident – 12WC7563

The Arbitrator finds several discrepancies between the Petitioner's testimony, medical records, subjective complaints and non-rebutted exhibits entered into evidence by the Respondent. In regard to the actual accident on December 2, 2011, Petitioner testified that while she was walking across a platform, she slipped and fell off the platform. (T.20) Petitioner stated that the fall resulted in her hitting her head and losing consciousness. (T.20) Additionally, Petitioner stated that her whole body hit the floor on her right side and she injured her ribs. In contrast, the Triage Assessment Report from the hospital, states that Petitioner's subjective complaint was that she felt dizzy, had a headache with back pain. (R.X2) Petitioner also reported that she had not had breakfast or taken her diabetic medication and denied any trauma. (R.X2) Petitioner testified at trial that on the date of the accident she had not felt dizzy, weak, or tired. (T.26)

Furthermore, the Respondent entered into evidence unrebutted ambulance records also referred to as "Patient Care Reports" from the Franklin Park Department. (R.X1, R.X6) The records reflect reports and evidence depositions from the paramedic staff members Mr. Stewart and Mr. Shamie (R.X1) Mr. Stewart's report states that Petitioner was found confused and oriented with a primary impression of syncope, fainting and dizziness. (R.X1) In addition, his secondary impression was that these were due to diabetic symptoms (Hypoglycemia). (R.X1) Specifically, Mr. Stewarts' report stated that Petitioner was awake when she was found, alert but confused and lethargic. (R.X6) He stated that they administered an IV of 200 cc fluids Bolus to help bring Petitioner's elevated glucose level down. (R.X6) Mr. Stewart ultimately testified that there was no trauma at the scene because he would have marked it on the reports as a trauma call. In addition, the way their system is set up in regard to logging in, if he would have marked that that it was a trauma call he would not have been able to log off the system until he completely filled out/elaborated in the trauma section of the report. (R.X6) He testified that the chief complaint and nature of the call were consistent. Witnesses stated that Petitioner was not feeling well and laid down and was stating that she was very thirsty. That there was no trauma to Petitioner. Petitioner was placed on a stretcher and transported to Gottlieb. (R.X1)

On April 5, 2012, Petitioner was referred to see Dr. Kevin Tu (hereinafter Dr. Tu) at G&T Orthopedics for a surgery consultation regarding her right shoulder. The Arbitrator notes that when Petitioner saw Dr. Tu, she gave a history of going up a step at work when she slipped and landed on her right shoulder. (P.X7) During Petitioner's visit on April 15, 2013, the records reflect that Petitioner requested to amend/clarify the original history she provided regarding her accident stating that she did not fall downstairs but actually fell off of scaffolding.

Overall, due to the discrepancies and contradictions between the Petitioner's testimony, medical records, exhibits admitted into evidence and conflicting testimony the Arbitrator finds the Petitioner's testimony to not be credible.

With respect to issue (C) whether an accident occurred that arose out of and in the course of employment with Respondent, the Arbitrator finds as follows:

March 3, 2011 accident – 12WC7561

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. The Arbitrator finds that Petitioner has proven by a preponderance of the evidence that her accident on March 3, 2011, arose out of and in the course of her employment with Respondent. "A claimant bears the burden of proving by a preponderance of the evidence that his injury arose out of and in the course of the employment." 820 ILCS 305/2 (West 2002). Both elements must be present in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483, 137 Ill. Dec. 658, 546, N.E.2d 603 (1987).

An injury 'arises out of' one's employment if it originates from a risk connected with, or incidental to, the employment, so as to create a causal connection between the employment and the accidental injury." *Brais v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 120820WC, ¶18. Therefore, "in order to determine whether the Petitioner's injury arose out of her [his] employment, one must first categorize the risk to which he or she was exposed. Illinois recognizes three categories of risk to which an employee may be exposed: (1) risks distinctly associated with employment; (2) risks personal to the employee, such as idiopathic falls, and (3) neutral risks which have no particular employment or personal characteristics." *Illinois Consolidated Telephone Co. v. Industrial Comm'n*, 314 Ill. App.3d 347, 352, 247 Ill. Dec. 333, 732 N.E.2d 49 (2000).

The Arbitrator finds that the Petitioner proved by a preponderance of the evidence that she was exposed to a risk distinctly associated with her employment creating a causal connection between her employment and the accidental injury. In order "for an injury caused by a fall to arise out of the employment, a claimant must present evidence which supports a reasonable inference the fall stemmed from a risk associated with her [his] employment." *Builders Square, Inc. v. Industrial Comm'n,* 339 Ill.App.3d 1006, 1010, 274 Ill. Dec 897,791 N.E.2d 1308. "Employment related risks associated with injuries sustained as a consequence of a fall are those to which the general public is not exposed such as the risk of tripping on a defect at the employer's premises, falling on uneven or slippery ground at the work site, or performing some work-related task which contributes to the risk of falling." *Nabisco Brands, Inc. v. Industrial Comm'n*, 266 Ill.App.3d 1103, 1107, 204 Ill. Dec. 354, 641 N.E.2d 578 (1994). Here, Petitioner testified that on March 3, 2011, while working for Respondent, she was on her way to her break and everything was blocked by a lot of production. (T.13) Specifically, the path she was walking through had a lot of oil on the floor that had been dropped. (T.13) Petitioner stated that when she encountered the oil on the floor she didn't notice it. When Petitioner walked through the path she slipped on the oil and fell. (T.13) Petitioner testified that she fell backwards and seated. (T.13) Petitioner testified that after she fell she went directly to the officer of the manager/personnel in chief to give notification of her accident. (T.13) The Arbitrator finds that the condition of the premises was the contributing cause to Petitioner's fall. Accordingly, the Arbitrator finds there was a risk present that was distinctly associated with the Petitioner's employment.

The Arbitrator finds the Petitioner proved by a preponderance of the evidence that her injury occurred "in the course of" her employment with Respondent. Petitioner provided unrebutted testimony that the incident occurred while she was at work, during work hours, and on her way to her break. (T.13) Accordingly, the Arbitrator finds the Petitioner's accident occurred in the course of her employment with Respondent.

December 2, 2011 accident – 12WC7563

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that her accident on December 2, 2011, arose out of and in the course of her employment with Respondent. "A claimant bears the burden of proving by a preponderance of the evidence that his [her] injury arose out of and in the course of the employment." 820 ILCS 305/2 (West 2002). Both elements must be present in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483, 137 Ill. Dec. 658, 546, N.E.2d 603 (1987).

An injury 'arises out of' one's employment if it originates from a risk connected with, or incidental to, the employment, so as to create a causal connection between the employment and the accidental injury." *Brais v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 120820WC, ¶18. Therefore, "in order to determine whether the Petitioner's injury arose out of her [his] employment, one must first categorize the risk to which he or she was exposed. Illinois recognizes three categories of risk to which an employee may be exposed: (1) risks distinctly associated with employment; (2) risks personal to the employee, such as idiopathic falls, and (3) neutral risks which have no particular employment or personal characteristics." *Illinois Consolidated Telephone Co. v. Industrial Comm'n*, 314 Ill. App.3d 347, 352, 247 Ill. Dec. 333, 732 N.E.2d 49 (2000).

Here, Petitioner claims while she was walking across a platform, when she slipped and fell off the platform. (T.20) "Falls resulting from an internal, personal origin or idiopathic in nature. An injury resulting from an idiopathic fall arises out of the employment only where the employment conditions significantly contributed to the injury by increasing the risk of the fall or the effects of the fall." *Stapleton v. Industrial Commission* 282 Ill.App3d 12 (1996).

In this case, not only is it questionable, based upon the paramedics' records and their depositions whether the petitioner had a fall on the date of accident, but there is also a lack of evidence that the employment conditions significantly contributed (or in any way contributed) to the injury by increasing the risk of a fall. (R.X1, R.X6) Petitioner relies solely on her testimony that while working on a machine and having to walk from one side of the line to the other side of the line, she slipped and fell off the platform. (T. 18, 20)

Petitioner's testimony regarding the mechanism of injury has been directly contradicted in several medical reports, evidence depositions, and histories she has provided to her own treaters. The Arbitrator notes that the within the paramedic reports and depositions, witnesses stated that Petitioner wasn't feeling well and laid down and was stating that she was very thirsty. (R.X1) The Triage Assessment Report from Gottlieb, states that Petitioner's subjective complaint was that she felt dizzy, had a headache with back pain. (R.X2) Petitioner also reported that she had not had breakfast or taken her diabetic medication and denied any trauma. (R.X2) On April 5, 2012, while seeing Dr. Tu at G&T Orthopedics for a surgery consultation regarding her right shoulder, she gave a history of going up a step at work when she slipped and landed on her right shoulder. (P.X7) However, on a follow-up visit on April 15, 2013, with Dr. Tu, the records reflect that Petitioner requested to amend/clarify the original history she provided regarding her accident stating that she did not fall downstairs but actually fell off of scaffolding.

The Arbitrator finds, due to the discrepancies between Petitioner's testimony, the un-rebutted medical records submitted into evidence, evidence depositions taken from the paramedics who assisted and took Petitioner to Gottlieb, and contradicting mechanisms of injury Petitioner provided to her treaters,

Petitioner has failed to prove that she was exposed to a risk distinctly associated with her employment creating a causal connection between her employment and the accidental injury.

Petitioner established that on December 2, 2011 she was working at Respondent when the alleged accident occurred. Therefore, the issue of whether the injury was in the course of employment is moot.

With respect to issue (F), whether the Petitioner's current condition of ill-being is causally related to the Injury, the Arbitrator finds as follows:

March 3, 2011 accident – 12WC7561

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. After hearing the testimony of Petitioner and reviewing the un-rebutted exhibits submitted, the Arbitrator finds that Petitioner's current condition of ill-being with regards to her cervical spine, lumbar spine, thoracic spine, right shoulder and arm are causally related to her injury of March 3, 2011.

Causation in a workers' compensation case may be established by a chain of events showing prior good health, an accident and a subsequent injury. *Gano Electric Contracting v. Industrial Comm'n*, 260 Ill. App. 3d 92, 96-97, 631 N.E.2d 724 (1994).

Here, the Petitioner was working for Respondent prior to her injury on March 3, 2011. Petitioner testified that she was injured on March 3, 2011 at work after slipping on oil located on the floor. (T.13) The Petitioner reported her accident to Respondent right away and was sent to its occupational health clinic for treatment related to the accident. (T.14, R.X3) Petitioner testified in result of the fall, she felt pain in her back, upper part of her leg, and pain running down to her foot. (T.15) Concentra provided Petitioner with the following restrictions: to not lift over 5lbs, no bending more than 5 times per hour, no pushing/pulling over 5lbs of force, no prolonged standing/walking longer than tolerated and that she should sit 80% of the time. (R.X3) Petitioner continued to receive treatment in the form of physical therapy and pain medication from the occupational health clinic. While receiving physical therapy, Petitioner testified that she was able to return to work on light duty with accommodations from the date of the accident until she was released to return to work full duty on April 19, 2011. (T.17, R.X3) The Respondent has not provided any rebuttal evidence that the Petitioner's injuries were not related to the accident of March 3, 2011.

Based on the foregoing, the Arbitrator finds that Petitioner's condition of ill-being regarding her cervical spine, lumbar spine, thoracic spine, right shoulder and arm are causally related to her injury on March 3, 2011.

December 2, 2011 accident – 12WC7563

As a finding has been made that the Petitioner's accident did not arise out of and in the course of her employment with Respondent, the other disputed issues are moot.

With respect to issue (J), whether the Respondent paid for all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

December 2, 2011 accident – 12WC7563

As a finding has been made that the Petitioner's accident did not arise out of and in the course of her employment with Respondent, the other disputed issues are moot.

With respect to issue (L), whether the Petitioner is entitled to TTD for the period of 4/1/12 through 9/12/12, representing 23.428 weeks, the Arbitrator finds as follows:

December 2, 2011 accident – 12WC7563

As a finding has been made that the Petitioner's accident did not arise out of and in the course of her employment with Respondent, the other disputed issues are moot.

With respect to issue (L) the Nature and Extent of the injury, the Arbitrator finds as follows:

March 3, 2011 accident – 12WC7561

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. For injuries that occur before September 1, 2011, the Commission evaluates the physical impairment and the effect of the disability on the injured employee's life. Petitioner testified that while working for Respondent on March 3, 2011, she sustained an injury that resulted in injuries to her cervical spine, lumbar spine, thoracic spine, right shoulder and arm. Petitioner's alleged accident occurred prior to September 1, 2011. Therefore, the factors to be considered are the individual's age, skill, occupation, training, inability to engage in certain kinds of activities, pain, stiffness or limitation of motion.

The Petitioner testified in result of the fall, she felt pain in her back, upper part of her leg, and pain running down to her foot. (T.15) Concentra assessed a lumbar strain, thoracic strain and shoulder strain. (R.X3) On May 15, 2011, Petitioner was released to return to work on light duty with restrictions. On April 19, 2011, Petitioner was released to work full duty, without restrictions, and at maximum medical improvement. (T.17, R.X3) On cross examination, Petitioner testified that she when she was last seen by the Concentra doctors she told them that she felt better. (T.39) The Arbitrator notes that Petitioner failed to provide any evidence through medical records, exhibits, or testimony that she sustained any permanent partial disability as a result of the accident of March 3, 2011.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner failed to prove that she sustained any permanent partial disability and benefits are denied.

December 2, 2011 accident – 12WC7563

As a finding has been made that the Petitioner's accident did not arise out of and in the course of her employment with Respondent, the other disputed issues are moot.

Tiffany Kay

05/24 /2019

Signature of Arbitrator **Date**

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	08WC005480
Case Name	BLANKSHAIN, ROBERT v. WALSH CONSTRUCTION CO
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0305
Number of Pages of Decision	4
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	John Popelka
Respondent Attorney	Peter Carlson

DATE FILED: 6/18/2021

/s/Deborah Simpson, Commissioner

Signature

08 WC 5480

STATE OF ILLINOIS)
)
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT BLANKSHAIN,

Petitioner,

vs. No: 08 WC 5480, 18 IWCC 451

WALSH CONSTRUCTION CO.,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Appellate Court of Illinois, 1ST District, Workers' Compensation Division. The Arbitrator found that Petitioner suffered work-related injuries to his shoulders bilaterally. He awarded Petitioner 169&4/7 of TTD/maintenance and 150 weeks of PPD, representing loss of the use of 30% of the person-as-a-whole. Petitioner sought review by the Commission and preserved the issues of vocational expenses, temporary total disability/maintenance, credit, prospective medical expenses, penalties and fees, and the nature and extent of Petitioner's permanent disability.

On review, the Commission modified the Decision of the Arbitrator. The Commission affirmed the Decision of the Arbitrator on all issues except for the PPD award. The Commission found that Petitioner had not proven he was permanently and totally disabled but increased the PPD award to 225 weeks, representing loss of 45% of the person-as-a-whole. The Commission agreed with the Arbitrator that Petitioner did not prove a diligent job search but also found that the Arbitrator put too much weight on his determination that Petitioner did not conduct such a job search in determining his PPD award.

Petitioner appealed the Decision of the Commission to the Circuit Court of Cook County arguing *inter alia* that the Commission erred in not finding him PTD. The Circuit Court reviewed the Commission decision under the manifest weight of the evidence standard of review. It found that the Commission finding that Petitioner did not conduct a diligent job search was not against the manifest weight of the evidence because he self-limited his search; not applying for certain jobs that were within his restrictions. The Circuit Court also found the Commission finding that Petitioner did not prove that he was PTD was not against the manifest weight of the evidence. However, the Circuit Court also found that "the Commission's determination with respect to the frequency of golf played by Petitioner" in assessing the adequacy of his job search was against the manifest weight of the evidence.

On the issue of prospective medical, the Court found that the Commission's affirmation of the denial of prospective medical treatment was against the manifest weight of the evidence and ordered the Commission to award prospective prescriptions of Celebrex prescribed by Petitioner's treating doctor, Dr. Marra, as well as necessary follow up doctor visits. The Circuit Court also confirmed the Decision of the Commission with regard to the denial of educational expenses, denial of maintenance benefits, and denial of the imposition of penalties and fees. The Circuit Court also remanded the matter to the Commission to determine Petitioner's claim for $103.07 in "incidental vocational rehabilitation expenses" which involved travel to job fairs.

Petitioner also appealed the Decision of the Circuit Court to the Appellate Court. The Appellate Court noted that even though the issue of jurisdiction was not argued by the Respondent, the Appellate Court found that it did not have jurisdiction over the matter because the appeal was interlocutory in nature. The Appellate court remanded the matter to the Commission to adjudicate the matter under the mandate of the Circuit Court.

The Commission is obligated to carry out the mandates of the Circuit and Appellate Courts. The Commission was reversed in denying prospective medical and the Circuit Court ordered the Commission to award prospective prescriptions of Celebrex and follow up doctor visits. Therefore, we award the prospective medical treatment as mandated.

Besides the mandate to award specific prospective medical treatment, the only other mandate from the Circuit Court was for the Commission to consider the issue of reimbursement to Petitioner of $103.07 for travel expenses associated with attending job fairs. On this issue, Petitioner testified he traveled to job fairs and mileage costs amounted to $103.07. Petitioner's testimony was unrebutted. These vocational rehabilitation expenses are generally reimbursable. Therefore, upon reconsideration, the Commission directs Respondent to reimburse Petitioner for $103.07 in vocational rehabilitation expenses.

The Commission notes that the Circuit Court did not direct the Commission to reconsider its PPD award and found our previous determination that he was not at PTD was not against the manifest weight of the evidence. Based on the language of the Circuit Court opinion we decline to reconsider our previous PPD award.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent authorize and pay for prospective medical treatment in the form of Dr. Marra's prescription for Celebrex as well as reasonable and necessary follow up visits with him.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent reimburse Petitioner the sum of $103.07 for expenses he incurred for travel expenses associated with vocational rehabilitation

IT IS FUTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $636.15 per week for a period of 225 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the partial disability to the extent of 45% of the person-as-a-whole.

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.

June 18, 2021

/s/ *Deborah L. Simpson*
Deborah L. Simpson

/s/ *Steven J. Mathis*
Steven J. Mathis

DLS/dw
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/s/ *Deborah J. Baker*
Deborah J. Baker

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC004753
Case Name	OLIVA, MARTHA v. KOCH FOODS
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0306
Number of Pages of Decision	41
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Brenton Schmitz
Respondent Attorney	Anthony Ulm

DATE FILED: 6/18/2021

/s/Deborah Simpson, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARTHA OLIVA,

Petitioner,

vs. NO: 15 WC 4753

KOCH FOODS,

Respondent.

DECISION AND OPINION ON REVIEW

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

This matter was consolidated with companion claims, 15 WC 4751 and 15 WC 4752. In the instant claim, the Arbitrator found Petitioner proved a compensable accident on November 24, 2014, found that accident caused a current condition of ill-being of her legs bilaterally, but he also found that Petitioner did not prove causation to alleged conditions of ill-being of her shoulder, elbow, and low back. He awarded her medical expenses incurred only at Physicians Immediate Care through December 5, 2014 and awarded her 10.75 weeks of PPD benefits representing loss of the use of 2.5% of each of the left and right legs.

Petitioner testified that on November 24, 2014, she was working on the assembly line processing chicken pieces while standing on a three to four-foot-high step. She got off the step to go the bathroom, slipped on liquid on the floor, and "did the splits." She immediately reported low back pain, as well as pain in her legs. The same day, she went to seek treatment from Respondent's preferred medical provider, Physicians Immediate Care, where she was diagnosed with lumbago, as well as knee/ankle/foot injuries.

The Arbitrator found that Petitioner proved the condition of ill-being of her legs were causally related to her slip-and-fall accident on November 24, 2014. However, the Arbitrator also found that Petitioner did not prove that her lumbar condition or any alleged conditions of ill-being of her elbow and shoulder were causally related to the work accident. The Commission agrees with the Arbitrator's findings of compensable accident, that the accident caused a condition of ill-being of her legs bilaterally, and his award to Petitioner of 10.75 weeks of PPD representing loss of the use of 2.5% of each of the left and right legs.

The Arbitrator based his conclusion that Petitioner did not prove that the accident on November 24, 2014 caused a lumbar condition of ill-being on the fact that after her treatment at Physicians Immediate Care, the medical records seem to indicate that her lumbar condition related back to her accident in 2012, adjudicated in a companion case. The Commission does not find such notations dispositive of this issue.

The Commission notes that in late 2013/early 2014, Petitioner basically stopped mentioning lower back pain until after the instant accident on November 24, 2014. The Commission also notes that Respondent did not schedule a Section 12 medical examination of Petitioner's lumbar spine after the November 24, 2014 accident to assess causation from that accident.

The Commission finds that Petitioner did sustain an injury to her lumbar spine in 2014 accident based on the following factors: Petitioner's low back pain after the 2014 accident was similar to her pain after the 2012 accident; she immediately reported low back pain after the instant accident; she was initially diagnosed with lumbago by Respondent's preferred provider; Dr. Jain opined that her lumbar condition of ill-being was causally related to the accident; and she stopped reporting low back pain for the months prior to the November 24, 2014 accident. Therefore, the Commission concludes that in the November 24, 2014 accident, Petitioner sustained a compensable aggravation of her previous low back condition necessitating additional medical treatment.

In this matter, the Arbitrator awarded medical expenses only for treatment provided by Physicians Immediate Care. He also denied TTD, denied PPD for her lumbar condition, and awarded her 10.75 weeks of PPD benefits representing loss of the use of 2.5% of each of the left and right legs. The Commission concurs with the Decision of the Arbitrator regarding the denial of TTD and the PPD award for Petitioner's legs. However, the Commission finds that Petitioner is entitled to additional medical treatment and a PPD award for her lumbar injury.

On the issue of medical expenses, the Commission finds that February 10, 2016 is a reasonable date to terminate lumbar treatment for his November 24, 2014 injury. After that point, it appears that Petitioner was primarily treating for her cervical condition and not her lumbar condition.

In addition, while we award medical expenses through February 24, 2016 for her lumbar condition, we specifically deny awarding chiropractic treatment for treatment of her lumbar spine. She had approximately 110 sessions of chiropractic treatment which appeared to be primarily for her cervical condition, and the treatment did not appear to have any significant positive effect on Petitioner's conditions of ill-being. Therefore, no chiropractic bills are awarded for treatment of Petitioner's lumbar condition.

In assessing an appropriate PPD award, the Arbitrator noted that no AMA impairment rating was submitted and therefore that factor was given no weight, He gave great weight to the fact that Petitioner was able to return to her prior occupation which required significant repetitive activity. He gave little weight to Petitioner's age, 53, at the time of the accident. He gave great weight to the fact that Petitioner showed no loss of future earning potential. Finally, the Arbitrator gave great weight to the limited evidence of Petitioner's disability corroborated by the medical records. In looking at the entire records before us, the Commission finds that an additional PPD award representing loss of the use of 2.5% of the person-as-a-whole is appropriate for Petitioner's lumbar condition.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Corrected Decision of the Arbitrator dated June 29, 2020 is hereby modified as noted above and is otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay for all reasonable and necessary medical expenses incurred to treat Petitioner's work-related lumbar condition through February 10, 2016, pursuant to §8(a) of the Act, subject to the applicable medical fee schedule in §8.2, except the Commission does not award any chiropractic expenses incurred to treat her lumbar condition.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner permanent partial disability benefits of $229.20 for a period of 12.5 weeks, as the injury caused the loss of the use of 2.5% of the person-as-a-whole pursuant to §8(d)(2).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner permanent partial disability benefits in the amount of $229.20 for 10.75 weeks, as the injury has caused the loss of the use of 2.5% of each of the left and right legs pursuant to §8(e) 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 $50,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

June 18, 2021

/s/Deborah L. Simpson
Deborah L. Simpson

/s/Steven J. Mathis
Steven J. Mathis

DLS/dw
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/s/Deborah J. Baker
Deborah J. Baker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

OLIVA, MARTHA
Employee/Petitioner

Case# **15WC004751**

15WC004752
15WC004753

KOCH FOODS
Employer/Respondent

On 6/29/2020, 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 0.17% 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 McHARGUE & JONES LLC
BRENTON M SCHMITZ
123 W MADISON ST SUITE 1800
CHICAGO, IL 60602

2337 INMAN & FITZGIBBONS LTD
ANTHONY ULM
33 N DEARBORN ST SUITE 1825
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
CORRECTED ARBITRATION DECISION

Martha Oliva
Employee/Petitioner

v.

Koch Foods
Employer/Respondent

Case # **15 WC 4751**

Consolidated cases: **15 WC 4752/4753**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **October 22** and **November 20, 2019**. 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 **8/7/2012**, 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 **$19,864.00**; the average weekly wage was **$382.00**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **0** dependent children.

Petitioner has received all reasonable and necessary medical services.

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

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

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

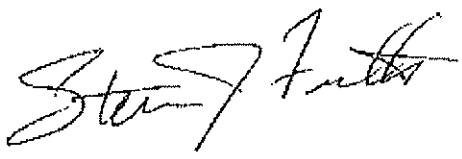
ORDER

All reasonable and related medical have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of $229.20/week for 10 weeks, as the injury has caused the loss of use of 2% of the person-as-a-whole under §8(d)(2).

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

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



Signature of Arbitrator

June 26, 2020
Date

JUN 29 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

OLIVA, MARTHA
Employee/Petitioner

Case# **15WC004752**

15WC004751
15WC004753

KOCH FOODS
Employer/Respondent

On 6/29/2020, 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 0.17% 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:

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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

Martha Oliva
Employee/Petitioner

v.

Koch Foods
Employer/Respondent

Case # **15 WC 4752**

Consolidated cases: **15 WC 4751/4753**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **October 22** and **November 20, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **10/12/2013**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**19,864.00**; the average weekly wage was $**382.00**.

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 $**0** under §8(j) of the Act.

ORDER

Respondent shall pay all bills presented by Petitioner as they relate to the cervical spine for a period of six (6) weeks after October 12, 2013, up to November 23, 2013, to be adjusted in accord with the medical fee schedule. No bills for medical care for the left shoulder are awarded.

Respondent shall pay Petitioner permanent partial disability benefits of $229.20/week for 50 weeks, as the injury has caused the loss of use of 10% of the person as a whole under §8(d)(2) with respect to the cervical spine.

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 4, 2020
Date

JUN 2 9 2020

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

Martha Oliva
Employee/Petitioner

v.

Koch Foods
Employer/Respondent

Case # **15 WC 4753**

Consolidated cases: **15 WC 4751/4752**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **October 22** and **November 20, 2019**. 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

C. ☐ 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 _____

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

OLIVA, MARTHA
Employee/Petitioner

Case# **15WC004753**

15WC004751
15WC004752

KOCH FOODS
Employer/Respondent

On 6/29/2020, 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 0.17% 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:

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CHICAGO, IL 60602

FINDINGS

On **11/24/2014**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$19,864.00**; the average weekly wage was **$382.00**.

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

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$2,279.97** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$2,279.97**.

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

ORDER

Respondent shall pay all bills presented by Physicians Immediate Care only, to be adjusted in accord with the medical fee schedule.

Petitioner claim for temporary total disability benefits is denied.

Respondent shall pay Petitioner permanent partial disability benefits of $229.20/week for 10.75 weeks, as the injuries sustained by Petitioner has caused a 2.5% loss of use of the right leg and a 2.5% loss of use of the left leg.

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 4, 2020
Date

JUN 2 9 2020

MARTHA OLIVA v. KOCH FOODS
15 WC 4751, consolidated 15 WC 4752, 15 WC 4753

INTRODUCTION

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

15 WC 4751 (DOI: 8/17/2012): ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***L:*** What is the nature and extent of the injury?

15 WC 4752 (DOI: 10/12/2013): ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***L:*** What is the nature and extent of the injury?

15 WC 4753 (DOI: 11/24/2014): ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** What temporary benefits are in dispute? TTD; ***L:*** What is the nature and extent of the injury?

Petitioner testified through a Spanish translator.

STATEMENT OF FACTS

Petitioner Martha Oliva testified that she was previously employed by Respondent Koch Foods. She began working for Respondent in February 2012. Respondent is a supplier of chicken breasts.

Petitioner was employed in slicing or cutting chicken breasts. She worked on a line, with 20 people on each side. She used a very sharp knife with her right hand to cut chicken breasts while holding them with her left hand. She would pick up breasts from in front of her at chest height with her left hand, cut them with her right hand, and then throw them onto another line in front of her at head level. She performed this job for approximately 6 months, and then was then placed on a laser cutter machine. The laser cutter involved 8 people. Workers would rotate between taking chicken pieces out of a

basket, then aligning pieces on the line, and then cleaning excess waste from the chicken pieces. The chicken pieces are cold, but not frozen. The production requirement was 70 pieces per minute for the line. During the years Petitioner worked with Respondent, the production requirement remained the same, but the number of people working on this machine dropped from 8 people to 6, and finally down to 2 people. Employees rotated between positions once per hour.

On August 17, 2012, Petitioner was throwing chicken pieces that had passed through the machine uncut onto another line to be redone. While doing this, she turned, slipped, and fell , doing the splits. A supervisor helped her get up, and she was taken to Physicians Immediate Care (PIC). Petitioner complained of pain in her left leg, her waist, and her back. She also complained of right elbow pain and tailbone pain (PX #1). Petitioner reported that she slipped and fell onto her right buttock and right leg. She also twisted her left knee. She was diagnosed with a hip contusion, lumbar sprain/strain, and left knee sprain.

She followed up with PIC August 20, August 27, September 4, September 11, and September 18, 2012. She received physical therapy through September 17, 2012. Petitioner was released to full duty work on August 27 several times in August and September 2012. In addition to physical therapy petitioner was prescribed Naproxen and Tylenol.

Petitioner was seen at PIC in 2012 after her accident for health concerns unrelated to her work accident injuries. No continuing complaints relating to her accident injuries were documented.

On October 12, 2013, Petitioner suffered a second work accident. She was working on the laser cutter. Only 3 people were working on the laser cutter at this point. Petitioner was working with a high volume of pieces, and felt a spasm in her left neck and shoulder. She reported her complaints and was sent home. She not taken to a doctor.

Petitioner consulted her primary care physician, Dr. Luiz Sudbrack, two days later, on October 14 (PX#2). Petitioner complained of "neck pain all the way down the arm & hand w/numbness on the hand...Patient suffered a work related injury because of repetitive [unknown]." A cervical MRI completed October 17, 2013 demonstrated multiple levels of disc bulging: a 2 mm diffuse bulge at C3-4, a 3 mm disc osteophyte complex with small herniation at C4-5, a 6.5 mm protrusion on the right at C5-6, and a 2.5 mm diffuse bulge at C6-7. Dr. Sudbrack recommended physical therapy and an MRI of the left shoulder on October 18, 2013. MRI Scans of the right elbow, left shoulder, and left elbow were all noted as normal. Petitioner received physical therapy at Norwegian American Hospital through January 16, 2014, which she said provided little relief.

Dr. Sudbrack's clinical notes were handwritten and difficult to decipher. The doctor rarely made notes that seemingly documented a clinical examination, much less an orthopedic or neurological exam. Dr. Sudbrack wrote a series of status notes where he incorporated his diagnosis of cervical radiculopathy without stating the clinical findings in support of that diagnosis. The doctor wrote a note on October 18, 2013 ordering six weeks of physical therapy and on October 24 wrote that Petitioner should be off work for six weeks to complete physical therapy. On December 5, 2013 Dr. Sudbrack wrote an order extending physical therapy for another six weeks. The doctor wrote a note December 30, 2013 that a decision for return to light duty work was dependent on a recommendation of a neurosurgeon at Northwestern Hospital.

Petitioner was referred to Dr. Nader Dahdaleh, whom she saw on December 18, 2013 (PX #2). Petitioner complained of neck pain radiating to both shoulders and the left upper extremity. She also complained of numbness in those areas. Petitioner stated that trigger point injections in the neck gave mild relief. The examination did not note an assessment of cervical range of motion, however motor strength in the upper and lower extremities was normal. Sensation to light touch in pinprick were normal except for the left lateral aspect of her left leg and over the left C6 dermatome of her arm.

Dr. Dahdaleh diagnosed chronic low back pain, chronic neck pain, cervical radiculopathy, and lumbar radiculopathy. Dr. Dahdaleh noted degenerative changes due to cervical spondylosis with foraminal stenosis at C5-6 and C6-7 due to large disc osteophyte complexes. He recommended continued physical therapy and prescribed a Medrol Dosepak. On January 29, 2014, Dr. Dahdaleh recommended a cervical epidural steroid injection, followed by possible C5-6 and C6-7 fusion. Petitioner elected not to have surgery and returned to work in a new position where she could sit.

At Respondent's request Petitioner was examined pursuant to §12 of the Act by orthopedic surgeon Dr. Jay Levin on December 19, 2013. Dr. Levin examined Petitioner separately for her cervical and thoracic spine (RX #1), and also for her lumbar spine (RX #2). Dr. Levin was assisted by case manager Martha Sanchez, R.N., who acted as an interpreter.

With regard to the cervical spine IME Dr. Levin took Petitioner's history of her work activities and her claimed injuries in August 2012 and on October 12, 2013 (PX #1). Dr. Levin also took petitioner's history of her medical care at an occupational health clinic in 2012 and then from Dr. Sudbrack after the 2013 accident. Petitioner's chief complaint was posterior neck pain going down her left arm to the elbow. She rated her pain at 10/10. She also complained of a little pain in her right arm to the elbow and "a lot" of weakness in the left arm. Petitioner also complained of pain between her shoulder blades. Dr. Levin

reviewed respondent's October 17, 2013 accident report, Petitioner's records from Agape Medical Center, the initial physical therapy evaluation from Norwegian American Hospital on October 28, 2013, and radiological imaging.

On examination Dr. Levin noted diminished cervical range of motion. There was bilateral trapezius tenderness but no trigger point tenderness. Spurling's test elicited right posterior cervical discomfort but without radiation into the arms. Spurling's on the left was negative. Toes/heels walking elicited lumbar area pain. Arm strength was normal, as well as reflexes. There was diminished sensation over there were right lateral deltoid, left dorsal, and left volar forearm. There was tenderness over the lower lumbar spine. Lumbar motion was somewhat diminished and painful. Sitting straight leg raise was negative bilaterally. Sensation was decreased over the left medial/lateral calf, medial/lateral thighs, and medial/lateral feet. FABER test on the right elicited central low back pain and on the left elicited left gluteal pain.

Dr. Levin noted radiographs demonstrated degenerative disc changes at C5-6 and also at L2-3 and L3-4. There was facet arthritis at L5-S1. The October 17, 2013 cervical MRI demonstrated age appropriate degenerative disc changes with central annular bulging at C2-3, degenerative right-sided annular bulges at C3-4 and C4-5, a right-sided disc herniation at C5-6, and a right-sided disc protrusion at C6-7. Dr. Levin noted that these findings were inconsistent with Petitioner's subjective complaints. Dr. Levin also noted the left shoulder MRI showed a normal rotator cuff and type II acromion.

Dr. Levin, "assuming [Petitioner] sustained an injury at all", diagnosed cervical myofascial strain. He opined that a course of physical therapy of 10 visits over 5 weeks would be medically appropriate. He found the cervical MRI was within the standard of care but did not believe the MRIs of the right elbow and left shoulder where indicated for any injury on October 12, 2013. He further opined that Petitioner should reach MMI within 4 to 6 weeks after the accident. He did not believe Petitioner required further medical care at that time and opined that Petitioner could return to full duty work.

With regard to the lumbar spine exam recited Petitioner's previously noted history of injury (PX #2). Petitioner reported that 10/10 low back pain, which he said was constant. She complained of pain travels down both by docs and both legs to the feet.. Petitioner reported that she can send for 5 minutes and then has to be a just and that she can walk for 5 minutes but then has to take a break.

On examination Petitioner complained of lower lumbar pain with toes/heels walking. Lumbar range of motion was diminished and painful. There was midline lower lumbar tenderness as well as bilateral lumbosacral and sciatic notch tenderness. Straight-leg raise on the right at 60° elicited low back pain but was negative on the left. However,

sitting straight-leg raise was negative bilaterally. Sensation was decreased over the left medial/lateral calf, medial/lateral thighs, and medial/lateral feet. FABER test on the right elicited central low back pain and on the left elicited left gluteal pain.

Plain X-rays demonstrated degenerative disc changes at L2-3 and L3-4 as well as facet arthritis at L5-S1. The lumbar MRI demonstrated degenerative disc changes at L2-3, L3-4, L4-5, and L5-S1. No significant canal encroachment was noted. There was no evidence of disc herniation at L4-5. There was bilateral facet arthritis with foraminal stenosis at L3-4. There was a left-sided disc protrusion with degenerative changes at L2-3, but L1-2 appeared normal.

Dr. Levin noted that he had not been able to review medical records of treatment for the October 2012 accident. He noted that he would need those records to determine any diagnosis referral to the accident. He further noted that the MRI findings were age-appropriate without evidence of a herniated nucleus pulposus. He further observed that Petitioner had been working following the 2012 accident up to the 2013 accident.

Petitioner did not treat again until September 12, 2014, when she returned to PIC with left neck and shoulder pain (PX #1). She complained of 7/10 left-sided neck and shoulder pain. She reported it was the result of a work-related injury with a sudden onset with a change in her job to a higher speed line. On examination Petitioner had reduced range of motion, but it was noted that she exhibited guarding out of proportion to the injury. It was also noted that Petitioner exhibited hypersensitivity out of proportion to the injury.

Petitioner sought care at PIC June 18, June 19, and June 26, 2014 for bruising around the left eye. She reported that while at work she stepped off a stepstool and struck her left orbit while sneezing. There were no complaints relating to the neck or back. On examination particular Petitioner's neck was noted as supple with good range of motion. There was no tenderness of the neck or cervical spine. No continuing complaints relating to her more recent accident injuries were documented.

On November 24, 2014, Petitioner was again working at Respondent in a seated position on a stool. Petitioner stepped off the stool to use the restroom and slipped on the wet floor, again doing the splits. She felt pain in her back and left hip. She was taken to PIC that day, where she complained of pain in the left thigh, left knee, right side, and right knee. She also complained of neck and low back pain with "tingling." In addition, she complained of pain in the left and right hands with "tingling." The clinical exam was essentially normal. X-rays were negative. Petitioner was diagnosed with a knee contusion, ankle/foot pain, and lower back pain. She was taken off work that day and released to return to work on November 25 with restrictions to avoid squatting and

extended standing until December 1, 2014. "All Day" and "Non-Aspirin" pain medication was dispensed.

Petitioner returned to PIC December 1, 2014 with continuing complaints of pain in the left thigh, left knee, right thigh, and right knee. The clinical examination was essentially normal, and the diagnoses were unchanged. She was released with restrictions for sit-down work only. "All Day" pain medication was discontinued. Petitioner returned to PIC December 5, 2014 with the same complaints but were reported as mild. She reported that she could stand and walk and a normal pace without discomfort. She did note a cracking noise in her knee, which one was not noted, when she walked fast. Petitioner was released to full duty work without restrictions, and it was noted that she should attain full resolution in 7 days.

Petitioner continued to follow up with her primary care physician, Dr. Sudbrack, in 2014 for unrelated issues. She saw Dr. Sudbrack December 17, 2014 with left knee complaints after falling at work 8 days before. Dr. Sudbrack's handwritten notes were indecipherable such that it is impossible to determine the extent of the clinical examination.

Petitioner returned to Dr. Sudbrack on January 14, 2015, who then recommended a left knee MRI without noting whether he had assessed Petitioner's knee with clinical testing for a torn meniscus or ligament. The January 23, 2015 MRI demonstrated mild effusion only (PX #2). Petitioner continued to follow with Dr. Sudbrack through February and March 2015. On February 5 Dr. Sudbrack noted that he filled out disability forms. Petitioner had a lumbar MRI February 25, 2015 on order of Dr. Sudbrack, but a complete copy of the radiology report was not included in Petitioner's Exhibit #2. The complete report was incorporated in Petitioner's Exhibit #12. The radiologist noted multilevel diffuse disc bulging and hypertrophy, as well as spondylolisthesis, from L2-3 through L5-S1.

Petitioner testified that she then sought care at New Life Medical Center (New Life) on February 6, 2015 (PX #7). The New Life records, PX #7, document Petitioner's first contact with chiropractor Dr. Irene Ma was on September 18, 2014, which Petitioner did not testify about at trial. On September 18 Petitioner gave a history of her work injury on October 12, 2013. She complained of constant neck pain and muscle spasm in the neck and pain across the left shoulder and down the left arm with numbness and tingling in her left arm. She complained of 10/10 pain. Dr. Ma diagnosed cervical sprain/strain, cervicalgia, cervical radiculitis, shoulder sprain/strain, shoulder pain, shoulder stiffness, arm pain, muscle spasm, and work related injury. Petitioner then received extensive chiropractic care for her neck and shoulder from Dr. Ma, however the dates of care are obscured in the copied records.

Petitioner testified that she was taken off work at the February 6, 2015 consultation and did not return to work for Respondent.

There are no clinical notes for Petitioner's consultation with Dr. Ma on February 6, 2015 (PX #7), although there were billing records. There are billing records for February 10, February 12, February 13, February 17, February 19, February 20, February 24, and February 27, 2015, for which there are chiropractic progress notes but no physician notes. Dr. Ma's first clinical note March 10, 2015 documents Petitioner's complaints of 9/10 pain in the neck, 9/10 pain in the left shoulder, and 9/10 pain in the left arm with numbness/tingling/weakness in the left arm. However, there was no reference to Petitioner's claimed work accident on November 24, 2014. Dr. Ma added a diagnosis of cervical disc herniation at that time. There were no notes regarding Petitioner's work status.

Petitioner testified that she was referred to Dr. Neeraj Jain for her pain, whom she saw on March 25, 2015 with complaints of neck and back pain. Petitioner gave a history of feeling a pop in her neck with severe neck pain and left arm weakness on October 12, 2013 at work. She did not mention a work accident on November 24, 2014. She complained of pain radiated into her left arm. She also complained of paresthesia Petitioner also complained of pain in her right arm. Petitioner reported that her back pain began in 2012 with a work-related incident. She also reported that physical therapy had restarted in September 2014 but stopped after one or two months. A third round of physical therapy started in March 2015.

Dr. Jain reiterated the radiologist's findings from the 2013 cervical MRI. He also reiterated the radiologist's findings of mild spondylosis at L2 through L5 with annular disc bulging from the 2013 lumbar MRI. He noted the 2013 left shoulder MRI showed a normal rotator cuff and a type II acromion.

Dr. Jain noted significantly reduced cervical range of motion with pain. Lumbar range of motion was also reduced. Straight-leg raise was positive on the right. There was reduced sensation to touch in the left upper extremity without described distribution. Dr. Jain noted prominent weakness in the left upper extremity. Diagnosed neck pain related to the October 12, 2013 accident. Dr. Jain recommended a C5-6 and C6-7 epidural and another lumbar MRI. Petitioner continued to receive chiropractic care from Dr. Ma March and April 2015.

Dr. Ma's clinical note on April 14, 2015 noted Petitioner claimed 9/10 pain in her neck, left shoulder, and left arm. She also complained of numbness and weakness in the left arm. There is no note that Petitioner reported an accident at work on November 24,

2014 in which she was again injured. Petitioner saw Dr. Ma again on May 19, 2015. Her pain remained 9/10. Again, there was no reference to a November 24, 2014 work accident. There was no note regarding work status. On June 23, 2015 Dr. Ma noted no change in Petitioner's complaints. Again, there was no reference to a November 24, 2014 work accident or any note regarding work status.

Dr. Jain administered an interlaminar cervical epidural steroid injection at C7-T1, assisted by Susan Jain, PA-C, on June 19, 2015. Dr. Jain administered bilateral L4-5 transforaminal epidural steroid injections (ESI) and selective nerve root blocks, assisted by Sarah Spring, P.A., in July 7, 2015. Petitioner's Exhibit #13 is billing statements of Thomas C. Corral, CRNA, Windy City Anesthesia, for administering nerve blocks on June 19, 2015 and on July 7, 2015. No clinical or operative reports by CRNA Corral for these procedures were included in Petitioner's Exhibit #13 or otherwise offered in evidence.

Petitioner saw Dr. Jain again on July 25, 2015, when he noted Petitioner had received bilateral L4-5 transforaminal ESI and selective nerve root block on "July 17" (*sic*). Dr. Jain also noted that Petitioner had received a cervical epidural steroid injection on "June 09, 2015" (*sic*).

Petitioner saw orthopedic surgeon Dr. Ronald Silver on April 25, 2015 (PX #5). Petitioner gave a history of her October 12, 2013 work injury from repetitive motion activity. Petitioner complained of pain in her neck and her shoulder and was treated with physical therapy and anti-inflammatories. He noted that Petitioner had been able to work until January 2015 when her pain became too severe. On examination Petitioner had reduced range of motion and had positive impingement and Hawkins' signs. He noted an MRI scan demonstrated inflammation of the rotator cuff, without noting if it was the 2013 or 2015 MRI he relied on. Dr. Silver diagnosed "rotator cuff" and impingement and administered a cortisone injection in the left shoulder. He also prescribed Meloxicam, hydrocodone, and Ultram.

Petitioner's Exhibit # 16 was billing from G & U Orthopedic for May 1, 2015 for $2,684.59 and for June 18, 2015 for $612.56 (PX #16). These charges were apparently for durable medical equipment ordered by Dr. Ma. Dr. Ma's notes in the New Life chart do not state the medical necessity for durable medical equipment.

On July 16, 2015, Dr. Silver noted a positive temporary response to the left shoulder injection. Petitioner's exam was essentially unchanged. Dr. Silver noted her complaints of left-sided neck pain radiating into the arm and hand, for which he recommended she see a cervical spine specialist. Dr. Silver recommended arthroscopic shoulder surgery without specifying what the surgery was intended to correct, which Petitioner declined.

Petitioner continued to consult with Dr. Jain through 2015 (PX #4). On August 12 Petitioner reported she was attending physical therapy 3 times a week which provided substantial benefit. However, it was noted Petitioner continued to be off work due to her substantial pain. Dr. Jain recommended an EMG of the upper extremities because of neck pain complaints radiating down the left arm. Dr. Jain also recommended a repeat lumbar L4-5 transforaminal ESI and selective nerve block.

Dr. Ma's clinical note on August 11, 2015 again referred to Petitioner's injury sustained while at work on October 12, 2013. Petitioner complained of 8/10 pain in her neck, left shoulder, and left arm. Again, she complained of numbness and tingling in the left arm. Again, there was no reference to a work accident on November 24, 2014. Dr. Ma's clinical note on October 8, 2015 was essentially identical to the August 11 note, as were Dr. Ma's notes on December 1, 2015 and January 22, 2016.

Petitioner had an EMG/NVC performed by chiropractor Dr. Gregory Thurston on September 14, 2015 (PX #8). The only finding was mild-moderate evidence of carpal tunnel syndrome.

On September 15, 2015 Dr. Jain noted that Petitioner's EMG showed no evidence of radiculopathy. She still complained of moderate to severe neck pain radiating into the left arm as well is bilateral back pain radiating into the left leg. Dr. Jain continued to recommend lumbar ESIs October 13, 2015 and on the last visit February 10, 2016.

Petitioner consulted neurosurgeon Dr. Robert Erickson March 30, 2016 for her cervical and lumbar pain which began with a work injury October 17, 2013 (PX #6). Petitioner reported the sudden onset of neck and left shoulder pain with radiation of abnormal sensation in all fingers of the left hand. Petitioner also reported the onset of low back pain soon thereafter which radiated into her left leg. Petitioner also reported low back pain secondary to a prior injury which she could not adequately describe. Dr. Erickson reviewed the 2013 and 2015 MRIs. He noted the cervical MRI showed a central disc herniation at C5-6 with slight rightward prominence. He noted there was a broad disc herniation at C6-7 of lesser significance.

On examination Dr. Erickson noted diminished left grip strength and Petitioner's report of paresthesia in all fingers. Light touch in pinprick for diminished over the dorsum of the hand and over the extensor forearm. Cervical motion was relatively full but painful. Dr. Erickson suspected C8 radiculopathy but wanted a new cervical MRI before a final surgical opinion. He suggested a somatosensory evoked potential test the upper extremities to rule out a C7 nerve problem.

On May 18, 2016 Dr. Erickson reviewed the SSEP of April 26, 2016. He noted there were significant delays bilaterally at C6, the right being worse. There were mild delays bilaterally at C7. He explained to Petitioner that the MRI compression of the spinal cord on the right and C5-6. He opined that Petitioner had a good chance of improving with an interior cervical discectomy and fusion at C5-6 and possibly C6-7.

Dr. Erickson commented on Dr. Levin's December 19, 2013 IME, in which Dr. Levin attributed the cervical disc herniation to degenerative joint disease. Dr. Erickson stated it is impossible to determine on MRI alone whether herniations exist as a result of trauma or as a result of degenerative change. He added that changes are often a combination of both processes and that the persistence of Petitioner's condition did not support Dr. Levin's diagnosis of myofascial strain.

On August 10, 2016 Dr. Erickson noted Petitioner hoped to avoid surgery. He explained that surgery was her best option but noted it was not an emergency situation. He did not recommend back surgery but did note petitioner was a good candidate for a second ESI.

Petitioner chose not to have this surgery as well due to a fear of surgery.

Petitioner returned to work for a new company, the Millard Group, working as a janitor, on November 10, 2016. She also worked on weekends selling jewelry in a flea market while she was between jobs. She testified she is in constant neck pain, and is regularly taking ibuprofen. She has constant low back pain as well. She is able to complete all of her tasks at work, as the work is not difficult.

Petitioner was examined again at Respondent's request pursuant to §12 on November 19, 2018 by orthopedic surgeon Dr. Babak Lami (RX #3). Dr. Lami's medical assistant served as an interpreter. Petitioner gave a history of working for Respondent from 2012 through 2015. She reported her initial injury in October 2012 when she developed neck and left arm pain. Petitioner reported a second injury for which she could not recall the exact dates but believed it was in 2013 when she slipped and fell onto her buttocks. Petitioner denied having any injuries in 2014.

At the time of the examination Petitioner rated her pain 8/10, localized at the base of her neck between her shoulder blades and the left shoulder. She did not report pain radiating down the left arm. Petitioner also complained of low back pain which also involve the posterior thigh and posterior left calf. Dr. Lami noted the left leg symptoms did not fall into a particular dermatome. Petitioner's main complaints were neck and low back pain and that her left shoulder and left leg were not her main complaints.

On examination Dr. Lami noted minimal cervical flexion and extension and only 30° rotation bilaterally. Lumbar spine extension was at 0°, flexion was 5°, and side bending was 10°. Dr. Lami found normal muscle strength in both the upper and lower extremities. Dr. Lami found sensation was grossly intact although Petitioner reported slightly altered sensation over the entire left arm.

Dr. Lami reviewed Petitioner's records from Norwegian American Hospital, New Life Medical Center, Dr. Sudbrack, Dr. Silver, Dr. Jain at Pinnacle Pain Management, Dr. Erickson, and Dr. Levin's IME reports. Dr. Lami he also reviewed various radiological studies and reports, as well as the September 14, 2015 EMG/NCV report performed by chiropractor Dr. Gregory Thurston.

Dr. Lami did not find that Petitioner sustained a work-related injury to her cervical spine. He did concede that Petitioner's assembly-line work activities could possibly cause a sprain, which would have been self-limiting. He noted that Petitioner's current symptomology of 8/10 pain was not explained by her lumbar and cervical MRIs. He found no evidence of radiculopathy or neurological deficit. He noted that the cervical MRI findings were right-sided, which was inconsistent with Petitioner's symptoms always being left-sided. Dr. Lami also noted that Petitioner's lumbar MRI findings were fairly benign with age-appropriate degenerative changes.

Dr. Lami could not support a need for treatment of Petitioner's claimed cervical spine condition. He particularly noted Petitioner's inability to provide a consistent history of the 3 alleged injuries. Dr. Lami opined that Petitioner's cervical spine symptoms would not be "amenable" to injections. He did not agree with the recommendation for a C5-6 fusion because Petitioner's symptoms were not consistent with radiculopathy. He particularly noted that any recommended surgery was not related to any work injury. Dr. Lami found Petitioner had reached MMI for her low back within 6 to 8 weeks and that Petitioner was capable of full time at full duty at selling gold on weekends as she reported doing for the previous 3 years.

Finally, Dr. Lami noted Petitioner's out of proportion complaints when compared to the MRI findings, exam findings, and the report of mechanism of injury. He noted this was consistent with symptom magnification.

Petitioner had another §12 IME with orthopedic surgeon Dr. Nikhil Verma of Midwest Orthopaedics at RUSH on December 17, 2018 (RX #4. Dr. Verma was assisted by a certified Spanish-English medical interpreter. Dr. Verma noted Petitioner's history of three work accidents on August 17, 2012, on October 12, 2013, and on November 24, 2014.

Dr. Verma noted that Petitioner was unclear as to specifically which body parts were injured in which event but that her current complaints were with neck pain, back pain, left upper extremity pain, and left lower extremity pain. She complained that her pain starts in the neck, radiates into the thoracic back and low back and also into her left arm and hand, as well as her left leg. She stated that when it stops at the knee she feels a sharp pain in the knee itself. Dr. Verma noted difficulty in obtaining a history of treatment from Petitioner.

Dr. Verma reviewed the records of Petitioner's medical care, including radiological studies. Dr. Verma noted Petitioner's care included physical therapy, chiropractic therapy, and spinal cortisone injections. On examination Petitioner complained of pain with neck movement. She had full range of shoulder motion and normal strength. Although Petitioner complained of hand numbness the neurological exam of the left arm was normal. Petitioner had full range of knee motion with negative Lachman's and drawers signs. Straight-leg raise was negative.

Dr. Verma found Petitioner's left knee was normal. He also found no abnormality in Petitioner's left shoulder, although he requested an opportunity to review her shoulder MRI. Dr. Verma did not believe that Petitioner sustained a left knee or left shoulder injury in as a result of either the 2012 or 2013 or 2014 reported accidents. He noted that Petitioner's medical records document claims of overuse repetitive lifting. He suspected possible left cervical radiculopathy rather than a left shoulder issue. He opined that Petitioner did not require medical treatment for her left knee or her left shoulder in relation to any work injury. He found Petitioner at MMI with regard to her left knee and left shoulder and that she was at full duty status with regard to the left knee and left shoulder. He saw no need for work restrictions. Finally, he commented that he saw no evidence that Petitioner sustained any permanent or partial disability with regard to her left knee or left shoulder.

Charmell Johnson testified on behalf of Respondent. Ms. Johnson work for respondent for six years. She is currently safety coordinator for the Berteau location. And 2013 she was a general labor employee and work that the DSI line. She is familiar with Petitioner, who also worked the DSI line.

Ms. Johnson is familiar with the job duties when working the DSI line. Workers are rotated every hour on the hour to different assignments. The DSI line requires 8 workers, 4 in front and for in back. If 8 workers were unavailable the DSI line would not be operated. Workers would handle chicken pieces weighing 8 to 10 ounces.

CONCLUSIONS OF LAW

15 WC 4751 (DOI: 8/17/2012)

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

The Arbitrator finds that Petitioner proved that her condition of ill-being in her low back was causally related to her work accident on August 17, 2012.

Petitioner suffered an undisputed accident at work where she slipped and fell on August 17, 2012. She claims injury to her left leg, waist, and back. She treated with Physicians Immediate Care until September 18, 2012, approximately one month, with a final diagnosis of a lumbar strain. The Arbitrator finds that Petitioner's lumbar spine strain was related to the August 17, 2012 accident.

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

The Arbitrator finds that Petitioner proved that the medical services provided for treatment of her injuries were reasonable and necessary and, further, the charges and fees for the care were also reasonable and necessary.

Petitioner suffered an undisputed accident at work where she slipped and fell on August 17, 2012. She claims injury to her left leg, waist, and back. She treated with Physicians Immediate Care (PIC) until September 18, 2012, approximately one month, with a final diagnosis of a lumbar strain. The Arbitrator finds that Petitioner's lumbar spine strain is related to the August 17, 2012 accident through her last date of service, September 18, 2012.

No outstanding bills from PIC were presented at trial, and therefore no bills are awarded under this claim.

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

Petitioner's claim for permanent partial disability was evaluated in accord with §8.1b of the Act:

i) No AMA Impairment Rating was offered in evidence. The Arbitrator cannot give any weight to this factor.

ii) Petitioner worked in a fast-paced food processing plant which required significant repetitive activity. Petitioner was able to return to work to her former job. The Arbitrator gives great weight to this factor.

iii) Petitioner was 50 years old at the time of her accident. She had a statistical life expectancy of approximately 32 years. The Arbitrator gives little weight to this factor.

iv) There was no evidence that Petitioner's future earning capacity was adversely affected by her injuries. She was able to return to full duty work until she was injured in a subsequent accident. The Arbitrator gives great weight to this factor.

v) The medical records show that Petitioner sustained a lumbar strain from which she recovered sufficiently to return to full duty work. The Arbitrator gives great weight to this factor.

Based on all the evidence, including the above five factors, the Arbitrator finds that Petitioner suffered a permanent partial disability of 2% of a person-as-a-whole, 10 weeks, due to injuries that she sustained at work August 17, 2012.

15 WC 4752 (DOI: 10/12/2013)

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

The Arbitrator finds that Petitioner proved that she sustained an accidental injury that arose out of and in the course of her employment by Respondent.

Petitioner testified credibly that on October 12, 2013 she experienced an onset of left-sided neck pain while working on the laser cutter line machine. While working quickly and trying to keep up with the chicken pieces on the line, her neck suddenly felt tensed and paralyzed. This was reported the same day, and Petitioner was immediately sent home. Her treating physician, Dr. Sudbrack, attributed the injury to repetitive work just two days later, on October 14, 2013.

The mechanisms of work activities described by Petitioner, particularly those she was engaged in on October 12, 2013, are sufficiently repetitive that the Arbitrator finds they arose out of Petitioner's employment with Respondent, constituting a risk incidental to her employment.

There was no evidence offered to rebut Petitioner's claim that her injury arose out of and in the course of her employment.

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

The Arbitrator finds that Petitioner proved that her condition of ill-being relating to her cervical spine is causally related to her work accident on October 12, 2013.

Petitioner testified that she had a sudden onset of neck and left shoulder pain while working October 12, 2013. She sought medical care from her primary physician, Dr. Sudbrack, two days later and was prescribed physical therapy. Dr. Sudbrack referred Petitioner to orthopedic surgeon Dr. Dahdaleh, who noted MRI findings of degenerative changes from C3 through C7 in Petitioner's cervical spine. Dr. Dahdaleh diagnosed cervical radiculopathy for which he recommended an anterior cervical fusion, which Petitioner declined. Dr. Erickson also recommended cervical fusion despite Petitioner's diffuse, vague, and inconsistent subjective complaints.

Dr. Jay Levin, who examined Petitioner on behalf of Respondent, diagnosed cervical myofascial strain. Dr. Levin noted in particular the age-appropriate degenerative changes in Petitioner's cervical spine which were inconsistent with Petitioner's subjective complaints. Dr. Levin, as well as Dr. Lami, noted Petitioner's left-sided upper extremity complaints were inconsistent with the MRI right-sided findings in her cervical spine. In addition, the Arbitrator notes Petitioner's consistent complaints of numbness and weakness in her left arm, excepting for Dr. Dahdaleh's one exam, were diffuse and vague and often accompanied normal neurological and strength testing. But for Dr. Dahdaleh, none of Petitioner's treating physicians identified Petitioner's complaints of left arm and numbness and weakness with any recognized dermatome.

In addition, Petitioner received seemingly unending chiropractic therapy from Dr. Ma which failed to provide relief or progress with Petitioner's condition.

There was significant evidence of Petitioner's symptoms magnification. She frequently and consistently complained of 10/10 pain to her treating physicians, who did not respond in a way appropriate to belief that the 10/10 pain complaints were genuine.

The evidence suggests, as noted by Dr. Levin, Petitioner had age-appropriate pre-existing degenerative changes in her cervical spine that did not correspond to her subjective complaints. The Arbitrator finds Dr. Levin's opinion Petitioner sustained a myofascial strain to her cervical spine to be convincing and persuasive. The arbitrator finds that petitioner failed to prove that she sustained an injury to her cervical spine for which surgery would have been medically necessary. It is particularly noteworthy that Petitioner returned to work before her third accident on November 24, 2014.

Dr. Silver examined Petitioner's left shoulder and recommended surgery despite an MRI demonstrating a normal rotator cuff and only a type II acromion. He never documented his reasoning or noted a clinical basis for recommending surgery. On the other hand, Respondent's examining physician Dr. Verma found no pathology petitioner's left shoulder and opined surgery was not medically necessary. The Arbitrator finds Dr. Verma's opinions reasonable and persuasive, and adopts the same.

To confirm, the Arbitrator finds that Petitioner failed to prove that she sustained cervical disc herniations and radiculopathy were causally related to the October 12, 2013 work accident. In addition, Petitioner failed to prove that she had sustained an injury to her left shoulder that was causally related to the October 12, 2013 work accident. Petitioner proved that she sustained a myofascial cervical strain that was causally related to the accident, which was likely an aggravation of her pre-existing degenerative cervical spine.

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?

As noted above the Arbitrator found that Petitioner sustained a myofascial strain to her cervical spine that was causally related to her October 12, 2013 work accident. Also noted above, the Arbitrator found the opinions of Dr. Levin to be reasonable and persuasive. Dr. Levin opined that Petitioner would benefit from 5 weeks of physical therapy and would likely achieve MMI within 6 weeks of the accident. Dr. Levin further opined that Petitioner did not require further medical care for her accident injuries.

The Arbitrator finds the opinion of Dr. Levin regarding Petitioner's MMI reasonable and persuasive. Therefore, it follows that the Arbitrator finds that the medical care provided Petitioner after 8 weeks following the October 12, 2013 work accident was not reasonable or necessary.

Dr. Levin noted that a cervical MRI was within the standard of care for assessing Petitioner's claimed neck injury. However, he noted that MRIs of the left shoulder and right elbow were not clinically indicated. The Arbitrator adopts Dr. Levin's opinion regarding the left shoulder and right elbow MRI and denies Petitioner's request for payment of those procedures.

The credibility and reliability of the care provided at New Life Medical Center is inherently suspect in light of the unending chiropractic services with no progress in relieving Petitioner's complaints, frequently noted at 10/10. In addition, the reliability of New Life's records were further undermined when there was no record of Petitioner's third work accident on November 24, 2014.

Dr. Lami opined, due to Petitioner's inconsistent clinical presentation and the lack of evidence of radiculopathy, and cervical spine injections were not medically indicated. Given Petitioner's well noted inconsistent symptoms and the negative EMG/NCV, the Arbitrator finds Dr. Lami's opinion reasonable and persuasive and denies Petitioner's

request for payment for those procedures. Although Dr. Lami did not opine whether Dr. Jain's lumbar spine injections were medically necessary, the evidence of the inconsistencies in Petitioner's clinical presentation of her claim in the back injury leads to the same conclusion that Petitioner failed to prove the medical necessity of the lumbar spine injections. Therefore, the Arbitrator does not award the medical fees and charges relating to either series of cervical or lumbar spine injections.

With regard to the spinal injections administered by Dr. Jain on June 19, 2015 and July 7, 2015, billing statements by Thomas Corral CRNA totaling $1,942 for June 19 and $2,002 for July 7 were admitted in Petitioner's Exhibit #13, Windy City Anesthesia . Dr. Jain noted that an anesthesiologist attended those procedures due to Petitioner's anxiety. Aside from noting that Mr. Corral is a Certified Registered Nurse Anesthetist rather than an anesthesiologist, there were no clinical or operative records by CRNA Corral admitted in evidence. The Arbitrator cannot award billing when there are no clinical records to correspond to the charges, rendering it impossible to determine the reasonableness of the charges.

In summary, the Arbitrator does not award medical expenses and charges for beyond 6 weeks after the accident on October 12, 2013.

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

Petitioner's claim for permanent partial disability was evaluated in accord with §8.1b of the Act:

i) No AMA Impairment Rating was offered in evidence. The Arbitrator cannot give any weight to this factor.

ii) Petitioner worked in a fast-paced food processing plant which required significant repetitive activity. Petitioner was able to return to work to her former job. The Arbitrator gives great weight to this factor.

iii) Petitioner was 52 years old at the time of her accident. She had a statistical life expectancy of approximately 30 years. The Arbitrator gives little weight to this factor.

iv) There was no evidence that Petitioner's future earning capacity was adversely affected by her injuries. She was able to return to full duty work until she was injured in a subsequent accident. The Arbitrator gives great weight to this factor.

v) The records show that Petitioner received aggressive medical care for a cervical myofascial strain. A competent and persuasive physician opined that Petitioner had reached MMI with her neck within 8 weeks of her October 12, 2013 work accident. No further medical would be necessary after reaching MMI. A competent and persuasive physician opined that Petitioner had not injured her left shoulder. In addition, the records also suggest that Petitioner's symptom magnification was the likely

justification for the unnecessary medical provided after she reached MMI. Moreover, there was a persuasive inference that, based on other reasoning, spinal injections were not medically indicated. It is also noteworthy that Petitioner declined recommendations for surgery and returned to her prior employment before being injured in a third work accident. The Arbitrator gives great weight to this factor.

Based on all the evidence, including the above five factors, the Arbitrator finds that Petitioner suffered a permanent partial disability of 10% of a person-as-a-whole, 50 weeks, due to injuries that she sustained at work October 12, 2013.

15 WC 4753 (DOI: 11/24/2014)

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

Although there is evidence that Petitioner sustained contusions to her right and left knees and legs in a work accident November 24, 2014, the Arbitrator finds that Petitioner failed to prove that her claimed current condition of ill-being in her left knee, left shoulder, and low back were causally related to the November 24 work accident.

Petitioner received emergent medical care at Physicians Immediate Care (PIC) on the day of her work accident. On intake, Petitioner complained of left thigh, right thigh, right knee, low back, neck, and bilateral hand pain. She was instructed to return to work in an essentially sedentary capacity until December 1, 2014. These restrictions were modified on December 1, 2014 to sit down work only, when her complaints were limited to both thighs and knees. Petitioner was released from PIC December 5, 2014 to full duty, with a note that full resolution of her symptoms would be within 7 days, although petitioner testified that she had continuing low back pain.

Petitioner once again sought out her primary care physician, Dr. Sudbrack, who took her off work again on December 17, 2014 due to left knee pain. Petitioner followed up with Dr. Sudbrack until February 6, 2015 when she testified that she began a course of treatment at New Life Medical Center. She was eventually referred to Dr. Neeraj Jain, who recommended and performed cervical and lumbar injections in June and July of 2015. Petitioner testified that these injections were only temporarily helpful.

However, as noted, the indecipherable handwritten clinical notes Dr. Sudbrack making it impossible to assess whether his medical care was causally related to petitioner's claimed injuries. The doctor ordered a left knee MRI, but the arbitrator was unable to determine if standard accepted clinical testing for a torn meniscus or ligament was performed. Such a clinical assessment with positive findings would support an order

for an MRI, however the Arbitrator finds no evidence of such an assessment. Dr. Sudbrack did have readable work status notes indicating cervical pathology without indicating whether it was related to the October 12, 2013 injury or the November 24, 2014 injury.

Petitioner testified that she returned care at New Life Medical Center on February 6, 2015, for which there were no clinical notes. In fact, no clinical notes in the New Life chart referred to any claimed injury at work on November 24, 2014. None of Dr. Jain's clinical notes referred to a work-related injury on November 24, 2014. Absent such documentation, the Arbitrator cannot find that Petitioner proved that she sustained any injury on November 24, 2014 that required medical care at New Life Medical Center or by Dr. Jain.

When Petitioner consulted Dr. Silver for her left shoulder complaints there was, again, no historical reference to a work accident on November 24, 2014.

When Petitioner consulted Dr. Erickson for her neck and back complaints there was, again, no historical reference to a work accident on November 24, 2014.

It was noted above that Dr. Lami, who had examined Petitioner on behalf of Respondent, opined that Petitioner should have reached MMI within 6 to 8 weeks of the October 12, 2013 accident. Inasmuch as Petitioner had denied to Dr. Lami that she had been injured in the 2014 accident, Dr. Lami offered no opinion regarding petitioner's claimed injuries from the November 24, 2014 incident at work.

It was noted by Dr. Verma, who also examined Petitioner on behalf of Respondent, that he could find no evidence of a left shoulder injury.

When all the evidence is weighed, the Arbitrator can only find that Petitioner sustained contusions to her left and right knees and legs, for which she received no physical therapy and from she recovered by the time of her released to full duty work by medical professionals at Physicians Immediate Care on December 5, 2014.

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

The Arbitrator finds, based on evidence and reasons stated above, that Petitioner proved that the medical services she received through December 5, 2014 were reasonable and necessary and that the charges for that care were also reasonable and necessary.

As noted above, healthcare providers consulted by Petitioner after her November 24, 2014 work accident did not document Petitioner's report that she had been injured in such an accident. All other healthcare providers following the November 24, 2014 accident referenced Petitioner's October 12, 2013 accident as the initiating event relating to her complaints. The Arbitrator cannot find that medical care provided by chiropractors and physicians would reasonably relate that care to an accident they knew nothing about.

K: What temporary benefits are in dispute? TTD

The Arbitrator finds that Petitioner failed to prove that she is entitled to total temporary disability benefits as claimed from February 6, 2015 to November 1, 2016 (ArbX #3).

Petitioner's claim that she was totally disabled from employment from February 6, 2015 as relating to her injuries claimed from a work accident on November 24, 2014 is not supported by the evidence. Petitioner testified that she first sought care at New Life Medical Center on February 6, 2015, for which there are no clinical notes. However, each New Life clinical note failed to document a report from Petitioner that she had been injured on November 24, 2014. The only date of injury during the treatment following November 24, 2014 was October 12, 2013. In addition, there were no work status notes in the New Life chart notes.

While other healthcare providers did take Petitioner off work, those physicians did not have a history of Petitioner's claimed November 24, 2014 work accident. Those physicians always referenced the October 12, 2013 injuries. Therefore, their off work directives could not be related to the claimed November 24, 2014 work injuries.

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

Petitioner's claim for permanent partial disability was evaluated in accord with §8.1b of the Act:

i) No AMA Impairment Rating was offered in evidence. The Arbitrator cannot give any weight to this factor.

ii) Petitioner worked in a fast-paced food processing plant which required significant repetitive activity. Petitioner was released to full duty to her former job. The Arbitrator gives great weight to this factor.

iii) Petitioner was 53 years old at the time of her accident. She had a statistical life expectancy of approximately 29 years. The Arbitrator gives little weight to this factor.

iv) There was no evidence that Petitioner's future earning capacity was adversely affected by the injuries she proved. She was released to return to

full duty work on directions of healthcare professionals at Physicians Immediate Care. The Arbitrator gives great weight to this factor.

v) The medical records show the Petitioner received minimal medical intervention at Physicians Immediate Care following her accident. Petitioner was released to full duty work December 5, 2014. All subsequent healthcare providers, excepting for Dr. Sudbrack, were unaware of Petitioner's claimed work accident on November 24, 2014. Dr. Sudbrack's records and adequately documented Petitioner's diagnosis and the necessity of further medical care. The Arbitrator gives great weight to this factor

After evaluating all the evidence, including the above five factors, the arbitrator finds that Petitioner sustained contusions to his right and left legs and knees which resulted in permanent partial disability of 2.5% of the right leg and permanent partial disability of 2.5% in the left leg, a total of 10.75 weeks.

Steven J. Fruth, Arbitrator

June 26, 2020
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC004752
Case Name	OLIVA, MARTHA v. KOCH FOODS
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0307
Number of Pages of Decision	40
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Brenton Schmitz
Respondent Attorney	Anthony Ulm

DATE FILED: 6/18/2021

/s/Deborah Simpson, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARTHA OLIVA,

Petitioner,

vs. NO: 15 WC 4752

KOCH FOODS,

Respondent.

DECISION AND OPINION ON REVIEW

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

This matter was consolidated with companion claims, 15 WC 4751 and 15 WC 4753. In the instant claim, the Arbitrator found Petitioner proved a compensable accident on October 12, 2013, found that accident caused a current condition of ill-being of a myofascial strain of her cervical spine, awarded her medical expenses incurred through November 23, 2013, and awarded her 50 weeks of PPD benefits representing loss of the use of 10% of the person-as-a-whole.

The Commission agrees with the Arbitrator's findings of compensable accident, that accident caused a condition of ill-being of a cervical myofascial strain, and his award of 50 weeks of PPD representing loss of 10% of the use of the person-as-a-whole. Therefore, the Commission afforms and adopts those aspects of the Decision of the Arbitrator.

The Arbitrator specified that he was only awarding medical treatment within six weeks of the work accident/injury. The Arbitrator did so based on Dr. Jay Levin's Section 12 medical report, in which he diagnosed that Petitioner sustained a myofascial strain in the work accident and she should have been at MMI within six weeks of the injury. The Commission agrees with the Arbitrator's determination that Petitioner sustained only a myofascial cervical strain in the work accident.

However, in this instance the Commission disagrees with the arbitrary cut-off of payment of medical expenses after six weeks based on the theoretical determination of expected MMI opined by a Section 12 medical examiner. Rather, the Commission finds September 12, 2014 as a more appropriate date to terminate medical expenses for the instant injury. On that date, Petitioner presented to Physicians Immediate Care, was declared at MMI for her cervical condition, and released to work at full duty for that condition. Therefore, the Commission modifies the Decision of the Arbitrator to extend Respondent's obligation to pay medical expenses associated with Petitioner's cervical condition through September 12, 2014.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Corrected Decision of the Arbitrator dated June 29, 2020 is hereby modified as noted above and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay for all reasonable and necessary medical expenses incurred to treat Petitioner's work-related cervical condition through September 12, 2014, pursuant to §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner permanent partial disability benefits in the amount of $229.20 for 50 weeks, as the injury has caused the loss of the use of 10% of the person-as-a-whole pursuant to §8(d)(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 $25,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

June 18, 2021

/s/ *Deborah L. Simpson*
Deborah L. Simpson

/s/ *Steven J. Mathis*
Steven J. Mathis

DLS/dw
O-4/20/21
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/s/ *Deborah J. Baker*
Deborah J. Baker

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0307
NOTICE OF ARBITRATOR DECISION
CORRECTED

OLIVA, MARTHA
Employee/Petitioner

Case# **15WC004751**

15WC004752
15WC004753

KOCH FOODS
Employer/Respondent

On 6/29/2020, 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 0.17% 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 McHARGUE & JONES LLC
BRENTON M SCHMITZ
123 W MADISON ST SUITE 1800
CHICAGO, IL 60602

2337 INMAN & FITZGIBBONS LTD
ANTHONY ULM
33 N DEARBORN ST SUITE 1825
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
CORRECTED ARBITRATION DECISION

Martha Oliva
Employee/Petitioner

v.

Koch Foods
Employer/Respondent

Case # **15 WC 4751**

Consolidated cases: **15 WC 4752/4753**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **October 22** and **November 20, 2019**. 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 **8/7/2012**, 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 **$19,864.00**; the average weekly wage was **$382.00**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **0** dependent children.

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

All reasonable and related medical have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of $229.20/week for 10 weeks, as the injury has caused the loss of use of 2% of the person-as-a-whole under §8(d)(2).

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

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

Signature of Arbitrator

June 26, 2020
Date

JUN 29 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

OLIVA, MARTHA
Employee/Petitioner

Case# **15WC004752**

15WC004751
15WC004753

KOCH FOODS
Employer/Respondent

On 6/29/2020, 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 0.17% 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:

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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

Martha Oliva
Employee/Petitioner

v.

Koch Foods
Employer/Respondent

Case # **15 WC 4752**

Consolidated cases: **15 WC 4751/4753**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **October 22** and **November 20, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **10/12/2013**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$19,864.00**; the average weekly wage was **$382.00**.

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 **$0** under §8(j) of the Act.

ORDER

Respondent shall pay all bills presented by Petitioner as they relate to the cervical spine for a period of six (6) weeks after October 12, 2013, up to November 23, 2013, to be adjusted in accord with the medical fee schedule. No bills for medical care for the left shoulder are awarded.

Respondent shall pay Petitioner permanent partial disability benefits of $229.20/week for 50 weeks, as the injury has caused the loss of use of 10% of the person as a whole under §8(d)(2) with respect to the cervical spine.

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 4, 2020
Date

JUN 2 9 2020

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

Martha Oliva
Employee/Petitioner

v.

Koch Foods
Employer/Respondent

Case # **15 WC 4753**

Consolidated cases: **15 WC 4751/4752**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **October 22** and **November 20, 2019**. 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

C. ☐ 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 ____

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

OLIVA, MARTHA
Employee/Petitioner

Case# **15WC004753**

15WC004751
15WC004752

KOCH FOODS
Employer/Respondent

On 6/29/2020, 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 0.17% 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:

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CHICAGO, IL 60602

FINDINGS

On **11/24/2014**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$19,864.00**; the average weekly wage was **$382.00**.

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

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$2,279.97** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$2,279.97**.

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

ORDER

Respondent shall pay all bills presented by Physicians Immediate Care only, to be adjusted in accord with the medical fee schedule.

Petitioner claim for temporary total disability benefits is denied.

Respondent shall pay Petitioner permanent partial disability benefits of $229.20/week for 10.75 weeks, as the injuries sustained by Petitioner has caused a 2.5% loss of use of the right leg and a 2.5% loss of use of the left leg.

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 4, 2020
Date

JUN 29 2020

MARTHA OLIVA v. KOCH FOODS
15 WC 4751, consolidated 15 WC 4752, 15 WC 4753

INTRODUCTION

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

15 WC 4751 (DOI: 8/17/2012): ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***L:*** What is the nature and extent of the injury?

15 WC 4752 (DOI: 10/12/2013): ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***L:*** What is the nature and extent of the injury?

15 WC 4753 (DOI: 11/24/2014): ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** What temporary benefits are in dispute? TTD; ***L:*** What is the nature and extent of the injury?

Petitioner testified through a Spanish translator.

STATEMENT OF FACTS

Petitioner Martha Oliva testified that she was previously employed by Respondent Koch Foods. She began working for Respondent in February 2012. Respondent is a supplier of chicken breasts.

Petitioner was employed in slicing or cutting chicken breasts. She worked on a line, with 20 people on each side. She used a very sharp knife with her right hand to cut chicken breasts while holding them with her left hand. She would pick up breasts from in front of her at chest height with her left hand, cut them with her right hand, and then throw them onto another line in front of her at head level. She performed this job for approximately 6 months, and then was then placed on a laser cutter machine. The laser cutter involved 8 people. Workers would rotate between taking chicken pieces out of a

basket, then aligning pieces on the line, and then cleaning excess waste from the chicken pieces. The chicken pieces are cold, but not frozen. The production requirement was 70 pieces per minute for the line. During the years Petitioner worked with Respondent, the production requirement remained the same, but the number of people working on this machine dropped from 8 people to 6, and finally down to 2 people. Employees rotated between positions once per hour.

On August 17, 2012, Petitioner was throwing chicken pieces that had passed through the machine uncut onto another line to be redone. While doing this, she turned, slipped, and fell , doing the splits. A supervisor helped her get up, and she was taken to Physicians Immediate Care (PIC). Petitioner complained of pain in her left leg, her waist, and her back. She also complained of right elbow pain and tailbone pain (PX #1). Petitioner reported that she slipped and fell onto her right buttock and right leg. She also twisted her left knee. She was diagnosed with a hip contusion, lumbar sprain/strain, and left knee sprain.

She followed up with PIC August 20, August 27, September 4, September 11, and September 18, 2012. She received physical therapy through September 17, 2012. Petitioner was released to full duty work on August 27 several times in August and September 2012. In addition to physical therapy petitioner was prescribed Naproxen and Tylenol.

Petitioner was seen at PIC in 2012 after her accident for health concerns unrelated to her work accident injuries. No continuing complaints relating to her accident injuries were documented.

On October 12, 2013, Petitioner suffered a second work accident. She was working on the laser cutter. Only 3 people were working on the laser cutter at this point. Petitioner was working with a high volume of pieces, and felt a spasm in her left neck and shoulder. She reported her complaints and was sent home. She not taken to a doctor.

Petitioner consulted her primary care physician, Dr. Luiz Sudbrack, two days later, on October 14 (PX#2). Petitioner complained of "neck pain all the way down the arm & hand w/numbness on the hand...Patient suffered a work related injury because of repetitive [unknown]." A cervical MRI completed October 17, 2013 demonstrated multiple levels of disc bulging: a 2 mm diffuse bulge at C3-4, a 3 mm disc osteophyte complex with small herniation at C4-5, a 6.5 mm protrusion on the right at C5-6, and a 2.5 mm diffuse bulge at C6-7. Dr. Sudbrack recommended physical therapy and an MRI of the left shoulder on October 18, 2013. MRI Scans of the right elbow, left shoulder, and left elbow were all noted as normal. Petitioner received physical therapy at Norwegian American Hospital through January 16, 2014, which she said provided little relief.

Dr. Sudbrack's clinical notes were handwritten and difficult to decipher. The doctor rarely made notes that seemingly documented a clinical examination, much less an orthopedic or neurological exam. Dr. Sudbrack wrote a series of status notes where he incorporated his diagnosis of cervical radiculopathy without stating the clinical findings in support of that diagnosis. The doctor wrote a note on October 18, 2013 ordering six weeks of physical therapy and on October 24 wrote that Petitioner should be off work for six weeks to complete physical therapy. On December 5, 2013 Dr. Sudbrack wrote an order extending physical therapy for another six weeks. The doctor wrote a note December 30, 2013 that a decision for return to light duty work was dependent on a recommendation of a neurosurgeon at Northwestern Hospital.

Petitioner was referred to Dr. Nader Dahdaleh, whom she saw on December 18, 2013 (PX #2). Petitioner complained of neck pain radiating to both shoulders and the left upper extremity. She also complained of numbness in those areas. Petitioner stated that trigger point injections in the neck gave mild relief. The examination did not note an assessment of cervical range of motion, however motor strength in the upper and lower extremities was normal. Sensation to light touch in pinprick were normal except for the left lateral aspect of her left leg and over the left C6 dermatome of her arm.

Dr. Dahdaleh diagnosed chronic low back pain, chronic neck pain, cervical radiculopathy, and lumbar radiculopathy. Dr. Dahdaleh noted degenerative changes due to cervical spondylosis with foraminal stenosis at C5-6 and C6-7 due to large disc osteophyte complexes. He recommended continued physical therapy and prescribed a Medrol Dosepak. On January 29, 2014, Dr. Dahdaleh recommended a cervical epidural steroid injection, followed by possible C5-6 and C6-7 fusion. Petitioner elected not to have surgery and returned to work in a new position where she could sit.

At Respondent's request Petitioner was examined pursuant to §12 of the Act by orthopedic surgeon Dr. Jay Levin on December 19, 2013. Dr. Levin examined Petitioner separately for her cervical and thoracic spine (RX #1), and also for her lumbar spine (RX #2). Dr. Levin was assisted by case manager Martha Sanchez, R.N., who acted as an interpreter.

With regard to the cervical spine IME Dr. Levin took Petitioner's history of her work activities and her claimed injuries in August 2012 and on October 12, 2013 (PX #1). Dr. Levin also took petitioner's history of her medical care at an occupational health clinic in 2012 and then from Dr. Sudbrack after the 2013 accident. Petitioner's chief complaint was posterior neck pain going down her left arm to the elbow. She rated her pain at 10/10. She also complained of a little pain in her right arm to the elbow and "a lot" of weakness in the left arm. Petitioner also complained of pain between her shoulder blades. Dr. Levin

reviewed respondent's October 17, 2013 accident report, Petitioner's records from Agape Medical Center, the initial physical therapy evaluation from Norwegian American Hospital on October 28, 2013, and radiological imaging.

On examination Dr. Levin noted diminished cervical range of motion. There was bilateral trapezius tenderness but no trigger point tenderness. Spurling's test elicited right posterior cervical discomfort but without radiation into the arms. Spurling's on the left was negative. Toes/heels walking elicited lumbar area pain. Arm strength was normal, as well as reflexes. There was diminished sensation over there were right lateral deltoid, left dorsal, and left volar forearm. There was tenderness over the lower lumbar spine. Lumbar motion was somewhat diminished and painful. Sitting straight leg raise was negative bilaterally. Sensation was decreased over the left medial/lateral calf, medial/lateral thighs, and medial/lateral feet. FABER test on the right elicited central low back pain and on the left elicited left gluteal pain.

Dr. Levin noted radiographs demonstrated degenerative disc changes at C5-6 and also at L2-3 and L3-4. There was facet arthritis at L5-S1. The October 17, 2013 cervical MRI demonstrated age appropriate degenerative disc changes with central annular bulging at C2-3, degenerative right-sided annular bulges at C3-4 and C4-5, a right-sided disc herniation at C5-6, and a right-sided disc protrusion at C6-7. Dr. Levin noted that these findings were inconsistent with Petitioner's subjective complaints. Dr. Levin also noted the left shoulder MRI showed a normal rotator cuff and type II acromion.

Dr. Levin, "assuming [Petitioner] sustained an injury at all", diagnosed cervical myofascial strain. He opined that a course of physical therapy of 10 visits over 5 weeks would be medically appropriate. He found the cervical MRI was within the standard of care but did not believe the MRIs of the right elbow and left shoulder where indicated for any injury on October 12, 2013. He further opined that Petitioner should reach MMI within 4 to 6 weeks after the accident. He did not believe Petitioner required further medical care at that time and opined that Petitioner could return to full duty work.

With regard to the lumbar spine exam recited Petitioner's previously noted history of injury (PX #2). Petitioner reported that 10/10 low back pain, which he said was constant. She complained of pain travels down both by docs and both legs to the feet.. Petitioner reported that she can send for 5 minutes and then has to be a just and that she can walk for 5 minutes but then has to take a break.

On examination Petitioner complained of lower lumbar pain with toes/heels walking. Lumbar range of motion was diminished and painful. There was midline lower lumbar tenderness as well as bilateral lumbosacral and sciatic notch tenderness. Straight-leg raise on the right at 60° elicited low back pain but was negative on the left. However,

sitting straight-leg raise was negative bilaterally. Sensation was decreased over the left medial/lateral calf, medial/lateral thighs, and medial/lateral feet. FABER test on the right elicited central low back pain and on the left elicited left gluteal pain.

Plain X-rays demonstrated degenerative disc changes at L2-3 and L3-4 as well as facet arthritis at L5-S1. The lumbar MRI demonstrated degenerative disc changes at L2-3, L3-4, L4-5, and L5-S1. No significant canal encroachment was noted. There was no evidence of disc herniation at L4-5. There was bilateral facet arthritis with foraminal stenosis at L3-4. There was a left-sided disc protrusion with degenerative changes at L2-3, but L1-2 appeared normal.

Dr. Levin noted that he had not been able to review medical records of treatment for the October 2012 accident. He noted that he would need those records to determine any diagnosis referral to the accident. He further noted that the MRI findings were age-appropriate without evidence of a herniated nucleus pulposus. He further observed that Petitioner had been working following the 2012 accident up to the 2013 accident.

Petitioner did not treat again until September 12, 2014, when she returned to PIC with left neck and shoulder pain (PX #1). She complained of 7/10 left-sided neck and shoulder pain. She reported it was the result of a work-related injury with a sudden onset with a change in her job to a higher speed line. On examination Petitioner had reduced range of motion, but it was noted that she exhibited guarding out of proportion to the injury. It was also noted that Petitioner exhibited hypersensitivity out of proportion to the injury.

Petitioner sought care at PIC June 18, June 19, and June 26, 2014 for bruising around the left eye. She reported that while at work she stepped off a stepstool and struck her left orbit while sneezing. There were no complaints relating to the neck or back. On examination particular Petitioner's neck was noted as supple with good range of motion. There was no tenderness of the neck or cervical spine. No continuing complaints relating to her more recent accident injuries were documented.

On November 24, 2014, Petitioner was again working at Respondent in a seated position on a stool. Petitioner stepped off the stool to use the restroom and slipped on the wet floor, again doing the splits. She felt pain in her back and left hip. She was taken to PIC that day, where she complained of pain in the left thigh, left knee, right side, and right knee. She also complained of neck and low back pain with "tingling." In addition, she complained of pain in the left and right hands with "tingling." The clinical exam was essentially normal. X-rays were negative. Petitioner was diagnosed with a knee contusion, ankle/foot pain, and lower back pain. She was taken off work that day and released to return to work on November 25 with restrictions to avoid squatting and

extended standing until December 1, 2014. "All Day" and "Non-Aspirin" pain medication was dispensed.

Petitioner returned to PIC December 1, 2014 with continuing complaints of pain in the left thigh, left knee, right thigh, and right knee. The clinical examination was essentially normal, and the diagnoses were unchanged. She was released with restrictions for sit-down work only. "All Day" pain medication was discontinued. Petitioner returned to PIC December 5, 2014 with the same complaints but were reported as mild. She reported that she could stand and walk and a normal pace without discomfort. She did note a cracking noise in her knee, which one was not noted, when she walked fast. Petitioner was released to full duty work without restrictions, and it was noted that she should attain full resolution in 7 days.

Petitioner continued to follow up with her primary care physician, Dr. Sudbrack, in 2014 for unrelated issues. She saw Dr. Sudbrack December 17, 2014 with left knee complaints after falling at work 8 days before. Dr. Sudbrack's handwritten notes were indecipherable such that it is impossible to determine the extent of the clinical examination.

Petitioner returned to Dr. Sudbrack on January 14, 2015, who then recommended a left knee MRI without noting whether he had assessed Petitioner's knee with clinical testing for a torn meniscus or ligament. The January 23, 2015 MRI demonstrated mild effusion only (PX #2). Petitioner continued to follow with Dr. Sudbrack through February and March 2015. On February 5 Dr. Sudbrack noted that he filled out disability forms. Petitioner had a lumbar MRI February 25, 2015 on order of Dr. Sudbrack, but a complete copy of the radiology report was not included in Petitioner's Exhibit #2. The complete report was incorporated in Petitioner's Exhibit #12. The radiologist noted multilevel diffuse disc bulging and hypertrophy, as well as spondylolisthesis, from L2-3 through L5-S1.

Petitioner testified that she then sought care at New Life Medical Center (New Life) on February 6, 2015 (PX #7). The New Life records, PX #7, document Petitioner's first contact with chiropractor Dr. Irene Ma was on September 18, 2014, which Petitioner did not testify about at trial. On September 18 Petitioner gave a history of her work injury on October 12, 2013. She complained of constant neck pain and muscle spasm in the neck and pain across the left shoulder and down the left arm with numbness and tingling in her left arm. She complained of 10/10 pain. Dr. Ma diagnosed cervical sprain/strain, cervicalgia, cervical radiculitis, shoulder sprain/strain, shoulder pain, shoulder stiffness, arm pain, muscle spasm, and work related injury. Petitioner then received extensive chiropractic care for her neck and shoulder from Dr. Ma, however the dates of care are obscured in the copied records.

Petitioner testified that she was taken off work at the February 6, 2015 consultation and did not return to work for Respondent.

There are no clinical notes for Petitioner's consultation with Dr. Ma on February 6, 2015 (PX #7), although there were billing records. There are billing records for February 10, February 12, February 13, February 17, February 19, February 20, February 24, and February 27, 2015, for which there are chiropractic progress notes but no physician notes. Dr. Ma's first clinical note March 10, 2015 documents Petitioner's complaints of 9/10 pain in the neck, 9/10 pain in the left shoulder, and 9/10 pain in the left arm with numbness/tingling/weakness in the left arm. However, there was no reference to Petitioner's claimed work accident on November 24, 2014. Dr. Ma added a diagnosis of cervical disc herniation at that time. There were no notes regarding Petitioner's work status.

Petitioner testified that she was referred to Dr. Neeraj Jain for her pain, whom she saw on March 25, 2015 with complaints of neck and back pain. Petitioner gave a history of feeling a pop in her neck with severe neck pain and left arm weakness on October 12, 2013 at work. She did not mention a work accident on November 24, 2014. She complained of pain radiated into her left arm. She also complained of paresthesia Petitioner also complained of pain in her right arm. Petitioner reported that her back pain began in 2012 with a work-related incident. She also reported that physical therapy had restarted in September 2014 but stopped after one or two months. A third round of physical therapy started in March 2015.

Dr. Jain reiterated the radiologist's findings from the 2013 cervical MRI. He also reiterated the radiologist's findings of mild spondylosis at L2 through L5 with annular disc bulging from the 2013 lumbar MRI. He noted the 2013 left shoulder MRI showed a normal rotator cuff and a type II acromion.

Dr. Jain noted significantly reduced cervical range of motion with pain. Lumbar range of motion was also reduced. Straight-leg raise was positive on the right. There was reduced sensation to touch in the left upper extremity without described distribution. Dr. Jain noted prominent weakness in the left upper extremity. Diagnosed neck pain related to the October 12, 2013 accident. Dr. Jain recommended a C5-6 and C6-7 epidural and another lumbar MRI. Petitioner continued to receive chiropractic care from Dr. Ma March and April 2015.

Dr. Ma's clinical note on April 14, 2015 noted Petitioner claimed 9/10 pain in her neck, left shoulder, and left arm. She also complained of numbness and weakness in the left arm. There is no note that Petitioner reported an accident at work on November 24,

2014 in which she was again injured. Petitioner saw Dr. Ma again on May 19, 2015. Her pain remained 9/10. Again, there was no reference to a November 24, 2014 work accident. There was no note regarding work status. On June 23, 2015 Dr. Ma noted no change in Petitioner's complaints. Again, there was no reference to a November 24, 2014 work accident or any note regarding work status.

Dr. Jain administered an interlaminar cervical epidural steroid injection at C7-T1, assisted by Susan Jain, PA-C, on June 19, 2015. Dr. Jain administered bilateral L4-5 transforaminal epidural steroid injections (ESI) and selective nerve root blocks, assisted by Sarah Spring, P.A., in July 7, 2015. Petitioner's Exhibit #13 is billing statements of Thomas C. Corral, CRNA, Windy City Anesthesia, for administering nerve blocks on June 19, 2015 and on July 7, 2015. No clinical or operative reports by CRNA Corral for these procedures were included in Petitioner's Exhibit #13 or otherwise offered in evidence.

Petitioner saw Dr. Jain again on July 25, 2015, when he noted Petitioner had received bilateral L4-5 transforaminal ESI and selective nerve root block on "July 17" (*sic*). Dr. Jain also noted that Petitioner had received a cervical epidural steroid injection on "June 09, 2015" (*sic*).

Petitioner saw orthopedic surgeon Dr. Ronald Silver on April 25, 2015 (PX #5). Petitioner gave a history of her October 12, 2013 work injury from repetitive motion activity. Petitioner complained of pain in her neck and her shoulder and was treated with physical therapy and anti-inflammatories. He noted that Petitioner had been able to work until January 2015 when her pain became too severe. On examination Petitioner had reduced range of motion and had positive impingement and Hawkins' signs. He noted an MRI scan demonstrated inflammation of the rotator cuff, without noting if it was the 2013 or 2015 MRI he relied on. Dr. Silver diagnosed "rotator cuff" and impingement and administered a cortisone injection in the left shoulder. He also prescribed Meloxicam, hydrocodone, and Ultram.

Petitioner's Exhibit # 16 was billing from G & U Orthopedic for May 1, 2015 for $2,684.59 and for June 18, 2015 for $612.56 (PX #16). These charges were apparently for durable medical equipment ordered by Dr. Ma. Dr. Ma's notes in the New Life chart do not state the medical necessity for durable medical equipment.

On July 16, 2015, Dr. Silver noted a positive temporary response to the left shoulder injection. Petitioner's exam was essentially unchanged. Dr. Silver noted her complaints of left-sided neck pain radiating into the arm and hand, for which he recommended she see a cervical spine specialist. Dr. Silver recommended arthroscopic shoulder surgery without specifying what the surgery was intended to correct, which Petitioner declined.

Petitioner continued to consult with Dr. Jain through 2015 (PX #4). On August 12 Petitioner reported she was attending physical therapy 3 times a week which provided substantial benefit. However, it was noted Petitioner continued to be off work due to her substantial pain. Dr. Jain recommended an EMG of the upper extremities because of neck pain complaints radiating down the left arm. Dr. Jain also recommended a repeat lumbar L4-5 transforaminal ESI and selective nerve block.

Dr. Ma's clinical note on August 11, 2015 again referred to Petitioner's injury sustained while at work on October 12, 2013. Petitioner complained of 8/10 pain in her neck, left shoulder, and left arm. Again, she complained of numbness and tingling in the left arm. Again, there was no reference to a work accident on November 24, 2014. Dr. Ma's clinical note on October 8, 2015 was essentially identical to the August 11 note, as were Dr. Ma's notes on December 1, 2015 and January 22, 2016.

Petitioner had an EMG/NVC performed by chiropractor Dr. Gregory Thurston on September 14, 2015 (PX #8). The only finding was mild-moderate evidence of carpal tunnel syndrome.

On September 15, 2015 Dr. Jain noted that Petitioner's EMG showed no evidence of radiculopathy. She still complained of moderate to severe neck pain radiating into the left arm as well is bilateral back pain radiating into the left leg. Dr. Jain continued to recommend lumbar ESIs October 13, 2015 and on the last visit February 10, 2016.

Petitioner consulted neurosurgeon Dr. Robert Erickson March 30, 2016 for her cervical and lumbar pain which began with a work injury October 17, 2013 (PX #6). Petitioner reported the sudden onset of neck and left shoulder pain with radiation of abnormal sensation in all fingers of the left hand. Petitioner also reported the onset of low back pain soon thereafter which radiated into her left leg. Petitioner also reported low back pain secondary to a prior injury which she could not adequately describe. Dr. Erickson reviewed the 2013 and 2015 MRIs. He noted the cervical MRI showed a central disc herniation at C5-6 with slight rightward prominence. He noted there was a broad disc herniation at C6-7 of lesser significance.

On examination Dr. Erickson noted diminished left grip strength and Petitioner's report of paresthesia in all fingers. Light touch in pinprick for diminished over the dorsum of the hand and over the extensor forearm. Cervical motion was relatively full but painful. Dr. Erickson suspected C8 radiculopathy but wanted a new cervical MRI before a final surgical opinion. He suggested a somatosensory evoked potential test the upper extremities to rule out a C7 nerve problem.

On May 18, 2016 Dr. Erickson reviewed the SSEP of April 26, 2016. He noted there were significant delays bilaterally at C6, the right being worse. There were mild delays bilaterally at C7. He explained to Petitioner that the MRI compression of the spinal cord on the right and C5-6. He opined that Petitioner had a good chance of improving with an interior cervical discectomy and fusion at C5-6 and possibly C6-7.

Dr. Erickson commented on Dr. Levin's December 19, 2013 IME, in which Dr. Levin attributed the cervical disc herniation to degenerative joint disease. Dr. Erickson stated it is impossible to determine on MRI alone whether herniations exist as a result of trauma or as a result of degenerative change. He added that changes are often a combination of both processes and that the persistence of Petitioner's condition did not support Dr. Levin's diagnosis of myofascial strain.

On August 10, 2016 Dr. Erickson noted Petitioner hoped to avoid surgery. He explained that surgery was her best option but noted it was not an emergency situation. He did not recommend back surgery but did note petitioner was a good candidate for a second ESI.

Petitioner chose not to have this surgery as well due to a fear of surgery.

Petitioner returned to work for a new company, the Millard Group, working as a janitor, on November 10, 2016. She also worked on weekends selling jewelry in a flea market while she was between jobs. She testified she is in constant neck pain, and is regularly taking ibuprofen. She has constant low back pain as well. She is able to complete all of her tasks at work, as the work is not difficult.

Petitioner was examined again at Respondent's request pursuant to §12 on November 19, 2018 by orthopedic surgeon Dr. Babak Lami (RX #3). Dr. Lami's medical assistant served as an interpreter. Petitioner gave a history of working for Respondent from 2012 through 2015. She reported her initial injury in October 2012 when she developed neck and left arm pain. Petitioner reported a second injury for which she could not recall the exact dates but believed it was in 2013 when she slipped and fell onto her buttocks. Petitioner denied having any injuries in 2014.

At the time of the examination Petitioner rated her pain 8/10, localized at the base of her neck between her shoulder blades and the left shoulder. She did not report pain radiating down the left arm. Petitioner also complained of low back pain which also involve the posterior thigh and posterior left calf. Dr. Lami noted the left leg symptoms did not fall into a particular dermatome. Petitioner's main complaints were neck and low back pain and that her left shoulder and left leg were not her main complaints.

On examination Dr. Lami noted minimal cervical flexion and extension and only 30° rotation bilaterally. Lumbar spine extension was at 0°, flexion was 5°, and side bending was 10°. Dr. Lami found normal muscle strength in both the upper and lower extremities. Dr. Lami found sensation was grossly intact although Petitioner reported slightly altered sensation over the entire left arm.

Dr. Lami reviewed Petitioner's records from Norwegian American Hospital, New Life Medical Center, Dr. Sudbrack, Dr. Silver, Dr. Jain at Pinnacle Pain Management, Dr. Erickson, and Dr. Levin's IME reports. Dr. Lami he also reviewed various radiological studies and reports, as well as the September 14, 2015 EMG/NCV report performed by chiropractor Dr. Gregory Thurston.

Dr. Lami did not find that Petitioner sustained a work-related injury to her cervical spine. He did concede that Petitioner's assembly-line work activities could possibly cause a sprain, which would have been self-limiting. He noted that Petitioner's current symptomology of 8/10 pain was not explained by her lumbar and cervical MRIs. He found no evidence of radiculopathy or neurological deficit. He noted that the cervical MRI findings were right-sided, which was inconsistent with Petitioner's symptoms always being left-sided. Dr. Lami also noted that Petitioner's lumbar MRI findings were fairly benign with age-appropriate degenerative changes.

Dr. Lami could not support a need for treatment of Petitioner's claimed cervical spine condition. He particularly noted Petitioner's inability to provide a consistent history of the 3 alleged injuries. Dr. Lami opined that Petitioner's cervical spine symptoms would not be "amenable" to injections. He did not agree with the recommendation for a C5-6 fusion because Petitioner's symptoms were not consistent with radiculopathy. He particularly noted that any recommended surgery was not related to any work injury. Dr. Lami found Petitioner had reached MMI for her low back within 6 to 8 weeks and that Petitioner was capable of full time at full duty at selling gold on weekends as she reported doing for the previous 3 years.

Finally, Dr. Lami noted Petitioner's out of proportion complaints when compared to the MRI findings, exam findings, and the report of mechanism of injury. He noted this was consistent with symptom magnification.

Petitioner had another §12 IME with orthopedic surgeon Dr. Nikhil Verma of Midwest Orthopaedics at RUSH on December 17, 2018 (RX #4. Dr. Verma was assisted by a certified Spanish-English medical interpreter. Dr. Verma noted Petitioner's history of three work accidents on August 17, 2012, on October 12, 2013, and on November 24, 2014.

Dr. Verma noted that Petitioner was unclear as to specifically which body parts were injured in which event but that her current complaints were with neck pain, back pain, left upper extremity pain, and left lower extremity pain. She complained that her pain starts in the neck, radiates into the thoracic back and low back and also into her left arm and hand, as well as her left leg. She stated that when it stops at the knee she feels a sharp pain in the knee itself. Dr. Verma noted difficulty in obtaining a history of treatment from Petitioner.

Dr. Verma reviewed the records of Petitioner's medical care, including radiological studies. Dr. Verma noted Petitioner's care included physical therapy, chiropractic therapy, and spinal cortisone injections. On examination Petitioner complained of pain with neck movement. She had full range of shoulder motion and normal strength. Although Petitioner complained of hand numbness the neurological exam of the left arm was normal. Petitioner had full range of knee motion with negative Lachman's and drawers signs. Straight-leg raise was negative.

Dr. Verma found Petitioner's left knee was normal. He also found no abnormality in Petitioner's left shoulder, although he requested an opportunity to review her shoulder MRI. Dr. Verma did not believe that Petitioner sustained a left knee or left shoulder injury in as a result of either the 2012 or 2013 or 2014 reported accidents. He noted that Petitioner's medical records document claims of overuse repetitive lifting. He suspected possible left cervical radiculopathy rather than a left shoulder issue. He opined that Petitioner did not require medical treatment for her left knee or her left shoulder in relation to any work injury. He found Petitioner at MMI with regard to her left knee and left shoulder and that she was at full duty status with regard to the left knee and left shoulder. He saw no need for work restrictions. Finally, he commented that he saw no evidence that Petitioner sustained any permanent or partial disability with regard to her left knee or left shoulder.

Charmell Johnson testified on behalf of Respondent. Ms. Johnson work for respondent for six years. She is currently safety coordinator for the Berteau location. And 2013 she was a general labor employee and work that the DSI line. She is familiar with Petitioner, who also worked the DSI line.

Ms. Johnson is familiar with the job duties when working the DSI line. Workers are rotated every hour on the hour to different assignments. The DSI line requires 8 workers, 4 in front and for in back. If 8 workers were unavailable the DSI line would not be operated. Workers would handle chicken pieces weighing 8 to 10 ounces.

CONCLUSIONS OF LAW

15 WC 4751 (DOI: 8/17/2012)

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

The Arbitrator finds that Petitioner proved that her condition of ill-being in her low back was causally related to her work accident on August 17, 2012.

Petitioner suffered an undisputed accident at work where she slipped and fell on August 17, 2012. She claims injury to her left leg, waist, and back. She treated with Physicians Immediate Care until September 18, 2012, approximately one month, with a final diagnosis of a lumbar strain. The Arbitrator finds that Petitioner's lumbar spine strain was related to the August 17, 2012 accident.

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

The Arbitrator finds that Petitioner proved that the medical services provided for treatment of her injuries were reasonable and necessary and, further, the charges and fees for the care were also reasonable and necessary.

Petitioner suffered an undisputed accident at work where she slipped and fell on August 17, 2012. She claims injury to her left leg, waist, and back. She treated with Physicians Immediate Care (PIC) until September 18, 2012, approximately one month, with a final diagnosis of a lumbar strain. The Arbitrator finds that Petitioner's lumbar spine strain is related to the August 17, 2012 accident through her last date of service, September 18, 2012.

No outstanding bills from PIC were presented at trial, and therefore no bills are awarded under this claim.

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

Petitioner's claim for permanent partial disability was evaluated in accord with §8.1b of the Act:

i) No AMA Impairment Rating was offered in evidence. The Arbitrator cannot give any weight to this factor.

ii) Petitioner worked in a fast-paced food processing plant which required significant repetitive activity. Petitioner was able to return to work to her former job. The Arbitrator gives great weight to this factor.

iii) Petitioner was 50 years old at the time of her accident. She had a statistical life expectancy of approximately 32 years. The Arbitrator gives little weight to this factor.

iv) There was no evidence that Petitioner's future earning capacity was adversely affected by her injuries. She was able to return to full duty work until she was injured in a subsequent accident. The Arbitrator gives great weight to this factor.

v) The medical records show that Petitioner sustained a lumbar strain from which she recovered sufficiently to return to full duty work. The Arbitrator gives great weight to this factor.

Based on all the evidence, including the above five factors, the Arbitrator finds that Petitioner suffered a permanent partial disability of 2% of a person-as-a-whole, 10 weeks, due to injuries that she sustained at work August 17, 2012.

15 WC 4752 (DOI: 10/12/2013)

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

The Arbitrator finds that Petitioner proved that she sustained an accidental injury that arose out of and in the course of her employment by Respondent.

Petitioner testified credibly that on October 12, 2013 she experienced an onset of left-sided neck pain while working on the laser cutter line machine. While working quickly and trying to keep up with the chicken pieces on the line, her neck suddenly felt tensed and paralyzed. This was reported the same day, and Petitioner was immediately sent home. Her treating physician, Dr. Sudbrack, attributed the injury to repetitive work just two days later, on October 14, 2013.

The mechanisms of work activities described by Petitioner, particularly those she was engaged in on October 12, 2013, are sufficiently repetitive that the Arbitrator finds they arose out of Petitioner's employment with Respondent, constituting a risk incidental to her employment.

There was no evidence offered to rebut Petitioner's claim that her injury arose out of and in the course of her employment.

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

The Arbitrator finds that Petitioner proved that her condition of ill-being relating to her cervical spine is causally related to her work accident on October 12, 2013.

Petitioner testified that she had a sudden onset of neck and left shoulder pain while working October 12, 2013. She sought medical care from her primary physician, Dr. Sudbrack, two days later and was prescribed physical therapy. Dr. Sudbrack referred Petitioner to orthopedic surgeon Dr. Dahdaleh, who noted MRI findings of degenerative changes from C3 through C7 in Petitioner's cervical spine. Dr. Dahdaleh diagnosed cervical radiculopathy for which he recommended an anterior cervical fusion, which Petitioner declined. Dr. Erickson also recommended cervical fusion despite Petitioner's diffuse, vague, and inconsistent subjective complaints.

Dr. Jay Levin, who examined Petitioner on behalf of Respondent, diagnosed cervical myofascial strain. Dr. Levin noted in particular the age-appropriate degenerative changes in Petitioner's cervical spine which were inconsistent with Petitioner's subjective complaints. Dr. Levin, as well as Dr. Lami, noted Petitioner's left-sided upper extremity complaints were inconsistent with the MRI right-sided findings in her cervical spine. In addition, the Arbitrator notes Petitioner's consistent complaints of numbness and weakness in her left arm, excepting for Dr. Dahdaleh's one exam, were diffuse and vague and often accompanied normal neurological and strength testing. But for Dr. Dahdaleh, none of Petitioner's treating physicians identified Petitioner's complaints of left arm and numbness and weakness with any recognized dermatome.

In addition, Petitioner received seemingly unending chiropractic therapy from Dr. Ma which failed to provide relief or progress with Petitioner's condition.

There was significant evidence of Petitioner's symptoms magnification. She frequently and consistently complained of 10/10 pain to her treating physicians, who did not respond in a way appropriate to belief that the 10/10 pain complaints were genuine.

The evidence suggests, as noted by Dr. Levin, Petitioner had age-appropriate pre-existing degenerative changes in her cervical spine that did not correspond to her subjective complaints. The Arbitrator finds Dr. Levin's opinion Petitioner sustained a myofascial strain to her cervical spine to be convincing and persuasive. The arbitrator finds that petitioner failed to prove that she sustained an injury to her cervical spine for which surgery would have been medically necessary. It is particularly noteworthy that Petitioner returned to work before her third accident on November 24, 2014.

Dr. Silver examined Petitioner's left shoulder and recommended surgery despite an MRI demonstrating a normal rotator cuff and only a type II acromion. He never documented his reasoning or noted a clinical basis for recommending surgery. On the other hand, Respondent's examining physician Dr. Verma found no pathology petitioner's left shoulder and opined surgery was not medically necessary. The Arbitrator finds Dr. Verma's opinions reasonable and persuasive, and adopts the same.

To confirm, the Arbitrator finds that Petitioner failed to prove that she sustained cervical disc herniations and radiculopathy were causally related to the October 12, 2013 work accident. In addition, Petitioner failed to prove that she had sustained an injury to her left shoulder that was causally related to the October 12, 2013 work accident. Petitioner proved that she sustained a myofascial cervical strain that was causally related to the accident, which was likely an aggravation of her pre-existing degenerative cervical spine.

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?

As noted above the Arbitrator found that Petitioner sustained a myofascial strain to her cervical spine that was causally related to her October 12, 2013 work accident. Also noted above, the Arbitrator found the opinions of Dr. Levin to be reasonable and persuasive. Dr. Levin opined that Petitioner would benefit from 5 weeks of physical therapy and would likely achieve MMI within 6 weeks of the accident. Dr. Levin further opined that Petitioner did not require further medical care for her accident injuries.

The Arbitrator finds the opinion of Dr. Levin regarding Petitioner's MMI reasonable and persuasive. Therefore, it follows that the Arbitrator finds that the medical care provided Petitioner after 8 weeks following the October 12, 2013 work accident was not reasonable or necessary.

Dr. Levin noted that a cervical MRI was within the standard of care for assessing Petitioner's claimed neck injury. However, he noted that MRIs of the left shoulder and right elbow were not clinically indicated. The Arbitrator adopts Dr. Levin's opinion regarding the left shoulder and right elbow MRI and denies Petitioner's request for payment of those procedures.

The credibility and reliability of the care provided at New Life Medical Center is inherently suspect in light of the unending chiropractic services with no progress in relieving Petitioner's complaints, frequently noted at 10/10. In addition, the reliability of New Life's records were further undermined when there was no record of Petitioner's third work accident on November 24, 2014.

Dr. Lami opined, due to Petitioner's inconsistent clinical presentation and the lack of evidence of radiculopathy, and cervical spine injections were not medically indicated. Given Petitioner's well noted inconsistent symptoms and the negative EMG/NCV, the Arbitrator finds Dr. Lami's opinion reasonable and persuasive and denies Petitioner's

request for payment for those procedures. Although Dr. Lami did not opine whether Dr. Jain's lumbar spine injections were medically necessary, the evidence of the inconsistencies in Petitioner's clinical presentation of her claim in the back injury leads to the same conclusion that Petitioner failed to prove the medical necessity of the lumbar spine injections. Therefore, the Arbitrator does not award the medical fees and charges relating to either series of cervical or lumbar spine injections.

With regard to the spinal injections administered by Dr. Jain on June 19, 2015 and July 7, 2015, billing statements by Thomas Corral CRNA totaling $1,942 for June 19 and $2,002 for July 7 were admitted in Petitioner's Exhibit #13, Windy City Anesthesia . Dr. Jain noted that an anesthesiologist attended those procedures due to Petitioner's anxiety. Aside from noting that Mr. Corral is a Certified Registered Nurse Anesthetist rather than an anesthesiologist, there were no clinical or operative records by CRNA Corral admitted in evidence. The Arbitrator cannot award billing when there are no clinical records to correspond to the charges, rendering it impossible to determine the reasonableness of the charges.

In summary, the Arbitrator does not award medical expenses and charges for beyond 6 weeks after the accident on October 12, 2013.

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

Petitioner's claim for permanent partial disability was evaluated in accord with §8.1b of the Act:

i) No AMA Impairment Rating was offered in evidence. The Arbitrator cannot give any weight to this factor.

ii) Petitioner worked in a fast-paced food processing plant which required significant repetitive activity. Petitioner was able to return to work to her former job. The Arbitrator gives great weight to this factor.

iii) Petitioner was 52 years old at the time of her accident. She had a statistical life expectancy of approximately 30 years. The Arbitrator gives little weight to this factor.

iv) There was no evidence that Petitioner's future earning capacity was adversely affected by her injuries. She was able to return to full duty work until she was injured in a subsequent accident. The Arbitrator gives great weight to this factor.

v) The records show that Petitioner received aggressive medical care for a cervical myofascial strain. A competent and persuasive physician opined that Petitioner had reached MMI with her neck within 8 weeks of her October 12, 2013 work accident. No further medical would be necessary after reaching MMI. A competent and persuasive physician opined that Petitioner had not injured her left shoulder. In addition, the records also suggest that Petitioner's symptom magnification was the likely

justification for the unnecessary medical provided after she reached MMI. Moreover, there was a persuasive inference that, based on other reasoning, spinal injections were not medically indicated. It is also noteworthy that Petitioner declined recommendations for surgery and returned to her prior employment before being injured in a third work accident. The Arbitrator gives great weight to this factor.

Based on all the evidence, including the above five factors, the Arbitrator finds that Petitioner suffered a permanent partial disability of 10% of a person-as-a-whole, 50 weeks, due to injuries that she sustained at work October 12, 2013.

15 WC 4753 (DOI: 11/24/2014)

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

Although there is evidence that Petitioner sustained contusions to her right and left knees and legs in a work accident November 24, 2014, the Arbitrator finds that Petitioner failed to prove that her claimed current condition of ill-being in her left knee, left shoulder, and low back were causally related to the November 24 work accident.

Petitioner received emergent medical care at Physicians Immediate Care (PIC) on the day of her work accident. On intake, Petitioner complained of left thigh, right thigh, right knee, low back, neck, and bilateral hand pain. She was instructed to return to work in an essentially sedentary capacity until December 1, 2014. These restrictions were modified on December 1, 2014 to sit down work only, when her complaints were limited to both thighs and knees. Petitioner was released from PIC December 5, 2014 to full duty, with a note that full resolution of her symptoms would be within 7 days, although petitioner testified that she had continuing low back pain.

Petitioner once again sought out her primary care physician, Dr. Sudbrack, who took her off work again on December 17, 2014 due to left knee pain. Petitioner followed up with Dr. Sudbrack until February 6, 2015 when she testified that she began a course of treatment at New Life Medical Center. She was eventually referred to Dr. Neeraj Jain, who recommended and performed cervical and lumbar injections in June and July of 2015. Petitioner testified that these injections were only temporarily helpful.

However, as noted, the indecipherable handwritten clinical notes Dr. Sudbrack making it impossible to assess whether his medical care was causally related to petitioner's claimed injuries. The doctor ordered a left knee MRI, but the arbitrator was unable to determine if standard accepted clinical testing for a torn meniscus or ligament was performed. Such a clinical assessment with positive findings would support an order

for an MRI, however the Arbitrator finds no evidence of such an assessment. Dr. Sudbrack did have readable work status notes indicating cervical pathology without indicating whether it was related to the October 12, 2013 injury or the November 24, 2014 injury.

Petitioner testified that she returned care at New Life Medical Center on February 6, 2015, for which there were no clinical notes. In fact, no clinical notes in the New Life chart referred to any claimed injury at work on November 24, 2014. None of Dr. Jain's clinical notes referred to a work-related injury on November 24, 2014. Absent such documentation, the Arbitrator cannot find that Petitioner proved that she sustained any injury on November 24, 2014 that required medical care at New Life Medical Center or by Dr. Jain.

When Petitioner consulted Dr. Silver for her left shoulder complaints there was, again, no historical reference to a work accident on November 24, 2014.

When Petitioner consulted Dr. Erickson for her neck and back complaints there was, again, no historical reference to a work accident on November 24, 2014.

It was noted above that Dr. Lami, who had examined Petitioner on behalf of Respondent, opined that Petitioner should have reached MMI within 6 to 8 weeks of the October 12, 2013 accident. Inasmuch as Petitioner had denied to Dr. Lami that she had been injured in the 2014 accident, Dr. Lami offered no opinion regarding petitioner's claimed injuries from the November 24, 2014 incident at work.

It was noted by Dr. Verma, who also examined Petitioner on behalf of Respondent, that he could find no evidence of a left shoulder injury.

When all the evidence is weighed, the Arbitrator can only find that Petitioner sustained contusions to her left and right knees and legs, for which she received no physical therapy and from she recovered by the time of her released to full duty work by medical professionals at Physicians Immediate Care on December 5, 2014.

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

The Arbitrator finds, based on evidence and reasons stated above, that Petitioner proved that the medical services she received through December 5, 2014 were reasonable and necessary and that the charges for that care were also reasonable and necessary.

As noted above, healthcare providers consulted by Petitioner after her November 24, 2014 work accident did not document Petitioner's report that she had been injured in such an accident. All other healthcare providers following the November 24, 2014 accident referenced Petitioner's October 12, 2013 accident as the initiating event relating to her complaints. The Arbitrator cannot find that medical care provided by chiropractors and physicians would reasonably relate that care to an accident they knew nothing about.

K: What temporary benefits are in dispute? TTD

The Arbitrator finds that Petitioner failed to prove that she is entitled to total temporary disability benefits as claimed from February 6, 2015 to November 1, 2016 (ArbX #3).

Petitioner's claim that she was totally disabled from employment from February 6, 2015 as relating to her injuries claimed from a work accident on November 24, 2014 is not supported by the evidence. Petitioner testified that she first sought care at New Life Medical Center on February 6, 2015, for which there are no clinical notes. However, each New Life clinical note failed to document a report from Petitioner that she had been injured on November 24, 2014. The only date of injury during the treatment following November 24, 2014 was October 12, 2013. In addition, there were no work status notes in the New Life chart notes.

While other healthcare providers did take Petitioner off work, those physicians did not have a history of Petitioner's claimed November 24, 2014 work accident. Those physicians always referenced the October 12, 2013 injuries. Therefore, their off work directives could not be related to the claimed November 24, 2014 work injuries.

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

Petitioner's claim for permanent partial disability was evaluated in accord with §8.1b of the Act:

i) No AMA Impairment Rating was offered in evidence. The Arbitrator cannot give any weight to this factor.

ii) Petitioner worked in a fast-paced food processing plant which required significant repetitive activity. Petitioner was released to full duty to her former job. The Arbitrator gives great weight to this factor.

iii) Petitioner was 53 years old at the time of her accident. She had a statistical life expectancy of approximately 29 years. The Arbitrator gives little weight to this factor.

iv) There was no evidence that Petitioner's future earning capacity was adversely affected by the injuries she proved. She was released to return to

full duty work on directions of healthcare professionals at Physicians Immediate Care. The Arbitrator gives great weight to this factor.

v) The medical records show the Petitioner received minimal medical intervention at Physicians Immediate Care following her accident. Petitioner was released to full duty work December 5, 2014. All subsequent healthcare providers, excepting for Dr. Sudbrack, were unaware of Petitioner's claimed work accident on November 24, 2014. Dr. Sudbrack's records and adequately documented Petitioner's diagnosis and the necessity of further medical care. The Arbitrator gives great weight to this factor

After evaluating all the evidence, including the above five factors, the arbitrator finds that Petitioner sustained contusions to his right and left legs and knees which resulted in permanent partial disability of 2.5% of the right leg and permanent partial disability of 2.5% in the left leg, a total of 10.75 weeks.

Steven J. Fruth, Arbitrator

June 26, 2020
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC004751
Case Name	OLIVA, MARTHA v. KOCH FOODS
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0308
Number of Pages of Decision	39
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Brenton Schmitz
Respondent Attorney	Anthony Ulm

DATE FILED: 6/18/2021

/s/Deborah Simpson, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARTHA OLIVA,

Petitioner,

vs. NO: 15 WC 4751

KOCH FOODS,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, TTD, PPD, and medical expenses both current and prospective and being advised of the facts and law, changes the Corrected Decision of the Arbitrator as stated below and otherwise affirms and adopts the Corrected Decision of the Arbitrator, which is attached hereto and made a part hereof.

This matter was consolidated with companion claims, 15 WC 4752 and 15 WC 4753. In the instant claim, the Arbitrator found Petitioner proved a compensable accident, that accident caused a current condition of ill-being, found that all medical expenses had been paid, and awarded her PPD of 10 weeks representing loss of the use of 2% of the person-as-a-whole. The Commission agrees with the findings of the Arbitrator and affirms and adopts the award of the Arbitrator.

However, the Commission notes that in the "Findings" section of the Decision of the Arbitrator indicates that the accident occurred on "8/7/12" while the official records of the Commission indicate that the accident occurred on 8/17/12. The Commission corrects that clerical error and otherwise affirms and adopts the Corrected Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Corrected Decision of the Arbitrator dated June 29, 2020 is hereby changed as noted above and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent has paid for all reasonable and necessary medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner permanent partial disability benefits in the amount of $229.20 for 10 weeks, as the injury has caused the loss of the use of 2% of the person-as-a-whole pursuant to §8(d)(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 $2,400.00. 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.

June 18, 2021

/s/*Deborah L. Simpson*
Deborah L. Simpson

/s/*Steven J. Mathis*
Steven J. Mathis

DLS/dw
O-4/20/21
46

/s/*Deborah J. Baker*
Deborah J. Baker

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0308
NOTICE OF ARBITRATOR DECISION
CORRECTED

OLIVA, MARTHA
Employee/Petitioner

Case# **15WC004751**

15WC004752
15WC004753

KOCH FOODS
Employer/Respondent

On 6/29/2020, 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 0.17% 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 McHARGUE & JONES LLC
BRENTON M SCHMITZ
123 W MADISON ST SUITE 1800
CHICAGO, IL 60602

2337 INMAN & FITZGIBBONS LTD
ANTHONY ULM
33 N DEARBORN ST SUITE 1825
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
CORRECTED ARBITRATION DECISION

Martha Oliva
Employee/Petitioner

v.

Koch Foods
Employer/Respondent

Case # **15 WC 4751**

Consolidated cases: **15 WC 4752/4753**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **October 22** and **November 20, 2019**. 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 **8/7/2012**, 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 **$19,864.00**; the average weekly wage was **$382.00**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **0** dependent children.

Petitioner has received all reasonable and necessary medical services.

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

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

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

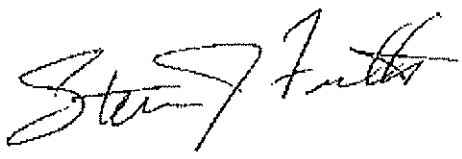
ORDER

All reasonable and related medical have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of $229.20/week for 10 weeks, as the injury has caused the loss of use of 2% of the person-as-a-whole under §8(d)(2).

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

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



Signature of Arbitrator

June 26, 2020
Date

JUN 29 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

OLIVA, MARTHA
Employee/Petitioner

Case# **15WC004752**

15WC004751
15WC004753

KOCH FOODS
Employer/Respondent

On 6/29/2020, 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 0.17% 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:

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123 W MADISON ST SUITE 1800
CHICAGO, IL 60602

2337 INMAN & FITZGIBBONS LTD
ANTHONY ULM
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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

Martha Oliva
Employee/Petitioner

v.

Koch Foods
Employer/Respondent

Case # **15 WC 4752**

Consolidated cases: **15 WC 4751/4753**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **October 22** and **November 20, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **10/12/2013**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**19,864.00**; the average weekly wage was $**382.00**.

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 $**0** under §8(j) of the Act.

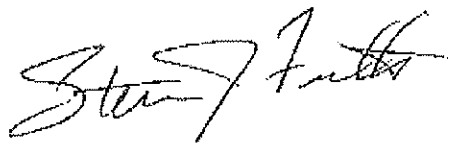
ORDER

Respondent shall pay all bills presented by Petitioner as they relate to the cervical spine for a period of six (6) weeks after October 12, 2013, up to November 23, 2013, to be adjusted in accord with the medical fee schedule. No bills for medical care for the left shoulder are awarded.

Respondent shall pay Petitioner permanent partial disability benefits of $229.20/week for 50 weeks, as the injury has caused the loss of use of 10% of the person as a whole under §8(d)(2) with respect to the cervical spine.

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 4, 2020
Date

JUN 2 9 2020

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

Martha Oliva
Employee/Petitioner

v.

Koch Foods
Employer/Respondent

Case # **15 WC 4753**

Consolidated cases: **15 WC 4751/4752**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **October 22** and **November 20, 2019**. 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

C. ☐ 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 _____

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

OLIVA, MARTHA
Employee/Petitioner

Case# **15WC004753**

15WC004751
15WC004752

KOCH FOODS
Employer/Respondent

On 6/29/2020, 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 0.17% 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:

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CHICAGO, IL 60602

2337 INMAN & FITZGIBBONS LTD
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33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

FINDINGS

On **11/24/2014**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$19,864.00**; the average weekly wage was **$382.00**.

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

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$2,279.97** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$2,279.97**.

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

ORDER

Respondent shall pay all bills presented by Physicians Immediate Care only, to be adjusted in accord with the medical fee schedule.

Petitioner claim for temporary total disability benefits is denied.

Respondent shall pay Petitioner permanent partial disability benefits of $229.20/week for 10.75 weeks, as the injuries sustained by Petitioner has caused a 2.5% loss of use of the right leg and a 2.5% loss of use of the left leg.

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 4, 2020
Date

JUN 2 9 2020

MARTHA OLIVA v. KOCH FOODS
15 WC 4751, consolidated 15 WC 4752, 15 WC 4753

INTRODUCTION

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

15 WC 4751 (DOI: 8/17/2012): ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***L:*** What is the nature and extent of the injury?

15 WC 4752 (DOI: 10/12/2013): ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***L:*** What is the nature and extent of the injury?

15 WC 4753 (DOI: 11/24/2014): ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** What temporary benefits are in dispute? TTD; ***L:*** What is the nature and extent of the injury?

Petitioner testified through a Spanish translator.

STATEMENT OF FACTS

Petitioner Martha Oliva testified that she was previously employed by Respondent Koch Foods. She began working for Respondent in February 2012. Respondent is a supplier of chicken breasts.

Petitioner was employed in slicing or cutting chicken breasts. She worked on a line, with 20 people on each side. She used a very sharp knife with her right hand to cut chicken breasts while holding them with her left hand. She would pick up breasts from in front of her at chest height with her left hand, cut them with her right hand, and then throw them onto another line in front of her at head level. She performed this job for approximately 6 months, and then was then placed on a laser cutter machine. The laser cutter involved 8 people. Workers would rotate between taking chicken pieces out of a

basket, then aligning pieces on the line, and then cleaning excess waste from the chicken pieces. The chicken pieces are cold, but not frozen. The production requirement was 70 pieces per minute for the line. During the years Petitioner worked with Respondent, the production requirement remained the same, but the number of people working on this machine dropped from 8 people to 6, and finally down to 2 people. Employees rotated between positions once per hour.

On August 17, 2012, Petitioner was throwing chicken pieces that had passed through the machine uncut onto another line to be redone. While doing this, she turned, slipped, and fell , doing the splits. A supervisor helped her get up, and she was taken to Physicians Immediate Care (PIC). Petitioner complained of pain in her left leg, her waist, and her back. She also complained of right elbow pain and tailbone pain (PX #1). Petitioner reported that she slipped and fell onto her right buttock and right leg. She also twisted her left knee. She was diagnosed with a hip contusion, lumbar sprain/strain, and left knee sprain.

She followed up with PIC August 20, August 27, September 4, September 11, and September 18, 2012. She received physical therapy through September 17, 2012. Petitioner was released to full duty work on August 27 several times in August and September 2012. In addition to physical therapy petitioner was prescribed Naproxen and Tylenol.

Petitioner was seen at PIC in 2012 after her accident for health concerns unrelated to her work accident injuries. No continuing complaints relating to her accident injuries were documented.

On October 12, 2013, Petitioner suffered a second work accident. She was working on the laser cutter. Only 3 people were working on the laser cutter at this point. Petitioner was working with a high volume of pieces, and felt a spasm in her left neck and shoulder. She reported her complaints and was sent home. She not taken to a doctor.

Petitioner consulted her primary care physician, Dr. Luiz Sudbrack, two days later, on October 14 (PX#2). Petitioner complained of "neck pain all the way down the arm & hand w/numbness on the hand...Patient suffered a work related injury because of repetitive [unknown]." A cervical MRI completed October 17, 2013 demonstrated multiple levels of disc bulging: a 2 mm diffuse bulge at C3-4, a 3 mm disc osteophyte complex with small herniation at C4-5, a 6.5 mm protrusion on the right at C5-6, and a 2.5 mm diffuse bulge at C6-7. Dr. Sudbrack recommended physical therapy and an MRI of the left shoulder on October 18, 2013. MRI Scans of the right elbow, left shoulder, and left elbow were all noted as normal. Petitioner received physical therapy at Norwegian American Hospital through January 16, 2014, which she said provided little relief.

Dr. Sudbrack's clinical notes were handwritten and difficult to decipher. The doctor rarely made notes that seemingly documented a clinical examination, much less an orthopedic or neurological exam. Dr. Sudbrack wrote a series of status notes where he incorporated his diagnosis of cervical radiculopathy without stating the clinical findings in support of that diagnosis. The doctor wrote a note on October 18, 2013 ordering six weeks of physical therapy and on October 24 wrote that Petitioner should be off work for six weeks to complete physical therapy. On December 5, 2013 Dr. Sudbrack wrote an order extending physical therapy for another six weeks. The doctor wrote a note December 30, 2013 that a decision for return to light duty work was dependent on a recommendation of a neurosurgeon at Northwestern Hospital.

Petitioner was referred to Dr. Nader Dahdaleh, whom she saw on December 18, 2013 (PX #2). Petitioner complained of neck pain radiating to both shoulders and the left upper extremity. She also complained of numbness in those areas. Petitioner stated that trigger point injections in the neck gave mild relief. The examination did not note an assessment of cervical range of motion, however motor strength in the upper and lower extremities was normal. Sensation to light touch in pinprick were normal except for the left lateral aspect of her left leg and over the left C6 dermatome of her arm.

Dr. Dahdaleh diagnosed chronic low back pain, chronic neck pain, cervical radiculopathy, and lumbar radiculopathy. Dr. Dahdaleh noted degenerative changes due to cervical spondylosis with foraminal stenosis at C5-6 and C6-7 due to large disc osteophyte complexes. He recommended continued physical therapy and prescribed a Medrol Dosepak. On January 29, 2014, Dr. Dahdaleh recommended a cervical epidural steroid injection, followed by possible C5-6 and C6-7 fusion. Petitioner elected not to have surgery and returned to work in a new position where she could sit.

At Respondent's request Petitioner was examined pursuant to §12 of the Act by orthopedic surgeon Dr. Jay Levin on December 19, 2013. Dr. Levin examined Petitioner separately for her cervical and thoracic spine (RX #1), and also for her lumbar spine (RX #2). Dr. Levin was assisted by case manager Martha Sanchez, R.N., who acted as an interpreter.

With regard to the cervical spine IME Dr. Levin took Petitioner's history of her work activities and her claimed injuries in August 2012 and on October 12, 2013 (PX #1). Dr. Levin also took petitioner's history of her medical care at an occupational health clinic in 2012 and then from Dr. Sudbrack after the 2013 accident. Petitioner's chief complaint was posterior neck pain going down her left arm to the elbow. She rated her pain at 10/10. She also complained of a little pain in her right arm to the elbow and "a lot" of weakness in the left arm. Petitioner also complained of pain between her shoulder blades. Dr. Levin

reviewed respondent's October 17, 2013 accident report, Petitioner's records from Agape Medical Center, the initial physical therapy evaluation from Norwegian American Hospital on October 28, 2013, and radiological imaging.

On examination Dr. Levin noted diminished cervical range of motion. There was bilateral trapezius tenderness but no trigger point tenderness. Spurling's test elicited right posterior cervical discomfort but without radiation into the arms. Spurling's on the left was negative. Toes/heels walking elicited lumbar area pain. Arm strength was normal, as well as reflexes. There was diminished sensation over there were right lateral deltoid, left dorsal, and left volar forearm. There was tenderness over the lower lumbar spine. Lumbar motion was somewhat diminished and painful. Sitting straight leg raise was negative bilaterally. Sensation was decreased over the left medial/lateral calf, medial/lateral thighs, and medial/lateral feet. FABER test on the right elicited central low back pain and on the left elicited left gluteal pain.

Dr. Levin noted radiographs demonstrated degenerative disc changes at C5-6 and also at L2-3 and L3-4. There was facet arthritis at L5-S1. The October 17, 2013 cervical MRI demonstrated age appropriate degenerative disc changes with central annular bulging at C2-3, degenerative right-sided annular bulges at C3-4 and C4-5, a right-sided disc herniation at C5-6, and a right-sided disc protrusion at C6-7. Dr. Levin noted that these findings were inconsistent with Petitioner's subjective complaints. Dr. Levin also noted the left shoulder MRI showed a normal rotator cuff and type II acromion.

Dr. Levin, "assuming [Petitioner] sustained an injury at all", diagnosed cervical myofascial strain. He opined that a course of physical therapy of 10 visits over 5 weeks would be medically appropriate. He found the cervical MRI was within the standard of care but did not believe the MRIs of the right elbow and left shoulder where indicated for any injury on October 12, 2013. He further opined that Petitioner should reach MMI within 4 to 6 weeks after the accident. He did not believe Petitioner required further medical care at that time and opined that Petitioner could return to full duty work.

With regard to the lumbar spine exam recited Petitioner's previously noted history of injury (PX #2). Petitioner reported that 10/10 low back pain, which he said was constant. She complained of pain travels down both by docs and both legs to the feet.. Petitioner reported that she can send for 5 minutes and then has to be a just and that she can walk for 5 minutes but then has to take a break.

On examination Petitioner complained of lower lumbar pain with toes/heels walking. Lumbar range of motion was diminished and painful. There was midline lower lumbar tenderness as well as bilateral lumbosacral and sciatic notch tenderness. Straight-leg raise on the right at 60° elicited low back pain but was negative on the left. However,

sitting straight-leg raise was negative bilaterally. Sensation was decreased over the left medial/lateral calf, medial/lateral thighs, and medial/lateral feet. FABER test on the right elicited central low back pain and on the left elicited left gluteal pain.

Plain X-rays demonstrated degenerative disc changes at L2-3 and L3-4 as well as facet arthritis at L5-S1. The lumbar MRI demonstrated degenerative disc changes at L2-3, L3-4, L4-5, and L5-S1. No significant canal encroachment was noted. There was no evidence of disc herniation at L4-5. There was bilateral facet arthritis with foraminal stenosis at L3-4. There was a left-sided disc protrusion with degenerative changes at L2-3, but L1-2 appeared normal.

Dr. Levin noted that he had not been able to review medical records of treatment for the October 2012 accident. He noted that he would need those records to determine any diagnosis referral to the accident. He further noted that the MRI findings were age-appropriate without evidence of a herniated nucleus pulposus. He further observed that Petitioner had been working following the 2012 accident up to the 2013 accident.

Petitioner did not treat again until September 12, 2014, when she returned to PIC with left neck and shoulder pain (PX #1). She complained of 7/10 left-sided neck and shoulder pain. She reported it was the result of a work-related injury with a sudden onset with a change in her job to a higher speed line. On examination Petitioner had reduced range of motion, but it was noted that she exhibited guarding out of proportion to the injury. It was also noted that Petitioner exhibited hypersensitivity out of proportion to the injury.

Petitioner sought care at PIC June 18, June 19, and June 26, 2014 for bruising around the left eye. She reported that while at work she stepped off a stepstool and struck her left orbit while sneezing. There were no complaints relating to the neck or back. On examination particular Petitioner's neck was noted as supple with good range of motion. There was no tenderness of the neck or cervical spine. No continuing complaints relating to her more recent accident injuries were documented.

On November 24, 2014, Petitioner was again working at Respondent in a seated position on a stool. Petitioner stepped off the stool to use the restroom and slipped on the wet floor, again doing the splits. She felt pain in her back and left hip. She was taken to PIC that day, where she complained of pain in the left thigh, left knee, right side, and right knee. She also complained of neck and low back pain with "tingling." In addition, she complained of pain in the left and right hands with "tingling." The clinical exam was essentially normal. X-rays were negative. Petitioner was diagnosed with a knee contusion, ankle/foot pain, and lower back pain. She was taken off work that day and released to return to work on November 25 with restrictions to avoid squatting and

extended standing until December 1, 2014. "All Day" and "Non-Aspirin" pain medication was dispensed.

Petitioner returned to PIC December 1, 2014 with continuing complaints of pain in the left thigh, left knee, right thigh, and right knee. The clinical examination was essentially normal, and the diagnoses were unchanged. She was released with restrictions for sit-down work only. "All Day" pain medication was discontinued. Petitioner returned to PIC December 5, 2014 with the same complaints but were reported as mild. She reported that she could stand and walk and a normal pace without discomfort. She did note a cracking noise in her knee, which one was not noted, when she walked fast. Petitioner was released to full duty work without restrictions, and it was noted that she should attain full resolution in 7 days.

Petitioner continued to follow up with her primary care physician, Dr. Sudbrack, in 2014 for unrelated issues. She saw Dr. Sudbrack December 17, 2014 with left knee complaints after falling at work 8 days before. Dr. Sudbrack's handwritten notes were indecipherable such that it is impossible to determine the extent of the clinical examination.

Petitioner returned to Dr. Sudbrack on January 14, 2015, who then recommended a left knee MRI without noting whether he had assessed Petitioner's knee with clinical testing for a torn meniscus or ligament. The January 23, 2015 MRI demonstrated mild effusion only (PX #2). Petitioner continued to follow with Dr. Sudbrack through February and March 2015. On February 5 Dr. Sudbrack noted that he filled out disability forms. Petitioner had a lumbar MRI February 25, 2015 on order of Dr. Sudbrack, but a complete copy of the radiology report was not included in Petitioner's Exhibit #2. The complete report was incorporated in Petitioner's Exhibit #12. The radiologist noted multilevel diffuse disc bulging and hypertrophy, as well as spondylolisthesis, from L2-3 through L5-S1.

Petitioner testified that she then sought care at New Life Medical Center (New Life) on February 6, 2015 (PX #7). The New Life records, PX #7, document Petitioner's first contact with chiropractor Dr. Irene Ma was on September 18, 2014, which Petitioner did not testify about at trial. On September 18 Petitioner gave a history of her work injury on October 12, 2013. She complained of constant neck pain and muscle spasm in the neck and pain across the left shoulder and down the left arm with numbness and tingling in her left arm. She complained of 10/10 pain. Dr. Ma diagnosed cervical sprain/strain, cervicalgia, cervical radiculitis, shoulder sprain/strain, shoulder pain, shoulder stiffness, arm pain, muscle spasm, and work related injury. Petitioner then received extensive chiropractic care for her neck and shoulder from Dr. Ma, however the dates of care are obscured in the copied records.

Petitioner testified that she was taken off work at the February 6, 2015 consultation and did not return to work for Respondent.

There are no clinical notes for Petitioner's consultation with Dr. Ma on February 6, 2015 (PX #7), although there were billing records. There are billing records for February 10, February 12, February 13, February 17, February 19, February 20, February 24, and February 27, 2015, for which there are chiropractic progress notes but no physician notes. Dr. Ma's first clinical note March 10, 2015 documents Petitioner's complaints of 9/10 pain in the neck, 9/10 pain in the left shoulder, and 9/10 pain in the left arm with numbness/tingling/weakness in the left arm. However, there was no reference to Petitioner's claimed work accident on November 24, 2014. Dr. Ma added a diagnosis of cervical disc herniation at that time. There were no notes regarding Petitioner's work status.

Petitioner testified that she was referred to Dr. Neeraj Jain for her pain, whom she saw on March 25, 2015 with complaints of neck and back pain. Petitioner gave a history of feeling a pop in her neck with severe neck pain and left arm weakness on October 12, 2013 at work. She did not mention a work accident on November 24, 2014. She complained of pain radiated into her left arm. She also complained of paresthesia Petitioner also complained of pain in her right arm. Petitioner reported that her back pain began in 2012 with a work-related incident. She also reported that physical therapy had restarted in September 2014 but stopped after one or two months. A third round of physical therapy started in March 2015.

Dr. Jain reiterated the radiologist's findings from the 2013 cervical MRI. He also reiterated the radiologist's findings of mild spondylosis at L2 through L5 with annular disc bulging from the 2013 lumbar MRI. He noted the 2013 left shoulder MRI showed a normal rotator cuff and a type II acromion.

Dr. Jain noted significantly reduced cervical range of motion with pain. Lumbar range of motion was also reduced. Straight-leg raise was positive on the right. There was reduced sensation to touch in the left upper extremity without described distribution. Dr. Jain noted prominent weakness in the left upper extremity. Diagnosed neck pain related to the October 12, 2013 accident. Dr. Jain recommended a C5-6 and C6-7 epidural and another lumbar MRI. Petitioner continued to receive chiropractic care from Dr. Ma March and April 2015.

Dr. Ma's clinical note on April 14, 2015 noted Petitioner claimed 9/10 pain in her neck, left shoulder, and left arm. She also complained of numbness and weakness in the left arm. There is no note that Petitioner reported an accident at work on November 24,

2014 in which she was again injured. Petitioner saw Dr. Ma again on May 19, 2015. Her pain remained 9/10. Again, there was no reference to a November 24, 2014 work accident. There was no note regarding work status. On June 23, 2015 Dr. Ma noted no change in Petitioner's complaints. Again, there was no reference to a November 24, 2014 work accident or any note regarding work status.

Dr. Jain administered an interlaminar cervical epidural steroid injection at C7-T1, assisted by Susan Jain, PA-C, on June 19, 2015. Dr. Jain administered bilateral L4-5 transforaminal epidural steroid injections (ESI) and selective nerve root blocks, assisted by Sarah Spring, P.A., in July 7, 2015. Petitioner's Exhibit #13 is billing statements of Thomas C. Corral, CRNA, Windy City Anesthesia, for administering nerve blocks on June 19, 2015 and on July 7, 2015. No clinical or operative reports by CRNA Corral for these procedures were included in Petitioner's Exhibit #13 or otherwise offered in evidence.

Petitioner saw Dr. Jain again on July 25, 2015, when he noted Petitioner had received bilateral L4-5 transforaminal ESI and selective nerve root block on "July 17" (*sic*). Dr. Jain also noted that Petitioner had received a cervical epidural steroid injection on "June 09, 2015" (*sic*).

Petitioner saw orthopedic surgeon Dr. Ronald Silver on April 25, 2015 (PX #5). Petitioner gave a history of her October 12, 2013 work injury from repetitive motion activity. Petitioner complained of pain in her neck and her shoulder and was treated with physical therapy and anti-inflammatories. He noted that Petitioner had been able to work until January 2015 when her pain became too severe. On examination Petitioner had reduced range of motion and had positive impingement and Hawkins' signs. He noted an MRI scan demonstrated inflammation of the rotator cuff, without noting if it was the 2013 or 2015 MRI he relied on. Dr. Silver diagnosed "rotator cuff" and impingement and administered a cortisone injection in the left shoulder. He also prescribed Meloxicam, hydrocodone, and Ultram.

Petitioner's Exhibit # 16 was billing from G & U Orthopedic for May 1, 2015 for $2,684.59 and for June 18, 2015 for $612.56 (PX #16). These charges were apparently for durable medical equipment ordered by Dr. Ma. Dr. Ma's notes in the New Life chart do not state the medical necessity for durable medical equipment.

On July 16, 2015, Dr. Silver noted a positive temporary response to the left shoulder injection. Petitioner's exam was essentially unchanged. Dr. Silver noted her complaints of left-sided neck pain radiating into the arm and hand, for which he recommended she see a cervical spine specialist. Dr. Silver recommended arthroscopic shoulder surgery without specifying what the surgery was intended to correct, which Petitioner declined.

Petitioner continued to consult with Dr. Jain through 2015 (PX #4). On August 12 Petitioner reported she was attending physical therapy 3 times a week which provided substantial benefit. However, it was noted Petitioner continued to be off work due to her substantial pain. Dr. Jain recommended an EMG of the upper extremities because of neck pain complaints radiating down the left arm. Dr. Jain also recommended a repeat lumbar L4-5 transforaminal ESI and selective nerve block.

Dr. Ma's clinical note on August 11, 2015 again referred to Petitioner's injury sustained while at work on October 12, 2013. Petitioner complained of 8/10 pain in her neck, left shoulder, and left arm. Again, she complained of numbness and tingling in the left arm. Again, there was no reference to a work accident on November 24, 2014. Dr. Ma's clinical note on October 8, 2015 was essentially identical to the August 11 note, as were Dr. Ma's notes on December 1, 2015 and January 22, 2016.

Petitioner had an EMG/NVC performed by chiropractor Dr. Gregory Thurston on September 14, 2015 (PX #8). The only finding was mild-moderate evidence of carpal tunnel syndrome.

On September 15, 2015 Dr. Jain noted that Petitioner's EMG showed no evidence of radiculopathy. She still complained of moderate to severe neck pain radiating into the left arm as well is bilateral back pain radiating into the left leg. Dr. Jain continued to recommend lumbar ESIs October 13, 2015 and on the last visit February 10, 2016.

Petitioner consulted neurosurgeon Dr. Robert Erickson March 30, 2016 for her cervical and lumbar pain which began with a work injury October 17, 2013 (PX #6). Petitioner reported the sudden onset of neck and left shoulder pain with radiation of abnormal sensation in all fingers of the left hand. Petitioner also reported the onset of low back pain soon thereafter which radiated into her left leg. Petitioner also reported low back pain secondary to a prior injury which she could not adequately describe. Dr. Erickson reviewed the 2013 and 2015 MRIs. He noted the cervical MRI showed a central disc herniation at C5-6 with slight rightward prominence. He noted there was a broad disc herniation at C6-7 of lesser significance.

On examination Dr. Erickson noted diminished left grip strength and Petitioner's report of paresthesia in all fingers. Light touch in pinprick for diminished over the dorsum of the hand and over the extensor forearm. Cervical motion was relatively full but painful. Dr. Erickson suspected C8 radiculopathy but wanted a new cervical MRI before a final surgical opinion. He suggested a somatosensory evoked potential test the upper extremities to rule out a C7 nerve problem.

On May 18, 2016 Dr. Erickson reviewed the SSEP of April 26, 2016. He noted there were significant delays bilaterally at C6, the right being worse. There were mild delays bilaterally at C7. He explained to Petitioner that the MRI compression of the spinal cord on the right and C5-6. He opined that Petitioner had a good chance of improving with an interior cervical discectomy and fusion at C5-6 and possibly C6-7.

Dr. Erickson commented on Dr. Levin's December 19, 2013 IME, in which Dr. Levin attributed the cervical disc herniation to degenerative joint disease. Dr. Erickson stated it is impossible to determine on MRI alone whether herniations exist as a result of trauma or as a result of degenerative change. He added that changes are often a combination of both processes and that the persistence of Petitioner's condition did not support Dr. Levin's diagnosis of myofascial strain.

On August 10, 2016 Dr. Erickson noted Petitioner hoped to avoid surgery. He explained that surgery was her best option but noted it was not an emergency situation. He did not recommend back surgery but did note petitioner was a good candidate for a second ESI.

Petitioner chose not to have this surgery as well due to a fear of surgery.

Petitioner returned to work for a new company, the Millard Group, working as a janitor, on November 10, 2016. She also worked on weekends selling jewelry in a flea market while she was between jobs. She testified she is in constant neck pain, and is regularly taking ibuprofen. She has constant low back pain as well. She is able to complete all of her tasks at work, as the work is not difficult.

Petitioner was examined again at Respondent's request pursuant to §12 on November 19, 2018 by orthopedic surgeon Dr. Babak Lami (RX #3). Dr. Lami's medical assistant served as an interpreter. Petitioner gave a history of working for Respondent from 2012 through 2015. She reported her initial injury in October 2012 when she developed neck and left arm pain. Petitioner reported a second injury for which she could not recall the exact dates but believed it was in 2013 when she slipped and fell onto her buttocks. Petitioner denied having any injuries in 2014.

At the time of the examination Petitioner rated her pain 8/10, localized at the base of her neck between her shoulder blades and the left shoulder. She did not report pain radiating down the left arm. Petitioner also complained of low back pain which also involve the posterior thigh and posterior left calf. Dr. Lami noted the left leg symptoms did not fall into a particular dermatome. Petitioner's main complaints were neck and low back pain and that her left shoulder and left leg were not her main complaints.

On examination Dr. Lami noted minimal cervical flexion and extension and only 30° rotation bilaterally. Lumbar spine extension was at 0°, flexion was 5°, and side bending was 10°. Dr. Lami found normal muscle strength in both the upper and lower extremities. Dr. Lami found sensation was grossly intact although Petitioner reported slightly altered sensation over the entire left arm.

Dr. Lami reviewed Petitioner's records from Norwegian American Hospital, New Life Medical Center, Dr. Sudbrack, Dr. Silver, Dr. Jain at Pinnacle Pain Management, Dr. Erickson, and Dr. Levin's IME reports. Dr. Lami he also reviewed various radiological studies and reports, as well as the September 14, 2015 EMG/NCV report performed by chiropractor Dr. Gregory Thurston.

Dr. Lami did not find that Petitioner sustained a work-related injury to her cervical spine. He did concede that Petitioner's assembly-line work activities could possibly cause a sprain, which would have been self-limiting. He noted that Petitioner's current symptomology of 8/10 pain was not explained by her lumbar and cervical MRIs. He found no evidence of radiculopathy or neurological deficit. He noted that the cervical MRI findings were right-sided, which was inconsistent with Petitioner's symptoms always being left-sided. Dr. Lami also noted that Petitioner's lumbar MRI findings were fairly benign with age-appropriate degenerative changes.

Dr. Lami could not support a need for treatment of Petitioner's claimed cervical spine condition. He particularly noted Petitioner's inability to provide a consistent history of the 3 alleged injuries. Dr. Lami opined that Petitioner's cervical spine symptoms would not be "amenable" to injections. He did not agree with the recommendation for a C5-6 fusion because Petitioner's symptoms were not consistent with radiculopathy. He particularly noted that any recommended surgery was not related to any work injury. Dr. Lami found Petitioner had reached MMI for her low back within 6 to 8 weeks and that Petitioner was capable of full time at full duty at selling gold on weekends as she reported doing for the previous 3 years.

Finally, Dr. Lami noted Petitioner's out of proportion complaints when compared to the MRI findings, exam findings, and the report of mechanism of injury. He noted this was consistent with symptom magnification.

Petitioner had another §12 IME with orthopedic surgeon Dr. Nikhil Verma of Midwest Orthopaedics at RUSH on December 17, 2018 (RX #4. Dr. Verma was assisted by a certified Spanish-English medical interpreter. Dr. Verma noted Petitioner's history of three work accidents on August 17, 2012, on October 12, 2013, and on November 24, 2014.

Dr. Verma noted that Petitioner was unclear as to specifically which body parts were injured in which event but that her current complaints were with neck pain, back pain, left upper extremity pain, and left lower extremity pain. She complained that her pain starts in the neck, radiates into the thoracic back and low back and also into her left arm and hand, as well as her left leg. She stated that when it stops at the knee she feels a sharp pain in the knee itself. Dr. Verma noted difficulty in obtaining a history of treatment from Petitioner.

Dr. Verma reviewed the records of Petitioner's medical care, including radiological studies. Dr. Verma noted Petitioner's care included physical therapy, chiropractic therapy, and spinal cortisone injections. On examination Petitioner complained of pain with neck movement. She had full range of shoulder motion and normal strength. Although Petitioner complained of hand numbness the neurological exam of the left arm was normal. Petitioner had full range of knee motion with negative Lachman's and drawers signs. Straight-leg raise was negative.

Dr. Verma found Petitioner's left knee was normal. He also found no abnormality in Petitioner's left shoulder, although he requested an opportunity to review her shoulder MRI. Dr. Verma did not believe that Petitioner sustained a left knee or left shoulder injury in as a result of either the 2012 or 2013 or 2014 reported accidents. He noted that Petitioner's medical records document claims of overuse repetitive lifting. He suspected possible left cervical radiculopathy rather than a left shoulder issue. He opined that Petitioner did not require medical treatment for her left knee or her left shoulder in relation to any work injury. He found Petitioner at MMI with regard to her left knee and left shoulder and that she was at full duty status with regard to the left knee and left shoulder. He saw no need for work restrictions. Finally, he commented that he saw no evidence that Petitioner sustained any permanent or partial disability with regard to her left knee or left shoulder.

Charmell Johnson testified on behalf of Respondent. Ms. Johnson work for respondent for six years. She is currently safety coordinator for the Berteau location. And 2013 she was a general labor employee and work that the DSI line. She is familiar with Petitioner, who also worked the DSI line.

Ms. Johnson is familiar with the job duties when working the DSI line. Workers are rotated every hour on the hour to different assignments. The DSI line requires 8 workers, 4 in front and for in back. If 8 workers were unavailable the DSI line would not be operated. Workers would handle chicken pieces weighing 8 to 10 ounces.

CONCLUSIONS OF LAW

15 WC 4751 (DOI: 8/17/2012)

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

The Arbitrator finds that Petitioner proved that her condition of ill-being in her low back was causally related to her work accident on August 17, 2012.

Petitioner suffered an undisputed accident at work where she slipped and fell on August 17, 2012. She claims injury to her left leg, waist, and back. She treated with Physicians Immediate Care until September 18, 2012, approximately one month, with a final diagnosis of a lumbar strain. The Arbitrator finds that Petitioner's lumbar spine strain was related to the August 17, 2012 accident.

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

The Arbitrator finds that Petitioner proved that the medical services provided for treatment of her injuries were reasonable and necessary and, further, the charges and fees for the care were also reasonable and necessary.

Petitioner suffered an undisputed accident at work where she slipped and fell on August 17, 2012. She claims injury to her left leg, waist, and back. She treated with Physicians Immediate Care (PIC) until September 18, 2012, approximately one month, with a final diagnosis of a lumbar strain. The Arbitrator finds that Petitioner's lumbar spine strain is related to the August 17, 2012 accident through her last date of service, September 18, 2012.

No outstanding bills from PIC were presented at trial, and therefore no bills are awarded under this claim.

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

Petitioner's claim for permanent partial disability was evaluated in accord with §8.1b of the Act:

i) No AMA Impairment Rating was offered in evidence. The Arbitrator cannot give any weight to this factor.

ii) Petitioner worked in a fast-paced food processing plant which required significant repetitive activity. Petitioner was able to return to work to her former job. The Arbitrator gives great weight to this factor.

iii) Petitioner was 50 years old at the time of her accident. She had a statistical life expectancy of approximately 32 years. The Arbitrator gives little weight to this factor.

iv) There was no evidence that Petitioner's future earning capacity was adversely affected by her injuries. She was able to return to full duty work until she was injured in a subsequent accident. The Arbitrator gives great weight to this factor.

v) The medical records show that Petitioner sustained a lumbar strain from which she recovered sufficiently to return to full duty work. The Arbitrator gives great weight to this factor.

Based on all the evidence, including the above five factors, the Arbitrator finds that Petitioner suffered a permanent partial disability of 2% of a person-as-a-whole, 10 weeks, due to injuries that she sustained at work August 17, 2012.

15 WC 4752 (DOI: 10/12/2013)

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

The Arbitrator finds that Petitioner proved that she sustained an accidental injury that arose out of and in the course of her employment by Respondent.

Petitioner testified credibly that on October 12, 2013 she experienced an onset of left-sided neck pain while working on the laser cutter line machine. While working quickly and trying to keep up with the chicken pieces on the line, her neck suddenly felt tensed and paralyzed. This was reported the same day, and Petitioner was immediately sent home. Her treating physician, Dr. Sudbrack, attributed the injury to repetitive work just two days later, on October 14, 2013.

The mechanisms of work activities described by Petitioner, particularly those she was engaged in on October 12, 2013, are sufficiently repetitive that the Arbitrator finds they arose out of Petitioner's employment with Respondent, constituting a risk incidental to her employment.

There was no evidence offered to rebut Petitioner's claim that her injury arose out of and in the course of her employment.

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

The Arbitrator finds that Petitioner proved that her condition of ill-being relating to her cervical spine is causally related to her work accident on October 12, 2013.

Petitioner testified that she had a sudden onset of neck and left shoulder pain while working October 12, 2013. She sought medical care from her primary physician, Dr. Sudbrack, two days later and was prescribed physical therapy. Dr. Sudbrack referred Petitioner to orthopedic surgeon Dr. Dahdaleh, who noted MRI findings of degenerative changes from C3 through C7 in Petitioner's cervical spine. Dr. Dahdaleh diagnosed cervical radiculopathy for which he recommended an anterior cervical fusion, which Petitioner declined. Dr. Erickson also recommended cervical fusion despite Petitioner's diffuse, vague, and inconsistent subjective complaints.

Dr. Jay Levin, who examined Petitioner on behalf of Respondent, diagnosed cervical myofascial strain. Dr. Levin noted in particular the age-appropriate degenerative changes in Petitioner's cervical spine which were inconsistent with Petitioner's subjective complaints. Dr. Levin, as well as Dr. Lami, noted Petitioner's left-sided upper extremity complaints were inconsistent with the MRI right-sided findings in her cervical spine. In addition, the Arbitrator notes Petitioner's consistent complaints of numbness and weakness in her left arm, excepting for Dr. Dahdaleh's one exam, were diffuse and vague and often accompanied normal neurological and strength testing. But for Dr. Dahdaleh, none of Petitioner's treating physicians identified Petitioner's complaints of left arm and numbness and weakness with any recognized dermatome.

In addition, Petitioner received seemingly unending chiropractic therapy from Dr. Ma which failed to provide relief or progress with Petitioner's condition.

There was significant evidence of Petitioner's symptoms magnification. She frequently and consistently complained of 10/10 pain to her treating physicians, who did not respond in a way appropriate to belief that the 10/10 pain complaints were genuine.

The evidence suggests, as noted by Dr. Levin, Petitioner had age-appropriate pre-existing degenerative changes in her cervical spine that did not correspond to her subjective complaints. The Arbitrator finds Dr. Levin's opinion Petitioner sustained a myofascial strain to her cervical spine to be convincing and persuasive. The arbitrator finds that petitioner failed to prove that she sustained an injury to her cervical spine for which surgery would have been medically necessary. It is particularly noteworthy that Petitioner returned to work before her third accident on November 24, 2014.

Dr. Silver examined Petitioner's left shoulder and recommended surgery despite an MRI demonstrating a normal rotator cuff and only a type II acromion. He never documented his reasoning or noted a clinical basis for recommending surgery. On the other hand, Respondent's examining physician Dr. Verma found no pathology petitioner's left shoulder and opined surgery was not medically necessary. The Arbitrator finds Dr. Verma's opinions reasonable and persuasive, and adopts the same.

To confirm, the Arbitrator finds that Petitioner failed to prove that she sustained cervical disc herniations and radiculopathy were causally related to the October 12, 2013 work accident. In addition, Petitioner failed to prove that she had sustained an injury to her left shoulder that was causally related to the October 12, 2013 work accident. Petitioner proved that she sustained a myofascial cervical strain that was causally related to the accident, which was likely an aggravation of her pre-existing degenerative cervical spine.

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?

As noted above the Arbitrator found that Petitioner sustained a myofascial strain to her cervical spine that was causally related to her October 12, 2013 work accident. Also noted above, the Arbitrator found the opinions of Dr. Levin to be reasonable and persuasive. Dr. Levin opined that Petitioner would benefit from 5 weeks of physical therapy and would likely achieve MMI within 6 weeks of the accident. Dr. Levin further opined that Petitioner did not require further medical care for her accident injuries.

The Arbitrator finds the opinion of Dr. Levin regarding Petitioner's MMI reasonable and persuasive. Therefore, it follows that the Arbitrator finds that the medical care provided Petitioner after 8 weeks following the October 12, 2013 work accident was not reasonable or necessary.

Dr. Levin noted that a cervical MRI was within the standard of care for assessing Petitioner's claimed neck injury. However, he noted that MRIs of the left shoulder and right elbow were not clinically indicated. The Arbitrator adopts Dr. Levin's opinion regarding the left shoulder and right elbow MRI and denies Petitioner's request for payment of those procedures.

The credibility and reliability of the care provided at New Life Medical Center is inherently suspect in light of the unending chiropractic services with no progress in relieving Petitioner's complaints, frequently noted at 10/10. In addition, the reliability of New Life's records were further undermined when there was no record of Petitioner's third work accident on November 24, 2014.

Dr. Lami opined, due to Petitioner's inconsistent clinical presentation and the lack of evidence of radiculopathy, and cervical spine injections were not medically indicated. Given Petitioner's well noted inconsistent symptoms and the negative EMG/NCV, the Arbitrator finds Dr. Lami's opinion reasonable and persuasive and denies Petitioner's

request for payment for those procedures. Although Dr. Lami did not opine whether Dr. Jain's lumbar spine injections were medically necessary, the evidence of the inconsistencies in Petitioner's clinical presentation of her claim in the back injury leads to the same conclusion that Petitioner failed to prove the medical necessity of the lumbar spine injections. Therefore, the Arbitrator does not award the medical fees and charges relating to either series of cervical or lumbar spine injections.

With regard to the spinal injections administered by Dr. Jain on June 19, 2015 and July 7, 2015, billing statements by Thomas Corral CRNA totaling $1,942 for June 19 and $2,002 for July 7 were admitted in Petitioner's Exhibit #13, Windy City Anesthesia . Dr. Jain noted that an anesthesiologist attended those procedures due to Petitioner's anxiety. Aside from noting that Mr. Corral is a Certified Registered Nurse Anesthetist rather than an anesthesiologist, there were no clinical or operative records by CRNA Corral admitted in evidence. The Arbitrator cannot award billing when there are no clinical records to correspond to the charges, rendering it impossible to determine the reasonableness of the charges.

In summary, the Arbitrator does not award medical expenses and charges for beyond 6 weeks after the accident on October 12, 2013.

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

Petitioner's claim for permanent partial disability was evaluated in accord with §8.1b of the Act:

i) No AMA Impairment Rating was offered in evidence. The Arbitrator cannot give any weight to this factor.

ii) Petitioner worked in a fast-paced food processing plant which required significant repetitive activity. Petitioner was able to return to work to her former job. The Arbitrator gives great weight to this factor.

iii) Petitioner was 52 years old at the time of her accident. She had a statistical life expectancy of approximately 30 years. The Arbitrator gives little weight to this factor.

iv) There was no evidence that Petitioner's future earning capacity was adversely affected by her injuries. She was able to return to full duty work until she was injured in a subsequent accident. The Arbitrator gives great weight to this factor.

v) The records show that Petitioner received aggressive medical care for a cervical myofascial strain. A competent and persuasive physician opined that Petitioner had reached MMI with her neck within 8 weeks of her October 12, 2013 work accident. No further medical would be necessary after reaching MMI. A competent and persuasive physician opined that Petitioner had not injured her left shoulder. In addition, the records also suggest that Petitioner's symptom magnification was the likely

justification for the unnecessary medical provided after she reached MMI. Moreover, there was a persuasive inference that, based on other reasoning, spinal injections were not medically indicated. It is also noteworthy that Petitioner declined recommendations for surgery and returned to her prior employment before being injured in a third work accident. The Arbitrator gives great weight to this factor.

Based on all the evidence, including the above five factors, the Arbitrator finds that Petitioner suffered a permanent partial disability of 10% of a person-as-a-whole, 50 weeks, due to injuries that she sustained at work October 12, 2013.

15 WC 4753 (DOI: 11/24/2014)

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

Although there is evidence that Petitioner sustained contusions to her right and left knees and legs in a work accident November 24, 2014, the Arbitrator finds that Petitioner failed to prove that her claimed current condition of ill-being in her left knee, left shoulder, and low back were causally related to the November 24 work accident.

Petitioner received emergent medical care at Physicians Immediate Care (PIC) on the day of her work accident. On intake, Petitioner complained of left thigh, right thigh, right knee, low back, neck, and bilateral hand pain. She was instructed to return to work in an essentially sedentary capacity until December 1, 2014. These restrictions were modified on December 1, 2014 to sit down work only, when her complaints were limited to both thighs and knees. Petitioner was released from PIC December 5, 2014 to full duty, with a note that full resolution of her symptoms would be within 7 days, although petitioner testified that she had continuing low back pain.

Petitioner once again sought out her primary care physician, Dr. Sudbrack, who took her off work again on December 17, 2014 due to left knee pain. Petitioner followed up with Dr. Sudbrack until February 6, 2015 when she testified that she began a course of treatment at New Life Medical Center. She was eventually referred to Dr. Neeraj Jain, who recommended and performed cervical and lumbar injections in June and July of 2015. Petitioner testified that these injections were only temporarily helpful.

However, as noted, the indecipherable handwritten clinical notes Dr. Sudbrack making it impossible to assess whether his medical care was causally related to petitioner's claimed injuries. The doctor ordered a left knee MRI, but the arbitrator was unable to determine if standard accepted clinical testing for a torn meniscus or ligament was performed. Such a clinical assessment with positive findings would support an order

for an MRI, however the Arbitrator finds no evidence of such an assessment. Dr. Sudbrack did have readable work status notes indicating cervical pathology without indicating whether it was related to the October 12, 2013 injury or the November 24, 2014 injury.

Petitioner testified that she returned care at New Life Medical Center on February 6, 2015, for which there were no clinical notes. In fact, no clinical notes in the New Life chart referred to any claimed injury at work on November 24, 2014. None of Dr. Jain's clinical notes referred to a work-related injury on November 24, 2014. Absent such documentation, the Arbitrator cannot find that Petitioner proved that she sustained any injury on November 24, 2014 that required medical care at New Life Medical Center or by Dr. Jain.

When Petitioner consulted Dr. Silver for her left shoulder complaints there was, again, no historical reference to a work accident on November 24, 2014.

When Petitioner consulted Dr. Erickson for her neck and back complaints there was, again, no historical reference to a work accident on November 24, 2014.

It was noted above that Dr. Lami, who had examined Petitioner on behalf of Respondent, opined that Petitioner should have reached MMI within 6 to 8 weeks of the October 12, 2013 accident. Inasmuch as Petitioner had denied to Dr. Lami that she had been injured in the 2014 accident, Dr. Lami offered no opinion regarding petitioner's claimed injuries from the November 24, 2014 incident at work.

It was noted by Dr. Verma, who also examined Petitioner on behalf of Respondent, that he could find no evidence of a left shoulder injury.

When all the evidence is weighed, the Arbitrator can only find that Petitioner sustained contusions to her left and right knees and legs, for which she received no physical therapy and from she recovered by the time of her released to full duty work by medical professionals at Physicians Immediate Care on December 5, 2014.

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

The Arbitrator finds, based on evidence and reasons stated above, that Petitioner proved that the medical services she received through December 5, 2014 were reasonable and necessary and that the charges for that care were also reasonable and necessary.

As noted above, healthcare providers consulted by Petitioner after her November 24, 2014 work accident did not document Petitioner's report that she had been injured in such an accident. All other healthcare providers following the November 24, 2014 accident referenced Petitioner's October 12, 2013 accident as the initiating event relating to her complaints. The Arbitrator cannot find that medical care provided by chiropractors and physicians would reasonably relate that care to an accident they knew nothing about.

K: What temporary benefits are in dispute? TTD

The Arbitrator finds that Petitioner failed to prove that she is entitled to total temporary disability benefits as claimed from February 6, 2015 to November 1, 2016 (ArbX #3).

Petitioner's claim that she was totally disabled from employment from February 6, 2015 as relating to her injuries claimed from a work accident on November 24, 2014 is not supported by the evidence. Petitioner testified that she first sought care at New Life Medical Center on February 6, 2015, for which there are no clinical notes. However, each New Life clinical note failed to document a report from Petitioner that she had been injured on November 24, 2014. The only date of injury during the treatment following November 24, 2014 was October 12, 2013. In addition, there were no work status notes in the New Life chart notes.

While other healthcare providers did take Petitioner off work, those physicians did not have a history of Petitioner's claimed November 24, 2014 work accident. Those physicians always referenced the October 12, 2013 injuries. Therefore, their off work directives could not be related to the claimed November 24, 2014 work injuries.

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

Petitioner's claim for permanent partial disability was evaluated in accord with §8.1b of the Act:

i) No AMA Impairment Rating was offered in evidence. The Arbitrator cannot give any weight to this factor.

ii) Petitioner worked in a fast-paced food processing plant which required significant repetitive activity. Petitioner was released to full duty to her former job. The Arbitrator gives great weight to this factor.

iii) Petitioner was 53 years old at the time of her accident. She had a statistical life expectancy of approximately 29 years. The Arbitrator gives little weight to this factor.

iv) There was no evidence that Petitioner's future earning capacity was adversely affected by the injuries she proved. She was released to return to

full duty work on directions of healthcare professionals at Physicians Immediate Care. The Arbitrator gives great weight to this factor.

v) The medical records show the Petitioner received minimal medical intervention at Physicians Immediate Care following her accident. Petitioner was released to full duty work December 5, 2014. All subsequent healthcare providers, excepting for Dr. Sudbrack, were unaware of Petitioner's claimed work accident on November 24, 2014. Dr. Sudbrack's records and adequately documented Petitioner's diagnosis and the necessity of further medical care. The Arbitrator gives great weight to this factor

After evaluating all the evidence, including the above five factors, the arbitrator finds that Petitioner sustained contusions to his right and left legs and knees which resulted in permanent partial disability of 2.5% of the right leg and permanent partial disability of 2.5% in the left leg, a total of 10.75 weeks.

Steven J. Fruth, Arbitrator

June 26, 2020
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC016837
Case Name	AUTON,KIM v. BEL AIRE VETERINARY SERVICES
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0309
Number of Pages of Decision	16
Decision Issued By	Maria Portela, Commissioner

Petitioner Attorney	Matthew Brewer
Respondent Attorney	Jessica Bell

DATE FILED: 6/21/2021

/s/ Maria Portela, Commissioner

Signature

21IWCC0309

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 A. AUTON,

Petitioner,

vs. NO: 17 WC 16837

BEL AIRE VETERINARY SERVICES,

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 permanency as well as the credit awarded to Respondent 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 affirms the award of permanency. Additionally, the Commission further clarifies that the award of a credit in the amount of $2,274.14 ($1,518.00 for TTD and $756.14 for TPD) shall not be applied against the permanency award per stipulation of the parties.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $253.00 per week for a period of 125 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 25% loss 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 $31,725.00. 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.

June 21, 2021

/s/ *Maria E. Portela*

/s/ *Thomas J. Tyrrell*

MEP/dmm
O: 050421
49

/s/ *Kathryn A. Doerries*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0309

AUTON, KIMBERLY
Employee/Petitioner

Case# **17WC016837**

BEL AIRE VETERINARY SERVICES
Employer/Respondent

On 11/26/2019, 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 1.58% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2934 BOSHARDY LAW OFFICE PC
JOHN V BOSHARDY
1610 S 6TH ST
SPRINGFIELD, IL 62703

0264 HEYL ROYSTER VOELKER & ALLEN
JESSICA M BELL
300 HAMILTON BLVD PO BOX 6199
PEORIA, IL 61601-6199

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

KIMBERLY AUTON,
Employee/Petitioner

v.

BEL AIRE VETERINARY SERVICES,
Employer/Respondent

Case # **17** WC **16837**

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 **Springfield**, on **10/30/19**. 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 **4/4/16**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**18,308.16**; the average weekly wage was $**352.80**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **no** dependent children.

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

Respondent ***has or will*** pay all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**1,518.00** for TTD, $**756.14** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**2,274.14**.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $253.00/week for 125 weeks, because the injuries sustained caused the petitioner a 25% 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

11/19/19
Date

NOV 26 2019

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 50 year old receptionist, sustained an accidental injury to her right shoulder that arose out of and in the course of her employment by respondent on 4/4/16. Petitioner denied any problems with her right shoulder before 4/4/16.

Petitioner's duties as a receptionist in the small veterinary clinic were to greet clients, answer phones, schedule appointments, take animals and their owners to the examination rooms, take animals to the kennel area, kept lobbies and exam rooms clean, and mop and sweep the floors, especially after an animal may have had an accident. She also sold cans and cases of food weighing up to 10 pounds, and bags of dog food weighing up to 28 pounds. She testified that she would take larger dogs on a leash to the kennel, but smaller animals she would carry. She also carried cats in their carriers. Petitioner also weighed the animals.

On 4/4/16 petitioner checked a cat in for boarding. The owner took the cat out of the carrier. Petitioner took the cat into both arms, and was carrying the carrier in her right hand. As she was walking through the door she went flying through the air, letting go of the cat and the carrier, and ended up on the ceramic floor. She landed on her right side. Petitioner tripped on an old microwave that had been left on the ground in the hallway. When she fell she noticed pain in her right shoulder. She stated that it was so intense she could not move her right arm. Dr. Minick came to help her. He got her up and into a chair. Petitioner's son came and got here and took her to the emergency room at Decatur Memorial Hospital.

Petitioner was taken to the emergency room. She reported a consistent history of the injury. A CT scan revealed a comminuted, impacted, overriding, and intra-articular fracture of the proximal humeral head and neck. She was an inpatient overnight for pain relief. She was discharged on 4/5/16. Surgery was scheduled with Dr. Brustein on 4/7/16, after pre-operative testing with her primary care physician with Dr. Turgut.

On 4/7/16 petitioner underwent a right shoulder hemiarthroplasty of the fracture. This procedure was performed by Dr. Marshall Brustein. Her post-operative diagnosis was right proximal humerus fracture, comminuted intra-articularly displaced (head splitting). Petitioner was discharged on 4/10/16.

On 4/20/16 petitioner followed-up with Dr. Brustein. She stated that she was doing well. Dr. Brustein performed an examination and took x-rays. His diagnosis was 4 part fracture of the surgical neck of the right humerus, subsequent encounter for fracture with routine healing. Dr. Brustein ordered physical therapy for 4-6 weeks. He continued her in a sling. She was released to light duty restrictions for the right upper extremity. She could write, type, and talk on the phone. On 4/25/16 petitioner began a course of physical therapy.

On 5/6/16 petitioner followed-up with Dr. Brustein. Petitioner stated that she was doing well, but had stiffness in her shoulder. She was still taking Ultram for her pain. Her range of motion was increased, but she

still had weakness. Her pain and swelling were improved. X-rays showed that the arthroplasty was well aligned. Dr. Brustein continued her in therapy and in a sling. Her restrictions were continued.

On 5/20/16 petitioner returned to Dr. Brustein. Dr. Brustein was of the opinion that petitioner was making adequate progress. The arthroplasty was well aligned. Dr. Brustein told petitioner to wean from her sling and begin using her arm for light activities. He recommended that she continue in physical therapy and begin active range of motion. He restricted her from no lifting, pushing, pulling greater than 2 pounds, and no overhead work. She was told she could write, type, and talk on the phone.

On 6/20/16 Dr. Brustein noted that petitioner appeared to be making adequate progress. Her pain and motion were coming along. He continued her in physical therapy so she could progress to strengthening. He increased her restrictions to 2-5 pounds, with no overhead work.

On 7/22/16 petitioner followed-up with Dr. Brustein. Petitioner stated that she was feeling better. Dr. Brustein noted that her pain and motion were coming along. He continued her in physical therapy to continue working on motion and strengthening. He continued her restrictions.

On 8/19/16 petitioner returned to Dr. Brustein. Her pain and motion were improving. He continued her in physical therapy to work on motion and strength. He increased her work restrictions to 20 pounds with her right upper extremity.

On 9/16/16 petitioner presented to Dr. Brustein with shoulder pain. He noted that petitioner's pain and motion were coming along nicely. X-rays showed good alignment and position of the prosthesis. He recommended that she transition to a home exercise program in therapy. He continued her 20 pound weight restriction with the right upper extremity.

On 10/28/16 petitioner returned to Dr. Brustein with shoulder pain. Dr. Brustein noted that petitioner's motion had slightly improved since her last visit. He noted that most of her pain seemed to be weather related. She still had some weakness. He explained that this would likely continue with time. He told petitioner that shoulder injuries can make slow improvements for quite some time. He recommended a lifetime permanent 20 pound weight restriction, and limited overhead work. He told petitioner to follow-up on her one year anniversary.

On 4/5/17 petitioner returned to Dr. Brustein. X-rays were taken that showed a well aligned arthroplasty. Petitioner had increased range of motion, but denied pain, tenderness, and swelling. He recommended she continue her normal activities and call with any problems. He told her to return in a year for repeat x-rays and checkup.

On 7/25/17 petitioner underwent a Functional Capacity Evaluation. Petitioner provided maximal effort. Petitioner's current functioning level was determined to be in the "Sedentary" category (0-10#) for waist to crown lift; within the "Light" category (11-20#) for waist to floor lift; and, and within the "Medium" category (21-50#) for front carry. The three varying physical demand levels were due to function depending upon how much or little she was able to keep the right arm at her side, and therefore the amount stress/demand placed on the right shoulder during tasks. Her main symptom reports consisted of right shoulder and upper arm pain.

On 8/14/17 petitioner presented to Dr. Brustein to review the results of the Functional Capacity Evaluation. She reported that she had occasional pain, but was doing well. She stated that she continued to do her home exercise program. He gave her permanent restrictions of no lift, push, or pull greater than 5-10 pounds with her right upper extremity, and no overhead work. Dr. Brustein released petitioner on an as needed basis.

On 2/1/18 Dr. Gordon performed an AMA Rating consistent with the 6th Edition Guides to Evaluation of Permanent Impairment, on behalf of respondent, for petitioner's right shoulder injury. Dr. Gordon performed a permanent impairment rating evaluation pursuant to the Guides to the Evaluation of Permanent Impairment, Sixth Edition, as published by the American Medical Association. Dr. Gordon reviewed the mechanism of injury, and performed a record review. He also got a current status from petitioner and what medications she is taking. He examined petitioner. Based on this information, Dr. Gordon's impression was status post fall on 4/4/16 resulting in right shoulder comminuted, impacted, overriding, and intra-articular fracture of the proximal humeral head and neck. He noted that the fracture was treated operatively by Dr. Brustein, for which a right shoulder hemiarthroplasty was performed. Dr. Gordon then performed a permanent impairment rating calculation. He determined that petitioner's impairment was 25% of the right upper extremity impairment, or 15% whole person impairment.

On 4/23/18 the evidence deposition of Dr. Robert Gordon was taken on behalf of the petitioner. Dr. Gordon specializes in occupational and environmental medicine. Dr. Gordon testified in detail how he utilized the 6th Edition of the AMA Guide, his examination of petitioner, and medical information to determine petitioner's AMA Rating.

On 4/16/19 a Paradigm Vocational Progress Report, was completed by Case Manager David Morgan, that laid out petitioner's restrictions as defined in the FCE. Morgan noted that petitioner had returned to full duty work as a receptionist for respondent. Morgan noted that petitioner's duties, as reported by petitioner, include lifting and carrying pets in pet carriers, leading large dogs on leashes, placing clients and pets in the exam rooms, stocking product in the shop including large bags of dog and cat food, and lifting or reaching overhead to the shelves. Morgan noted that he was unsure if petitioner was required to stock bags of pet food over 25-30

pounds. Morgan noted that the FCE placed petitioner at the Sedentary level for waist to crown lift, the Light level for floor to waist lift, and the Medium level for front carry. Morgan was of the opinion that based on the FCE petitioner was capable of performing the Sedentary occupation of a Receptionist. Morgan was of the opinion that in his experience the majority of receptionist positions do not require the worker to reach overhead with both upper extremities. He was further of the opinion that receptionist positions within petitioner's capabilities are available in the Labor Market.

On 10/7/19 petitioner underwent a vocational assessment by James Ragain, a Certified Rehabilitation Counselor, of Ragain's Vocational Services, at the request of the petitioner. Petitioner was evaluated concerning employability issues. Ragain interviewed petitioner and collected psychosocial aspects, education and training information, military status, criminal record, hobbies and special interests, work history, medical status, and transferable skills analysis.

Based on his vocational assessment Ragain was of the opinion that petitioner, at the time of injury, was performing duties that would exceed the USDOL Occupational Description for Receptionist (237.367-038). He was of the opinion that the actual position she held, and now holds with accommodations, is Animal Hospital Clerk (245.262-018). He was of the opinion that if petitioner's current job was terminated, none of her past relevant work as described and analyzed would be available without her new employer making accommodations for her permanent restrictions. Ragain did not believe petitioner could return to any of her previous jobs because they would exceed her restrictions. Ragain was of the opinion that her age, transferable skills and restrictions, would severely limit the scope of alternative occupations that petitioner would have available to her. He did not believe a stable market would exist for petitioner in the surrounding job markets. Ragain believed that petitioner's work restrictions are consistent with receptionist work, but he did not believe the transferable skills with respondent do not fully match up with duties of a receptionist because she has only limited, modest computer and keyboard usage skills, and is not fully knowledgeable or fluent in Microsoft Office Suite software. He believed she could work as a receptionist or Hospital Admitting Clerk.

Petitioner testified that she still works for respondent and has not had an increase in her pay. She stated that she makes minimum wage. Petitioner is a high school graduate. She testified that respondent is accommodating her restrictions.

Petitioner testified that in addition to herself and the doctor, there are 2 certified vet techs, an assistant, and kennel worker in the office. She testified that after returning to work certain duties were transferred to other workers. She testified that she no longer sweeps and mops, nor does she take animals to the kennel or surgery area. Petitioner testified that she only sells 3 and 7 pound bags of food, if they are low to the floor.

Petitioner sustained a prior injury on 1/30/07 when she fell on the ice and injured her back. She ultimately underwent a discectomy at L5-S1 and a subsequent surgery to clean up scar tissue. These procedures did not ultimately relieve all her symptoms. As a result, petitioner underwent a Functional Capacity Evaluation on 3/6/08 that determined she was functioning at the light physical demand level which included material handling at 20 pounds occasionally (0-33%), 10 pounds frequently (34-66%), and negligible weight constantly (67-100%).

On 3/13/08 the therapist, Joe Williams, sent a letter to Dr. Fulbright, petitioner's treater. Williams noted that the FCE placed petitioner at the Light-Medium physical demand level, which was below the required demand level for performance of her current job duties at that time. Williams stated that petitioner was capable of lifting 20-30 pounds to waist level, 10 pounds lifting overhead, 23 pounds for carrying, and 24 pounds of force for pushing and pulling, all on an occasional basis. It was also recommended that petitioner would have the frequent need for positional changes, alternating between sitting, standing and walking. Williams also believed that the petitioner may be able to improve these functional tolerances over time if she was motivated to do so.

Petitioner settled her claim with respect to her prior 2007 low back case based on the restrictions placed on her by the FCE. After she settled her claim on 7/6/09, petitioner underwent a reexploration and decompression at L5-S1, on the left on 11/20/09. On 3/15/10, petitioner was informed that she did not have permanent restrictions. She was instructed to use common sense and avoid lifting heavy objects (> 75-100 pounds) and repetitive bending/twisting/turning at the waist.

On 6/26/13 petitioner was diagnosed with lateral left ankle pain, longitudinal tear of the flexor halluses longus, and RSD. She underwent medication management at the DMH Millenium Pain Center. At that time, her sedentary work restrictions were permanent, and she was released with permanent sedentary restrictions. For this injury, petitioner entered into an IWCC settlement contract on 12/17/13. She testified that this condition has improved since then. She testified that her nerve issues are much better. She denied any problems with standing or walking with respondent prior to the injury.

Dr. Brenton Minick, a veterinarian and petitioner's boss, was called as a witness on behalf of respondent. Dr. Minick testified that petitioner was hired in May of 2015 to handle the reception area. He testified that her main responsibilities were to answer phones, greet clients, place clients and their animals in the examination rooms, clean counter tops and windows, and janitorial duties as needed if the animals had an accident. Dr. Minick testified that since there are so few employees in the office everybody helps out with all duties as needed. Dr. Minick testified that the function of the office has changed because of petitioner's restrictions. He testified that other employees help out and perform duties petitioner can no longer perform. Dr. Minick

testified that petitioner is still performing all the receptionist duties, and he has not hired anyone else to do what she no longer does. He also testified that there is no change in petitioner's job title, and no official changes in her job duties because there is no real list of job duties.

On cross examination Dr. Minick agreed that petitioner can no longer perform certain duties such as mopping and sweeping, but can escort people to examination rooms, and do accounting for sale of dog food.

Currently, petitioner has pain everyday in the middle of her scar line. She stated that it can radiate to her back and neck. The pain is dull and achy, but sometimes is sharp and stabbing. She testified that her arm gets a dull ache when writing for a long period of time. She stated that she gets stabbing pains even when she is not doing anything. She reported her baseline pain level is 5/10 and her maximum pain level is 10/10. Petitioner takes Extra Strength Tylenol three times a day. She stated that the motion in her right arm is decreased. She reported that she can raise her right arm to 90 degrees, or a little higher if she pushes it with her other hand. She stated that she can reach her right arm behind her to the side of her buttock cheek, and has 45-90 degrees of side motion.

Petitioner testified that her injury has also affected her activities of daily living. She reported trouble putting on coats, dressing, brushing her teeth, styling her hair, cooking, folding laundry, doing dishes, making her bed, showering, vacuuming, sweeping, and mopping. She testified that she does not wear sleeveless clothes because of her scar, and has difficulty getting bras and shirts to fit because her right shoulder is lower than the left. Petitioner testified that she does do light dishes. She stated that she cannot lift more than a 2 quart container of tea. Petitioner also reported that she can only sleep for 1-2 hours before she gets pain in her right shoulder, has to get up and do exercises, before going back to sleep. Petitioner testified that she cannot lift her grandchildren.

On cross examination petitioner testified that she is working at the same location and the same hours as she was prior to her injury. She also testified that she has had no reduction in pay. Petitioner admitted that when she started working for respondent she had permanent Sedentary restrictions related to her foot injury that were never lifted.

Prior to working for respondent petitioner worked for Decatur Public Schools. She stated that her last job was in the print shop. She also covered the switchboard in the mailroom while that person went to lunch. Petitioner worked in the mailroom for 8 years before the print shop.

In her current receptionist position with respondent petitioner still accepts payments for services and animal food. She also testified that she has never received any training as a vet technician. She stated that vet

technicians have 2 years of college, and assist with surgery, give injections, and treat of animals. She testified that she does none of these duties for respondent.

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

For injuries that occurred after 9/1/11, according to 820 ILCS 305/8.1B(b) the Commission shall base its determination of permanent partial disability based upon five factors including an AMA report, the occupation of the injured employee, the age of the employee at the time of injury, the employee's future earning capacity and evidence of disability corroborated by treating medical records.

With regard to subsection (i) of §8.1b(b), Dr. Gordon offered an AMA rating of 25% of the right upper extremity impairment, or 15% whole person impairment. The Arbitrator therefore gives some weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the petitioner was a 50 year old receptionist at the time of injury. Petitioner was hired as a receptionist, but being in an office of only 5 employees, her duties included greeting clients, answering phones, scheduling appointments, taking animals and their owners to the examination rooms, taking animals to the kennel area, keeping lobbies and exam rooms clean, and mopping and sweeping the floors, especially after an animal may have had an accident. She also sold cans and cases of food weighing up to 10 pounds, and bags of dog food weighing up to 28 pounds. She testified that she would take larger dogs on a leash to the kennel, but smaller animals she would carry. She also carried cats in their carriers. Petitioner also weighed the animals.

After her injury petitioner still works as a receptionist for respondent and is still performing her receptionist duties. Dr. Minick testified that there has been no change in her job title, and no official changes in her job duties because there is no real list of her job duties. Dr. Minick also testified that although the function of the office has changed since petitioner returned to work, petitioner is still performing the receptionist duties, and the other employees are performing some the duties she is no longer able to perform such as mopping and sweeping, carrying animals, and lifting large bags or cans of food. The arbitrator notes that prior to coming to work for respondent petitioner had permanent light duty restrictions as a result of her 2012 injury. The permanent restrictions placed on petitioner after her 2007 low back injury were lifted after she had another surgery on her low back in 2009, but she instructed to use common sense and avoid lifting heavy objects (> 75-100 pounds) and repetitive bending/twisting/turning at the waist. For these reasons the arbitrator gives some weight to this factor.

With regard to subsection (iii) of §8.1b(b), the age of the employee, the Arbitrator notes that the petitioner has returned to the job of receptionist, and according to Dr. Minick, is still performing the duties of

the receptionist, but is not performing the other duties that she did before the injury, that were not specifically receptionist duties. Petitioner was 50 years old at the time of the injury and could have a decade or more of working years ahead of her. However, the arbitrator finds it significant that when petitioner was hired by respondent she already had permanent sedentary restrictions following a left ankle injury in 2013. Although petitioner testified that she was released in 2009 to full duty, the arbitrator notes that she was not released to full duty in 2010 after her third surgery on her low back, but rather was instructed to avoid lifting over 75-100 pounds, and avoid repetitive bending/twisting/turning at the waist. Given that at the time petitioner began working for respondent she already had permanent sedentary restrictions, restrictions on lifting over 75-100 pounds, and restrictions on repetitive bending/twisting/turning at the waist, the arbitrator 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 returned to her receptionist job with respondent after she was released with permanent restrictions. She testified that she is making the same money she was making prior to the injury, which is minimum wage. Therefore, the arbitrator 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 finds the petitioner sustained a right shoulder comminuted, impacted, overriding, and intra-articular fracture of the proximal humeral head and neck as a result of the injury on 4/4/16. For this injury petitioner underwent a right shoulder hemiarthroplasty. Her post-operative diagnosis was a right proximal humerus fracture. Petitioner underwent post-operative treatment and an FCE that placed her at the Sedentary physical demand level for waist to crown lift, at the Light physical demand level for waist to floor lift, and the Medium physical demand level for front carry. On 8/14/17 Dr. Brustein gave petitioner permanent restrictions of no lift, push, or pull greater than 5-10 pounds with her right upper extremity, and no overhead work.

The Vocational Progress Report of Case Manager Morgan indicated that based on the results of the FCE that petitioner was capable of performing the Sedentary Occupation of a Receptionist. He was of the opinion that in his experience that the majority of receptionist positions do not require the worker to reach overhead with both extremities. He was further of the opinion that receptionist positions within petitioner's capabilities are available in the Labor Market.

Ragain performed a vocational assessment of petitioner at the request of the petitioner's attorney. Ragain believed that petitioner, at the time of the injury, was performing duties that exceeded the USDOL Occupational Description for Receptionist (237.367-038). He was of the opinion that the actual position she held, and now holds with accommodations, is Animal Hospital Clerk (245.262-018). The arbitrator finds this opinion unsupported by the credible record, given that Dr. Minick, and petitioner, testified that she is only doing

receptionist duties. Ragain, was further of the opinion that if petitioner's current job was terminated, none of her past relevant work as described and analyzed would be available without her new employer making accommodations for her permanent restrictions. Again, the arbitrator finds this opinion unsupported by the credible evidence, given that petitioner is currently performing the duties of a receptionist for respondent. Ragain also believed petitioner could return to any of her previous jobs because they would exceed her restrictions. The arbitrator finds this claim also unsupported by the credible record, because she is performing receptionist duties for respondent. Ragain was also of the opinion that her age, transferable skills and restrictions, would severely limit the scope of alternative occupations that petitioner would have available to her. This claim is also unsupported by the credible record because the petitioner is performing all her duties as a receptionist for respondent, even though she no longer performs the additional duties she was performing as part of a "all hands on deck" staff of 5 in a small office. Ragain believed that petitioner's work restrictions are consistent with receptionist work, but he did not believe the transferable skills with respondent fully match up with duties of a receptionist because she has only limited, modest computer and keyboard usage skills, and is not fully knowledgeable or fluent in Microsoft Office Suite software. He believed she could work as a receptionist or Hospital Admitting Clerk.

The arbitrator finds the credible evidence does not support Ragain's overall opinions. The arbitrator finds the petitioner was initially hired as a receptionist by Dr. Minick. Petitioner began doing the duties of a receptionist, but because there are only 5 employees in the office, everybody helped out, and petitioner had additional duties. There is no indication that petitioner was paid any more for these additional duties, and in fact petitioner testified that she was hired at minimum wage, and still earns minimum wage. The arbitrator also finds it significant that Dr. Minick testified that the job duties petitioner is currently performing are those of a receptionist. Although Ragain did not believe petitioner's transferable skills with respondent fully match up with the duties of a receptionist because she has only limited, modest computer and keyboard usage skills, and is not fully knowledgeable or fluent in Microsoft Office Suite software, the arbitrator finds the credible record does not contain any credible evidence to support a finding that petitioner would not be capable of finding a receptionist position at minimum wage, where knowledge of Microsoft Office Suite Software is not needed; a minimum wage receptionist position where she may have the requisite level of knowledge in Microsoft Office Suite Software and computer for the job; or, a job where she would get on the job training for whatever software programs she may need for the job. Additionally, if it is a true receptionist position, there is no credible evidence that the petitioner could not perform the same receptionist duties she is currently performing for respondent.

The arbitrator also finds it significant that prior to working for respondent petitioner was already working under permanent sedentary restrictions following a left ankle injury in 2013, and additional restrictions she was given in 2010 related to her low back that include instructions to avoid lifting heavy objects (> 75-100 pounds) and to avoid repetitive bending/twisting/turning at the waist.

Currently, petitioner testified that she has pain every day in the middle of her scar line that can radiate to her back and neck. The pain is dull and achy, but sometimes is sharp and stabbing. She testified that her arm gets a dull ache when writing for a long period of time. She also stated that she gets stabbing pains even when she is not doing anything. She reported her baseline pain level is 5/10 and her maximum pain level is 10/10. Petitioner stated that she takes Extra Strength Tylenol three times a day. She stated that her motion in her right arm is decreased. She reported that she can raise her right arm to 90 degrees, or a little higher if she pushes it with her other hand. She stated that she can reach her right arm behind her to the side of her buttock cheek, and has 45-90 degrees of side motion.

Petitioner testified that her injury has also affected her activities of daily living. She reported trouble putting on coats, dressing, brushing her teeth, styling her hair, cooking, folding laundry, doing dishes, making her bed, showering, vacuuming, sweeping, and mopping. She testified that she does not wear sleeveless clothes because of her scar, and has difficulty getting bras and shirts to fit because her right shoulder is lower than the left. Petitioner testified that she does do light dishes. Petitioner testified that she cannot lift more than a 2 quart container of tea. Petitioner also reported that she can only sleep for 1-2 hours before she gets pain in her right shoulder, has to get up and do exercises, before going back to sleep. Petitioner testified that she cannot lift her grandchildren.

The arbitrator finds some of petitioner's current complaints at trial are inconsistent with her complaints the last time she saw Dr. Brustein and the complaints she had during her FCE. The arbitrator finds this most significant as it relates to petitioner's report that her pain levels reach 10/10, given that she only reported occasional pain when she last saw Dr. Brustein after the FCE in 2017.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner sustained a 25% loss of use of her person as whole pursuant to Section 8(d)2 of the Act for her right shoulder injury.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC021152
Case Name	PYLE, SUSAN v. HAMPTON INN
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0310
Number of Pages of Decision	16
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Giambattista Patti
Respondent Attorney	Amber Cameron

DATE FILED: 6/21/2021

DISSENT

/s/ Thomas Tyrrell, Commissioner

Signature

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

Susan Pyle,

Petitioner,

vs. NO: 18 WC 021152

Hampton Inn,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, temporary total disability, medical expenses, and prospective medical treatment, and being advised of the facts and law, provides additional analysis on the issue of medical expenses 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 (1980).

The Arbitrator awarded medical expenses related to the diagnosis and treatment of Petitioner's low back condition incurred prior to her date of maximum medical improvement, which the Arbitrator found to be September 25, 2018. Although the MRI spectroscopy ordered by Dr. Gornet was performed well after the date of MMI and was not, therefore, included in the Arbitrator's award of medical expenses, the Arbitrator explicitly noted that Petitioner had failed to prove that the MRI spectroscopy was reasonable and necessary for the diagnosis of her low back condition. In this case, Dr. Michael Chabot, Respondent's Section 12 examiner, testified that MRI spectroscopy was not an approved test or procedure in the United States for determining disc pathology. Dr. Gornet testified that MRI spectroscopy was used in the FDA clinical trials in which he was involved, but the fact that the FDA might approve of the procedure in this context does not establish that the procedure is generally accepted, reasonable or necessary in ordinary practice. Accordingly, given the testimony in this case, the Commission affirms the denial of the medical expenses incurred for the MRI spectroscopy performed by Dr. Gornet.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 26, 2020, is hereby affirmed with the additional reasoning as stated herein. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

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.

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.

No bond for removal of this cause to the Circuit Court by Respondent is required. 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.

June 21, 2021

tjt/dak
o: 6/3/21
068

/s/ *Barbara N. Flores*
Barbara N. Flores

/s/ *Christopher A. Harris*
Christopher A. Harris

CONCURRENCE IN PART AND DISSENT IN PART

I concur in part and dissent in part with the decision of the majority. I concur with the majority in affirming the Decision of the Arbitrator with regard to all issues except the finding that Petitioner suffered only a low back sprain which resolved by September 25, 2018. I find the diagnoses and treatment plan of Petitioner's treating specialist, Dr. Gornet, to be more convincing than those of Respondent's expert, Dr. Chabot, who opined that Petitioner's post-September 2018 low back complaints were degenerative and age-related. Dr. Gornet diagnosed

Petitioner with a right-sided herniation and annular tear at L4-5 and a central disc protrusion at L3-4, plus painful pathologies at L5-S1. Dr. Gornet recommended surgery consisting of an anterior lumbar fusion at L5-S1 and a disc replacement at L4-5.

I would have found that Petitioner has not yet reached MMI with regard to her low back injuries and would have ordered Respondent to authorize and pay for the surgery recommended by Dr. Gornet, as well as any associated medical expenses, except for the MRI spectroscopy, and temporary total disability benefits. I agree with the majority's exclusion of MRI spectroscopy as being not generally accepted, reasonable or necessary in ordinary orthopedic practice.

Therefore, I respectfully dissent from that part of the majority's decision which affirmed the Decision of the Arbitrator finding that Petitioner had reached MMI with regard to her low back injuries and terminating medical and temporary total disability benefits related to those injuries on September 25, 2018. I concur with the remainder of the majority decision.

/s/ *Thomas J. Tyrrell*
Thomas J. Tyrrell

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

21IWCC0310

PYLE, SUSAN
Employee/Petitioner

Case# **18WC021152**

HAMPTON INN
Employer/Respondent

On 10/26/2020, 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 0.11% 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:

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

2091 HEYL ROYSTER VOELKER & ALLEN
AMBER CAMERON
105 W VANDALIA ST SUITE 100
EDWARDSVILLE, IL 62025

528-22 TT/ADC

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 AMENDED DECISION
19(b)

Susan Pyle
Employee/Petitioner

v.

Hampton Inn
Employer/Respondent

Case # **18 WC 021152**

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 **Herrin**, on **September 10, 2020**. 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 June 19, 2018, 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 $17,875.39; the average weekly wage was $343.76.

On the date of accident, Petitioner was 51 years of age, ***single*** with 3 child under 18.

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

Respondent shall be given a credit of $13,972.98 for TTD, $00.00 for TPD, $00.00 for maintenance, and $00.00 for other benefits, for a total credit of $13,972.98.

ORDER

Petitioner reached maximum medical improvement for her low back condition on September 25, 2018 and reached maximum medical improvement for her right knee condition on November 28, 2018. Petitioner failed to prove that her current low back condition is casually related to her June 19, 2018 work accident, as set forth in the attached Conclusions of Law attached hereto;

Respondent shall pay reasonable and necessary medical services for the low back through September 25, 2018 and shall pay reasonable and necessary medical services for the right knee through November 28, 2018, as identified in PX 9, pursuant to Sections 8(a) and 8.2 of the Act and the fee schedule, with the exception of the MRI spectroscopy. Respondent is entitled to a credit for any medical bills Respondent previously paid pursuant to Section 8(j) of the Act and Respondent shall hold Petitioner harmless for any medical bills which Respondent claims a credit. Petitioner failed to prove the MR spectroscopy, ordered by Dr. Gornet, was related, reasonable and necessary. Petitioner also failed to prove she is entitled to prospective medical care, as set forth in the Conclusions of Law attached hereto;

Respondent shall pay Petitioner temporary total disability benefits of $229.18 per week for 23 2/7 weeks, commencing June 19, 2018 through November 28, 2018, as provided in Section 8(b) of the Act. Respondent paid TTD benefits totaling $13,972.98. Respondent shall receive a credit for any TTD benefits previously paid and, in the event of an overpayment of TTD benefits, Respondent is entitled to a credit on any future PPD award as set forth in the Conclusions of Law attached hereto.

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

10/23/2020
Date

ICArbDec19(b)

OCT 26 2020

FINDINGS OF FACT

Susan Pyle (hereinafter referred to as "Petitioner") testified on June 19, 2018 she was 51 years old and was working as a lead housekeeping supervisor at Hampton Inn hotel (hereinafter referred to as "Respondent") in Alton, IL. (T. 12-14). She testified that, on that date, she entered a guest room to inspect the room when she slipped on the tile floor, catching herself as she slipped. (T.14). Petitioner testified she did not fall to the ground or strike the ground. (T.32). Petitioner finished her shift before going to the emergency room at Alton Memorial Hospital. (T33).

Petitioner testified that she immediately felt pain the middle of her low back and her right knee. Petitioner testified, prior to her work accident on June 19, 2018, she had experienced back pain and had underwent chiropractic treatment. Petitioner testified the pain, after June 19, 2018, was more severe than it had been in the past. (T15). Prior to the June 19, 2018, Petitioner rated her back pain level as 3-4 out of 10 and, after June 19, 2018, she rated her pain level as 7 out of 10. (T16-17). Petitioner testified she was able to work full duty prior to June 19, 2018 and never missed work due to her back. (T15-16). Petitioner also testified she had a total hip replacement in 2013, suffers from rheumatoid arthritis and had been treating for that disease since 2011 which she takes Tramadol and a muscle relaxer prescribed by her primary care doctor. (T38-39, 40-41, T44).

On June 19, 2018, Petitioner presented to the emergency room at Alton Memorial Hospital and was diagnosed with a right knee sprain and low back strain. Petitioner was prescribed medication, given crutches, and instructed to follow up with her primary care physician. (PX1). On June 26, 2018, prior to presenting to her primary care physician, Petitioner returned to the emergency room at Alton Memorial Hospital reporting continued pain and limitations primarily with her right knee. Petitioner was evaluated for potential DVT. (PX1).

On July 3, 2018, Petitioner presented to Dr. Mark Belew, an orthopedic surgeon, for her right knee condition. (RX5). At that time, Petitioner was diagnosed with a medial meniscus tear. Petitioner underwent surgery on August 10, 2018 (RX5).

On July 19, 2018, Petitioner presented to Dr. Ravindra Shitut, an orthopedic surgeon, for her low back condition. (RX7; T17, 35). At that visit, Petitioner reported low back pain with numbness into the right lower extremity. Upon examination, Dr. Shitut noted mild muscle spasms, restriction with flexion but not extension and Petitioner had negative straight leg signs bilaterally. Petitioner was prescribed physical therapy and medications. (RX7).

On July 30, 2018, after Dr. Shitut's initial evaluation, Petitioner was involved in a motor vehicle accident. Petitioner was a restrained passenger in a car that was struck on the passenger side. (T 17, RX6). Petitioner testified that she was treated at the emergency room at Fairfield Medical Center for mainly cervical and right shoulder complaints. (RX6, T17-18, T36-37).

On August 31, 2018, Petitioner returned to Dr. Shitut reporting that her radicular symptoms resolved but she continued to experience low back symptoms. At that visit, Dr. Shitut noted that Petitioner's radicular symptoms resolved but she was now reporting that her right foot was numb. Dr. Shitut believed the right foot numbness could be due to her recent arthroscopic surgery to the right knee or the bandages needed to be loosened. Dr. Shitut stated that Petitioner's exam was benign with no neurological deficits noted. Dr. Shitut recommended Petitioner continue with physical therapy and he ordered an MRI of the lumbar spine to rule out any structural abnormalities, which she underwent on September 18, 2018. (PX 2, RX 7).

On September 17, 2018, Petitioner returned to Dr. Belew for her right knee. Dr. Belew indicated Petitioner was recovering from her arthroscopy surgery and that she could return to work performing sedentary duties. (RX 5).

On September 20, 2018, Petitioner followed up with Dr. Belew for her right shoulder condition. At that visit, Dr. Belew assessed a right rotator cuff tear and he recommended rotator cuff repair surgery. (PX 5).

On September 25, 2018, Petitioner returned to Dr. Shitut to review the results of the September 18, 2018 MRI. Dr. Shitut interpreted the MRI to being normal except for minor age anticipated degenerative changes. At that time, Dr. Shitut diagnosed a resolving lumbar sprain and he released Petitioner from care without any work restrictions. In his records, Dr. Shitut wrote *"In light of paucity of objective symptoms no further follow-up appears necessary...No further treatment appears necessary and discharging her form my care.* (PX 2).

On October 12, 2018, Petitioner underwent right shoulder rotator cuff surgery. Petitioner continued to treat with Dr. Belew until October 15, 2018. On that date, Dr. Belew's stated Petitioner's pain improved, and the plan was to discharge. Dr. Belew also stated Petitioner was instructed to call for an earlier appointment if her pain continued or was persistent. On November 29, 2018, Sherri Ann Shoe, PA, authored a note referring Petitioner to physical therapy due to osteoarthritis of the right knee. (PX 8). [1]

After Petitioner was released by Dr. Shitut for the low back sprain and Dr. Belew for the right knee and the non-work-related shoulder injuries, Petitioner was instructed, by her attorney, to see Dr. Matthew Gornet. (T20). On December 3, 2018 Petitioner presented to Dr. Gornet reporting low back and neck pain. Petitioner stated her low back pain was on both sides, both buttocks, right leg and she was experiencing numbness down her right leg and into her right foot.[2] Dr. Gornet examined Petitioner and noted that her motor examination noted mild decrease in EHL function on the right at 4/5 but otherwise she was 5/5 in all groups. Petitioner was able to bend and forward flex. Dr. Gornet reviewed the MRI and said the quality of the MRI was poor but that it showed bilateral facet changes and fluid signs at L5-S1. Dr. Gornet opined that Petitioner's current back, buttock and right leg symptoms were causally connected to her work injury based upon the history Petitioner was factually correct. [3] Dr. Gornet did not exam Petitioner's right knee or make any findings regarding the right knee. Dr. Gornet ordered a repeat of the lumbar MRI and prescribed Celebrex. Dr. Gornet also took Petitioner off work but it is unclear from the records whether Petitioner was prescribed medications and taken off work for her low back condition or the unrelated cervical and right shoulder conditions. (PX 4).

On March 3, 2019, Petitioner underwent the second MRI at MRI Partners of Chesterfield. Dr. Gornet reviewed the MRI and noted disc bulges, protrusions and annular tears at L2-S1. Dr. Gornet recommended cervical and lumbar steroid injections. Petitioner underwent the L5-S1 epidural steroid injection on April 9, 2019. (PX4).

On May 9, 2019 Petitioner returned to Dr. Gornet who recommended additional testing consisting of a CT discogram an MRI spectroscopy. (PX4). Dr. Gornet indicated the discogram, conducted on July 10, 2019, showed provocative test results at L4-5 and non-provocative test results at L5-S1. (PX7, PX4). Dr. Gornet also indicated the MR spectroscopy showed chemicals at L3-4 and L5-S1 and a signal artifact at L4-5. (PX4). On August 12, 2019, Dr. Gornet stated in his records that Petitioner could either live with her symptoms and return to work with permanent restrictions or she could undergo fusion surgery at L5-S1 with a disc replacement at L4-5. (PX4). Petitioner testified it was her understanding Dr. Gornet

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[1] A review of the records from Dr. Belew and CH Orthopedic and Spine Surgeons do not show a treatment note for November 29, 2018 nor do they show any right knee complaints or treatment after September 17, 2018 other then the physical therapy referral, dated November 29, 2018, authored by Sherri Ann Shoe, PA. (PX 8).

[2] Dr. Gornet's medical records do not show any right knee complaints reported by Petitioner at her initial examination on December 3, 2018. (PX 4).

[3] The Arbitrator notes the low back symptoms Petitioner described to Dr. Gornet, at the initial visit, were different than the low back symptoms documented in Dr. Shitut's records and the medical records from Alton Memorial Hospital. The Arbitrator also notes that Dr. Gornet's records do not indicate that Petitioner was released from care by Dr. Shitut. (PX 4).

suggested she could work light duty while waiting for the spinal surgery, but she did not receive a light duty work slip from Dr. Gornet. (T.42-43).

On July 3, 2019, Petitioner was examined by Dr. Michael Chabot, pursuant to Section 12 of the Act. Dr. Chabot reviewed Petitioner's medical records, including the lumbar MRIs dated September 18, 2018 and March 7, 2019. Dr. Chabot examined Petitioner and determined that the examination showed no evidence of physical findings or persistent residuals which could be deemed related to her June 19, 2018 accident. Dr. Chabot noted the MRIs showed evidence of mild degenerative changes involving the lumbar spine, disc desiccation and degeneration at L2-L5 with bulging discs at those levels but, he opined, the disc changes and the small area of increased signal within the disc at L4-5 were age-related and predated Petitioner's June 19, 2018 back sprain. (RX2). In his July 3, 2019 report, Dr. Chabot opined he agreed with the findings and opinions of Dr. Shitut that Petitioner suffered a lumbar sprain, reached maximum medical improvement as of September 25, 2018 and she did not require any work restrictions or additional medical treatment. (RX2).

On July 2, 2020, Dr. Chabot authored a supplemental medical report after reviewing the CT discogram and MR spectroscopy. In his report, Dr. Chabot stated that his opinions remained unchanged. Dr. Chabot opined that Petitioner did not have any altered disc pathology at the L4-5 level due to the June 19, 2018 incident. Dr. Chabot also opined the MRI findings suggest the presence of multi-level degeneration involving the lumbar spine at L2-3, L3-4, L4-5 with various abnormalities associated with chronic degeneration. Dr. Chabot also noted that at the time of his examination, Petitioner presented a high level of subjective complaints with no corresponding significant objective physical findings. (RX2).

Dr. Chobot noted the MR spectroscopy report was unavailable for review. (RX2). Regarding the use of an MRI spectroscopy for diagnostic purposes, Dr. Chabot opined the use of this test was not authorized by the FDA for diagnostic purposes for the lumbar spine. (RX2). The MR spectroscopy report was not admitted into evidence.

Dr. Gornet testified when he first examined Petitioner, she reported that her current low back problems began on June 19, 2018 when she slipped on a wet floor and grabbed some furniture and rotated rapidly. Petitioner also reported feeling a pop and developing increased back pain. Petitioner also reported being involving in a car accident on July 31, 2018 which caused her shoulder pain and the need for right rotator cuff surgery. Dr. Gornet testified he reviewed the MRI, dated September 18, 2018, which showed some bilateral facet changes and fluid in the facet joints at L5-S1. Dr. Gornet testified the second MRI showed some disc pathology with a right-sided herniation and annular tear at L4-5, central disc protrusion at L3-4 and foraminal stenosis with other changes. Dr. Gornet recommended an injection at the right side of L5-S1. Dr. Gornet testified the low back injection did not provide relief so he ordered a CT discogram to assess the facet joints and a MRI spectroscopy to assess chemicals associated with back pain. Dr. Gornet testified the MRI spectroscopy is FDA approved for assessing chemicals associated with back pain. (PX 5).

Dr. Gornet testified the discogram was positive for a central or right-sided tear at L4-5 but was negative at L5-S1. Dr. Gornet noted the discogram also showed facet arthropathy. Dr. Gornet testified the MRI spectroscopy showed chemicals at L5-S1 and L3-4 and a significant artifact at L4-5. Dr. Gornet testified an artifact is the result of problems during the test process such that one is unable to make a finding and the term "artifact" is similar to the term "gobbledygook". Dr. Gornet testified Petitioner had structural disc pathology at L4-5 and the MRI spectroscopy showed painful chemical pathologies at L5-S1. Dr. Gornet recommended surgery consisting of and anterior lumbar fusion at L5-S1 and a disc replacement at L4-5. Dr. Gornet opined based upon the history provided to him and his review of the radiographic evidence the cause of Petitioner's lumbar spine problems is the result of the injury she sustained on June 19, 2018. (PX 5).

Dr. Chabot, who preformed the Section 12 examination, testified Petitioner reported slipping on wet tile and loosing her footing while at work on June 19, 2018. Petitioner also reported she did not fall, and she was able to hold onto a counter to support herself. Dr. Chabot examined Petitioner on July 3, 2019 and noted Petitioner did not appear to be in distress, did not walk with a list or limp, and did not use a cane. Dr. Chabot testified the lumbar examination revealed only mild tension and that Petitioner could forward flexion to 75 degrees, extension to 25 degrees and side bend to 35 degrees. Dr. Chabot noted that Petitioner sat on the examination table at 90 degrees and was able to remove her socks and sneakers. Dr. Chabot also noted that Petitioner sat cross-legged at greater than 90 degrees which he testified, suggested Petitioner's active range of motion did not correlate with his observations. Dr. Chabot testified that Petitioner's active range of motion was just shy of normal and she was able to flex greater than 90 degrees when she was sitting on the examination table and flexed forward to remove her socks and sneakers. Dr. Chabot testified the lower extremity neurologic examination showed intact sensation with 5 plus motor strength and Petitioner's reflexes were symmetric. Dr. Chabot testified the straight leg raise testing was negative and he did not appreciate any motor or sensory deficit, as described by Dr. Gornet. (RX 1).

Dr. Chabot testified he reviewed the September 18, 2018 MRI which showed disk desiccation at L2-3, L3-4, L4-5. Dr. Chabot testified a healthy disk signal was present at L5-S1 and the MRI also showed evidence of mild facet degeneration with no evidence of disc herniation or nerve compression at L1-2. He further testified the MRI showed evidence of an asymmetric disk bulge expending into the left neural foramen with mild left neuroforaminal stenosis at L2-3. Dr. Chabot also noted facet hypertrophy and disc degeneration with mild ligamentum flavum hypertrophy at L3-4 with no focal disk herniations at L4-5. Dr. Chabot testified the MRI showed mild to moderate facet narrowing bilaterally with increased signal in the facet joints with no evidence of neural compression at L5-S1. Dr. Chabot opined the September 2018 MRI did not show any evidence of an acute injury. Dr. Chabot testified he compared the September 2018 MRI to the March 7, 2019 MRI, which, he said, showed evidence of small right-sided high intensity zone on the posterior anulus at L4-5 with no obvious disk herniation. Dr. Chabot opined no acute injury was seen on the March 2019 MRI and was common to see annual high intensity zones associated with progression of degeneration of a disk. (RX 1).

Dr. Chabot testified he reviewed Dr. Shitut's medical records from September 25, 2018 and noted that Dr. Shitut made no mention of radicular complaints radiating down Petitioner's leg, found no neurologic changes and found the MRI to be normal but for minor age-related degenerative changes. Dr. Chabot testified that he agreed with Dr. Shitut's diagnosed a resolving lumbar strain and opinion that no further medical treatment was needed. (RX 1)

Dr. Chabot opined Petitioner sustained a right knee injury and a lumbar strain which was related to her work injury of June 19, 2019. Dr. Chabot also opined Petitioner reached maximum medical improvement for her low back strain on September 25, 2018, at the time Dr. Shitut determined Petitioner reached maximum medical improvement. Dr. Chabot also opined that Petitioner did not sustain an intrinsic injury to the disk or an aggravation of her facet disease. Dr. Chabot testified Petitioner has rheumatoid arthritis which affects the joints and causes inflammation, affects the synovial joints and could be seen in an MRI. Dr. Chabot opined Petitioner could return to work full duty and that no additional medical treatment was needed regarding her low back condition. (RX 1)

Dr. Chabot testified he does not agree with the Dr. Gornet's surgical recommendation based upon the MRIs, lack of physical findings and discogram results. Dr. Chabot testified he would not recommend the surgery because the surgery would alter the spine, causing stress on the other levels including L3-4, and further reduce Petitioner's capacity and Petitioner also suffers from an unrelated neck and cervical injury and has longstanding history of rheumatoid arthritis which could affect the surgical outcome. (RX1).

Respondent objects to the reasonableness and necessity of the MR spectroscopy ordered by Dr. Gornet. The MR spectroscopy report was not admitted into evidence but was mentioned in Dr. Gornet's August 12, 2019 office visit note. A health insurance claim form for the MR Spectroscopy was not entered into evidence with the bills submitted by Petitioner. Dr. Gornet testified the MR spectroscopy is FDA approved for diagnostic purposes in the low spine as he is aware of a tracking code. (PX5). Dr. Chabot testified that according to the FDA, an MR spectroscopy is only valid for use in diagnostic testing for brain tumors, not for the lumbar spine. (RX1). Dr. Chabot went on to state that the only doctor he was aware of in the greater metro area attempting to use an MR spectroscopy for diagnosis of spinal complaints was Dr. Gornet. (RX1).

Petitioner testified she felt she was able to work in her current physical condition. (T24). Petitioner testified she can walk about 10 minutes before having pain complaints (T28-29). Petitioner testified she has trouble sleeping, standing and sitting for extended periods due to back pain. (T25).

Petitioner testified she has not worked since the accident and received TTD benefits through August 20, 2019. (T31). Respondent paid TTD benefits from June 18, 2018 thru August 20, 2019, for 60 6/7 weeks totaling $13,972.98. (Arb. Ex. #1, RX 3).

Petitioner stipulated Respondent accepted her low back injury through September 25, 2018 and the claim was thereafter disputed. (T. 10). Petitioner also stipulated her right knee injury was fully accepted by Respondent and that all the medical care was provided by Respondent. (T. 10, 14). Petitioner stipulated that she was involved in an unrelated motor vehicle accident and the injuries to her right shoulder and cervical spine are unrelated to this claim (T10, 11).

The Arbitrator does not find that Petitioner provided an accurate history of her low back symptoms to Dr. Gornet.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law as set forth below. The claimant bears the burden of proving every aspect of her claim by a preponderance of the evidence. *Hutson v. Industrial Commission*, 223 Ill App. 3d 706 (1992). To obtain compensation under the Act, the claimant bears the burden of showing by a preponderance of the evidence, he suffered a disabling injury which arose out of, and in the course of his employment. *Baggett v. Industrial Commission*, 201, Ill 2d. 187, 266 Ill. Dec. 836, 775 N.E. 2d 908 (2002).

The parties stipulated to an accident arising out of the and in the course of Petitioner's employment with Respondent on June 19, 2018. The parties stipulated the medical treatment involving Petitioner's cervical spine and right shoulder are unrelated to her work accident of June 19, 2018 accident. The parties also stipulated that Petitioner reached MMI for her work-related right knee injury on November 28, 2018 and reasonable and related medical treatment for the right knee has been paid by Respondent. The parties further stipulated that treatment Petitioner received for her low back through September 25, 2018 is reasonable and related to her June 19, 2018 work accident except for an MRI spectroscopy.

With respect to issue "F", whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds as follows:

In pre-existing condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the pre-existing disease such that the employee's current condition of ill-being can be said to have been causally-connected to the work-related injury and not simply the result of a

normal degenerative process of a pre-existing condition. *Caterpillar Tractor Co. v. Industrial Comm'n,* 92 Ill.2d 30, 36-37. When a worker's physical structures, diseased or not, give way under the stress of their usual tasks, the law views it as an accident arising out of and in the course of employment. *General Electric Co. v. Industrial Comm'n,* 89 Ill.2d 432, 60 Ill.Dec. 629, 433 N.E.2d 671 (1982). When an employee with a preexisting condition is injured in the course and of his employment the Commission must decide whether there was an accidental injury which arose out of the employment, whether the accidental injury aggravated or accelerated the preexisting condition or whether the preexisting condition alone was the cause of the injury. *Sisbro, Inc. Industrial Comm'n,* 207 Ill.2d 193, 278 Ill.Dec. 70,797 N.E.2d 665, (2003). Even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Caterpillar Tractor Co. v. Industrial Comm'n,* 129 Ill.2d 52, 133 Ill. Dec. 454, 541 N.E.2d 665 (1989).

The Arbitrator finds that Petitioner sustained a workplace accident on June 19, 2018 which resulted in and injury to her right knee and an injury to her low back. The Arbitrator further finds that Petitioner failed to prove by the preponderance of the evidence that her current low back condition is casually related to the June 19, 2018 work injury.

The Arbitrator finds the opinions of Drs. Shitut and Chabot persuasive and consistent with their exam observations, objective testing and radiographic findings. During his examination, Dr. Chabot found Petitioner's active range of motion just shy of normal and she was able to flex greater than 90 degrees when she was sitting on the examination table and flexed forward to remove her socks and sneakers. Dr. Chabot also found that Petitioner's lower extremity neurologic examination showed intact sensation with 5 plus motor strength and her reflexes were symmetric and the straight leg raise test was negative. Dr. Chabot stated he did not appreciate any motor or sensory deficits. (RX 1). Dr. Shitut also found Petitioner's exam to be benign with no neurological deficits. (RX5, PX7). Dr. Shitut reviewed the September 18, 2018 MRI which, he said, was normal except for minor age anticipated degenerative changes and he diagnosed a resolving lumbar sprain. On September 25, 2018, Dr. Shitut wrote "*In light of paucity of objective symptoms no further follow-up appears necessary...No further treatment appears necessary and discharging her form my care.* (PX 2). Dr. Chabot also opined that Petitioner reached maximum medical improvement for her back strain as of September 25, 2018 and she did not sustain an intrinsic injury to the disk or an aggravation of her facet disease. Dr. Chabot reviewed the September 2018 MRI and opined the MRI did not show evidence of an acute injury. Dr. Chabot testified he compared the September 2018 MRI to the March 7, 2019 MRI, and the March 7, 2019 MRI only showed evidence of small right-sided high intensity zone on the posterior anulus at L4-5 with no obvious disk herniation and it was common to see annual high intensity zones associated with the progression of the degeneration of a disc. Dr. Chabot opined no acute injury was seen on the March 2019 MRI. (RX 1). As such, the Arbitrator finds Petitioner reached maximum medical improvement for her low back injury as of September 25, 2018.

When Petitioner was examined by Dr. Gornet after being released from care by Dr. Shitut, she reported low back on both sides, both buttocks, right leg and she was experiencing numbness down her right leg into her right foot. Petitioner also reported feeling a pop in her low back and that her pain started on June 19, 2018 after slipping at work. The Arbitrator notes that Petitioner did not testify to feeling a pop in her low back when she slipped at work nor do the histories Petitioner provided to Dr. Shitut and Alton Memorial Hospital indicate that Petitioner experienced a pop in her low back at the time of the accident. The Arbitrator also notes the type, nature, location and duration of symptoms Petitioner provided to Dr. Gornet are different than the symptoms contained in the medical records of Dr. Shitut and Alton Memorial Hospital. As such, the Arbitrator finds the opinions of Dr Gornet to be unreliable because they are based, in part, upon the history of symptoms Petitioner provided to him which are inconsistent with Petitioner's trial testimony and the symptoms she previously reported to Dr. Shitut and the medical staff at the Alton Memorial Hospital emergency room. Internal inconsistencies in a claimant's testimony, as well as conflicts between the claimant's testimony and medical records, may be taken to indicate unreliability. *Gilbert vb. Martin & Bayley/Hucks,* 08 IL.W.C. 004187 (Ill. Indus. Comm'n 2010). 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. 507, 514-515 (First Dist. 2000).

With respect to issue "J" whether the medical services provided were reasonable and necessary and issue "K" is Petitioner entitled to prospective medical care, the Arbitrator finds as follows:

The Arbitrator references and incorporates herein the findings made in Section F as noted above.

Under Section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of employment which are necessary to diagnose, relieve, or cure the effects of the claimant's injury. *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n,* 409 Ill.App.3d 463, 470 (4th Dist. 2011).

The parties stipulated the medical care Petitioner received related to her right knee through November 28, 2018 was reasonable and related to Petitioner's work accident of June 19, 2018 and Petitioner reached MMI as of November 28, 2018 for her right knee condition. The parties also stipulated the medical care and treatment Petitioner received for her low back was reasonable and necessary through September 25, 2018, except for the MR spectroscopy. As such, Respondent shall pay for the medical treatment provided to the right knee through November 28, 2018 and the medical treatment for the low back through September 28, 2018 except for the MR spectroscopy, pursuant to Sections 8(a) and 8.2 of the Act and the fee schedule.

Petitioner claims Respondent is liable for certain unpaid medical expenses related to the low back after September 25, 2018. As stated above, the Arbitrator found Petitioner reached MMI as related to the low back as of September 25, 2018. As such, the Arbitrator finds that Petitioner failed to prove by the preponderance of the evidence the low back treatment after September 25, 2018 was related to her June 19. 2018 work accident.

Respondent disputes the lumbar MR spectroscopy, ordered by Dr. Gornet, was reasonable or necessary. The MR Spectroscopy report was not entered into evidence as an exhibit but was mentioned in Dr. Gornet's office note of August 12, 2019. A health insurance claim form for the MR Spectroscopy was not submitted into evidence. Dr. Chabot testified that according to the FDA, an MR spectroscopy is only valid for use in diagnostic testing for brain tumors but not for the lumbar spine. Dr. Chabot further testified there are clinical trials underway regarding the use of MR spectroscopy for lumbar pain, however, they are not yet indicated for diagnostic procedure at this time. The Arbitrator notes the MR spectroscopy report was not placed into evidence. The Arbitrator finds that Petitioner failed to prove by the preponderance of the evidence the MR spectroscopy was reasonable and necessary.

The Petitioner seeks prospective medical care consisting of the lumbar fusion and disc replacement surgery proposed by Dr. Gornet. The Arbitrator finds that Petitioner failed to prove by the preponderance of the evidence she is entitled to prospective medical treatment. As stated above, Petitioner's failed to prove that her current low back condition is causally related to her June 19, 2018 work injury and the Arbitrator found the opinions of Dr. Chabot to be more persuasive than those of Dr. Gornet. Dr. Chabot testified he does not agree with Dr. Gornet's surgical recommendation based upon the MRIs, discogram results and lack of physical findings noted during the examinations. Dr. Gornet also opined that he does not find the surgery reasonable or necessary because the surgery would alter the spine causing stress on the other levels including L3-4 and further reduce her capacity and he also testified that Petitioner suffers from an unrelated cervical injury and has a longstanding history of rheumatoid arthritis which could affect her surgical outcome. (RX1).

With respect to issue "L" whether Petitioner is entitled to TTD benefits, the Arbitrator finds as follows:

The Arbitrator references and incorporates herein the findings made in Section F, J and K as noted above.

"The period of temporary total disability encompasses the time from which the injury incapacitates the claimant until such time as the claimant has recovered as much as the character of the injury will permit, "*i.e.*, until the condition has stabilized." *Gallentine v. Industrial Comm'n*, 201 Ill. App. 3d 880, 886 (2nd Dist. 1990). The dispositive test is whether the claimant's condition has stabilized, i.e., reached MM.I. *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC at 28 (June 26, 2014, Opinion Filed); *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 760 (4th Dist. 2003). To show entitlement to temporary total disability benefits, a claimant must prove not only that he did not work, but also that he was unable to work. *Gallentine*, 201 Ill. App. 3d at 887; *see also City of Granite City v. Industrial Comm'n*, 279 Ill. App. 3d 1087, 1090 (5th Dist. 1996).

The parties stipulate Petitioner was paid TTD benefits from June 19, 2018 through August 20, 2019 or the sum of $13,972.98. Respondent stipulates that Petitioner was entitled to receive TTD benefits from June 19, 2018 through November 28, 2018, a period of 23 2/7 weeks. Respondent disputes liability for TTD benefits after November 28, 2018, the date Petitioner was released to return to work for her right knee. Petitioner seeks TTD benefits from November 28,2018 through September 10, 2020. (Arb. Ex # 1). As stated above, the Arbitrator found that Petitioner failed to prove her current low back condition is causally related to her work accident of June 19, 2018 and she reached MMI as of September 25, 2018 for her low back condition. As such, the Arbitrator finds Petitioner failed to prove by the preponderance of the evidence she is entitled to TTD benefits from November 28, 2018 thru September 10, 2020 and her claim for TTD benefits is hereby denied. The Arbitrator finds Petitioner was entitled to TTD benefits from June 19, 2018 thru November 28, 2018, a period of 23 2/7 weeks.

With respect to issue "N" whether Respondent is due a credit for TTD benefits paid, the Arbitrator finds as follows:

The Arbitrator references and incorporates herein the findings made in Section F, J, K, and L as noted above.

As stated above, Respondent is liable for temporary total disability benefits of $229.18 per week for 23 2/7 weeks, commencing June 19, 2018 through November 28, 2018, as provided in Section 8(b) of the Act. Respondent paid TTD benefits totaling $13,972.98. As such, Respondent shall receive a credit for any TTD benefits previously paid and, in the event of an overpayment of TTD benefits, Respondent is entitled to a credit on any future PPD award

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	13WC040244
Case Name	DELGADO, IRINEO v. ELECTRONIC PLATING CO INC
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0311
Number of Pages of Decision	27
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Lindsey Strom
Respondent Attorney	Adam McCall

DATE FILED: 6/21/2021

/s/ Stephen Mathis, Commissioner

Signature

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

Irineo Delgado,

Petitioner,

vs. No. 13WC 040244

Electronic Plating Co., Inc., and Illinois State Treasurer as Ex-Officio Custodian of The Injured Workers' Benefit Fund,

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Injured Workers' Benefit Fund and notice given to all parties, the Commission, after considering the issues of insurance coverage/liability, 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 April 14, 2020, is hereby affirmed, and adopted.

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

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondents 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.

June 21, 2021

/s/*Stephen J. Mathis*
Stephen J. Mathis

SJM/sj
o-05/18/2021
44

/s/ *Deborah J. Baker*
Deborah J. Baker

/s/ *Deborah L. Simpson*
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0311

DELGADO, IRINEO
Employee/Petitioner

Case# **13WC040244**

ELECTRONIC PLATING CO INC & STATE TREASURER AND EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND ET AL
Employer/Respondent

On 4/14/2020, 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 0.29% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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0000 PROG HR CORPORATION
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Irineo Delgado v. Electronic Plating Co., Inc., 13 WC 040244

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

Irineo Delgado
Employee/Petitioner
v
Electronic Plating Co., Inc. & State Treasurer and ex-offico custodian of the Injured Workers' Benefit Fund, et al
Employer/Respondent

Case # **13** WC **040244**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian Cronin and Jeffrey Huebsch,** Arbitrators of the Commission, in the city of **Chicago,** on **Febuary 20, 2019, April 4, 2019, and June 25, 2019**. 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 **Which of Respondents and respective funds will provide coverage; the liability of the Injured Workers' Benefit Fund; Respondent IWBF's Motion to Dismiss it as a party to this claim.**

Irineo Delgado v. Electronic Plating Co., Inc., 13 WC 040244

FINDINGS

On **12/2/13**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent Employer Electronic Plating Co., Inc.

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

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

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

In the year preceding the injury, Petitioner earned **$19,240.00**; the average weekly wage was **$370.00**.

On the date of accident, Petitioner was **31** years of age, with **1** dependent child.

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

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

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

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

ORDER

Respondent, Electronic Plating Co., Inc., shall pay reasonable and necessary medical services of $241,982.01, subject to the Illinois Fee Schedule, as provided in Sections 8(a) and 8.2 of the Act, and as is set forth below.

Respondent, Electronic Plating Co., Inc., shall pay Petitioner temporary total disability benefits of $253.00/week for 125 & 5/7 weeks, commencing 2-6-14 to 6-29-15 & 8-20-15 to 8-26-16, as provided in Section 8(b) of the Act.

Respondent, Electronic Plating Co., Inc., shall pay Petitioner permanent partial disability benefits of $253.00/week for 200 weeks because the injuries sustained caused Petitioner to suffer the 40% loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

Petitioner failed to prove an employee/employer relationship existed between him and Respondents Employco Usa, Inc., HR STAFF WORKS, INC., Prog HR Corporation and Markets Plus. Accordingly, the claim for compensation against said Respondents are denied and dismissed.

Petitioner failed to prove that a workers' compensation insurance policy providing coverage for the date of accident existed, Accordingly, Petitioner's claim against the Illinois Insurance Guaranty Fund is denied and dismissed.

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event Respondent Electronic Plating fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent Electronic Plating shall reimburse the Injured Workers' Benefit Fund for any compensation

obligations of Respondent Electronic Plating that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

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

Signature of Arbitrator

April 13, 2020
Date

ICArbDec p. 2

APR 14 2020

INTRODUCTORY

This action was pursued under the Illinois Workers' Compensation Act (the "Act") by Petitioner, Irineo Delgado ("Petitioner"), and sought relief from the Respondent-Employer, Electronic Plating, Co. ("Electronic Plating"), and Respondents Employco USA, Inc. ("Employco"), HR Staffworks, Inc., Prog HR Corporation ("Prog HR"), Markets Plus, the Illinois Insurance Guaranty Fund ("IIGF"), and the Illinois State Treasurer as *Ex-Officio* Custodian of the Illinois Injured Workers' Benefit Fund ("IWBF").

Proofs were opened on February 20, 2019 and closed on April 4, 2019 before Arbitrator Brian Cronin. On May 13, 2019, Arbitrator Cronin granted Respondent IWBF's Motion to Re-Open Proofs. Proofs were re-opened on June 25, 2019 before Arbitrator Jeffrey Huebsch and then closed. Attorneys Raul Rodriguez and Lindsey Strom appeared on behalf of Petitioner. Attorney Paul J. Prybylo appeared on behalf of Electronic Plating. Attorney David T. Polous appeared on behalf of Employco and HR Staffworks, Inc. Attorney Miles Cahill appeared on behalf of the IIGF. AAG Ana Vazquez and AAG Kristin Leasia appeared on behalf of the

IWBF. Respondents Prog HR Corporation and Markets Plus were provided proper notice of hearing, but did not appear and were not represented.

Petitioner served notice to all the Respondents of the February 20, 2019, April 4, 2019, and June 25, 2019 hearing dates. *See PX 1A, 1B and 1C.*

Respondent, IWBF's Exhibit No. 2 (submitted on June 25, 2019) contained information that was redacted by the Arbitrator in accordance with SCR 138.

FINDINGS OF FACT

Petitioner testified via Spanish/English interpreters.

Petitioner's Testimony regarding Employment

Irineo Delgado ("Petitioner") is a 37 year-old right-handed machine operator who currently resides in Chicago. *See 2/20/19 Trial Tx at 23-24.* Petitioner testified that on December 2, 2013 he was employed by Respondent Electronic Plating and that he had worked there since 2011. *See Id at 24, 26.* Also, in the patient questionnaire for the 8-20-15 visit with Dr. John Fernandez, Petitioner listed "Electronic Plating" as his employer. *See PX 15 at 16.*

Petitioner testified that his job duties as a machine operator for Electronic Plating included operating a machine that would fill and seal barrels containing chemicals. *See 4/4/19 Trial Tx at 15.* Specifically, Petitioner testified that the machine had two holes --located above his head—that were used as insertion points for the barrels. *See* Id at 17. With respect to lifting requirements, Petitioner testified that he sometimes had to lift over 100 LBS. *See 2/20/19 Trial Tx at 26.*

Petitioner testified that Ken McElmore—a supervisor at Electronic Plating – directed Peitioner's work, by instructing Petitioner on what chemicals had to go in the barrels, and controlled Petitioner's work schedule. *See 4/4/19 Trial Tx at 24, 26 90, 93, 102.* He testified that Electronic Plating provided all the equipment and machinery to complete his work. *See Id at 96.* In addition, Petitioner also testified to only being employed by Electronic Plating in 2013. *See 2/20/19 Trial Tx at 26.*

Petitioner testified to receiving IRS W2 forms for 2013 from three different entities which are all Respondents in the case -- Markets Plus reflecting earnings in 2013 of $5,217.00, Prog HR Corporation reflecting earnings in 2013 of $5,075.94, and HR Staff Works reflecting earnings in 2013 of $5,075.94 -- for the work he performed in 2013. *See PX. 3.* Petitioner further testified that the earnings on the foregoing W2s were for work he performed for Electronic Plating. *See 2/20/19 Trial Tx at 30, 41, 44.* In addition, Petitioner testified to never having any direct contact with anyone associated with Respondents Markets' Plus, Prog HR, HR Staff Works, or Employco and to not understanding the relationship between the foregoing entities and Respondent Electronic Plating. *See 2/20/19 Trial Tx at 40-44; 4/4/19 Trial Tx at 102.*

Petitioner's Testimony regarding Wages

Petitioner testified that in the year proceeding the "Date of Accident", as hereinafter defined, he earned approximately $350 to $360 a week, that he was not married, but that he had 2 dependents in the form of a live-in girlfriend and her daughter. *See 2/20/19 Trial Tx at 26; PX2.* Additionally, Petitioner identified pay stubs from Electronic Plating that reflected the following wages with corresponding pay periods:

- 8/14/13 to 8/20/13 - $ 370.00
- 8/28/13 to 9/3/13 - $397.75
- 9/4/13 to 9/10/13 – $564.27;
- 10/16/13 to 10/22/13 - $333.00; and,
- 11/13/13 to 11/19/13 - $370.00;

See PX 2; 2/20/19 Trial Tx at 27-29.

Petitioner's Testimony regarding Accident

Petitioner testified that on December 2, 2013 ("Date of Accident") he injured his left hand when it got caught in the gears in a machine. *See 4/4/19 Trial Tx at 20, 103.* Petitioner testified that on the Date of the

Accident, the machine he operated failed because it failed to properly take in barrels. *See 4/4/19 Trial Tx. at 16.* Petitioner then manually stopped the machine but noticed that a barrel—approximately two feet above his head--was about to fall on him. *See 4/4/19 Trial Tx at 103.* So, Petitioner moved and braced himself to avoid being hit by the barrel when his left hand was caught in one of the gears. *See 4/4/19 Trial Tx at 20, 103.* According to Petitioner, the machine did not have a guard to prevent the type of injury Petitioner suffered. *See 4/4/19 Trial Tx at 103-104.* Immediately after the accident, Petitioner noticed that his left hand was bloody and he was in pain. *See* 4/4/19 *Trial Tx at 103.*

Petitioner's Testimony regarding Notice

Petitioner testified to notifying Ken McElmore, a supervisor at Electronic Plating, about the accident. *See 4/4/19 Trial Tx at 24.* Petitioner used his co-worker Heriberto to help interpret what Petitioner tried to communicate with Ken, who did not speak Spanish, about the accident. *See Id at 25.* According to Petitioner, Heriberto frequently served as an interpreter when Petitioner communicated with Ken; whenever Herriberto was not present, Ken would use his phone to interpret so that he could communicate with Petitioner. *See Id at 26.* Petitioner testified that Ken did not fill out an incident report. *See Id at 26.* Then, according to Petitioner's testimony, Ken told Heriberto to take Petitioner to the hospital. *See Id at 27.* Heriberto then drove Petitioner to Lorretto Hospital. *See Id at 30.*

Robert Porcelli Testimony regarding Employment and Accident

Robert Porcelli is the President of Respondent Electronic Plating, a position he has held for over 50 years. *See 6/25/19 Trial Tx at 13.* He testified that Electronic Plating is an electroplating company that plates fasteners, rivets, screws, blots, and different coatings. *See Id.* On the Date of Accident, Electronic Plating employed approximately 20 employees. *See Id.* Per Mr. Porcelli's testimony, Petitioner was one of these employees. *See Id at 61 & 65.* Furthermore, Mr. Porcelli testified to being aware of Petitioner's injury on the

Date of Accident. *See Id at 61.* He also testified to having some knowledge of Petitioner's medical treatment and the corresponding medical bills. *See Id at 64.*

Robert Porcelli Testimony regarding Insurance Coverage

Robert Porcelli testified to making numerous payments to Respondent Prog HR and Respondent EmployCo for Workers' Compensation coverage and taxes. *See 6/25/19 Trial Tx at 44-46.* Specifically, on November 27, 2013, a week before the Date of Accident, Respondent Electronic Plating made a payment of $1,055.30 to Respondent Prog HR for "Work Comp Coverage and Risk Management". *See Resp IWBF Ex. 2.* Additionally, on December 6, 2013, a few days after the Date of Accident, Respondent Electronic Plating made a payment of $1,044.48 to Respondent Prog HR for "Work Comp Coverage and Risk Management". *See Id.* He also testified to sending medical bills to EmployCo. *See 6/25/19 Trial Tx at 26.* However, despite making these payments, Robert Porcelli testified to having no evidence that a Workers' Compensation insurance policy actually existed. *See Id at 100-103; 110-112.*

Illinois Injured Workers Benefit Fund.

On the Date of Accident, Respondents Electronic Plating, Markets' Plus (Market Plus per PX 8), Prog HR, and HR Staffworks Corporation were not carrying workers' compensation insurance. As evidence of the foregoing, Petitioner provided an individual certification from the National Council on Compensation Insurance for the foregoing Respondents. *See PX 4, 8, 9, 10.* Petitioner Amended the Application for Adjustment of Claim to include the Illinois Injured Workers Benefit Fund ("IWBF") as a party to the case. *See AX 4.* In addition, Petitioner served Notice to all the Respondents of the February 20, 2019, April 4, 2019 and June 25, 2019 hearing. *See PX 1A, 1B and 1C.*

Illinois Insurance Guaranty Fund

On the Date of Accident, Respondent Employco was carrying a workers' compensation insurance policy with Freestone Insurance Co ("Freestone"). *See PX 5.* However, the Court of Chancery of the State of Delaware entered a Liquidation and Injunction Order regarding Freestone on July 22, 2014. *See PX 5.* As such, Petitioner amended the Application for Adjustment of Claim to include the Illinois Insurance Guaranty Fund ("IIGF") as a party to the case. *See AX 3.*

Medical Treatment

Loretto Hospital and Stroger Hospital

Immediately after the accident, Petitioner sought treatment at Loretto Hospital and he was then transferred, via ambulance, to John Stroger Hospital in Chicago. *See Trial Tx at 30; PX 11 at 3.* At Stroger, Petitioner was diagnosed with a circumferential degloving injury of the left hand as well as a communited 1st metacarpal fracture and dorsally angulated fracture of the second distal phalanx. *See PX. 11 at 20, 42, 66, 139.* Petitioner then underwent a series of operative procedures including an open reduction of fracture of phalanges of the left hand with internal fixation; open reduction of fracture of carpals and metacarpals with internal fixation; excisional debridement; local excision; and skin graft from the left thigh. *See Id. at 20, 37, 66, 139, 166.* Stroger Hospital discharged Petitioner from care on December 5, 2013, but Petitioner followed up for visits at Stroger Hospital on December 20, 2013; January 3, 2014, January 10, 2013 and January 24th. *See Id at 20-27; 234-240.* Petitioner was then referred for physical therapy and decided to attend physical therapy at Rehab Dynamix. *See 4/4/19 Trial Tx at 36.* Petitioner testified that the treatment at Stroger helped him. *See 4/4/19 Trial Tx at 36-37.*

Rehab Dynamix, Ltd.

Petitioner then sought treatment with Dr. Lee De Las Casas at Rehab Dynamix, Ltd. Dr. Lee De Las Casas provided chiropractic and therapy beginning on January 27, 2014. *See 4/4/19 Trial Tx at 36; PX. 12.* He also referred Petitioner to Chicago Pain and Orthopedic Institute. *See PX. 12; PX. 13 at 4.*

Chicago Pain and Orthopedic Institute – Dr. Axel Vargas and Dr. Steven Sclamberg

Dr. Lee De Las Casas referred Petitioner to Dr. Axel Vargas at Chicago Pain and Orthopedic Institute ("Chicago Pain"). *See PX. 13 at 4.* Petitioner initially saw Dr. Vargas on February 6, 2014 and complained of constant burning pain localized through the volar and dorsal aspect of the left forearm, left wrist and left hand. *See Id at 4-8.* Dr. Vargas diagnosed Petitioner with traumatic carpel tunnel syndrome and suspected Petitioner might be suffering from Complex Regional Pain Syndrome ("CRPS") and recommended pain medication and physical therapy. *See Id at 6.* Dr. Vargas took Petitioner off of work. *See Id.* The CRPS treatment was not approved. *See Id at 12.* Dr. Vargas referred Petitioner to Dr. Steven Sclamberg—an orthopedic surgeon who also practiced at Chicago Pain.

Dr. Sclamberg saw Petitioner on February 28, 2014 and recommended an x-ray of the left wrist and continuation of physical therapy. *See PX. 13 at 9-10.* Dr. Sclamberg kept Petitioner off-work. *See Id at 11.* Petitioner underwent the x-ray on March 12, 2013 and it revealed "[p]ostsurigcal changes of the ORIF involving the first metacarpal bone." *See Id at 2.*

On March 6, 2014, Petitioner followed up with Dr. Vargas who continued the recommendation for therapy and continued to recommend pain medication. *See Id at 12-13.* Again, Dr. Vargas kept Petitioner off work. *See Id at 14.* Petitioner followed up with Dr. Sclamberg-- on March 14 and on April 25, 2014-- who kept Petitioner off work during both visits. *See Id at 15-18.* During the latter visit, Dr. Sclamberg diagnosed Petitioner with a delayed union of the fracture in the left hand, noted a deformity in Petitioner's left hand, and he recommended a bone stimulator for Petitioner. *See Id at 18.*

On May 1, 2014, Petitioner followed up again with Dr. Vargas who recommended Petitioner continue his course of therapy and continue attempting to get CRPS treatment approved. *See Id at 21-22.* Dr. Vargas also opined that Petitioner was not yet at MMI and that the treatment rendered to Petitioner at that point in time had been reasonable and necessary to treat his work related injury. *See Id at 22.*

Marian Orthopedics & Rehabiliation – Dr. John O'Keefe

Dr. Sclamberg referred Petitioner to Dr. John O'Keefe at Marian Orthopedics & Rehabilitation ("Marian"). *See PX. 14 at 26.* On September 30, 2014, Petitioner had his first visit with Dr. O'Keefe who documented the following history:

> Left hand: Examination limited to the left hand. [Mr. Delgado] is severely limited hypoesthetic on the 1st ray, both volar and dorsal. The hypoedthesia moves 7 cm towards the ulna on the dorsum and 4 cm towards the ulna on the palmar side. He has decent deep pinprick sensation distal of the flexor crease of the palm on the palmar side. He has decent deep pinprick sensation distal of the flexor crease of the palm on the palmar side. He has hypoesthesia to pinprick testing on the radial nerve distribution of the 2nd and 3rd rays. He's completely anesthetic on the on the thumb. Thumb has very poor range of motion...Examination of the thenar area shows a severe atrophy of the thenar muscle, probably secondary to either transection of the median nerve or loss of tissue at the time of the contusion/laceration. *See Id.*

Dr. O'Keefe then determined that Petitioner had a nonunion of the 1st metacarpal with retained alignment hardware. *See Id.* Dr. O'Keefe recommended a procedure to correct the nonunion and remove the hardware and he determined that Petitioner should be off-work. *See Id.*

On October 9, 2014, Petitioner followed up with Dr. O'Keefe who kept Petitioner off work and recommended electrical testing to determine Petitioner's function in the left hand. *See Id at 30.* Then, Petitioner underwent an electrophysiological study that determined that Petitioner's median nerves were within normal limits. *See Id at 32.*

After visits on November 4, 2014 and November 20, 2014, during which Petitioner was kept off-work, Dr. O'Keefe performed surgery on 12/3/14 at Accredited Ambulatory Care LLC. *See Id at 8-10; 34-40.*

Following the surgery, Dr. O'Keefe kept Petitioner off work and recommended therapy. *See Id at 40-42.* Dr. O'Keefe kept Petitioner off-work during follow-up visits on December 11, 2014; December 18, 2014; January 22, 2015; February 5, 2015; and February 26, 2015. See *Id at 42, 44, 46, 49 and 52.* Specifically, during the February 26, 2015 visit, Dr. O'Keefe documented the ongoing presence of carpel tunnel symptoms. *See Id at 53.*

On March 31, 2015, Dr. O'Keefe returned Petitioner to light duty employment with a 5 LBS lifting restriction. *See Id at 60.* Electronic Plating, however, did not accommodate this restriction. *See 4-4-19 Trial Tx at 53.* Then, Dr. O'Keefe kept Petitioner off-work during the April 16, 2015 office visit. *See PX. 14 at 63.* During the May 19, 2015 visit, Dr. O'Keefe recommended that Petitioner undergo an autologous bone graft procedure and he placed Petitioner on a 15 LBS lifting restriction. *See Id at 63-65.* Electronic Plating, however, did not accommodate this restriction. *See 4-4-19 Trial Tx at 55*; *See PX. 14 at 66.* During the June 18, 2018 visit, Dr. O'Keefe allowed Petitioner to return to full duty employment as of June 29, 2015. *See Id at 66.* Petitioner followed up with Dr. O'Keefe one last time on July 21, 2015. *See Id at 70.* During this visit, Dr. O'Keefe noted that Petitioner had been working in a lighter duty capacity, training others to use commercial equipment and Petitioner was only lifting 10-20 LBS at Electronic Plating. *See Id.* Dr. O'Keefe then ordered Petitioner to not do any lifting that would lead to pain and recommended that Petitioner follow up in six months. *See Id.*

Petitioner also underwent physical therapy at Marian from December 3, 2015 until June 11, 2015. *See* PX. 14 at 111-212. *See* 4-4-*19 Trial Tx at 55*

Dr. John Fernandez

On June 26, 2014 Petitioner attended a Section 12 Independent Medical Examination with Dr. John Fernandez at Midwest Orthopedics at Rush. *See PX 15 at Pg 10-14.* Dr. Fernandez opined that Petitioner's injury condition was related to the work accident. *See Id at 13-14.* On August 20, 2015, Petitioner returned to Dr. Fernandez but this time for a treatment visit. *See PX 15-17.* Petitioner chose to continue his treatment with

Dr. Fernandez because Dr. Fernandez spoke Spanish. *See 4-4-19 Trial Tx at 58.* Dr. Fernandez recommended surgery in the form of a reconstruction for the metacarpal nonunion and a tendon transfer. *See PX 15 at 17.* Also during the August visit, Dr. Fernandez opined that, with no further treatment, Petitioner would be at Maximum Medical Improvement ("MMI") with a 5-10 LBS restrictions. *See* Id. Respondent Electronic Plating did not accommodate the restrictions. *See* 4-*4-19 Trial Tx at 61.*

Petitioner returned to Dr. Fernandez on October 27, 2015. *See PX 15 at 18-19.* At that time, Dr. Fernandez recommended the use of a splint and placed Petitioner on a 5-10 LBS lifting restriction. *See Id.* Respondent Electronic Plating did not accommodate the restrictions. *See 4-4-19 Trial Tx at 61.* Petitioner returned to Dr. Fernandez on February 23, 2016, March 8, 2016, and April 19, 2016 to discuss surgery. *See PX 15 at 20-25.* During those visits, Dr. Fernandez continued the 5-10 LBS restrictions. *See Id.* Respondent Electronic Plating did not accommodate the restrictions. *See 4-4-19 Trial Tx at 61.*

On June 24, 2016, Dr. Fernandez performed a surgery on Petitioner in the form of a left hand/ thumb removal of deep hardware, plate and screws and left thumb tenolysis, extensor pollicis brevis. *See PX 15 at 8-9.* Petitioner returned for a post-surgical follow up on July 7, 2016 where Dr. Fernandez provided a no-use of the left hand work restriction. *See Id at 25-27.* Respondent Electronic Plating did not accommodate the restriction. *See 4-4-19 Trial Tx at 61.* On July 21, 2016, Petitioner followed up with Dr. Fernandez who kept Petitioner on a no-use of the left hand work restriction *See PX 15 at 8-9.* Respondent Electronic Plating refused to accommodate the restrictions. *See 4-4-19 Trial Tx at 61.*

On August 18, 2016, Dr. Fernandez advised Petitioner that he would need a metacarpal reconstruction in the future and placed Petitioner at MMI with a 5-10 LBS lifting restriction. *See See PX 15 at 32.* During this visit, Dr. Fernandez noted that Petitioner continued to have pain with activities involving grip and pinch as well as contracture of the thumb webspace. *See Id at 31.* Petitioner returned to Dr. Fernandez on August 26, 2016 and asked that his restriction be removed because Electronic Plating would not take him back with restrictions and he could not find work. *See Id at 33; 4-4-19 Trial Tx at 61; 6-25-19 Trial Tx at 64,90.* Dr. Fernandez removed the restrictions on August 26, 2018. *See Px 15 at 33.*

Petitioner testified that the treatment provided by Dr Fernandez was helpful. *See Id at 63-64.*

Petitioner's testimony regarding Employment after Medical Treatment

Petitioner testified, that after he was released from Dr. Fernandez's care, he worked for Respondent Electronic Plating on a full-duty basis for an unspecified period of time, but he was unable to continue this job because he could not operate their machinery due to condition of his hand. *See 4/4/19 Trial Tx at 81-82; 87-88.* He then worked at a company named Belmont Plating for approximately two months making $11.00 an hour; but, Petitioner testified that he was also unable to continue this job because of the condition of his hand. *See Id at 83; 118.* Petitioner then found employment at Tony's Fresh Market ("Tony's"), a grocer. *See Id at 64-65.* At Tony's, Petitioner is in charge of sorting and gathering produce and then putting the produce on display to be sold. *See Id at 65-66.* In order to accomplish this task, Petitioner is required to put the produce on a cart and he usually pushes the cart with his right hand because he cannot use his left hand to grab the produce. *See Id at 141-142.* Petitioner also testified that at Tony's, he occasionally has to lift boxes of produce weighing 30-40 LBS but that he usually seeks and obtains the assistance of coworkers when lifting boxes weighing that much. *See Id at 142.*

Robert Porcelli's Testimony regarding Employment after Medical Treatment

With Respect to Petitioner's ability to work for Respondent Electronic Plating after Petitioner's treatment ended, Robert Porcelli testified that "[Petitioner] came and wanted to come back to work after the Surgery. I [said] ' I can't put you back on until you have a letter from the doctor,' which [he] did'". *See 6/25/19 Trial Tx. at pg 64,90;*

Petitioner's Testimony Regarding Nature and Extent

Petitioner testified that, prior to accident, he used to be able to partake in household and everyday activities such as cooking, washing dishes, and putting on button down shirts, but he currently struggles to do

these activities. *See 4/4/19 Trial Tx at 69.* Petitioner also testified that he feels more pain in the left hand when the weather turns cold and that he cannot bend his left thumb. *See Id at 69.* With respect to how his left hand injury limits him at work, Petitioner testified that he cannot find work wherever he wants because he can no longer do heavy work at the "yards." *See Id at 70-71.* Petitioner also testified that the he feels numbness in the area near the base of the left index finger, the base of the thumb, and the radial aspect of the left hand near the thumb. *See Id at 73-74.*

Petitioner testified that due to this injury and his lack of education—having only gone to school from age 6 to age 12 in Mexico—and the condition of his hand, he is required to take jobs that are less physically demanding, such as his current job at Tony's. *See Id at 110-112.* Petitioner also testified to an 8 by 11 inch piece of skin from his thigh being removed to be used as graft to replace the skin, from his left hand, that was lost during the work accident. *See Id at 104 to 110.*

Robert Porcelli's Testimony Regarding the Nature and Extent of Petitioner's Injuries

Robert Porcelli testified that he desires that Petitioner be paid Workers Compensation benefits and that he wants Petitioner, as his employee, to be made whole for his injuries. *See 6/25/19 Trial Tx at pg 65.*

Medical Bills

Petitioner offered, without objection from any of the Respondents, and the Arbitrator admitted the following medical bills into evidence:

John Stroger Hospital- $75,328.07

Midwest Ortho @ Rush- $2,993.12

Goldcoast Surgicenter- $13,295.48

Dr. Roberto Segura- $1,765.00

MRI Lincoln Imaging- $456.00

Advantage MRI Logan Square- $175.00

Metro Milwaukee Anesthesia- $5,055.09

Accredited Ambulatory Care- $48,525.90

Chicago Pain and Orthopedic Institute- $1,772.34

Marian Orthopedic- $45,083.05

SCR Medical Transportation- $1,196.00

EQMD- $10,783.09

Medical Management Group, LLC - $4,514.58

Rehab Dynamix- $31,039.29

See PX 17.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in Case No. 15 WC 037125 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)

In support of the Arbitrator's decision relating to issues (A), whether Petitioner and Respondent were operating under the Illinois Workers' Compensation or Occupational Diseases Act; and (B), whether their relationship was one of employee and employer, the Arbitrator Finds:

Respondent, Electronic Plating Co, Inc. was operating under the Act. This finding is based on the testimony of Petitioner and Robert Porcelli.

The relationship between Petitioner and Respondent, Electronic Plating Co., Inc. was that of employee/employer. This finding is based on the testimony of Petitioner and Robert Porcelli.

Petitioner failed to prove that he had an employee/employer with any of the other named non government Respondents: Employco USA, Inc.; HR Staffworks, Inc.; Markets Plus; and Prog HR. Of course, there was no employee/employer relationship as to the IIGF and the IWBF. Any liability as to IIGF or IWBF is derivative and will be addressed below.

In support of the Arbitrator's decision relating to issues (C), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent; and (D), what was the date of the accident?, the Arbitrator Finds:

Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on December 2, 2013. This finding is based upon the unrebutted testimony of Petitioner, the testimony of Porcelli and the medical records.

In support of the Arbitrator's decision relating to issues (E), whether timely notice of the accident given to Respondent, the Arbitrator Finds:

Petitioner gave timely notice of the accident to Respondent. This finding is based upon the testimony of Petitioner and Porcelli.

In support of the Arbitrator's decision relating to issue (F) whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator Finds:

Petitioner's current condition of ill-being regarding his left hand and left thigh is causally related to the injury. This finding is based on Petitioner's testimony and the medical records.

In support of the Arbitrator's decision relating to issue (G), Petitioner's earnings, the Arbitrator Finds:

The Arbitrator finds that Petitioner's Average Weekly Wage ("AWW") on the date of accident was $370.00. Petitioner submitted paycheck stubs reflecting the following wages:

- 8/14/13 – 8/20/13 - $ 370.00
- 8/28/13 – 9/3/13 - $397.75
- 9/4/13 to 9/10/13 – $564.27;
- 10/16/13 to 10/22/13 - $333.00; and,
- 11/13/13 to 11/19/13 - $370.00. (*Px 2*)

Based on Petitioner's testimony that he worked for Respondent for a few years prior to the accident., the foregoing paystubs do not reflect all of Petitioner's earnings. However, they do reflect that Petitioner earned $9.25 an hour while working for Electronic Plating Co. The Arbitrator, therefore, draws a reasonable inference that Petitioner earned $9.25 an hour while working 40 hours per week. **As such, the Arbitrator finds that Petitioner had an AWW of $370.00 in the year preceding the injury.**

In support of the Arbitrator's decision relating to issues (H), Petitioner's age at the time of the accident; and (I), Petitioner's marital status at the time of the accident, the Arbitrator Finds:

Petitioner claimed that he was 31 years old and married with 1 dependent child. (ArbX 1-5) He testified that he was not married and he had children under the age of 18. His date of birth is June 28, 1982. Petitioner's testimony was unrebutted.

Based upon Petitioner's claims on the RFH forms (ArbX 1-5) and his testimony, the Arbitrator finds that Petitioner was 31 years old and had 1 dependent child on the date of accident.

In support of the Arbitrator's decision relating 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:

The medical services that were provided to Petitioner were reasonable and necessary and causally related to the injuries sustained. The total amount of $241,982.01 is claimed for unpaid medical charges related to Petitioner's medical treatment. The breakdown is as follows:

John Stroger Hospital- $75,328.07

Midwest Ortho @ Rush- $2,993.12

Goldcoast Surgicenter- $13,295.48

Dr. Roberto Segura- $1,765.00

MRI Lincoln Imaging- $456.00

Advantage MRI Logan Square- $175.00

Metro Milwaukee Anesthesia- $5,055.09

Accredited Ambulatory Care- $48,525.90

Chicago Pain and Orthopedic Institute- $1,772.34

Marian Orthopedic- $45,083.05

SCR Medical Transportation- $1,196.00

EQMD- $10,783.09

Medical Management Group, LLC - $4,514.58

Rehab Dynamix- $31, 039.29

Accordingly, Respondent shall pay Petitioner $241,982.01 in medical bills, pursuant to the Medical Fee Schedule and in accordance with Sections 8(a) and 8.2 of the Act.

With Respect to Issue K, Is Petitioner entitled to TTD benefits?, the Arbitrator Finds:

All findings of fact stated above and conclusions of law are adopted and incorporated by reference herein. The Arbitrator awards Petitioner 125 & 5/7 weeks of Temporary Total Disability benefits ("TTD") from February 6, 2014 to June 29, 2015 and August 20, 2015 until August 26, 2016.

Dr. Vargas took Petitioner off work on February 6, 2014 and then Petitioner remained off work per Dr. Sclamberg and Dr. O'Keefe's orders. Petitioner then returned to work full duty on June 29, 2015 but Respondent was unable to accommodate restrictions once Dr. Fernandez put him on light duty on August 20, 2015. On August 18, 2016, Dr. Fernandez placed Petitioner back to work with a 5 LBS lifting restriction. Since the Respondent requested that Petitioner have these restrictions removed, Petitioner asked Dr. Fernandez, on August 26, 2016, to release Petitioner to full duty work, which Dr. Fernandez did.

As such, Petitioner is owed 125 & 5/7 weeks of Temporary Total Disability ("TTD") at his TTD rate of $253.00 per week.

With regard to issue (L), What is the nature and extent of Petitioner's injuries, the Arbitrator Finds:

In determining the level of PPD the Arbitrator must take the following factors into account:

(i) the reported level of impairment pursuant to an American Medical Association's "Guides to the Evaluation of Permanent Impairment" ("AMA Rating");
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earing capacity; and
(v) evidence of disability corroborated by the treating medical records.

"No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order." *820 ILCS 305/8.1b(b).*

Evidence of Impairment - No Weight

With Respect to 8.1b(b)(i), no AMA Rating was admitted into evidence. Therefore, the Arbitrator gives no weight to this factor.

Occupation - Great Weight

With respect to 8.1b(b)(ii), Petitioner was a machine operator who sealed barrels with chemicals and was required to lift barrels weighing 100 LBS. On August 18, 2016, Dr. John Fernandez initially released Petitioner to Maximum Medical Improvement with a 5-10 LBS lifting restriction. However, due to the fact Electronic Plating Co. refused to employ Petitioner with that restriction, Petitioner asked Dr. Fernandez to remove the restriction. Dr. Fernandez, therefore, removed the restriction and Petitioner attempted to return to Electronic Plating but he was physically unable to perform his job duties. Petitioner attempted to work as a machine operator at Belmont Plating, but was again physically unable to perform his job duties. Petitioner now works a light to medium duty job as a produce handler at Tony's Fresh Market. As such, the Arbitrator gives great weight to this factor.

Age - Moderate Weight

With respect to 8.1b(b)(iii), the employee was 31 years on the Date of Accident. Given the fact that 67 is expected age of retirement, the serious injuries occurred 36 years before Petitioner's expected retirement age. As such, the Arbitrator gives moderate weight to this factor.

Future Earning Capacity-Moderate Weight

With respect to 8.1b(b)(iv), the Petitioner testified to earning higher wages at his current job than during his employment with Respondent. However, Petitioner also testified to being unable to work at higher paying more physically demanding jobs due the condition of his hand. As such, the Arbitrator gives moderate weight to this factor.

Evidence of Disability-Great Weight

Petitioner suffered a gruesome degloving injury to the left hand in the course and scope of his employment on December 2, 2013. Petitioner went directly to Lorretto Hospital and was immediately transferred to John Stroger Hopsital in Chicago. He was diagnosed with a circumferential degloving injury of the left hand as well as a communited 1st metacarpal fracture and dorsally angulate fracture of the second distal phalanx. *See PX. 11 at 20, 42, 66, 139.* Petitioner then underwent a series of operative procedures including an open reduction of fracture of phalanges of hand with internal fixation; open reduction of fracture of carpals and metacarpals with internal fixation; Excisional debridement; local excision; and skin graft. *See Id. at 20, 37, 66, 139, 166.*

Dr. O'Keefe performed a procedure to remove hardware as did Dr. John Fernandez, who performed left hand/ thumb removal of deep hardware, plate and screws and left thumb tenolysis, extensor pollicis brevis. *See PX 14 at 8-10; 34-40; PX 15 at 8-9.* Following the procedure, Dr. Fernandez noted that Petitioner continued to have pain with activities involving grip and pinch as well as contracture of the thumb webspace. *See PX 15 at 32.*

On August 18, 2016, Dr. John Fernandez initially released Petitioner to Maximum Medical Improvement with a 5-10 LBS lifting restriction. However, due to the fact Electronic Plating refused to employ Petitioner with the foregoing restriction, Petitioner asked Dr. Fernandez to remove the restriction. In addition, Robert Porcelli, the President of Respondent Electronic Plating, testified to telling Petitioner that he needed a revised work status note in order to return to work for Electronic Plating. Dr. Fernandez, therefore, removed the restriction and Petitioner attempted to return to Electronic Plating but, even with a full duty restriction, was physically unable to perform his job duties. Petitioner attempted to work as a machine operator at Belmont Plating but was again physically unable to perform his job duties. Petitioner now works a light to medium duty job as a produce handle at Tony's Fresh Market.

Petitioner credibly testified that he cannot find work wherever he wants because he can no longer do heavy work at the "yards." because his lack of education—having only gone to school from age 6 to age 12 in

Mexico—and the condition of his hand. Petitioner also testified to an 5 by 5 inch piece of skin from his thigh being removed to be used as graft to replace the skin that was lost during the work accident.

Award- 40 % MAW

Therefore, based on the foregoing analysis and the entirety of the evidence adduced, the Arbitrator finds that as a result of the injuries sustained, Petitioner suffered the 40% loss of use of the Person-as-a-Whole, in accordance with Section 8(d)2 of the Act.

With regard to issue (N), whether Respondent is owed a credit and issue (O), which Respondent or fund is Responsible for Coverage, the Arbitrator Finds:

Liability of the IWBF, in accordance with Section 4(d) of the Act, has been established.

This finding is based on the Arbitrator's findings above regarding Act, an employee/employer relationship between Petitioner and Electronic Plating, accident and notice, above, and the Arbitrator's finding that Electronic Plating was not covered by a workers' compensation insurance policy on the date of accident.

Petitioner provided a certification from NCCI as evidence that Respondent Electronic Plating was not carrying workers compensation insurance on the date of accident. In addition, Respondent Electronic Plating did not provide evidence of a valid workers' compensation insurance policy. As such, the Arbitrator determines that the Injured Workers Benefit Fund ("IWBF") is responsible for coverage of this injury.

As there was no proof of any workers' compensation insurance policy, the IIGF has no liability.

There was no proof that Electronic Plating or the IWBF is entitled to any credit. Accordingly, none is awarded.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC031468
Case Name	MONTOYA, NATHANAEL v. GLK INC DBA ASHLAND MILLWORK
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0312
Number of Pages of Decision	29
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Stephen Martay
Respondent Attorney	John Maciorowski

DATE FILED: 6/21/2021

DISSENT

/s/Deborah Baker, Commissioner

Signature

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

NATHANAEL MONTOYA,

Petitioner,

vs. NO: 18WC 31468

GLK INC D/B/A ASHLAND MILLWORK,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue(s) of accident, medical expenses, causal connection, prospective medical care, notice, 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 April 21, 2020 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.

June 21, 2021

/s/ *Stephen J. Mathis*
Stephen J. Mathis

SJM/sj
o-4/20/2021
44

/s/ *Deborah Simpson*
Deborah Simpson

DISSENT

I disagree with the majority's decision to affirm and adopt the Arbitrator's denial of benefits based on his finding that "Petitioner has not proven by a preponderance of the evidence that he suffered an injury in the course of his employment on September 28, 2018." I note that the Arbitrator made no findings as to whether Petitioner proved that he suffered an accidental injury that arose out of his employment with Respondent on September 28, 2018.

I. Credibility

At the outset, I find that the Arbitrator's credibility determination was based on several inaccuracies and omissions. The Commission exercises original jurisdiction and is not bound by an arbitrator's findings. *See R & D Thiel v. Illinois Workers' Compensation Comm'n*, 398 Ill. App. 3d 858, 866, 923 N.E.2d 870, 877 (1st Dist. 2010) (finding that when evaluating whether the Commission's credibility findings which are contrary to those of the arbitrator are against the manifest weight of the evidence, "resolution of the question can only rest upon the reasons given by the Commission for the variance.") My reasons for making credibility findings that are contrary to the Arbitrator's findings are below.

Testimony

On direct examination. Petitioner testified that he worked for Respondent as a wood worker/carpenter on September 28, 2018 and had worked in that position for three years. Petitioner testified that his job duties included unloading lumber and "milling" it, which meant that he would unload wood and cut it to a certain thickness. Petitioner's work hours were typically from 7:30 a.m. to sometime between 4:00 and 5:00 p.m. Petitioner testified that on a typical day, he waits for the lumber to be delivered, unloads the lumber, and moves the lumber to a wall. Petitioner described his job as follows: "we always wait for lumbar [sic] to come in to unload it, and move it to get - - have it ready. We move it to a wall, we stand it up, to leave it there, and then we grab what we need and we cut it to make the parts for the door." Petitioner clarified that he carries the wood, puts it in a "car," and then moves the wood to another location where he stands it up on a wall or puts it on the floor. Petitioner testified that he would sometimes move the wood with the help of others. Petitioner described the wood as

approximately 16 feet by 10 inches wide and about one-and-a-half to three inches thick. Petitioner testified that the wood weighed between 80 and 100 pounds.

Petitioner testified that on September 28, 2018, he arrived at work around 7:30 a.m. and had to unload lumber. Petitioner stated: "I had to unload lumbar [sic], a lot of lumbar, from the first lift and from a pile I have to move it, and I have to move a lot of lumbar because there were - - one of guys had resigned, so that was major role. He resigned and so I had to do this extra work to be moving more lumbar on that day [sic]." Petitioner testified that he moved approximately 50 planks of wood, approximately six feet that day. Petitioner moved the planks of wood one at a time and put the wood on a cart and then rolled the cart to a wall where he placed the wood. Petitioner testified that he moved wood to the cart and then to the wall approximately 20 times total on September 28, 2018. Petitioner worked the entire day. The following colloquy took place:

> Q. And while you were at work on that date [September 28, 2018], did anything unusual happen to you?
> A. Yes, at the end of the day I got hurt.
>
> Q. When you say at the end of the day, approximately what time?
> A. It was between 3:00 and 4:00.
>
> Q. And when you say you got hurt, what happened to you?
> A. I felt a sharp pain on my back on the left side of my lower back.
>
> Q. And what were you specifically doing when you felt that sharp pain?
> A. I was moving some lumbar [sic]. I was picking them up from the pile to put them on the cart.

Petitioner testified that he did not report the injury to Respondent that day as he did not think it was going to get worse. On October 3, 2018, Petitioner called "Mike" at Ashland Millwork and told him that he could not come to work because he had a lot of pain. Petitioner told Mike that he "got hurt lifting some heavy boards." A man named "Justus" called Petitioner the next day and Petitioner told him that he was injured at work on Friday.

Petitioner testified that September 28, 2018 was a Friday. Petitioner did not go to the emergency room that day because he thought he was going to get better. Petitioner testified that on the following Monday, which was October 1, 2018, Petitioner went to the emergency room and reported sustaining a work injury. Petitioner told the hospital ER staff that he got hurt at work lifting some heavy boards. Petitioner testified that he sought follow up treatment after going to the emergency room.

Petitioner testified that prior to September 28, 2018, he had previous issues with his back. Petitioner stated that he first had back problems around 2008 which he related to a work injury while working for a different employer. Petitioner did not file a workers' compensation claim at that time. Petitioner testified that he had some physical therapy for his back. Petitioner testified

that he had other treatment for his back after 2008 but before 2018, sometime around 2013. Petitioner underwent an MRI for his lumbar spine, and he might have had some physical therapy but he could not recall. Petitioner testified that between 2013 and 2018, he did not have any additional treatment for his back. Petitioner did not have work restrictions while he was working on September 28, 2018. Petitioner testified that to his knowledge, Respondent had terminated his employment, however, he was never sent a letter stating that he was laid off or terminated.

Petitioner testified that since being released from Dr. Mirkovic's care, he had worked some jobs part-time. Petitioner helped his brother install furniture sometimes and he worked part-time for a stone granite company measuring countertops. Petitioner does not have to do heavy lifting at these jobs. Petitioner testified that following surgery to his back, he experienced stiffness and pain when the weather changed. Petitioner stated that prior to September 28, 2018, he shoveled snow and played soccer. However, he was unable to shovel snow and play soccer after September 28, 2018, as he was afraid that he would experience more pain and would be unable to work. Petitioner takes Tylenol once-in-a-while. Petitioner testified that there is an emergency room related to his back treatment that he was paying, but aside from this, Blue Cross Blue Shield (BCBS) had paid his medical bills. Petitioner requested that he be held harmless for any bills paid by BCBS. Petitioner testified that he was either off work or released to work with light duty restrictions between October 5, 2018 and February 28, 2019. Petitioner was not paid any temporary total disability (TTD) benefits.

On cross examination, Petitioner testified that he first began working for Respondent in 2016, then he left to work somewhere else until around January 2018, when he returned to work for Respondent. Petitioner testified extensively regarding a right shoulder injury, which is not part of the instant claim. Petitioner testified that on the morning of September 28, 2018, there were other people working but "they're doing their job and I was doing unloading lumbar [sic] from the forklift to move it to the wall." The following colloquy occurred:

> Q. Okay, wouldn't the forklift move the lumbar?
> A. No, you cannot drive it through the shop, I mean, you have to move a lot of things, it just wouldn't be possible, you have to put it in a car [sic] and take it and move it to a wall and stand it up.
>
> ***
>
> Q. You removed the lumbar [sic] off the forklift and stood it up against the wall?
> A. No, I put the lumbar [sic] in the cart. I lift the lumbar and put it in the cart, and then from the cart I put it to the wall.
>
> ***
>
> Q. And it's your testimony sometime around 3:00 o'clock you were crouching down to lift one of these 16-foot planks and that's when you experienced back pain?
> A. Yes.

Q. And you knew that's when your back pain started, right?
A. No, my back was really sore already of all the work that I have been doing.

Q. Your back has been sore for a number of years, is that correct?
A. I had some minor pain, but the work –

Q. Was this pain different?
A. This pain was more, yes.

Q. Okay, and you noticed that's when you had the more pain at 3:00 o'clock when you were lifting this board?
A. Like I said, all the lumbar [sic] had – I was having a sore back really after moving all that lumbar and carrying it my back was really sore and then I had – when I lift this board from the floor from a pile, I had a sharp pain on my back, lower back.

Q. What part of your lower back?
A. Left.

Q. So you knew that that's what your sharp low back on the left side pain was from when you lifted the board, is that correct?
A. Yes.

Q. Would you consider that an accident?
A. Yes.

Q. And then you continued to work until the end of shift, and if your timecard records indicate that you punched out at 4:15, would that be correct?
A. Probably.

Petitioner testified further that when he saw Dr. Wehner, Respondent's section 12 examining doctor, he told her that he had injured his back at "Old Plank," which is where he worked prior to working for Respondent. Petitioner again testified that he underwent an MRI of his back in 2013 and reported having low back pain. When asked again whether his pain started on Friday at 3:00 on September 28, Petitioner responded, "I said the whole day all the lumbar [sic] caused me a lot of pain throughout the day, there was a lot of lumbar [sic] to move." The following colloquy occurred:

Q. Was there a specific incident on September 28th or was it lifting the one board, or was it you're saying the general job?
A. Lifting the board I felt the pain.

Petitioner testified further that when he spoke to Justus on October 4, 2018, he told Justus that he would not be at work and he had sustained an injury on Friday, September 18. Petitioner also

spoke to Justus about how there was not enough people working and Petitioner had to do a lot more heavy lifting because some people had left and it was more heavy lifting for him. When asked whether he recalled completing a form on October 5, 2018 at Dr. Mirkovic's office, Petitioner stated that the form looked familiar and he recalled writing that his pain began in 2010/2008, however, with respect to the pain diagram, the handwriting did not look like his handwriting and he did not recall completing the pain diagram. Petitioner testified that he remembered walking by Justus and saying "see you" as he left on September 28, 2018. When asked about a February 28, 2019 note from Dr. Mirkovic, Petitioner testified that he recalled lifting a little box and having a little pain but he did not recall having restrictions again. While being questioned, Petitioner could not remember multiple dates and could not remember when he had restrictions. Petitioner did not know what a Functional Capacity Evaluation (FCE) was. Petitioner could not remember the last date that he saw Dr. Mirkovic.

On redirect examination, Petitioner testified that he did not undergo treatment for his back between 2008 and 2013.

Petitioner's timecard records as submitted into evidence as Respondent's Exhibit 2 indicates that on September 28, 2018, he left work at 4:15 p.m. That week, Petitioner had clocked out at work at 4:12 p.m., 4:13 p.m., 4:06 p.m., and 3:59 p.m. The week prior, Petitioner had clocked out at work at 4:43 p.m., 4:01 p.m., 4:10 p.m., 4:38 p.m., and 4:05 p.m.

I find that Petitioner's testimony was credible, straight-forward, and corroborated by the medical records. The Arbitrator's credibility assessment, which is based on several inaccuracies and factual omissions, is as follows:

> The Arbitrator finds that the testimony of the Petitioner was not credible. Petitioner's manner of speech and body language gave the Arbitrator pause. Also curious was the timing of the alleged accident which was at the very end of his shift on Friday afternoon. Testimony by co-workers contradicted Petitioner. Review of the medical records provided an almost total rebuke of Petitioner's account.
>
> ***
>
> Petitioner's testimony was further eroded by the inconsistent indications of pain in his lower extremities.

The Arbitrator's basis for finding Petitioner not credible was that his "manner of speech and body language gave the Arbitrator pause," however, there is no explanation or description of Petitioner's "manner of speech" or body language. With respect to the timing of the accident, the Arbitrator concluded that it was "curious," but did not explain what this means. In stating this, the Arbitrator relied on testimony by "co-workers" who were actually Justus Joseph (shop supervisor), Kathy Kirsten (office manager), and Mike Williams (Vice President) for Respondent. Although the Arbitrator relied on the testimony of Respondent's witnesses in finding Petitioner not credible, the testimony of Respondent's witnesses is scarcely addressed in the Arbitrator's Decision and the credibility of Respondent's witnesses was not addressed. I find

that the testimony of Justus Joseph was not credible as it was inconsistent and changed throughout his testimony. I find the testimony of Mike Williams to be generally credible as it was generally consistent and realistic. I find the testimony of Kathy Kirsten to be unimportant and irrelevant in this case, but generally credible.

Justus Joseph testified that he worked for Respondent for 16 years and on September 28, 2018, he was the shop supervisor. Mr. Justus was familiar with Petitioner and he testified that Petitioner started working for Respondent after a period of being away, in January 2018 as a woodworker. Mr. Justus was Petitioner's direct supervisor. As a woodworker, Petitioner built doors and part of Petitioner's job duties included cutting strips of wood. Mr. Justus testified that these "strips of wood" "would go from two pounds like to 15, to about 15, 20 pounds, depending what we're doing." Mr. Justus testified that *Petitioner would not have to unload wood from anywhere*. Mr. Justus testified that there was no shortage of staff on September 28, 2018. Mr. Justus testified that on September 28, 2018, Petitioner did not have to move 50 planks of wood that were 16 feet long and put them on a cart and *Petitioner would never have to do "that type of activity."* Mr. Justus testified that on that day, Petitioner "would be ripping, we were working on creating door parts, so he would be ripping the pieces for the stable core," which weighed about 5 to 10 pounds. Mr. Justus saw Petitioner at the end of the day and did not notice anything unusual about Petitioner. Mr. Justus testified that Petitioner said goodbye and then left. Mr. Justus testified that Petitioner did not call him on October 4, 2018 and denied that Petitioner ever told him that he had sustained an injury on September 28, 2018. Mr. Justus testified that the "work comp carrier" asked him to complete a statement and he did so on January 17, 2019 (which was about 11 days before Petitioner's section 12 examination with Dr. Wehner). The record contains a letter on Respondent's letterhead dated January 17, 2019 and addressed to a claims adjuster with EMC Insurance Companies which states: "On Friday 9/28/18 Nathan Montoya left work at his normal time. He said goodbye to me and did not appear to be in any pain. He never mentioned to me he was injured." The letter is signed by Justus Joseph.

On cross examination, Mr. Justus testified that Petitioner was a good worker. The following colloquy took place:

> Q. And it's your testimony that he would never had to lift more than 15 pounds, is that accurate?
>
> A. Well, *I didn't say he would never have to lift more than 15 pounds. I said on that particular date.*
>
> Q. Okay.
>
> A. He probably wasn't lifting more than 15 pounds.
>
> Q. Okay, on that particular date?
>
> A. Yes.
>
> Q. How much weight would be the maximum he would ever have to lift?
>
> A. *Well, the weight would have to be like what you feel you can lift,* and normally we ask everyone to ask someone to help with whatever you feel is

not suitable for you to lift.

Q. So is there is not an actual wight restrictions?
A. *Everybody lifts what they feel they can lift.*

***

Q. Okay, and, it's your testimony that Mr. Montoya would never have to unload the wood and bring it to his workstation, is that right?
A. Okay. So – no, normally, like whenever we normally have some of the guys help out to get the wood when the guys bring it in, the guys, the receiving guy bring the wood in to in the shop and then we have other guys help out to move the wood wherever we need to move it. Normally we move it to a cart and we put it to a chop saw.

Q. Okay, so Mr. Montoya would be one of the guys helping to unload that wood?
A. Yes, he could be helping out sometimes, helping out with some other person moving the wood around.

Q. And approximately how long are these wood planks?
A. Normally like 10 feet wide, about an inch thick, 10 feet long, sorry, and about anywhere from six – anywhere from four inches wide to 10 inches wide.

Q. And approximately how heavy would these be?
A. I don't have the actual weight of that. I'm not sure.

Further, Mr. Justus testified that he did not know that Petitioner's case was filed on October 19, 2018 and he doesn't pay attention to "any case." However, Mr. Justus stated that on January 17, 2019, he remembered exactly what happened on Friday, September 28, 2018. Mr. Justus testified that he called Petitioner sometime after September 28, 2018, within a week, to ask how he was doing and to find out how Petitioner was injured. Petitioner told him that his back hurt but also said, "I can't talk to you." When asked, "So this would have been before he hired me he told you he couldn't speak with you?" Mr. Justus stated, "Well I'm not sure on the date. I'm not sure." Mr. Justus then testified that he was not sure if he spoke to Petitioner within one week or within two weeks of September 28, 2018.

I find that Mr. Justus' testimony was not credible and that the answers he provided on direct examination were contradicted by his answers on cross examination. At first, Mr. Justus stated that Petitioner would not have to unload wood anytime in the position that he was in. Then on cross examination, Mr. Justus stated that sometimes, Petitioner would in fact help unload wood with other workers. Mr. Justus testified further that the wood Petitioner would sometimes help to unload was 10 feet long, but he did not know how much that wood weighed. I find that Mr. Justus' testimony was conveniently vague with respect to how much the wood weighed. Additionally, Mr. Justus stated that he clearly remembered talking to Petitioner within a week of

the injury and stated that although Petitioner told him he injured his back, Petitioner also said, "I can't talk to you." Then, Mr. Justus changed his testimony and said he could not remember if he spoke to Petitioner within one week of the injury after Petitioner's counsel indicated that Petitioner had not hired counsel by that time. I find Mr. Justus' testimony to be unreliable and all too convenient with respect to the level of detail that he could and could not recall. I find that Petitioner's testimony, which is supported by all of the medical records, to be more credible than Mr. Justus' testimony.

Mike Williams testified that he is the Vice President for Respondent and he had worked for Respondent for 15 years. Mr. Williams testified that Respondent is a company that distributes windows, doors, millwork, and manufactures custom millwork. Mr. Williams was familiar with Petitioner and confirmed that Petitioner left Respondent and then returned in January 2018. Mr. Williams testified that Petitioner's job duties included building custom woodwork pieces, such as custom front entry doors, brackets, and other wood products. When asked, "what would be the heaviest item in the general course of his duties that he would have to lift?" Mr. Williams testified, "I would say around 25 pounds. It's really up to the individual to know what they're capacity is I guess without straining themselves. *Mr. Williams also testified that "guys like Nathan" would do the stacking of the wood onto a cart after the wood was unloaded from a truck by a forklift.*

Additionally, the following colloquy occurred:

> Q. Would you have various types of projects, there was testimony by Mr. Joseph on September 28th as to it being a lighter type of job, can you explain specifically more what was being done on that day?
>
> A. I guess *I don't have firsthand knowledge of what was done on that day.* I was told they were making door parts, taking – if you will taking a one by eight and ripping it into smaller pieces which would then become the core of the door.

Mr. Williams testified further that Petitioner called him on October 1, 2018 and Petitioner told him that he was going to the doctor because his back wasn't feeling well and he would not be able to work that day. Petitioner did not tell him that he sustained a work injury. Mr. Williams testified that on October 9, 2018, Petitioner text him and said that his doctor placed him off work for two weeks and he wanted to make sure that his insurance was paid. On October 19, 2018, Petitioner called him and said that he went to the doctor, he was going to have surgery, and he was going to make a claim for "workman's comp." Mr. Williams testified that Petitioner told him his injury happened at work and Mr. Williams responded by saying that nobody knew he had a work injury.

On cross examination, *Mr. Williams testified that the heaviest piece of wood that someone could lift would probably be about 50 pounds, but he had never weighed any of the wood.* Mr. Williams also testified that Petitioner was a good worker. Mr. Williams testified that *he "would imagine" that he talked to Petitioner sometime between October 2 and October 8, 2018 via phone but he could not remember specifically.* Mr. Williams testified that Petitioner contacted him about returning to work on February 28, 2019, after Petitioner had surgery and

with restrictions of no lifting more than 35 pounds, but Mr. Williams felt that Petitioner was not ready to return to work. Mr Williams testified that when Petitioner was released to full duty work with no restrictions, Respondent had no work at that time and Mr. Williams did not respond to Petitioner's June 17, 2019 text regarding returning to work. Petitioner was never formally fired or laid off.

Kathy Kirsten testified that she is the office manager for Respondent. Ms. Kirsten testified that on October 8, 2018, Petitioner's wife called her to ask for a copy of Petitioner's insurance card. Ms. Kirsten never spoke to Petitioner.

I find that Mr. Williams' testimony was generally credible and was consistent with Petitioner's testimony. Mr. Williams confirmed that "guys like Nathan," would help stack the wood on the cart and that although the maximum weight Petitioner was generally required to lift was approximately 25 pounds, it was up to the individual and he had never actually weighed any of the wood. Mr. Williams also credibly testified that he did not have firsthand knowledge about the type of work Petitioner did on September 28, 2018 and he relied on what Mr. Justus told him.

Overall, both Mr. Justus and Mr. Williams eventually admitted that Petitioner did have to lift boards onto a cart as part of his job duties and neither one knew how much those boards weighed. Mr. Williams guessed that the heaviest thing Petitioner would have to lift would weigh 50 pounds, but this was a guess as he admitted he had never weighed the wood. Based on the above, I find that Petitioner's testimony that he was lifting heavy wood boards on September 28, 2018, to be credible and unrebutted. I also find that the wood likely weighed between 50 and 100 pounds.

Medical Records

With respect to the medical records, the Arbitrator concluded that "the medical records provided an almost total rebuke of Petitioner's account;" yet, a full and complete reading of the medical records actually shows that the medical records fully support and corroborate Petitioner's testimony.

The emergency room (ER) records from AMITA St. Alexius Medical Center, dated October 1, 2018, indicate that Petitioner arrived in the morning complaining of back pain. The ER record states: "Chief Complaint per patient, I am having back pain, I always have back pains, it started getting worse Sunday afternoon. Denies any injuries/trauma. *'I did a lot of work Friday, sometimes when I do a lot of work it gets bad again.*'" (Emphasis added.) Under the History of Present Illness section, it states: "The patient presents with Low back pain. The onset was Since Saturday afternoon. The course/duration of symptoms is constant. The character of symptoms is pain. The degree at onset was minimal. The degree at present is moderate." Petitioner was prescribed Naproxen, diagnosed with osteoarthritis, advised to follow up with a physician, and was released to activity as tolerated. I find that Petitioner's testimony was consistent with this ER note as Petitioner testified that his back injury occurred after doing a large amount of lifting wood on Friday, September 28, 2018. The ER note correctly states that Petitioner performed "a lot of work Friday and the pain worsened on Sunday. I find that the ER note itself has internal inconsistencies as the note states Petitioner had back pain after doing a lot of work on Friday but

also says that the onset of Petitioner's pain was on Saturday. I find that this is inconsistent and reflects an error in the ER note and is not a valid basis for finding Petitioner not credible.

On October 5, 2018, Petitioner sought treatment from Dr. Srdjan Mirkovic and his assistant, PA Karen Ferkau. In the History section, the note states that Petitioner had a sudden onset of low back pain across his back in 2008 following a work-related injury where he was lifting something to determine the weight. He had physical therapy in 2008 with minimal benefit. Significantly, the note also states: "*LBP remained constant since 2008 with severity waxing/waning, with worsening over the last few years, and even further since last Friday, after lifting wood… he has had constant more severe LBP since last Friday, which increased further on Saturday after sitting prolonged period in a car*." (Emphasis added.) The note indicates further that Petitioner could not lift his left lower extremity without having severe low back pain and that he had weakness in his left lower extremity since "last Friday." The note also indicates that Petitioner "denies having had or currently having LE pain." On examination, Petitioner had positive straight leg raises with increased low back pain in midline at full dorsiflexion on both the right and left sides. With single leg toe raises, Petitioner was able to perform with moderate difficulty secondary to low back pain on the left. Additionally, Petitioner had decreased sensation in the entire left extremity with sensory testing. *Dr. Mirkovic diagnosed Petitioner with low back pain and sciatica* and recommended Petitioner undergo an MRI of the lumbar spine. Dr. Mirkovic reviewed and signed-off on the note on October 8, 2018. On a History and Physical Information Entry Form, it states that the pain began between 2008 and 2010 and that the pain began both suddenly and gradually. The form also indicates that the pain resulted from an accident at work. On a pain diagram, a circle is drawn around the low back area.

With respect to Dr. Mirkovic's October 5, 2018 note, I find that it fully corroborates Petitioner's testimony and complaints of low back pain with radicular left leg symptoms. To his credit, and boosting his credibility, Petitioner provided Dr. Mirkovic and his PA with a detailed history of his back problems going back to 2008. The note accurately described Petitioner's pain from 2008 as "waxing/waning," which is how Petitioner described it at trial. The note also states that Petitioner's low back pain worsened and all of a sudden became constant "since last Friday" after lifting wood, which increased over the weekend. This is exactly what Petitioner testified to at the hearing. The note also details several left lower extremity symptoms such as pain in the low back with lifting, positive straight leg raises, weakness, and decreased sensation. Of note, the record only states that Petitioner denied direct pain to the left lower extremity, although he had numerous other symptoms in the left lower extremity. Additionally, and significantly, Dr. Mirkovic diagnosed Petitioner with low back pain *and sciatica* after examining Petitioner.

On October 10, 2018, Petitioner underwent a lumbar spine MRI that showed "left paracentral/subarticular disc extrusion showing mild caudal migration and effacement of the left subarticular recess at L4/L5." The MRI report indicates that Petitioner's clinical history was of chronic low back pain without sciatica, however, in the impression, the radiologist noted, "Please correlate with possible left L5 radicular symptoms." Again, Petitioner's complaints of radicular symptoms into the left leg are documented and consistent with Petitioner's testimony. I find that the MRI report has an internal inconsistency in that it first states that Petitioner did not have sciatica, even though Dr. Mirkovic had already diagnosed Petitioner with sciatica, and later in the impression, the radiologist states "Please correlate with possible left L5 radicular symptoms."

On October 18, 2018, Petitioner returned to Dr. Mirkovic. The note states:

> He relates history of chronic low backpain waxing and waning since 2008. *He states that on the Friday prior to his previous clinic visit on 10/05/2018, he was lifting a board when he experienced an acute exacerbation of low back pain. At that time, he also experienced acute onset of left posterolateral leg pain, which were new symptoms he had not experienced prior to Friday, notably during the period of 2008 until last Friday.* (Emphasis added.)

Dr. Mirkovic diagnosed Petitioner with the following:

1. Acute on chronic low back pain related to the work events on Friday prior to 10/06/2018.
2. New onset of left posterolateral leg pain correlating with left large lumbar disk herniation at L5-S1. This represents a new presentation, which is related to the work events on Friday prior to his last visit. More likely than not, the patient sustained acute left-sided disk herniation at the time of the work events on Friday prior to his last visit.

1. Work related onset of low back and left posterolateral leg pain with likely acute left-sided L4-L5 disk herniation.
2. Persistent pain with left leg pain greater than lower back pain.

Dr. Mirkovic placed Petitioner off work, recommended Petitioner continue pain management, and advised Petitioner to consider his treatment options of epidural steroid injections (ESIs), physical therapy, and a microdiscectomy surgery, noting that given the severity of Petitioner's pain and the size and location of the disc herniation, Petitioner would not benefit from ESIs or physical therapy. I find that this note also supports and corroborates Petitioner's testimony at the hearing.

Overall, I find Petitioner's testimony was credible and reliable. Respondent inaccurately states that Petitioner testified only that he sustained a specific work injury on September 28, 2018 while lifting a wood board around 3:00 p.m. However, this is inaccurate. Petitioner provided more context and details in his testimony and testified that he had originally injured his back in 2008 and underwent some treatment between 2008 and 2013. Petitioner's back problems waxed and waned over the years, as back problems do, until Petitioner sustained a work injury on September 28, 2018 after a long day of lifting several heavy wood boards and finally, when he lifted a board between 3:00 p.m. and 4:00 p.m., he felt an increased, sharp pain in his low back that he had not felt before. This is reflected in all the medical records and in Petitioner's testimony.

Respondent makes much ado about nothing in arguing Petitioner's testimony that the wood boards weighed approximately 80 to 100 pounds means he is not credible. However, Respondent fails to acknowledge that its own witnesses either guessed at how much the wood may have weighed as they had never weighed the wood (Williams), or stated that they did not

know how much the wood weighed (Joseph). Mr. Joseph's testimony as to wood weighing no more than 5 to 10 pounds was with respect to the strips of wood that are ripped in order to make a "stable core" and not the wood boards that are unloaded from a truck onto a cart. Mr. Justus testified that he did not know how much these wood boards weighed. Thus, I find Petitioner to be a credible and truthful witness based on a full and complete reading of the medical records and based on a full and complete understanding of Petitioner's testimony.

II. Accident

As detailed above, Petitioner credibly testified that after a long day of lifting wood planks or boards that were 16 feet by 10 inches on Friday, September 28, 2018, his back had begun to feel sore. Petitioner testified that between 3:00 p.m. and 4:00 p.m. that same day, he lifted a board and felt sharp pain that was more intense than other pain he had experienced before. Petitioner readily testified that he had some back problems before September 28, 2018, including an MRI in 2013, but he had no treatment for his back between 2013 and October 1, 2018. Additionally, he had been able to perform his full job duties for Respondent until September 28, 2018. Petitioner testified that he did not report the injury on September 28, 2018 because he thought the pain would get better over the weekend, however, the pain worsened, and he finally went to the ER on October 1, 2018. Petitioner reported the injury to Mike Williams on October 3, 2018, and Justus Joseph on October 4, 2018, by phone, and also filed a timely Application for Adjustment of Claim. Both Mr. Joseph and Mr. Williams either recalled speaking to Petitioner on those dates or could not remember.

Additionally, Respondent's witnesses admitted that part of Petitioner's job duties included lifting large wood boards or planks that weighed at least 50 pounds. Mr. Joseph's testimony that Petitioner was not lifting large boards on September 28, 2018 and that Petitioner did not tell him he was injured at work a few days later was not credible based on Mr. Joseph's malleable testimony. Respondent's witnesses failed to rebut Petitioner's testimony. Further, all the medical records support Petitioner's description of the accident and any inconsistencies are internal inconsistencies within the records that have little effect on the overall understanding of the record.

Under the Illinois Workers' Compensation Act ("Act"), in order for a claimant to be entitled to workers' compensation benefits, the injury must "aris[e] out of" and occur "in the course of" the claimant's employment. 820 ILCS 305/1(d) (West 2014). Therefore, in order to obtain compensation under the Act, a claimant bears the burden of proving by a preponderance of the evidence two elements: (1) that the injury occurred in the course of claimant's employment; and (2) that the injury arose out of claimant's employment. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003).

"In the course of employment" refers to the time, place and circumstances surrounding the injury. *Lee v. Industrial Comm'n*, 167 Ill.2d 77, 81. Petitioner proved that he sustained an accident in the course of his employment on September 28, 2018 with his credible testimony that the accident happened at work and with the medical records that establish the injury occurred on Friday after lifting wood boards at work.

A claimant's injury arises out of his or her employment if the origin of the injury "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." *Saunders v. Industrial Comm'n*, 189 Ill.2d 623, 627 (2000). A risk is incidental to the employment when it belongs to or is connected with what the employee has to do in fulfilling the employee's duties. *Orsini v. Industrial Comm'n*, 117 Ill.2d 38, 45 (1987). In order to prove that an accident "arises out of" employment, it must be shown that the employee was engaged in a risk that was distinctly associated with an employee's employment when at the time of the occurrence, the employee was performing: (1) acts he or she was instructed to perform by the employer; (2) acts that he or she had a common-law or statutory duty to perform; or (3) acts that the employee might reasonably be expected to perform incident to his or her assigned duties. *Caterpillar Tractor*, 129 Ill. 2d at 58; *see also McAllister v. Ill. Workers' Comp. Comm'n*, 2020 IL 124848, ¶¶ 36-40. I note that the Arbitrator made no findings with respect to whether the accident arose out of employment. In this case, it is clear that Petitioner was engaged in acts that he was instructed to perform by his employer by lifting wood boards used to make doors onto a cart based on the testimony of Mr. Williams. Additionally, lifting heavy wood boards is an act that Petitioner would reasonably be expected to perform incident to his assigned duties. Thus, I find that Petitioner met his burden and proved by the preponderance of the evidence that he sustained an accident that arose out of his employment with Respondent on September 28, 2018.

III.Causal Connection

I find that Petitioner proved his current condition of ill being to the lumbar spine and his need for surgery is causally related to the September 28, 2018 accident. It has long been recognized that, in pre-existing condition cases, recovery will depend on the employee's ability to show that a work related accident aggravated or accelerated the preexisting disease such that the employee's current condition of ill being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill.2d 193, 204-05 (2003). It is axiomatic that employers take their employees as they find them; even when an employee has a pre-existing condition which makes him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was a causative factor. *Id.* at 205. An employee need only prove that some act or phase of his employment was a causative factor of the resulting injury, the mere fact that he might have suffered the same disease, even if not working, is immaterial. *Twice Over Clean, Inc. v. Indus. Comm'n*, 214 Ill.2d 403, 414 (2005).

On November 30, 2018, Petitioner underwent a left L4-L5 hemilaminotomy and L4-L5 partial discectomy. On December 20, 2018, Petitioner followed up with Dr. Mirkovic who noted that Petitioner was doing exceptionally well post-surgery and ordered that Petitioner remain off work. On January 4, 2019, Dr. Mirkovic noted that Petitioner was progressing well and released Petitioner to light duty office work as long as he continued to avoid lifting greater than 10-15 pounds, and avoided repetitive bending, twisting, and stooping until completing physical therapy.

On January 28, 2019, Petitioner was examined by Dr. Julie Wehner pursuant to section 12 of the Illinois Workers' Compensation Act. During her deposition, Dr. Wehner testified that

after issuing her initial report, she also issued an addendum report on September 20, 2019. Dr. Wehner testified that Petitioner reported that he had previous back problems when he worked for a different employer and he treated in 2011 and 2013. Petitioner stated that his pain eventually went away with some occasional flare-ups. Dr. Wehner testified that she reviewed an MRI report dated January 18, 2013, *which is not contained in the record*, and it showed a small midline L4-5 disc protrusion and mild degenerative disc disease at L3-4. Dr. Wehner also reviewed an MRI dated October 10, 2018 and opined that it showed a left paracentral-subarticular disc extrusion showing mild caudal migration and effacement of the left subarticular recess at L4-5, which is the same as noted in the 2013 MRI.

When asked, "Do you challenge the necessity of the surgery in any way?" Dr. Wehner answered, "It's difficult for me to say at this point since I did not see him preoperatively." Dr. Wehner opined that there was no causal connection between the September 28, 2018 incident, if any, and the surgical procedure that Petitioner underwent for his lumbar spine. Dr. Wehner based her causal connection opinion on her opinion that the accident did not happen. Dr. Wehner relied on a note from Justus Joseph stating that Petitioner did not report an accident on September 28, 2018. Additionally, Dr. Wehner based her opinions on her assessment that Petitioner did not report a specific injury when he went to the ER, that Petitioner had prior back problems, and that she believed Petitioner did not report pain going down his legs when he saw Dr. Mirkovic.

On cross examination, Dr. Wehner testified "I'm not saying he didn't have a problem. I'm just saying that, you know, he – at the point where I'm seeing he doesn't have much pain, there's no evidence of symptom magnification. I'm not saying he's exaggerating his symptoms or anything like that …." Dr. Wehner testified that she did not review any medical records from any other physician that hinted Petitioner may have been exaggerating. Dr. Wehner acknowledged that she saw no medical records for treatment between January 18, 2013 and October 1, 2018. Dr. Wehner testified that she conducts between two to ten section 12 examinations per week and 100% of the examinations are at the request of Respondent law firms or insurance carriers.

On February 28, 2019, Petitioner returned to Dr. Mirkovic and reported leg pain rated 0 out of 10 and low back pain rated 1 out of 10. Petitioner also reported that he had occasional back discomfort. Dr. Mirkovic noted that Petitioner was doing well, released Petitioner to full duty work, and advised to follow up as needed.

On March 5, 2019, Petitioner returned to Dr. Mirkovic who noted: "He lifted a box 2 days ago at home, which transiently exacerbated his low back pain. He returns today questioning whether he can return to work his previous occupation requiring heavy lifting." Dr. Mirkovic discussed with Petitioner the likelihood of recurrent symptoms and the severity of which would wax and wane, as well as the "predisposition to low back pain with activities that engage the back more." Dr. Mirkovic recommended Petitioner undergo an FCE, prescribed further low back conditioning for four weeks, recommended Petitioner follow up in four weeks, *and encouraged Petitioner "to consider a change in employment given the severity of his symptoms."*

On April 16, 2019, Petitioner followed-up with Dr. Mirkovic who noted that Petitioner had completed additional work conditioning and had met a goal of lifting 75 pounds. Dr.

Mirkovic also noted that Petitioner was ready to return to work but was concerned that he could be required to slide exceptionally heavy doors weighing between 400 to 800 pounds with another coworker, which involved lifting and sliding the doors in order to position inside the frames. Petitioner did not feel that he could return to doing that. Dr. Mirkovic noted that Petitioner's concern was reasonable as it would require Petitioner to lift greater than 75 to 100 pounds. Dr. Mirkovic released Petitioner to full-time work with a 75-pound lifting restriction and noted "I do not believe that he can return to work sliding and lifting heavy doors with one man assist." Dr. Mirkovic opined:

> My opinion remains that Mr. Montoya's onset of symptoms, subsequent care and subsequent need for surgery are causally related to the increased pain on September 28, 2018 (Friday). My opinion is based on the fact that his symptoms that Mr. Montoya relates onset of symptoms on the same day. He was reluctant to report to his employer. I had a concern that this might lead to repercussions and also having had a history of low back symptoms that would resolve with that time. With the weekend coming, he felt his symptoms would resolve. However, his symptoms markedly worsened the following day (within 24 hours or at least within the following day next day) and the following day, notably Sunday (48 hours) requiring emergency room visit on Monday (72 hours) following increased symptoms on September 28, 2018 (Friday).
>
> The above acknowledges well documented by the emergency room records on October 1, as well as Mr. Montoya's addition of symptoms. This has also been the history provided by Mr. Montoya throughout his care.
>
> It is my opinion that Mr. Montoya's onset of symptoms of September 28, 2018, were presented exacerbation of a preexisting degenerative condition of the lumbar spine as well as exacerbation of symptomatology related to the disk herniation for which he subsequently required surgery.
>
> Whereby his previous generic low back symptoms would wax and wane, the symptoms he experienced on September 28, 2018, persisted and were refractory to aggressive nonoperative care. It is my opinion, therefore, there is a direct correlation between the events of September 28 subsequent need for treatment and need for surgery.
>
> The above opinions are based upon a reasonable degree of medical and surgical certainty.

Dr. Mirkovic's deposition testimony was consistent with the opinions he stated in his April 16, 2019 note. Further, Dr. Mirkovic testified that he reviewed the October 10, 2018 MRI, and he opined that it showed a herniated disc on the left side compressing the exiting L5 nerve root. Dr. Mirkovic testified that Petitioner's symptoms were very severe and the location of the herniation was not very favorable to improving symptoms with mild nonoperative care such as physical therapy. Dr. Mirkovic testified that Petitioner was a credible patient and showed no signs of malingering.

On May 30, 2019, Petitioner returned to Dr. Mirkovic and reported that he was doing exceptionally well, however, he had occasional left lower extremity discomfort that was relieved with stretching. Petitioner also reported noticing more symptoms when he did not do his back conditioning and exercise program as he had been noncompliant with his home exercise program. Petitioner requested to be released full duty without restrictions. Dr. Mirkovic released Petitioner to full duty work without restrictions and opined that Petitioner had reached maximum medical improvement (MMI). Dr. Mirkovic reiterated the importance of maintaining the home exercise program and encouraged Petitioner to return to physical therapy for further explanation about which exercises are related to strengthening and which are related to stretching.

Petitioner credibly testified that although he had pre-existing back problems that dated back to 2008, he had no treatment between 2013 and October 1, 2018 for his lumbar spine and he was able to perform his full job duties until September 28, 2018. There are no medical records indicating that Petitioner had treatment for the lumbar spine between 2013 and October 1, 2018. Additionally, Dr. Mirkovic's opinions are credible, persuasive, reasonable and based on accurate facts. Whereas, Dr. Wehner's opinions are not credible or persuasive. Dr. Wehner's opinions are based on her belief that the accident did not happen. However, it is the Commission's role to decide whether an accident happen. Additionally, Dr. Wehner based her opinion on the statement from Mr. Joseph, which was not credible, and on other incorrect facts that Respondent argues on review.

IV. Notice

With respect to notice, an Application For Adjustment of Claim was filed on October 19, 2018, and alleges a back injury from lifting heavy boards on September 28, 2018. The Illinois Workers' Compensation Act requires that "Notice of the accident shall be given to the employer as soon as practicable but not later than 45 days after the accident." 820 ILCS 305/6(c). The application alone is sufficient to prove that Respondent received timely notice of the September 28, 2018 accident and accordingly, there is no basis for a notice dispute.

V. Medical Expenses

Based on my finding that Petitioner sustained a compensable work accident at which time Petitioner injured his lumbar spine which required surgery, I find that all medical expenses should be awarded for treatment to the lumbar spine through Petitioner's date of MMI which was May 30, 2019.

VI. Temporary Total Disability

Based on my finding that Petitioner sustained a compensable work accident at which time Petitioner injured his lumbar spine which required surgery, I find that TTD benefits should be awarded from October 5, 2018 to February 28, 2019, as these are the dates to which Petitioner testified, although it appears that Respondent never offered Petitioner work within his restrictions up to May 30, 2019 based on Mr. Williams' testimony. I note that the Request For Hearing form, which contains the parties stipulations at the arbitration hearing is absent from the

record.

VII. Permanent Partial Disability

I find that Petitioner's work-related injuries caused permanent partial disability and Petitioner is entitled to a person-as-a-whole award under section 8(d)(2) of the Act to the extent of 30%.

For all of the above reasons, I respectfully dissent.

/s/ *Deborah J. Baker*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0312

MONTOYA, NATHANAEL Case# **18WC031468**

Employee/Petitioner

GLK INC D/B/A ASHLAND MILLWORK

Employer/Respondent

On 4/21/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2573 MARTAY LAW OFFICE
STEPHEN R MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

0507 RUSIN & MACIOROWSKI LTD
JOHN MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

21IWCC0312

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Nathanael Montoya
Employee/Petitioner

Case # 18 WC 31468

v.

Consolidated cases:

GLK, Inc. d/b/a Ashland Millwork
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 Arbitrator Charles Watts, Arbitrator of the Commission, in the city of Chicago, on December 6, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ What temporary benefits are in dispute?

☐ TPD ☐ Maintenance ☒ TTD

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

- On the date of the accident, September 28, 2018, Respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between Petitioner and Respondent.
- On this date, Petitioner did not sustain accidental injuries which arouse out of or in the course of employment.

ORDER

Claim for compensation **DENIED**. The Arbitrator finds that Petitioner has not proven by a preponderance of the evidence that he suffered an injury in the course of his employment on September 28, 2018.

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

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

Signature of Arbitrator

April 11, 2020
Date

APR 21 2020

FINDINGS OF FACT

Petitioner, Nathaneal Montoya worked as a woodworker for Respondent, Ashland Millwork, Inc. on September 28, 2018. His working hours ranged from approximately 7:30 a.m. through 4:30 p.m. His duties included unloading wood off carts, stacking wood against the wall and milling wood. Petitioner's immediate supervisor was Justus Joseph – a 16-year employee for the Respondent. Mr. Joseph's duties included setting the day's task list of what would be built by the employee millworkers, as well as overseeing their performance of the day's tasks.

With regard to how the wood was transported within the factory and ultimately to the carpenter's workstations, Petitioner, Mr. Joseph and Mike Williams, the vice president for the Respondent, testified that a truck would drop off loads of wood at the factory. These planks of wood would then be transferred from the dock floor to a mobile cart, then the cart would be moved to an area near the individual woodworker's workstation. Petitioner and Mr. Williams testified that it was customary to take the wood planks from the cart and stack them against the wall. Witness testimony differed as to size and weight of planks: Petitioner testified that the planks were 16' by 10" and weighing between 80-100 lbs. Mr. Williams agreed as to the dimensions of the planks but that they were no more than 25 lbs. per plank. Mr. Joseph testified that Petitioner was working with small pieces of wood for that day's work which weighed around 5 - 10 lbs. per piece. Mr. Joseph further testified that while heavier planks could be lifted during the course of a workday, the date of the alleged injury was not one of those days.

On Friday, September 28, 2018, Petitioner arrived at work at 7:55 a.m. (Resp. Ex. 2). Mr. Joseph testified that on this date, Petitioner had been working on "light duty" items – which consisted of small pieces of wood being used to make door frames. Petitioner testified that at some time between 3:00 p.m. and 4:00 p.m., he bent over to lift a plank of wood, twisted his back when lifting it, and felt a sharp pain in the lower left side of his back. Petitioner indicated that since the injury occurred at the end of the workday, he did not immediately report the injury as he believed he might feel better over the weekend. At 4:15 p.m. Petitioner clocked out for the day. (Resp. Ex. 2). Mr. Joseph testified Petitioner had done all the assigned tasks for the day, that there appeared to be nothing unusual about him, and that Petitioner said "goodbye" when leaving the mill. (Resp. Ex. 1). Mr. Joseph observed that Petitioner was walking "normally" at the time of his departure. Testimony reflected that Petitioner engaged in a variety of personal errands and activities over the weekend of September 29 and 30, where his back pain allegedly increased to the point of being unable to move without pain.

Petitioner presented to St. Alexius Medical Center at 9:34 a.m., Monday, October 1, 2018. (Pet. Ex. 1). Per the patient notes written by Nurse Ricky K. Shah Pa, Petitioner stated that he was, "having back pain. I always have back pain, it started getting worse Sunday afternoon". (Id. at pp. 4, 7). The treating notes further indicated that Petitioner denied trauma or specific injuries, stating:

> "I did a lot of work Friday, sometimes when I do a lot of work it gets back again". The history of present illness in the report further indicated that, "[P]atient presents with low back pain. The onset was since Saturday afternoon. The course/duration of the symptoms is constant…Risk factors consist of history of bulging disc. Had an MRI done three to four years ago… Reports of overexertion prior to onset of symptoms. No fall, injuries and trauma… underwent x-rays of the lumbar spine and was advised to remain off work for three days." (Id. at p. 4)

The x-ray taken during this visit reflected negative for fracture of malalignment with mild degenerative changes noted. (Id. at 6). Petitioner was prescribed a Medrol Dosepak, cyclobenzaprine, naproxen, and was referred to Dr. Khursheen Ahmed for a follow-up. (Id. at 6-7).

Petitioner had previously injured his lower back while working for another employer on or about 2008. Petitioner underwent an MRI of his lumbosacral spine on January 18, 2013 which showed a L4-L5 disc protrusion which mildly deformed the ventral thecal sac. (Resp. Ex. 4; Dep. Ex. 2, p. 5).

Upon referral from a friend, on October 5, 2018, Petitioner elected to receive medical care from Northshore Orthopaedic Institute and was seen by Dr. Srdjan Mirkovic and PA-C Karen F. Ferkau. Petitioner's chief complaint was recorded as, "low back pain across his back". (Resp. Ex. 4; Dep. Ex. 4, p. 3). The diagnosis was chronic low back pain without sciatica. (Id.). Nurse Ferkau's intake notes included patient's reported history, notating the following:

> "...reports having had sudden onset of low back pain (LBP) across his back in 2008 following a work-related injury where he was lifting something to determine the weight of the object. The item was full of metal and when he lifted the box, he felt the immediate onset of low back pain (LBP). He had physical therapy in 2008 with minimal benefit, without the home exercise program (HEP) continued. He denies having had or currently having LE pain. His LBP pain remained constant since 2008 with severity waxing/waning, with worsening over the last few years, and even further since last Friday, after lifting wood". (Id. at p. 9).

Physical examination revealed no spasm. (Id. at p. 12). Petitioner's handwritten history from the October 5th visit reflected that his pain started from 2008 and 2010 and was in his lower back - with no reference to pain in his leg. (Id. at p. 18). Petitioner further indicated on the questionnaire that he suffered two pain attacks a year and had a history of being diagnosed with bulging disc/degenerative disc disease. (Id. at pp. 19-20). Petitioner also completed a pain diagram and circled the low back with no indication of leg pain. (Id. at p. 23).

Dr. Mirkovic testified that, "[t]he main reason he was there to see us is because on Friday, roughly the Friday before he saw us, he was lifting wood and he developed acute onset of severe left-sided low back pain and severe left leg pain. He had not had a history of leg pain in the past. His pain in the past had been predominant low back pain". (Pet. Ex. 4). Petitioner was diagnosed with acute onset of low back pain secondary to the events of September 28, 2018 with radiating pain down the leg (Id. at 12). It was recommended Petitioner undergo an MRI of the lumbar spine, take medications and remain off work. (Id. at pp. 12-13).

An MRI of the lumbar spine was completed on October 10, 2018 at Ortho Lakeshore and were reviewed on October 18, 2018 (Pet. Ex. 4 at pp. 13-14). Dr. Mirkovic testified that the MRI showed a herniated disc on the left side compressing the exiting L5 nerve root (Id. at p. 14). Dr. Mirkovic recommended Petitioner remain off work and opined that Petitioner had sustained, "an exacerbation of a pre-existing degenerative condition of the lumbar spine, notably a disc herniation on that Friday, the Friday before I saw him" (Id. at 14-15). At a follow-up on November 1, 2018 he recommended Petitioner remain off work and undergo surgery. (Id. at p. 15-16).

Petitioner underwent a L4-L5 microdiscectomy on November 30, 2018 (Pet. Ex. 4 at p. 16). Petitioner followed up with Dr. Mirkovic on December 20, 2018 and was again advised to remain off work (Id. at p. 17). Dr. Mirkovic then produced a note on January 4, 2019 prescribing physical therapy for Petitioner and releasing him to sedentary duty (Id. at pp. 18-19). Petitioner followed up with Dr. Mirkovic on January 17, 2019 and

continued his therapy and sedentary work restriction (Id. at p. 19). Petitioner testified that Respondent did not accept Petitioner back to work with that restriction.

On January 28, 2019, an independent medical examination was performed on Petitioner by Dr. Julie Wehner, a board-certified orthopedic surgeon. (Resp. Ex. 4, p. 6). Dr. Wehner reviewed all available records, including the prior MRI report of January 18, 2013, as well as the emergency room records from St. Alexius Medical Center, Dr. Mirkovic, and the microdiscectomy surgical report. Dr. Wehner indicated the January 18, 2013 MRI showed the disc herniation at L4-L5. (R. Ex. 4, p. 12). This was the same area of the surgical intervention of November 30, 2018. (R. Ex. 4, p. 13).

Dr. Wehner noted that during the October 1, 2018 ER visit, Petitioner did not state that he had a specific injury on September 28, 2018 but instead indicated that his pain started on the subsequent Saturday or Sunday afternoon - September 29th or September 30th. (R. Ex. 4, p. 13, 14). The x-ray also listed a history of chronic low back pain. (Resp. Ex. 4, p. 15). Dr. Wehner found significant the history of October 5, wherein Petitioner acknowledged low back pain since 2008 as well as listing the duration of his symptomatology as 2008, absent any indication of pain in the lower extremities. (Resp. Ex. 4, p. 17). Further, when he underwent the MRI, the history indicated chronic low back pain without sciatica. (Id.).

Based upon her examination of the Petitioner, review of the medical records, and lack of consistency throughout Petitioner's records as to the cause and extent of Petitioner's injuries, Dr. Wehner opined that no causal relationship existed between any current condition of ill-being in the low back and need for surgical intervention, and the alleged date of accident of September 28, 2018. (Resp. Ex. 4, p. 18-21). Dr. Wehner further testified that Petitioner's pain on September 28th, if any, would merely have been a symptom of an underlying condition that had been present since 2008 and would not have caused any new condition of ill-being relative to his back. (Resp. Ex. 4, p. 21, 22). Dr. Wehner opined that if there was an acute herniation, the Petitioner would have been in noticeable pain. (Id. at p. 21, 22).

Petitioner followed up with Dr. Mirkovic on February 28, 2019 and was released back to work with no restrictions the same day. (Pet. Ex. 4 at 20). At this point, Petitioner testified that he reached out to Respondent about returning to work and Respondent did not reply to Petitioner. Petitioner presented back to Dr. Mirkovic on March 5, 2019 with some back pain from lifting a box, so Dr. Mirkovic advised Petitioner to undergo a functional capacity evaluation. (Id. at p. 48). There was no evidence provided of the FCE ever being conducted. On March 18, 2019, Dr. Mirkovic recommended Petitioner undergo therapy to strengthen his back (Id. at 22).

Dr. Mirkovic saw Petitioner again on April 16, 2019 and released Petitioner back to work with "no lifting" over 75 lbs. and with more extensive opinions as to how Petitioner was injured. (Id. at p. 23). He noted that the events on September 28, 2018, "more likely than not caused an exacerbation and possibly either a disc herniation at L4-L5 or worsening of symptoms related to a disc herniation at L4-L5". (Id. at p. 25). He noted several facts which led to that opinion; the sudden onset of symptoms with left-sided back and leg pain (Id.). He noted "more left leg pain than he had in the past which was consistent with a left disc herniation" (Id.). Petitioner saw Dr. Mirkovic for a final time on May 30, 2019 and was released back to full duty work and discharged from care at maximum medical improvement. (Id.)

At his evidence deposition, Dr. Mirkovic testified that he was relying upon his notes for testimony. (Pet. Ex. 4 at 9). Dr. Mirkovic testified that he could not tell if the herniation noted on the MRI of October 10, 2018 was acute or if it was present before Friday, September 28, 2018. (Id. at 15). Dr. Mirkovic indicated he did not recall reviewing records of Lutheran General nor the emergency room records of St. Alexius Medical Center. (Id at pp. 36-37). He did not know what, if any, history petitioner stated when seen on October 1, 2018. (Id. at p. 42). He admitted that if an MRI showed a disc protrusion which mildly deformed the thecal sac, it would be

indicative of nerve root compression. (Id. at p. 47). Dr. Mirkovic's opinion of causation was premised upon Petitioner experiencing the sudden onsets of symptoms with left-sided back and leg pain. (Id. at p. 25). Petitioner reported to him that he had immediate pain with lifting the piece of wood on September 28, 2018. (Id. at p. 36).

After the alleged injury on September 28, 2018, Petitioner first called the Respondent on October 1, 2018, indicating that his back was sore and that he would not be reporting to work that day.

On October 3,2018, Petitioner testified that he contacted Mr. Williams over the telephone and informed him that he had suffered a workplace injury the previous Friday. Mr. Williams does not dispute that a call took place but testified that Petitioner did not state that the injury to his back was work related.

On October 4, 2018, Mr. Joseph contacted Petitioner to inquire if he was coming into work, as Respondent was short-staffed that day. Petitioner indicated he would not be coming into work. Mr. Joseph was not aware that Petitioner had suffered an alleged workplace injury from the previous Friday or to what the cause of the injury was altogether.

Additional testimony was provided by Kathy Kirsten ("Ms. Kirsten"), Respondent's office manager. Ms. Kirsten testified that on October 8, 2018, she received a call from Petitioner's wife, requesting group insurance information. Ms. Kirsten responded by sending said information via text message to Petitioner's wife. Ms. Kirsten testified receiving no notification of the injury which allegedly took place on September 28th.

Petitioner and Mr. Williams testified that on October 9, 2018, they exchanged text messages where Petitioner indicated that he would need to be off of work for two weeks, that he had seen a doctor, and that he needed his group insurance information. The Arbitrator notes for the record that the text messages themselves were not offered into evidence by the parties.

Petitioner further testified on cross examination that on October 19th, he called Mr. Williams and stated that he wanted to make a Worker's Compensation Claim for an injury he suffered on September 28th. Mr. Williams testified that this was the first time that he had heard that Petitioner had suffered a workplace injury.

On October 19, 2018, Petitioner contacted Mr. Williams and indicated he needed to make a worker's compensation claim. Mr. Williams responded, "What claim?", and testified that at nobody was aware of any workplace accident and that this was Mr. Williams's first inclination that Petitioner back condition may be work related. Mr. Williams checked with Petitioner's direct supervisor, Mr. Joseph, who also had no recollection of Petitioner having been injured at work. Petitioner signed and submitted his application for adjustment of claim on October 19, 2018. (Resp. Ex. 3).

CONCLUSIONS OF LAW

The Arbitrator adopts and incorporates the above Findings of Fact in support of the foregoing Conclusion of Law.

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)

The Arbitrator finds that the testimony of the Petitioner was not credible. Petitioner's manner of speech and body language gave the Arbitrator pause. Also curious was the timing of the alleged accident which was at the very end of his shift on Friday afternoon. Testimony by co-workers contradicted Petitioner. Review of the medical records provided an almost total rebuke of Petitioner's account.

(C) Accident

Petitioner has failed to prove by a preponderance of the evidence that an injury arose in the course of his employment. Petitioner's testimony purporting to establish that his injury occurred in the course of his employment is that: (1) he was lifting wooden boards at work which weight 80-100 lbs.; (2) that around 3:00 p.m. in the afternoon he was lifting one of these boards and "felt a sharp pain in his lower back"; and (3) his representations to Nurse Ferkau in which he only indicated the sudden onset of low back pain (emphasis added). The Arbitrator finds that these representations made by Petitioner are not credible in light of the totality of the evidence presented in the case. First, Petitioner was adamant at trial that the boards weighed 85-100 lbs. – a contention definitively rejected by Messrs. Williams and Joseph, who testified that the boards weighed between 10 and 25 lbs. apiece. Petitioner specifically stated that he had not lifted multiple boards at the same time. (Resp. Ex.4, p. 9). This disparity is peculiar given the Petitioner's specific claim that he felt the onset of injury while lifting a board – supposedly weight much heavier that what was testified to by his former colleagues.

Second, Mr. Joseph recalls seeing Petitioner walk out of the warehouse on that date – and appearing to be in no pain. If Petitioner is to be believed, his lifting of a board immediately caused a pre-existing condition which, in Dr. Wehner's opinion, would have been immediately apparent. Instead, the evidence reflects Petitioner leaving the mill normally approximately an hour after the injury took place, and specifically stating that he was not injured at work in his medical records.

Third, Petitioner's credibility was further eroded by the inconsistent indications of pain in his lower extremities. From his testimony and the medical records, it was not until Petitioner visited Dr. Mirkovic on October 18th, that Petitioner complained of left-sided leg pain. (Pet. Ex. 2, p.12). Prior to that date, Petitioner never indicated that he had any leg pain. Dr. Mirkovic's own notes from October 5, 2018 indicate "no LE (lower extremity) pain, numbness, tingling". (Pet. Ex. 2, p. 6). Overall, the Arbitrator does not find Petitioner credible that an injury took place in the course of his work on September 28, 2018.

Petitioner has the burden of proof on the issue of injury and the Arbitrator finds that the preponderance of the evidence that an injury did not occur on the alleged date of injury of September 28, 2018. the alleged accident of September 28, 2018. The claim for compensation is therefore **DENIED**.

REMAINING ISSUES

As the Arbitrator has found that Petitioner failed to prove that there was an injury. All other disputed issues between the parties are moot.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC013863
Case Name	FILISHIO, MICHAEL v. VILLAGE OF ADDISON
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0313
Number of Pages of Decision	11
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Mark Maritote
Respondent Attorney	Timothy Alberts

DATE FILED: 6/21/2021

/s/ Stephen Mathis, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Filishio,

Petitioner,

vs. No. 15 WC 13863

Village of Addison,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, nature and extent of the disability, and "[a]ny and all other issues raised at trial," and being advised of the facts and law, expands, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

In affirming the permanency award, the Commission adds that Respondent's section 12 examiner, Dr. Wiedrich, noted the following: "[The claimant] states that currently he has trouble carrying groceries due to weakness and stiffness in the hand. He states that his fingers will not straighten he has difficulty reaching into his pocket. He states that *** he has asked coworkers to lift heavy things as he cannot do it with the right hand. He states there is only an occasional pain but for the most part he does not have pain. The majority of his problem is stiffness and weakness. He has hobbies of golf which he still can perform without difficulty. He states that when he gardens he will notice some discomfort in the hand at the end of the day." Physical examination showed a decreased range of motion and strength. X-rays showed "15° of apex dorsal angulation of the metacarpal." Dr. Wiedrich assessed: "There is some residual joint stiffness to the middle, ring and small fingers in extension. The joint contractions are fixed."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 14, 2020, is hereby expanded, affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to the 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.

June 21, 2021

/s/ *Stephen J. Mathis*
Stephen J. Mathis

SJM/sk
o-05/05/2021
44

/s/ *Deborah J. Baker*
Deborah J. Baker

/s/ *Deborah L. Simpson*
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0313

FILISHIO, MICHAEL
Employee/Petitioner

Case# **15WC013863**

VILLAGE OF ADDISON
Employer/Respondent

On 4/14/2020, 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 0.29% 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:

5342 R MARK MARITOTE PC
1060 E LAKE ST
HANOVER PARK, IL 60133

2542 BRYCE DOWNEY & LENKOV LLC
TIM ALBERTS
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Mike Filishio
Employee/Petitioner

v.

Village of Addison
Employer/Respondent

Case # **15** WC **13863**

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 **Charles Watts**, Arbitrator of the Commission, in the city of **Wheaton**, on **May 29, 2019**. By stipulation, the parties agree:

On the date of accident, **August 19, 2014**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**89,700**, and the average weekly wage was $**1725**.

At the time of injury, Petitioner was **54** 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 $**00** for TTD, $**00** for TPD, $**00** for maintenance, and $**00** for other benefits, for a total credit of $**00**.

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 $**735.37**/week for a further period of **41** weeks, as provided in Section **8(e) 9** of the Act, because the injuries sustained caused **permanent loss of use of the hand to the extent of 20% thereof.** .

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

April 8, 2020
Date

APR 14 2020

STATEMENT OF FACTS

Petitioner suffered a work-related injury to his dominant right hand August 19, 2014 when he fell after his feet became tangled in wire at road construction site in Addison. After the injury he first went to Elmhurst Occupational Health in Addison which after x rays referred him to Chicago Hand and Orthopedic Specialists in Oak Brook Terrace where he came under the care of Dr. Taruna Crawford who noted a comminuted fracture of the third metacarpal with rotation deformity and overlapping of the long and ring fingers secondary to fracture and deformity. Dr. Crawford recommended open reduction and internal fixation and scheduled surgery at Elmhurst Hospital for August 21. During surgery the doctor first reduced and fixed with two screws a large butterfly fragment of bone then the distal fragment was fixated to the proximal fragment with the butterfly fragment already attached. Two additional screws were used for the second repair.

Notably, and to his credit petitioner did not lose work from the accident choosing instead to work casted. Post-surgery consisted of a course of physical therapy beginning in September. During recovery exceptional stiffness was noted and inter articular corticosteroid injections performed in November and December of 2104 as well as January 2015.

Petitioner's difficulties continued, albeit with improvement as well. In April he reported to Dr. Crawford he had difficulty making a full fist and needed to warm up in therapy before he could fully flex his finger. Notes from his last physical therapy visit April 3, 2015 reflect "In the last 3 months of therapy has improved overall in TAM for getting a composite fist. He continues to lag in getting any further digit extension at the PIL J of D3-5 at this time. This has been the trend over the last 8 weeks and appears to have come to a plateau. Based on the end feel and lack of progress this may be as good as it gets for patient's end feel for

extension." Current limitations noted in the record included the inability to pull objects to complete work-related tasks and holding spoons, forks and knives.

Petitioner last visited Dr. Crawford June 9, 2015 with continued complaints of stiffness in the right long and small finger as well as the middle finger. Petitioner reported working around his limitations in part by modifying the grips on his golf clubs and tools.

Petitioner testified that he continues to have limitations in his hand. He demonstrated compellingly his inability to fully open his hand as well as an inability to make a complete fist. He further testified that his job includes physical and administrative components. Administratively he writes reports and orders supplies and equipment. He has trouble writing as his hand tires quickly. Physically he finds difficulty lifting and does not trust his hand as well as difficulty dragging measuring devices as part of his job. Petitioner demonstrated for the arbitrator the difficulty he has placing his right hand in his pants pocket.

The arbitrator notes an approximately two inch surgical scar from the August 2014 procedure on the back of petitioner's hand.

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

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). An injury is accidental within the meaning of the Act when it is traceable to a definite time, place, and cause and occurs in the course of employment, unexpectedly and without affirmative act or design of the employee. *Mathiessen & Hegeler Zinc. Co. V. Industrial Board*, 284 Ill. 378 (1918).

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 Ill. 2d 214 (1969).

Credibility is the quality of a witness which renders his evidence worthy of belief. The arbitrator, whose province it is to evaluate witness credibility, evaluates the demeanor of the witness and any external inconsistencies with his testimony. Where a claimant's testimony is inconsistent with his actual behavior and conduct, the Commission has held that an award cannot stand. *McDonald v. Industrial Commission*, 39 Ill. 2d 396 (1968); *Swift v. Industrial Commission*, 52 Ill. 2d 490 (1972). While it is true that an employee's uncorroborated testimony will not bar a recovery under the Act, it does not mean that the employee's testimony will always support an award of benefits when considering all the testimony and circumstances shown by the totality of the evidence. *Caterpillar Tractor Co. v. Industrial Commission*, 83 Ill. 2d 213 (1980). Internal inconsistencies in a claimant's testimony, as well as conflicts between the claimant's testimony and medical records, may be taken to indicate unreliability. *Gilbert v. Martin & Bayley/Hucks,* 08 ILWC 004187 (2010).

The Arbitrator finds, after observing Petitioner testify at trial and a review of the records, that Petitioner was credible. His demeanor at trial was serious and forthright. Petitioner answered questions easily and in a manner that was sincere. The medical records are consistent with Petitioner's testimony.

CAUSAL CONNECTION

Petitioner bears the burden of proving by a preponderance of the evidence all of 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 Petitioner must establish is that his condition of ill-being is causally connected to his employment. *Elgin Bd. of Education U-46 v. Workers' Compensation Comm'n,* 409 Ill. App. 3d 943, 948 (2011). The workplace injury need not be the sole factor, or even the primary factor of an injury, as long as it is a causative factor. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 205 (2003).

"A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in a disability may be sufficient circumstantial evidence to prove a causal connection between the accident and the employee's injury." *Int'l Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63-64 (1982). If a 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. Ill. Workers' Comp. Comm'n, 79 N.E.3d 833, 839 (Ill. App. 4th 2017).

Petitioner was credible and his testimony was unrebutted. All medical evidence supports his testimony. Therefore, the Arbitrator finds Petitioner's claimed injuries to be causally connected to the accident.

NATURE & EXTENT

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of 6% of hand as determined by Dr. Thomas Wiedrich, pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. (Exhibit #). The Arbitrator notes that this level of impairment does not necessarily equate to permanent partial disability under the Workers' Compensation Act, but instead is a factor to be considered in making such a disability evaluation. The doctor noted residual stiffness and swelling, objective evidence supporting subjective complaints of stiffness and clumsiness and objective evidence of weakness and lack of motion all in his dominant hand. Because the AMA guides make no distinction between dominant and non-dominant hand injuries and because petitioner's residual complaints involve both gross and fine motor skills as well as loss of strength, the Arbitrator therefore gives some weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a construction manager 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 petitioner's employment is both administrative and physical and his injury impairs his ability to perform or prevents him from performing tasks in both categories. Because of these deficiencies the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 54 years old at the time of the accident. Because of his age, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes petitioner continues in the same capacity as pre-accident, 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 physical therapy records, dr. Crawford's records and Dr. Wiedrich's report all support petitioner's testimony of stiffness, decreased motion, decreased grip, inability to fully extend the hand and inability to make a fist in his dominant hand. Because petitioner's limitations are corroborated across the board, the Arbitrator 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 20% loss of use of the right hand pursuant to §8(d)(2) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC029843
Case Name	MIKA, RICHARD v. CITY OF CHICAGO
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0314
Number of Pages of Decision	19
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Peter Bobber
Respondent Attorney	Jeffrey Powell

DATE FILED: 6/21/2021

/s/ Stephen Mathis, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Richard Mika,

Petitioner,

vs. No. 15 WC 29843

City of Chicago,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the parties herein and proper notice given, the Commission, after considering the issues of jurisdiction, accident, causal connection, medical expenses, prospective medical care, wage calculations, benefit rates, temporary disability, maintenance and permanent disability/wage differential, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission finds, based on Petitioner's credible testimony, that overtime was mandatory. Accordingly, the Commission calculates the average weekly wage as follows: $42,542.42 straight rate earnings / 26 weeks = $1,636.25.

The Commission calculates the wage differential as follows:

($36.95 x 49.34 hours a week - $480.00) x 2/3 = $895.41.

Our calculations are based on the difference between Petitioner's pre-accident 49.34-hour average workweek, including mandatory overtime, at the current union wage of $36.95 and Petitioner's present 40-hour workweek at $12.00 an hour.

The Commission agrees with the Arbitrator's award of partial maintenance benefits.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 15, 2020 is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $1,090.83 per week for a period of 78 6/7 weeks, from April 29, 2014 through December 8, 2014 and from January 27, 2016 through December 19, 2016, those being the periods of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner maintenance benefits of $1,090.83 per week for a further period of 85 3/7 weeks, from December 20, 2016 through August 9, 2018.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner wage differential benefits of $895.41 per week, commencing on February 13, 2019, until the age of 67 or five years from the date of the final award, whichever is later.

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

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

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

June 21, 2021

/s/ *Stephen J. Mathis*
Stephen J. Mathis

SJM/sk
o-05/05/2021
44

/s/ *Deborah J. Baker*
Deborah J. Baker

/s/ *Deborah L. Simpson*
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MIKA, RICHARD
Employee/Petitioner

Case# **15WC029843**

CITY OF CHICAGO
Employer/Respondent

On 6/15/2020, 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 0.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4788 HETHERINGTON KARPEL & BOBBER
PETER C BOBBER
120 N LASALLE ST SUITE 2810
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
JEFFREY N POWELL
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF **Cook**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Richard Mika
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **15** WC **29843**

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 **Tiffany Kay**, Arbitrator of the Commission, in the city of **Chicago**, on **July 23, 2019**. 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 **Subject Matter Jurisdiction**

FINDINGS

On **4/24/2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**42,542.43**; the average weekly wage was $**1,636.24**.

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

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

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

Respondent shall be given a credit of $**82,614.76** for TTD, $**0.00** for TPD, $**61,709.20** for maintenance, and $**0.00** for other benefits, for a total credit of $**144,323.96**.

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

ORDER

Respondent 's Motion to Dismiss is denied.

Respondent shall pay Petitioner temporary total disability benefits of $**1,090.83**/week for **78 4/7ths** weeks, commencing **4/29/2014** through**12/8/2014; and 1/27/2016** through **12/19/2016**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of $**1,090.83**/week for **85 2/7th** weeks, commencing **12/20/2016** through **08/09/2018**, as provided in Section 8(b) of the Act

Respondent shall pay Petitioner permanent partial disability benefits, commencing **2/13/2019**, of $**770.83**/week until Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

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

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

Signature of Arbitrator

04/30/2020
Date

JUN 15 2020

PROCEDURAL HISTORY

This matter was heard before Arbitrator Tiffany Kay (hereinafter "Arbitrator Kay") on July 23, 2019 in Chicago, Illinois.

The parties went to hearing with the following issues in dispute: whether on April 24, 2014, Mr. Richard Mika (hereinafter "Petitioner") and the City of Chicago (hereinafter "Respondent ") were operating under the Illinois Workers' Compensation Act, whether Petitioner sustained an accident on April 24, 2014 that arose out of and in the course of Petitioner's employment with Respondent , whether Petitioner's condition of ill-being was casually connected to his injury, whether Petitioner is entitled to temporary total disability (hereinafter "TTD") and maintenance, whether this court has subject matter jurisdiction to hear this matter, and the nature and extent of Petitioner's injury. (Arb.X1)

The parties stipulated that Petitioner gave Respondent notice of the accident within the time limits stated in the Act, that Petitioner was 49 years old, single and had 0 dependent children on April 24, 2014, that there are no unpaid medical bills, and that Petitioner paid $82,614.76 in TTD and $61,709.20 in maintenance in other benefits for which credit may be allowed under Section 8j of the Act. (Arb.X1)

The submitted records have been examined and the decision rendered by Arbitrator Kay.

STATEMENT OF FACTS AND EVIDENCE

Petitioner testified that he was born on December 1, 1964 and his highest level of education was high school. Prior to April 24, 2014, he never underwent any medical treatment to his left shoulder, suffered any injury to his left shoulder, or required any lost time from work for any problem or injury to his left shoulder.

Petitioner commenced his employment with the City of Chicago on October 29, 2013. Prior to starting that employment, Respondent required him to undergo a pre-employment physical at U.S. Health Works. (P.X.1 pp. 2-11). In addition to undergoing a physical examination, Petitioner was also required to perform physical exertion testing which included lifting a milk crate containing 100 pounds and walking up and down a hallway and putting it back down.

Petitioner's job title for Respondent was deck hand, which was a very heavy job. This was a union job covered under a collective bargaining agreement with Local 150 of the Operating Engineers.

At arbitration, Petitioner identified Petitioner's Exhibit 14 as all of his City of Chicago pay stubs he received for pay from his start date with Respondent through April 24, 2014. Petitioner testified that his overtime with the city was mandatory.

On April 24, 2014, Petitioner was working for Respondent in his role as a deckhand when he pulled a heavy rope and injured his left shoulder. Approximately one hour after injuring his left shoulder, Petitioner noticed pain and a burning sensation in his left shoulder. Following those symptoms, he continued work for another hour or so to the conclusion of his shift. Petitioner then worked Friday April 25, 2014, in a diminished capacity still noticing pain in his left shoulder. He did not seek medical treatment then, as he had hoped the pain would resolve once he rested his arm over the weekend. Unfortunately, when Petitioner returned to work on Monday, April 28, 2014, the pain, discomfort and weakness persisted.

On Tuesday, April 29, 2014, a representative of Respondent drove Petitioner to U.S. Health Works, Respondent 's chosen facility, for the purpose of Petitioner undergoing a medical examination of his left shoulder.

At U.S. Health Works, Petitioner provided a consistent history of his April 24, 2014 work accident. (P.X.1 pp.12, 21, 32). Dr. Stewart at U.S. Health Works issued work restrictions and medications after initially diagnosing a sprain of the left shoulder. (P.X.1 p.24). Respondent did not accommodate petitioner's work restrictions at any point during this claim. X-rays revealed mild soft tissue swelling in the left shoulder with no recent fractures. (P.X.1 p.27).

Petitioner returned to U.S. Health Works for a follow-up visit on May 5, 2014, at which time limited improvement was noted. (P.X.1 pp.34-36). At the May 12, 2014 visit at U.S. Health Works, in addition to the prior treatment and restrictions, physical therapy was ordered. (P.X.1 pp.37-39). Petitioner noted no improvement with this initial course of physical therapy.

On June 9, 2014, U.S. Health Works ordered an MRI of the left shoulder to rule out possible labral tear, (P.X.1 pp.44-45), and the diagnosis changed to left shoulder rotator cuff tendinosis and possible left shoulder impingement syndrome. (P.X.1 pp.48-49).

The June 23, 2014 MRI performed at Mercy Hospital Medical Center showed biceps tendinopathy and a possible tiny lose body within the biceps tendon sheath of the left arm, as well as mild supra and infraspinatus tendinopathy without a discreet rotator cuff tear, and Type II acromion with mild AC joint spurring indenting the superior portion of the supraspinatus tendon in the left shoulder. (P.X.1 pp.55-56). The radiologist also indicated that correlation for signs of impingement was recommended. (P.X.1 p.56).

Because his symptoms persisted, Petitioner commenced treatment with a physician of his choice on June 30, 2014. Dr. Dugan first examined Petitioner on June 30, 2014 diagnosing left shoulder impingement syndrome and ordering therapy at Achieve Physical Therapy with therapist David McCartney. (P.X.2 pp.9-10). She also instituted work restrictions including lifting up to 40 pounds and no lateral movement when lifting. (P.X.2 p.10). Respondent did not accommodate these restrictions. Dr. Dugan also noted a consistent history of the April 24, 2014 work accident. (P.X.2 p.13). Petitioner's course of therapy at Achieve Physical Therapy went from May 27, 2014 - November 18, 2014. Which initially included therapy and later included work hardening/conditioning. (P.X.3).

On August 20, 2014, Respondent retained Dr. Verma to conduct a Section 12 examination. Dr. Verma diagnosed Petitioner with biceps tendinitis of the left shoulder that was causally related to the April 24, 2014 work injury. (P.X.4 p.4). Dr. Verma went on to indicate all treatment was reasonable and necessary and causally related to the injury. He also recommended a functional capacity evaluation followed with a period of work conditioning if necessary. (P.X.2 p.4).

Respondent directed Petitioner to Accelerated Rehabilitation Center for this initial functional capacity evaluation which took place on October 23, 2014. There, the therapist noted a consistent history of the April 24, 2014 work accident, (P.X.5 p.3). The therapist also noted petitioner's job with Respondent was in the heavy physical demand capacity. (P.X.5 p.4). After examination, the examiner concluded that Petitioner did not demonstrate the physical capabilities and tolerance necessary to perform the essential functions of his job as a deck hand. (P.X.5 p.4). Therefore, the therapist recommended work conditioning for 4-5 days a week for up to 4 weeks and the therapist noted that "Mr. Mika put forth full and consistent effort during this evaluation". (P.X.2 p.4).

Following completion of the work hardening Dr. Dugan, despite Petitioner indicating he did not feel he was ready return to full duty work, indicated Petitioner could return to work full duty. (P.X.2 pp.84-86).

Upon returning to work on December 9, 2014, Petitioner noticed increased strength in the left shoulder but persistent pain in that shoulder which limited his ability to lift overhead. Because of his persistent problems and functional limitations, Petitioner decided to seek a second opinion with Dr. Burra. Dr. Burra first examined Petitioner on November 13, 2015, noting a consistent history of the April 24, 2014 work accident. (P.X.6 p.2). Dr. Burra diagnosed a SLAP lesion as well as biceps tendinitis on the left shoulder, noting that although Petitioner did previously respond partially with some functional improvement, he was never symptomatically relieved and the problems in his shoulder had continued. (P.X.6 p.6). Dr. Burra ordered and MRI arthrogram. (P.X.6 p.6). A December 3, 2015 left shoulder MRI arthrogram revealed superior and posterosuperior labral tear in addition to anteroinferior and inferior labral tear as well as a small Para labral cyst forming the inferior glenoid. (P.X.6 pp.10-11).

At the January 27, 2016, follow-up visit, Dr. Burra confirmed his prior diagnosis of left shoulder SLAP lesion and biceps tendinitis for which he recommended surgical repair of the labrum and he issued work restrictions for Petitioner of no lifting greater than 20 pounds with no overhead activity and no repetitive pushing or pulling with the left upper extremity. (P.X.6 pp.15-16). Once again, Respondent did not provide Petitioner accommodating work within these restrictions. Rather than approve the surgery prescribed by Dr. Burra, Respondent had Petitioner re-examined by Dr. Verma on April 20, 2016. After he had the opportunity to review the December 2015 MRI arthrogram, Dr. Verma concurred with Dr. Burra in diagnosing a SLAP lesion with biceps tendinitis. (P.X.4 p.18). Additionally, Dr. Verma agreed with Dr. Burra recommending arthroscopic surgery consisting of biceps tenodesis, subacromial decompression and consideration for an AC joint resection, with post-operative therapy and work conditioning following the surgery. (P.X.2 p.18).

On September 26, 2016, Petitioner returned to Dr. Burra electing non-operative approach because of his concerns about surgery and lack of improvement therefrom. (P.X.6 pp.29-32). Dr. Burra indicated it was reasonable to not proceed with surgery given that Petitioner had his pathology for a long time. (P.X.6 p.31). Dr. Burra maintained petitioner's off work status and indicated he should undergo another functional capacity evaluation.

Petitioner underwent a second functional capacity evaluation on October 20, 2016 at ATI Physical Therapy. That evaluation confirmed petitioner's physical demand level was at the medium to heavy level, but his occupation required working at the heavy physical demand level. (P.X.7 p.2). Therefore, the evaluator concluded that Petitioner gave a valid and consistent effort but his physical performance level fell below that of the job description as provided by the employer. (P.X.7 p.2). Petitioner then returned to Dr. Burra on December 19, 2016, at which time Dr. Burra adopted the findings of the October 20, 2016 FCE, indicated Petitioner was at maximum medical improvement and should continue with his home exercise program and could return to work with restrictions as indicated in that FCE. (P.X.6 pp.35-39).

Once again, Respondent did not accommodate Petitioner with work within his physical limitations. Instead, Respondent directed Petitioner to commence a self-directed job search during which it required Petitioner to make at least 10 contacts with potential employers per week, document those contacts on pre-printed forms, and personally deliver the completed forms weekly to Respondent every Monday. Petitioner performed the required job searching from February 1, 2017 continuing through June 18, 2018. Petitioner's Exhibit 9 contains copies of all of petitioner's job searching during this time period.

While Petitioner was undergoing his job search, Respondent had Petitioner undergo a third IME with Dr. Verma on October 18, 2017. Dr. Verma recommended that since the second FCE was performed over one year ago that a new FCE should be performed at an independent facility to determine whether petitioner's functional level has increased. (P.X.4 p.4). On January 25, 2018, Petitioner underwent a third functional capacity evaluation. This most recent one was performed at Illinois Bone & Joint Institute. This evaluation, consistent with the prior two, confirmed that Petitioner gave a valid effort and revealed that his functional level was at the medium-heavy physical demand level however his job with Respondent required a higher level of functioning. (P.X.8 pp.2-3). On February 24, 2018, Dr. Burra reviewed the FCE and confirmed that Petitioner has not met the physical demand level of his prior job with Respondent and given that his clinical exam findings continued to the same, Dr. Burra once again indicated permanent restrictions per the FCE. (P.X.6 p.48).

Once again, Respondent did not offer Petitioner any work within his physical restrictions. Instead, in addition to Petitioner undergoing the above-described self-directed job search, Respondent retained Vocamotive, a vocational rehabilitation company to provide vocational rehabilitation assistance to petitioner. Vocamotive first interviewed Petitioner on April 18, 2018. (P.X.10 p.6). Kari Staphseth, Vocamotive's certified rehabilitation counselor, concluded that Petitioner lost access to his former job as a deck hand. (P.X.10 p.15). She went on to opine that he would be employable earning $12.00-$17.00 an hour most probably with some possibility he could work as a mechanic earning up to $25.00 an hour. (P.X.10 p.15). Lastly, she recommended implementation of vocational rehabilitation services including the development of keyboard proficiency and computer illiteracy. (P.X.10 p.16). She also noted that Petitioner was not keyboard or computer efficient. (P.X.10 p.14).

Petitioner then commenced vocational rehabilitation services with Vocamotive. These services included Petitioner driving to Vocamotive's offices in Hinsdale, Illinois, which took him approximately one hour to travel each way from his home in far southern Chicago. He would have to travel to Vocamotive's offices several times a week for the purpose of computer keyboarding training. Petitioner testified that he has an aversion to technology, specifically that he does not own a cell phone and has never owned a computer or learned how to operate one. As Petitioner trained with Vocamotive on keyboarding skills, they also supplied him a laptop computer to take home. Petitioner performed the exercises required of him and did additional training during evenings and weekends when not required to do so. Petitioner testified that had the assistance of his girlfriend, who is computer proficient, to perform any and all necessary computer related actions to search for employment, Petitioner became increasingly frustrated and annoyed with Vocamotive's requirement that he continue to train on his keyboarding skills. Ultimately, by August of 2018, Petitioner terminated working with Vocamotive.

Thereafter, Petitioner reinitiated his self-directed job search. He, once again, kept a log of the potential employers he contacted and submitted that log at arbitration as Petitioner's Exhibit 11. This log shows Petitioner looked for work between the week of August 6, 2018 continuing through the end of January 2019. As a result of these job searching activities, Petitioner obtained a job offer. That job was as a Maintenance Mechanic I with United Forest Products. This job pays $12.00 an hour and is within his physical restrictions per the FCE. Petitioner commenced this alternative employment on February 13, 2019 and has worked there since. Petitioner identified pay stubs he received from his alternative employment in petitioner's Exhibit 12. These pay stubs show that Petitioner is paid at a base rate of $12.00 an hour, working full time with some overtime earnings as well. Other than this alternative employment, Petitioner received no other job offers although he has continued to look for better jobs through word of mouth, conversations with friends, relatives and talking to businesses he patronizes.

Respondent never offered Petitioner any light duty accommodating work. Vocamotive never indicated that the alternative employment Petitioner obtained was not suitable or appropriate.

Petitioner testified a present hourly rate for City of Chicago deck hand is $36.95. Petitioner's union pay scale supports this current pay rate. (P.X.13 p.9). Presently, Petitioner notes continued pain and weakness in the left shoulder. He notes that the pain limits his strength. At work, he modifies his work because his left arm cannot support heavy items and he is used to using both arms to lift equally but he adjusts his work to take weight off his left side. Further, his alternative employer purchased an engine hoist to assist Petitioner with lifting any heavy items or parts so Petitioner would not have to do so himself.

Regarding out of work activities, Petitioner testified that he can no longer move heavy appliances, he cannot shovel the snow and has difficulty doing simple things such as putting on his seat belt because of the motion that is required. Further, he does not get good sleep because when attempting to sleep on his left side his pain is increased. He also noted that attempting to put items in an upper cabinet or to pull down a window shade causes him difficulty due to his left shoulder. Petitioner also indicated that he is very sensitive to cold because cold increases the symptoms in his left shoulder and he has difficulty putting a cooler into the back of his truck because of the limitations of his left shoulder.

CONCLUSIONS OF LAW

With regard to issues (A) whether the Petitioner and Respondent were operating under the Illinois Workers' Compensation Act and (O) Subject Matter Jurisdiction, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. At Arbitration, Respondent stipulated that Petitioner and Respondent operated as employee and employer, but Respondent disputed the applicability of the Illinois Workers' Compensation Act, (hereinafter "Act"), claiming that said Act was preempted by the Jones Act or the Longshore and Harbor Workers' Compensation Act. Specifically, Respondent filed a Motion to Dismiss for Lack of Subject Matter Jurisdiction on July 22, 2019, one day prior to the hearing of this cause, (*See* R.X.6), despite the claim being on file with the Commission for nearly four years. Further, the Arbitrator notes respondent paid extensive benefits it classified as "TTD" and "Maintenance," which are terms utilized in the Act. (*See* R.X. 2, R.X.3).

Notwithstanding the above, Respondent now argues Petitioner's claim should have been brought under the Jones Act or Longshore and Harbor Workers' Compensation Act (hereinafter "LHWCA") rather than the Illinois Workers' Compensation Act.

In Green v. Industrial Commission, 307 Ill. App. 3d 271, at 274 717 N.E.2d 457, at 460 (1999), the Illinois Appellate Court stated that if a worker is deemed a "seaman," then the Jones Act pursuant to federal law would preempt a state's workers' compensation law. The Court in Greene then annunciated the applicable two-prong test for determining seaman status. First, the employee's duties must contribute to the function of the vessel or to the accomplishment of its mission. (*Id.*). Here, the Arbitrator notes that petitioner's work with respondent contributes to the function of the vessel. Specifically, the Arbitrator points to respondent's job description for petitioner's work as a deck hand which is in evidence as Respondent's Exhibit 5. In that exhibit, it states that the deck hand "provides manual support to assist in the operation and maintenance of a City-owned tugboat, and performs related duties as required." (R.X. 1).

The second prong to be deemed a "seaman" is the requirement that the employee must have a substantial connection in both duration and nature to a vessel in navigation. (Greene at 275, 461 *citing* Chandris v. Latsis, 515 U.S. 347 at 368, 132 L Ed.2d 314 at 337 (1995). Courts have repeatedly adopted the rule of thumb that a worker must spend more than 30% of his time on a vessel on a navigable waterway to be deemed a seaman. (Greene, at 277,462 *citing* Chandris, at 371, 339).

At arbitration, Petitioner testified that he performed *some* of his work on the boat and the rest of it on land at the Jardene Water Purification Plant, at dry docks, or at the water cribs, which are structures that serve as the water intake locations to bring lake water to the plant. The Arbitrator notes that work performed on stationary structures such at the Jarden Plant, dry docks or water cribs are not work "on a vessel" as such locations are unable to be used as navigable waterways.

The Arbitrator notes that there is no evidence as to what percentage of Petitioner's time is spent on the boat. Rather, Petitioner testified that some of his days he was not on the water at all, but for example on those days when the boat would travel to and from a water crib, petitioner could be on the water for a total of 2.5 hours. However, there is no evidence as to the frequency with which petitioner was required to travel to the water cribs and there was no evidence how long the work days were when Petitioner was required to travel to a water crib to be able to determine whether 30% of those work days were spent on the vessel.

On cross examination when asked if whether "most" days he was performing "at least some" of his work on the boat, Petitioner disagreed with that assertion and said most of his work was "pertaining to" the boat. Petitioner's job duties are stated in his job description (R.X.1), but the Arbitrator notes there was still no indication what percentage of a deck hand's time would be spent on the vessel, and more specifically, there is no indication of what percentage of Petitioner's work time would be spent on the vessel.

The Arbitrator notes that there is no evidence in the record to establish that 30% or more of petitioner's work time was on the boat. Further, the Arbitrator notes that respondent offered no witness testimony or documentary evidence such as the ship's log to substantiate the amount of time petitioner spent on the boat.

Based on the totality evidence in the record, the Arbitrator finds there was insufficient evidence to support respondent's contention that petitioner worked 30% or more of his time on respondent's tugboat. As such, the Arbitrator finds that the Jones Act does not preempt the Illinois Workers' Compensation Act in this matter.

Next, Respondent alleges the Act is preempted by the Longshore and Harbor Workers' Compensation Act (hereinafter "LHWCA"). The LHWCA is another federally-based workers' compensation program intended to cover "any person engaged in maritime employment, including any longshoreman or other person engaged in longshoring operations, and any harbor workers including a ship repairman, shipbuilder, and shipbreaker", but does not include a "member of a crew of any vessel, or any person engaged by the master to load or unload or repair any small vessel under eighteen tons net." (Dir. v. Perini North River Associates, 459 U.S.299 at 313, 103 S. Ct. 634 at 645, 74 L. Ed. 2d 465 at 478 (1983) *citing* LHWCA- 33 U.S.C. Section 902(3)).

In this claim, Petitioner does not perform any of the above enumerated occupations which qualify for coverage under the LHWCA. Further, Petitioner is a member of a crew and there is no evidence in the record indicating the weight of the vessel on which petitioner was working when injured. Therefore, the Arbitrator finds that the facts in the record do not support that petitioner would be considered an "employee" entitled to protection of the LHWCA.

Additionally, the Arbitrator notes that even if petitioner were deemed an "employee" pursuant to the LHWCA, unlike the Jones Act, the LHWCA provides for concurrent jurisdiction and state remedies are available to workers where the worker's employment is "maritime" and local in character. (Grant-Smith-Porter Ship Co. v. Rohde, 257 U.S. 469, 476-77, 66 L. Ed. 21 (1922). This "maritime but local" doctrine applies if the work injury occurs upon navigable waters, the workers' employment has no direct connection to navigation or commerce, and the application of local law would not materially affect the uniformity of maritime law. Uphold v. IWCC, 385, Ill. App 3d, 567 at 581-581; 908 N.E. 2d 828 at 842 (5th Dist. 2008) *citing* Dir. v. Perini North

River Associates, 459 U.S.299 at 306, 103 S. Ct. 634 at 641, 74 L. Ed. 2d 465 (1983). Here, Petitioner's employment by a local municipality has no direct connection with navigation or commerce and the Arbitrator finds that applying the Illinois Workers' Compensation Act to Petitioner, a City of Chicago employee, would not affect the uniformity of maritime law as this Respondent, a municipal employer, does not engage in interstate commerce or traversing waterways across multiple states or even multiple municipalities. Therefore, the Arbitrator finds that Petitioner's employment was clearly maritime in nature but local in character thus the LHWCA does not preempt applicability of the Illinois Workers' Compensation Act in this instance.

As such, the Arbitrator finds respondent was operating under and subject to the Illinois Workers' Compensation Act.

With regard to (C) whether the accident arose out of and in the course of Petitioner's employment with Respondent, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. At arbitration, Petitioner testified regarding the April 24, 2014 occurrence at work wherein he was pulling a rope and injured his left shoulder. Petitioner's unrebutted testimony is buttressed by Respondent's accident report which Respondent offered into evidence as Respondent's Exhibit 1. This exhibit, entitled "City of Chicago Report of Occupational Injury or Illness," indicated Petitioner injured his left shoulder while pulling an "incredibly heavy," water-logged rope which was trapped under new fendering which had been installed that day. (R.X. 1). Petitioner was attempting to moor the boat which is listed first on the list of Petitioner's "Essential Duties" working as a Deck Hand for respondent. (*See* R.X. 5).

Respondent offered no evidence refuting Petitioner's testimony or the accident report. Additionally, the Arbitrator notes that Respondent paid$144,323.96 in TTD and maintenance. Therefore, given that respondent offered no evidence refuting accident and it voluntarily paid significant benefits, the Arbitrator fails to appreciate what reasonable basis Respondent possesses to dispute "accident."

Based on the above, the Arbitrator finds that all evidence in the record regarding "accident" supports that on April 24, 2014, Petitioner suffered a work-related accident which arose out of and in the course of his employment with Respondent.

With regard to (F) whether Petitioner's condition of ill-being is causally connected to his injury, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. The medical records submitted into evidence support Petitioner's argument that his condition of ill-being is casually connected to his injury. First, when sent by Respondent to U.S. Health Works, Respondent's clinic, Petitioner offered a consistent history of the April 24, 2014 work accident. (P.X. 1, p.12). The examining healthcare professional at U.S. Health Works also noted a consistent history of accident, (P.X. 1, pp. 21, 32), and diagnosed a left shoulder strain with no cause other than the work accident noted. (P.X. 1, pp. 32-33). U. S. Health Works ordered therapy, prescribed medications, issued work restrictions and ordered an MRI. (P.X. 1, pp. 33, 36, 38, 41, 44-46).

Next, on June 30, 2014, Dr. Dugan at Rush Medical Center also noted a consistent history of the April 24, 2014 work accident with no pre-existing condition of ill-being to the left shoulder. (P.X. 2, p. 8). She noted Petitioner's 6/23/2014 left shoulder MRI revealed tendinopathy of the long head of the biceps, supraspinatus

and infraspinatus. (P.X. 2, p.8). Dr. Dugan went on to diagnose left shoulder impingement, issued work restrictions and ordered therapy. (P.X. 2, p.10).

Petitioner attended physical therapy at Achieve Manual Physical Therapy where a consistent history of the 4/24/2014 work accident was noted. (P.X. 2, p.3). Petitioner underwent 18 therapy visits from 5/27/2014 through 8/4/2014 noting increased left shoulder strength but persistent pain and soreness. (P.X. 2, pp. 2-55).

Dr. Verma performed an initial Section 12 examination on August 20, 2014. His report noted a consistent history of the April 24, 2014 work accident injuring the left shoulder with no pre-existing related condition. (P.X. 4, p. 2). He diagnosed left shoulder biceps tendonitis, recommended an FCE and opined that Petitioner's condition of ill-being was causally related to the April 24, 2014 work accident. (P.X. 4, p. 4).

Respondent then arranged for Petitioner to undergo an FCE on 10/23/2014 at Accelerated Rehabilitation. That testing noted a consistent history of the 4/24/2014 work accident and concluded Petitioner's job with Respondent required him to perform at the heavy physical demand level yet his functional abilities fell below that level. (P.X. 5, pp. 3-4). The evaluator noted that Petitioner put forth "full and consistent effort" during the evaluation. (P.X. 5, p.4). Lastly, the evaluator recommended Petitioner undergo work conditioning. (P.X. 5, p.4).

Petitioner underwent ten work conditioning sessions at Achieve from 11/5/2014 through 11/18/2014. (P. Ex.3, pp 56-93). Thereafter, on 12/8/2014, Dr. Dugan returned Petitioner to work full duty as of 12/9/2014 despite Petitioner indicating that "he does not feel he is ready to RTW full duty." (P. Ex. 2, pp. 84, 92).

Petitioner then returned to work on December 9, 2014. He noticed that his left arm was still in pain and he was limited in his ability to lift it overhead. Although he continued to attempt to work, he then sought a second opinion from Dr. Burra. Dr. Burra first examined Petitioner on 11/13/2015. He too noted a consistent history of the 4/24/2014 work accident. (P. X. 6, p.2). Dr. Burra went on to note that he "strongly agree(s) with the independent medical evaluation performed last year where a causal connection was established between his left shoulder symptoms and his work-related injury." (P.X. 6, p. 6). Dr. Burra diagnosed a tear of the labrum and bicep tendinitis for which he recommended Petitioner obtain another MRI, but this one with an arthrogram. (P.X. 6, p.6).

The 12/3/2015 MRI Arthrogram revealed tears of the superior and posterosuperior labrum as well as a tear of the anteroinferior and inferior labrum. (P.X. 6, p.11). On 1/27/2016, Dr. Burra issued work restrictions and recommended surgery. (P.X. 6, pp. 15, 17). He also opined that the labral tears were caused by the work accident. (P.X. 6, p. 15).

Next, as Petitioner awaited respondent's approval of the surgery Dr. Burra prescribed, Respondent ordered a second Section 12 examination with Dr. Verma on 4/20/2016. Dr. Verma agreed with Dr. Burra in prescribing arthroscopic surgery, and light duty restrictions until surgery. (P.X. 4, p.19).

Petitioner ultimately decided not to undergo surgery as there was no guarantee his function would improve as a result and there was no guarantee his left shoulder would not be made worse by the surgery. Dr. Burra opined that it was not unreasonable for Petitioner to elect for a more conservative approach, especially since he had the pathology for a long time since his work accident. (P.X. 6, p.31). Dr. Burra then ordered an FCE to determine Petitioner's functional abilities. (P.X. 6, p.31).

ATI Physical Therapy conducted Petitioner's second FCE on 10/20/2016. That evaluation showed Petitioner gave a valid effort and his capabilities fell below those as stated in his job description. (P.X. 7, p.2).

Subsequently, Dr. Burra deemed Petitioner at MMI on 12/19/2016 with permanent restrictions as per the FCE. (P.X. 6, p. 39).

Thereafter, Respondent arranged a third Section12 examination with Dr. Verma on 10/15/2017. Dr. Verma recommended a third FCE be undertaken at an "independent provider." (P.X.4, p.21).

Petitioner underwent his third FCE on 1/25/2018. This evaluation was performed at Illinois Bone and Joint Institute. The evaluation, noting the 4/24/2014 date of injury, revealed Petitioner gave "excellent effort" and the results were valid. (P.X.8, p.2). Similar to the prior two FCEs, this evaluation revealed Petitioner was unable to perform all of his required job demands for a deck hand for the City of Chicago. (P.X.8, p.3).

The Arbitrator notes that every medical provider involved in this claim points to the April 24, 2014 work accident as the cause of petitioner's left shoulder condition. Further, the Arbitrator notes there is no medical evidence in the record to the contrary. Based on the totality of evidence including Petitioner's credible testimony and the medical records submitted into evidence, the Arbitrator finds that there is causal connection between Petitioner's condition of ill-being involving his left shoulder and his April 14, 2014 work accident.

With regard to (K) Petitioner claims to be entitled to temporary total disability for the period of 4/29/2014 through 12/18/2014 and 1/27/2016 through 12/19/2016 representing 78 4/7ths weeks, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. As noted above in Section (f) regarding causal connection, Petitioner was under light duty restrictions from U.S. Health Works and Dr. Dugan from 4/29/2014 through 12/8/2014. (P.X. 1, P.X. 2). Further, Petitioner was again under restrictions or off work per Dr. Burra from 1/27/2016 through 12/19/2016, at which time he deemed him at MMI. (P.X. 6). Petitioner testified unrebutted that Respondent never offered him accommodating light duty work.

Given the Arbitrator's findings above as to accident and causal connection, and given there is no evidence in the record to the contrary, the Arbitrator finds that Petitioner was temporarily totally disabled from 4/29/2014 through 12/8/2014 and 1/27/2016 through 12/19/2016, totaling 78 4/7ths weeks.

Regarding maintenance, Petitioner testified that after being released with permanent light duty restrictions he waited to learn whether Respondent would offer him accommodating light duty work. Instead, Respondent required Petitioner to conduct a self-directed job search and personally turn in logs of such job searching on a weekly basis to Respondent. Those logs on Respondent's pre-printed forms entitled "City of Chicago Injury on Duty Job Search Log," encompass 2/1/2017 through 6/18/2018. (*See* P.X. 9).

Concurrently, respondent arranged for Petitioner to work with Vocamotive from April 18, 2018. (P. X. 10, pp.6-16). In August of 2018, Petitioner testified that he voluntarily terminated working with Vocamotive due to his frustration with being forced to learn computer keyboarding skills and on 8/9/2018, Vocamotive closed its file. (P.X. 10, p.67).

Petitioner testified that he reinitiated his self-directed job search in August of 2018 and continued it until February 13, 2019 when he commenced his alternative employment at United Forest Products. Petitioner documented this job search by once again maintaining weekly logs of the job searches he performed. (*See* P.X.11). Petitioner's commencement of employment with United Forest Products is confirmed by his initial paycheck stub. (P.X. 12, p.1).

Given Petitioner's credible testimony, which is supported by his job search logs, the Vocamotive records, and given the absence of any evidence to the contrary, the Arbitrator finds Petitioner performed diligent job searching, which was successful as noted above, and participated with Respondent's vocational rehabilitation efforts with Vocamotive until he voluntarily terminated working with Vocamotive on 8/9/2018. Therefore, Petitioner is entitled to maintenance from 12/20/2016 through 08/09/2018, totaling 85 2/7th weeks.

With regard to (L) the nature and extent of Petitioner's injury, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. The Arbitrator notes that Dr. Burra deemed Petitioner at MMI on 12/19/2016 with permanent restrictions as per the FCE, making this claim ripe. (P.X. 6, p. 39)

Partially Incapacitated from Pursuing Usual and Customary Line of Employment

As noted above, Petitioner underwent three functional capacity evaluations all of which were valid and all of which evidenced that his functional level fell below that as required by his employment with respondent as a Deck Hand. (See P.X. 5, p.4, P.X.7, p.2, P.X. 8, pp. 2-3). The most recent FCE indicated the functional requirements of the City of Chicago Deck Hand job are at the Very Heavy physical demand level but petitioner's functional level was at the Medium-Heavy physical demand level, including lifting 90 pounds from the floor, 80 pounds from the knee, shoulder lifting up to 50 pounds and overhead lifting of 45 pounds with a two-hand carry limit of 80 pounds. (P.X. 8, p.3). Dr. Burra, Petitioner's treating doctor, adopted the findings of the FCE as petitioner's permanent restrictions. (P.X. 6, p.48). The Arbitrator notes there is no medical opinion or other evidence refuting these restrictions.

Kari Stafseth, respondent's certified rehabilitation counselor, opined that due to the permanent restrictions resulting from his injury, Petitioner "lost access to his former job and line of employment of a Deck Hand." (P.X. 10, p.15).

Respondent offered no evidence that petitioner is capable of performing the job as a deck hand.

Based on the above and given the absence of evidence to the contrary, the Arbitrator finds that as a result of his April 24, 2014 work accident, Petitioner is partially incapacitated from pursuing his usual and customary line of employment as a deck hand.

Able to Earn in the Full Performance of his Duties in the Occupation in Which he was Engaged at the Time of the Accident

The Arbitrator notes that petitioner's AWW of $1,634.24 represents what Petitioner was able to earn in the full performance of his occupation as a deck hand in which he was engaged at the time of the accident.

The Average Amount Which He is Earning or Able to Earn in Some Suitable Employment

Once respondent did not provide petitioner accommodating work within his restrictions, petitioner conducted an extensive self-directed job search which he documented well. Specifically, Petitioner documented approximately 1,000 job contacts. (*See* P.X.9, P.X. 11). As a result of that job searching, Petitioner was successful in obtaining a job offer with United Forest Products as a Maintenance Mechanic I working full time and earning $12.00 per hour. He commenced this employment on February 13, 2019 and noted that job is within his restrictions and he can physically perform it.

Petitioner's Exhibit 12 are copies of Petitioner's pay stubs from his work with United Forest Products. These pay stubs confirm the $12.00 hourly rate and confirm that the employment appears to be full time (40 hours per week) with minimal overtime.

Kari Stafseth, respondent's Certified Rehabilitation Counselor, opined that Petitioner "would have a most probable wage-earning potential of $12.00 to $17.00 per hour." (P.X. 10, p.15).

Based on the above and given the absence of evidence to the contrary, the Arbitrator finds that the average amount Petitioner is earning or able to earn in some suitable employment is $480.00 ($12.00 per hour x 40 hours per week).

8(d)(1) Calculation

Based on the aforementioned, the Arbitrator finds that as a result of his April 24, 2014 work accident, petitioner has become partially incapacitated from pursuing his usual and customary line of employment as a deck hand. Pursuant to Section 8(d)(1) of the Act, respondent is ordered to pay Petitioner $770.83 per week, representing 66-2/3% of the difference between $1,636.24 (the amount he would be able to earn in the full performance of his deck hand job with respondent), and $480.00 (the amount he is earning or able to earn in some suitable employment), from February 13, 2019 and continuing until he reaches the age of 67.

Signature of Arbitrator

04/30/2020
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC026055
Case Name	BIRKHOLTZ, SUSAN v. THE FOUNTAIN GROUP AND CDK GLOBAL
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0315
Number of Pages of Decision	27
Decision Issued By	Stephen Mathis, Commissioner

Petitioner Attorney	Michael Brandenberg
Respondent Attorney	Katerina Kyros

DATE FILED: 6/21/2021

/s/ Stephen Mathis, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Susan Birkholtz,

Petitioner,

vs. No. 18 WC 26055

The Fountain Group and CDK Global,

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondents herein[1] and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary disability and permanent disability, and being advised of the facts and law, reverses the Decision of the Arbitrator and denies Petitioner's claim for the reasons stated below.

Petitioner, a corporate administrator, testified at the arbitration hearing that on August 15, 2018, she worked at a CDK Global office in Hoffman Estates. She had been hired by the Fountain Group to work at CDK Global. Every workday, Petitioner drove to the CDK Global office and parked in the CDK Global parking lot. CDK Global occupied the entire building, and the parking lot wrapped around the building. To Petitioner's knowledge, it was a private parking lot. CDK Global issued a parking sticker to Petitioner to place on her car.

On August 15, 2018, Petitioner parked her car in the employee parking area on the east side of the building, east of a long median and in the middle of a line of parking spots. Normally, Petitioner used a different entrance and parked in the area of the parking lot close to that entrance. After a threat against CDK Global, only the main entrance was open. Petitioner therefore parked in the vicinity of the main entrance. She walked across the median without incident on her way to the building.

[1] Only the Fountain Group filed a petition for review. However, the record shows privity between the Fountain Group and CDK Global and their counsels. During oral argument, CDK Global adopted the position of the Fountain Group.

While returning to her car at the end of the workday, Petitioner sustained injuries when she slipped and fell on the median on some mud that "appeared to be grass." It had rained, and the pavement was wet. Rather than taking a long way on a paved surface to reach her car (approximately seven or eight parking spot lengths around one side and then backtracking), Petitioner decided to take the most direct route across the median, which had a "gentle" slope. The grass on the median was wet. Unbeknownst to Petitioner, the soil was very muddy. Petitioner was wearing leather flats. Petitioner summarized her route: "I was exiting the building from the main entrance. I walked through the parking lot that was on the level of the entrance through to where my car was, which was almost directly from the entrance, and, in order to get to my car, I walked through a grassy median, and that's as far as I got." After falling on the grassy median, Petitioner noticed her right foot "was hanging off [her] right leg or ankle." Petitioner suffered a closed right trimalleolar fracture and ultimately required an open reduction and internal fixation surgery on the right ankle.

The Commission has carefully reviewed the photographs of the parking lot and the median.

Respondents argue the accident did not arise out of Petitioner's employment because Petitioner voluntarily and unnecessarily exposed herself to the dangers of the grassy median. Respondents rely on *Dodson v. Industrial Comm'n*, 308 Ill. App. 3d 572 (1999), *General Steel Castings Corp. v. Industrial Comm'n*, 388 Ill. 66 (1944), *Kapanowski v. Village of Merrionette Park Police Department*, 19 IWCC 0328, and *Dukich v. Workers' Compensation Comm'n*, 2017 IL App (2d) 160351WC. Petitioner argues *Dodson* is no longer good law, and the controlling case is *Mores-Harvey v. Industrial Comm'n*, 345 Ill. App. 3d 1034 (2004), which frames the issue as one of hazardous condition on the employer's premises. Alternatively, Petitioner argues the cases Respondent relies upon are distinguishable.

In *General Steel Castings*, the decedent was struck by a train while crossing railroad tracks on the way to his parked car after work. The supreme court denied compensation, stating: "[The employer] maintained a way from the north gate north some 300 feet to a grade crossing, prepared and maintained by the railroad company across the tracks. This was a recognized crossing and the engineer of each locomotive as it approached that crossing gave warning signals by blowing a whistle and sounding a bell to warn the general public of the approach of danger. This was not true of the point where [the decedent] met with his accident. The timekeeper's authorization was only to leave and enter the premises by the north gate. It cannot be construed as authorization to cross the railroad tracks where there was no crossing and where deceased would be a trespasser. [The decedent] chose an unnecessarily dangerous place to cross the tracks, and also an unnecessarily dangerous place to stand while the freight train was passing. We are of the opinion that [the decedent's] injury and death did not arise out of, or in the course of, his employment." *General Steel Castings*, 388 Ill. at 72.

In *Dodson*, "[c]laimant clocked out and exited the clubhouse through the employee exit. Claimant proceeded down several steps of the concrete sidewalk leading to the employee parking area and, because it was raining hard, she left the sidewalk and walked across a grassy slope to reach the driver's side of her car. The stairs and employee's sidewalk were in good condition and were not blocked by any obstructions. Claimant testified she walked across the grass because it was the most direct route to her car door. She also testified that she and other employees walked across the grassy slope many times in the past with employer's acquiescence. This time, while walking on the sloping grassy path, claimant fell backwards on her right foot and broke her ankle. As she pushed herself up from her fall, she noticed ice on her hands." *Dodson*, 308 Ill. App. 3d at 574. The appellate court

affirmed the denial of the claim, stating: "[A]n injury does not arise out of the employment where an employee voluntarily exposes himself or herself to an unnecessary personal danger solely for his own convenience. * * * The Commission concluded claimant's injuries resulted from exposure to an increased personal risk. She chose to take a shortcut to her vehicle and walked down a grassy slope that was ostensibly wet and icy from rain. Claimant did so instead of proceeding down the unobstructed stairs and sidewalk, both of which the employer provided for employees' ingress and egress. This was a voluntary decision that unnecessarily exposed her to a danger entirely separate from her employment responsibilities. Moreover, her choice was personal in nature, designed to serve her own convenience and not the interests of employer. * * * [W]e do not imply that an injury does not arise out of the employment simply because it was sustained while the employee was taking an alternative path to or from the work place. To be sure, employees are free to choose any safe route. However, where the employee ventures from a safe sidewalk provided by the employer and instead proceeds to walk down a grassy slope covered with water and ice, we cannot say the Commission's decision finding that the employee voluntarily exposed herself to an unnecessary personal risk only for her own convenience is against the manifest weight of the evidence." *Id.* at 576-77. We note the appellate court recently affirmed the continued validity of *Dodson*. See *Purcell v. Workers' Compensation Comm'n*, 2021 IL App (4th) 200359WC, ¶ 22-24.

In *Dukich*, the claimant fell on wet pavement at the employer's premises while walking to her car, parked in a designated parking space, on her way to lunch. "As she walked down a handicap ramp between the building's entrance and the street level, the claimant lost her footing on the wet ramp and fell face first onto the pavement of a crosswalk in an adjacent bus run, striking her head and nose. When asked during the arbitration hearing what caused her to fall, the claimant responded, '[t]he rain. The water.' " *Dukich*, 2017 IL App (2d) 160351WC, ¶ 8. The appellate court affirmed the denial of the claim, stating: "We agree with the Commission that the claimant's accident is not compensable. The dangers created by rainfall are dangers to which all members of the public are exposed on a regular basis. These dangers, unlike defects or particular hazardous conditions located at a particular worksite, are not risks distinctly associated with one's employment. Accordingly, the claimant's claim in this case should be analyzed under neutral risk principles; *i.e.*, recovery should be allowed only if the claimant can establish that she was exposed to the risks of injury from rainfall to a greater degree than the general public by virtue of her employment. The claimant presented no such evidence in this case. Although the employer provided the claimant a designated parking space, there is no evidence that the employer exercised any control over the particular route the claimant took to her car or required the claimant to traverse the particular handicap ramp on which she was injured. Nor is there any evidence suggesting that the claimant's employment duties somehow contributed to her fall or enhanced the risk of slipping on wet pavement. For example, the claimant was not carrying any work-related items or hurrying to complete a work-related task at the time she slipped and fell." *Id.* ¶ 36. The court distinguished cases involving a " 'hazardous condition' on the employer's premises. As noted, the claimant's injury was apparently caused by a paved surface that was wet due to *rainfall*. Each of the 'hazardous condition' cases cited above involves injuries caused by the natural accumulation of *snow and/or ice* in a parking lot or other outdoor space owned or controlled by the employer (see, *e.g.*, *Archer Daniels Midland Co.*, 91 Ill. 2d at 216; *Hiram Walker & Sons, Inc.*, 41 Ill. 2d 429; *Carr*, 26 Ill. 2d 347; *De Hoyos*, 26 Ill. 2d 110-11; *Mores-Harvey*, 345 Ill. App. 3d at 1040; *Suter*, 2013 IL App (4th) 130049WC, ¶ 40)." *Id.* ¶ 41. (Emphasis in original.)

In *Kapanowski*, the claimant fell because of a dip in between the grass and the top of the curb line. The Commission denied the claim, explaining: "As the claimants in both *Dodson* and *Hanson*,

Petitioner chose to expose himself to an unnecessary risk purely for his own convenience. Petitioner testified he was en route to his squad car which was parked in the lot provided by Respondent. Petitioner testified he decided to cut across a grass area to the north of the sidewalk. Petitioner did so for his own convenience in order to access his squad car faster. There was no evidence presented that such haste was necessitated by Petitioner's job duties. Petitioner testified a sidewalk which was unobstructed was available for access to his squad car. Detective Sergeant Cavazos confirmed an unobstructed paved sidewalk was available to Petitioner in order to access his squad car. Petitioner was performing a voluntary act—stepping into the grass for his own personal convenience—a shorter route to his car. Petitioner chose to step into the grass. It is grass; by its nature it is uneven which is why Respondent provided a paved parking lot and paved sidewalks."

As noted, *Mores-Harvey*, where the claim was ruled compensable, involved an accumulation of snow and ice, not rain, in the employer-provided parking lot.

The Commission finds the facts of the instant case are virtually indistinguishable from *Dodson*. The instant case falls squarely within the doctrine of "unnecessary personal risk," which defeats the "arising out of" component of Petitioner's claim. Moreover, under *Dukich* (wet pavement), Petitioner's claim would still not be compensable.

Lastly, Petitioner asserts, without any citation to legal authority, that "in the context of her employment with the Fountain Group, Petitioner's injury is compensable because she would be a traveling employee." Petitioner misapprehends the traveling employee doctrine. Petitioner was not a traveling employee. Rather, the Fountain Group was her loaning employer, and CDK Global was the borrowing employer. See 820 ILCS 305/1(a)4.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 14, 2020, is hereby reversed and Petitioner's claim is denied.

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.

June 21, 2021

/s/*Stephen J. Mathis*
Stephen J. Mathis

SJM/sk
o-4/20/2021
44

/s/*Deborah J. Baker*
Deborah J. Baker

/s/*Deborah L. Simpson*
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0315
NOTICE OF ARBITRATOR DECISION

BIRKHOLTZ, SUSAN Case# **18WC026055**
Employee/Petitioner

THE FOUNTAIN GROUP & CDK GLOBAL
Employer/Respondent

On 4/14/2020, 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 0.29% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0154 KROL BONGIORNO & GIVEN LTD
MIKE BRANDENBERG
20 S CLARK ST SUITE 1820
CHICAGO, IL 60603

0766 HENNESSY & ROACH PC
KATERINA D KYROS
140 S DEARBORN ST SUITE 700
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1596 MEACHUM BOYLE TRAUFMAN
JAMES JANNISCH
225 W WASHINGTON ST SUITE 500
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

Susan Birkholtz
Employee/Petitioner

v.

The Fountain Group & CDK Global
Employer/Respondent

Case # **18** WC **26055**

Consolidated cases: **None**

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 **Joseph Amarilio**, Arbitrator of the Commission, in the city of **Chicago**, on **February 13, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **August 15, 2018**, 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 **$96,200.00**; the average weekly wage was **$1,850.00**.

On the date of accident, Petitioner was **54** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$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

Respondents shall pay Petitioner temporary total disability benefits of $1,233.33/week for 14 weeks, representing the period between October 1, 2018 through January 6, 2019, as provided in Section 8(b) of the Act.

Respondents shall pay to Petitioner reasonable and necessary medical services of $60,595.70 under Sections 8(a) and 8.2 of the Act and subject to the limitations of the Medical Fee Schedule of Section 8.2. These are itemized as: 1. Village of Hoffman Estates– $1,514.00; 2. St. Alexius Medical Center—$9,885.00 3; Radiological Consultants of Woodstock--$96.00 4; Midwest Emergency Associates--$1,197.00 5; Dr. Paul Lucas --$1,890.00; 6. Elk Grove Radiology--$68.00 7; Resolute Anesthesia --$3,871.00 8; and, Alexian Brothers Medical Center --$42,074.70.

Respondents shall pay to Petitioner $80.00 for out-of-pocket expenses out of the awarded medical bills.

Respondents shall pay Petitioner permanent partial disability benefits of $813.87/week for 58.45 weeks, as provided in Section 8 of the Act, because the injuries sustained caused a 35% loss of use of the right foot.

Respondents shall pay Petitioner compensation that has accrued from August 15, 2018 through February 13, 2020, 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

04/13/2020
Date

APR 14 2020

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

SUSAN BIRKHOLTZ,	)	
	)	
Petitioner,	)	
	)	
vs.	)	No. 18 WC 26055
	)	
THE FOUNTAIN GROUP and CDK GLOBAL,	)	
	)	
Respondents.	)	

ADDENDUM TO DECISION OF ARBITRATOR

FINDINGS OF FACT

On February 13, 2020, the arbitration hearing was conducted with the Petitioner as the only testifying witness. The Petitioner and both Respondents were represented by their respective counsel.

Petitioner's Testimony and Medical Records

At the time of accident, Susan Birkholtz ("Petitioner") was a 54-year-old internal communications professional hired by The Fountain Group to work for CDK Global. She worked primarily at a desk for this job and took direction from a supervisor employed by CDK Global. (Tr., p. 10, 37- 38). On the day of the accident, August 15, 2018, Petitioner went to work at CDK's building located at 1950 Hassell Road in Hoffman Estates. (Tr., p. 10, 37- 38). On the end of the workday, she slipped and fell on some mud that was under grass. She had exited out of the main entrance of the CDK Global building and proceeded directly from the exit to where

her car was located. (Tr., p.16-17). While walking through a grassy median both of her feet became stuck in mud. Her right foot slipped, and she fell. After she slipped in the mud, she noticed that her right foot was hanging off her right leg and she felt pain. (Tr., p. 11-12). She did not try to get up or move, and she cradled her foot. She called her supervisor to report the injury. Her supervisor came to her aid. Security guards that were part of CDK Global also showed up and called an ambulance. (Tr., p. 36-37).

Petitioner first started working for CDK Global on June 25, 2018. Between that time and the date of the accident, Petitioner always drove to work at the same address and always parked her car in the same parking lot where she fell. Petitioner identified Petitioner's Exhibit 6 as a fair and accurate depiction of the CDK building and parking lot where she fell on August 15, 2018. The parking lot wraps around the main building. On the date of the accident, she parked her car on the east side of the building, which was not her usual parking area.

She parked in a spot to the east side of a long median that extended about fifteen car lengths. She parked her car in the middle of that line of parking, which she marked on PX6 with a circled "1". She marked the main entrance of the building where she exited from that day on PX6 with a circled "2". (Tr., pp. 13-16). Petitioner marked with an "X" on PX6 the spot where she fell on the median that day. (Tr., p. 45. Petitioner marked with a "3" on Petitioner's Exhibit 6 the sport where she normally parked prior to the accident date. (Tr., pp. 45, 54).

After she exited from the building on the date of the accident, Petitioner stepped onto the median in front of her car because it was the most direct route to her vehicle. It had rained earlier that day, but it was not raining in the morning when she initially crossed the median to get into work. (Tr., pp. 17, 25, 51). She did not notice any holes or large rocks in the median in the morning or

any large rocks. The median appeared to contain plain grass, which she believed was two-and-a-half steps across. On the date of the accident, Petitioner was wearing flats—not heels. (Tr., pp. 51-52). The grass on the median was wet when she approached her car at the end of that workday. The median appeared to have just grass when she stepped on it, but it was nothing but mud underneath. (Tr., pp. 20-21).

When she approached her vehicle that day, Petitioner chose to leave the pavement and cross the median. Nobody from CDK Global or The Fountain Group told her not to cross the median. (Tr., p. 53). She had seen other employees for the CDK Global walk over the same median before. That was the most direct route to the only entrance that was open on the date of the accident. (Tr., pp. 25-26). The parking lot pavement was wet when she walked to her car. If she had not stepped onto the median, she would have had to walk around half of the median, or seven to eight car lengths, and then back that same distance around the other side to reach her car. (Tr., p. 18). She did not walk around the parking lot pavement and walked over the grass as the most direct route. The parking lot was wet, but there was nothing blocking her. (Tr., p. 47).

Petitioner identified Petitioner's Exhibit 5 as a fair and accurate depiction of the median she parked her car next to on the date of the accident. There was a gentle slope down from the previous level on the median itself. The area where her car was parked on the accident date was lower than the other side of the median that was closer to the building. The pavement around the ends of the median sloped down towards the car as well. There was a sign stating that the spot where her car was located was reserved for employee parking. To her knowledge, this was a private parking lot. Petitioner identified Petitioner's Exhibit 4 as a photograph that she took of the back window of her car, showing a sticker that she was given by CDK Global to park in that lot. That sticker was on her car at the time of the accident. (Tr., p. 19-22). As far as Petitioner

knew, all the vehicles parked in that lot had to have a parking sticker and security did check the parking lot from time to time. (Tr., pp. 48-49).

Prior to the accident, Petitioner had normally been parking near a side door to the left of the main entrance because it was closer to where she worked inside the building. To get from the side door she usually entered and exited to where she normally parked her car, she did not have to cross any grassy medians.

She parked her car near the median on the date of the accident because CDK Global had sealed all the other doors for recent security reasons. The front, main entrance was the only door that employees could use that day. (Tr., pp. 23-24). None of the other parking in the lot was being blocked on the date of the accident. (Tr., p. 48). There were spots available closer to the main entrance, but those were for visitor parking or were occupied when she parked on the date of the accident, so she parked in the employee part of the lot next to the median. That was the only available spot. (Tr., p. 26). The spot she parked in that day was closer to the main entrance than the spot she normally parked in prior to the accident. (Tr., p. 55).

After the accident, Petitioner was transported by ambulance to the emergency room at St. Alexius Medical Center. She reported an injury walking down an incline when she slipped in the mud and fell to the ground. She initially inverted and then everted her right ankle, which was throbbing with pain. After undergoing x-rays and a closed reduction, Petitioner was diagnosed with a closed right trimalleolar fracture, her right ankle was splinted, and she was referred to see an orthopedic surgeon. (PX1).

On August 28, 2018, Petitioner was examined by Dr. Paul Lucas at Alexian Brothers Medical Center. She again reported falling and twisting her right ankle while on work property.

Examination of the right ankle revealed erythema, ecchymosis, and swelling with a lateral deviation of the foot. The diagnosis was closed trimalleolar fracture of the right ankle. Dr. Lucas re-splinted her right ankle and recommended that Petitioner undergo surgical repair on the ankle. (PX2).

On September 1, 2018, Petitioner underwent surgery performed by Dr. Lucas, including open reduction and internal fixation of the right ankle with placement of a plate and medial malleolar interfragmentary screw. The postoperative diagnosis was closed, displaced trimalleolar right ankle fracture. (PX2).

On September 8, 2018 and September 12, 2018, Petitioner followed up with Dr. Lucas, who splinted her right ankle and noted that she was non-weightbearing and using crutches. (PX2).

On September 19, 2018, Dr. Lucas noted some continued tenderness and bruising at Petitioner's right ankle. He recommended that she keep it immobilized, but she could return to work with restrictions of no weight bearing and elevation of the site. (PX2).

On September 27, 2018, Dr. Lucas reexamined Petitioner and kept her on the same restrictions. (PX2).

Respondent terminated Petitioner's employment at the end of September.

On October 11, 2018, Petitioner saw Dr. Lucas, reporting decreased pain and swelling in the right ankle. Dr. Lucas recommended she minimize activity and keep her right foot elevated as much as possible. She was still non-weightbearing and using crutches. (PX2).

On October 25, 2018, Dr. Lucas recommended the same restrictions and that Petitioner begin some weightbearing at home with a walker and a boot. (PX2).

Petitioner testified that she transitioned from a knee scooter, which she purchased on her own, to a boot to a secure ankle brace. (Tr. p. 41).

On November 12, 2018 and November 28, 2018, Dr. Lucas recommended the same restrictions and that Petitioner begin a course of formal physical therapy. (PX2).

On December 6, 2018, Petitioner underwent an initial physical therapy evaluation at St. Alexius Rehab Services. (PX1).

On January 8, 2019, Petitioner was discharged from therapy by St. Alexius Rehab Services due to no approval from the workers' compensation carrier. (PX1).

On January 7, 2019, Petitioner began a new job working for Allstate within her restrictions. (Tr. p. 30-31).

On January 9, 2019, Dr. Lucas again recommended the same work restrictions and that Petitioner undergo physical therapy. (PX2).

On February 2, 2019, Petitioner underwent a new evaluation and began a course of physical therapy at St. Alexius Rehab Services. (PX1).

On March 13, 2019, Dr. Lucas recommended that Petitioner end physical therapy and follow up in three months. (PX2).

On March 28, 2019, Petitioner was discharged from physical therapy by St. Alexius Rehab Services. (PX1).

On June 11, 2019, Petitioner saw Dr. Lucas, reporting that she was weightbearing with some tenderness in her right foot. Upon examination, her right ankle exhibited tenderness to palpation

with some bruising present in the right ankle. Dr. Lucas indicated that Petitioner may need use of a brace or orthotics and could follow up in another three months. (PX2).

Petitioner testified that she was not aware of any charity deduction on her medical bills and did not fill out any paperwork to obtain such a deduction. (Tr., p. 44).

Prior to the accident, Petitioner was not having any issues with her right foot or ankle. (Tr., p. 12). Petitioner was involved in a fender bender on February 7, 2019 and reported an injury to her toes. She does have a history of rheumatoid arthritis that she is on active treatment for. 43. She had bunions and hammertoes operated on both feet in 1996. (Tr., pp .42-44).

She currently notices pain in her right ankle, especially when she must drive for over an hour or walk for over two blocks. Walking up and down stairs causes an increase in stiffness because of the limited mobility in her ankle. She must walk significant distances for her current job at Allstate, and she has difficulty because she starts to develop pain and stiffness in her right ankle. Petitioner has not had the hardware removed from her ankle. (Tr., p. 32-34).

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)

Petitioner testified in open hearing before the arbitrator who had opportunity to view her demeanor under direct examination and under cross-examination. The arbitrator evaluated the testimony of the Petitioner in consideration of all the evidence in the record. The arbitrator finds that Petitioner was a credible witness. The arbitrator notes that Petitioner's testimony was corroborated by and consistent with the medical records and objective findings.

REGARDING DISPUTED ISSUE C, "DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT WITH RESPONDENT?", THE ARBITRATOR FINDS:

The issue of accident was placed in dispute at the time of hearing. The Arbitrator notes that two employers, The Fountain Group and CDK Global, were named as Respondents in this matter. Both employers stipulated at the time of hearing that their relation to Petitioner was one of employee and employer. Therefore, Petitioner's injury is compensable if it occurred in the course of and arose out of her employment with either employer, and both employers are joint and severally liable as Respondents under Section 1(a)4 of the Act. She maintains she was injured in an accident arising out of and in the course of her employment solely due to the fact her injury occurred on the employer's premises due to a dangerous or hazardous condition. "To obtain com-

pensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment." *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003).

The case law is well established that accidental injuries sustained on property that is either owned, maintained or controlled by an employer within a reasonable time before or after work are generally deemed to arise out of and in the course of employment when the petitioner's injury was sustained as a result of the condition of the employer's premises. See, *e.g., Archer Daniels Midland Co. v. Industrial Comm'n*, 91 Ill. 2d 210, 216, (1990) ("Where the claimant's injury was sustained as a result of the condition of the employer's premises, this court has consistently approved an award of compensation."); *see also Hiram Walker & Sons, Inc. v. Industrial Commission*, 41 Ill. 2d 429 (1968) (holding that claimant's fall in employer's ice-covered parking lot was compensable); *Carr v. Industrial Comm'n*, 26 Ill. 2d 347 (1962); *De Hoyos v. Industrial Commission*, 26 Ill. 2d 110 (1962) ; *Caterpillar Tractor Co.*, 1When29 Ill. 2d 52, 62 (1989) (suggesting that an injury is causally related to the employment if the injury occurs "as a direct result of a hazardous condition on the employer's premises"); *Mores-Harvey*, 345 Ill. App. 3d 1034, 1040 (2004) ("The presence of a hazardous condition on the employer's premises that causes a claimant's injury supports the finding of a compensable claim."); *Suter v. Illinois Workers' Compensation Comm'n*, 2013 IL App (4th) 130049WC, ¶ 40, 998 N.E.2d 971, 376 Ill. Dec. 261 (where the claimant slipped on ice in a parking lot furnished by her employer shortly after she arrived at work, the claimant was entitled to benefits under the Act "as a matter of law").

The key holding from *Mores-Harvey* that the courts have relied upon states that: "whether or not a parking lot is used primarily by employees or by the general public, the proper inquiry is whether the employer maintains and provides the lot for its employees' use." *Mores-Harvey*, 345 Ill. App. 3d at 1040, 804 N.E. 2d at 1092. If this is the case, then the lot constitutes part of the employer's premises. *Id.* The presence of a hazardous condition on the employer's premises that causes a claimant's injury supports the finding of a compensable claim. *Id.*

In the present case, Petitioner's injury occurred in a parking lot owned, or controlled or maintained by CDK Global for its employees. Petitioner's unrebutted testimony is that the lot was private, segregated visitor parking from employee parking, required an employee vehicle parking sticker, and was maintained by CDK Global's security. The sign shown in Petitioner's Exhibit 5, indicates that the specific part of the parking lot where she parked was designated for employees only.

Petitioner's injury arose out of and in the course of her employment because she was injured by the hazardous condition in CDK Global's parking lot in the location where she was required to work and, in an area, where she was required to park. In order to work for both CDK Global and The Fountain Group, Petitioner had to drive to the building at 1950 Hassell Road in Hoffman Estates on a daily basis, and she always parked in CDK's private parking lot. Furthermore, in the present case Petitioner was not able to park in her usual spot on the date of the accident because CDK Global closed off all entrances to the building aside from the main entrance. Therefore, Petitioner parked in the only available employee designated parking that was closest to the main entrance. She did not have to cross any medians to directly reach her car in the spot where she usually parked prior to the accident. She was exposed to the hazard of the muddy median as a

result of CDK Global's direction that all employees must use the main entrance that day because of a social media threat aimed at the head of CDK Global.

As shown by her testimony and demonstrated on Petitioner's Exhibit 6, she took the most direct route from her car to the main entrance and from the main entrance to her vehicle, which required her to step onto a grassy median in front of her vehicle. She had seen other CDK employees taking the same route over the median and had crossed the median on the morning of the accident because it was the most direct route to the building. The mud on the median where she fell was not noticeable prior to her feet becoming stuck there. This was the most reasonable and expected route for Petitioner to take. When she exited the building to return to her car, the pavement was wet because it had rained that afternoon. If she had not stepped onto the median, she would have had to walk a much greater distance over wet parking lot which would likely pose a greater, unnecessary risk of injury.

The Arbitrator notes that a pedestrian sidewalk was not provided for safe means of ingress and egress from the employee designated parking area to the entrance of the building.

Even though Petitioner's supervisor was at the post-accident scene of the occurrence as well as Respondent's security guard, neither employer offered any evidence nor provided any witness testimony to rebut Petitioner's testimony as to the muddy area where she fell. Respondents did not rebut that mud hidden from view by the grass caused her injury. The photographs submitted into evidence by the Respondent's were taken in December not in August. It is also clear that the photographs submitted by the Petitioner were taken after the summer when the grass would be shorter and sparser. The Arbitrator does not find the slight incline of the median and parking lot to be the cause of her injury nor to be hazardous in and of itself although it may have been a

cause of the muddy condition then and there existing.

The Arbitrator finds that Petitioner's fall was due to mud concealed in part by grass. The mud was of a sufficient amount to cause her feet to become stuck and cause her to fall, and, thus, constituted a hazardous condition. The muddy condition was especially hazardous, when concealed or made less readily apparent, due grass. The Arbitrator believes the Petitioner would not knowingly or willingly step into mud while wearing flats nor would she want to drag mud into her car. The Fountain Group's Exhibit 4 consisted of several photos which corroborate Petitioner's testimony regarding the location of the accident and the general description of the median and parking lot. RX4.

The Arbitrator has reviewed the evidence and the testimony of the Petitioner and the reasonable inference therefrom The Arbitrator finds that the presence of the mud hidden by grass on the employer's parking lot was a hazardous condition that caused Petitioner's injury and supports a finding of a compensable claim under the Act. The Arbitrator, therefore, concludes that an accident did occur which arose out of and in the course of Petitioner's employment with the Respondents.

REGARDING DISPUTED ISSUE F, "IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?", THE ARBITRATOR FINDS:

It is well settled under the law that a chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. *International Harvester v Illinois Worker's Compensation Commission* 93 Ill. 2d 59 (1982). It is also well established that an accident need not be the sole or primary cause-as long as

employment is a cause-of a claimant's condition. *Sisbro v Industrial Commission*, 207 Ill. 2d 193, 205 (2003). An employer takes its employees as it finds them. *St. Elizabeth Hospital v Worker's Compensation Commission*, 371 Ill. App 3d 882, 888 (2007). A claimant with a pre-existing condition may recover where employment aggravates or accelerates that condition. *Caterpillar Tractor Co. v Industrial Commission*, 92 Ill.2d 30, 36 (1982). That Petitioner had a pre-existing condition does not preclude the use of a chain of events analysis. *Schroeder v Illinois Worker's Compensation Commission*, 2017 Ill. App.(4th) 160192 WC (2017); *Corn Belt Energy Corp. v Illinois Worker's Compensation Commission,* 2016 Ill. App (3d) 150311 WC. The Arbitrator finds based on the weight of the credible evidence in this record, Petitioner's current condition of ill-being is causally related to the work accident of August 15, 2018.

The nature of Petitioner's injury is not in dispute. Petitioner testified that, prior to the accident on August 15, 2018, she was not having problems with her right foot and ankle. Immediately after falling on mud and twisting her right ankle, she noticed pain and that her right foot appeared to be hanging off of her right leg. She was diagnosed the same day at St. Alexius with a trimalleolar fracture of her right ankle after falling in mud. PX1.

Neither employer offered any medical opinion to rebut Petitioner's treating physicians nor any credible evidence of an intervening event that would break the chain of events.

The Arbitrator has had the opportunity to review the medical evidence and the credible testimony of the Petitioner. The Arbitrator finds a causal connection between Petitioner's present condition of ill-being in the right foot and ankle and the work accident of August 15, 2018.

REGARDING DISPUTED ISSUE J, "WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS THE RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL EXPENSES?", THE ARBITRATOR FINDS:

Petitioner was transported by ambulance to St. Alexius Medical Center on the day of the accident due to her inability to walk. She received emergency treatment and underwent a closed reduction of her fractured right ankle. She was referred to see specialist and was examined by Dr. Paul Lucas on August 28, 2018. He recommended the surgery that Petitioner underwent on September 1, 2018. On November 28, 2018, Dr. Lucas recommended a course of physical therapy. Petitioner underwent an initial evaluation with Amita Occupational Health on December 6, 2018, and she attended physical therapy there from February 2, 20219 through March 5, 2019. She continued post-operative treatment with Dr. Lucas through June 11, 2019. PX1, PX2.

Neither employer offered any medical opinion contradicting the reasonableness or necessity of any of the treatment. The Arbitrator finds all the medical treatment to be reasonable and necessary.

Petitioner presented medical bills as part of Exhibit 3. Based on the Arbitrator's findings in Section "F", Petitioner is awarded the following bills:

1. Village of Hoffman Estates—DOS 8/15/18: $1,514.00
2. St. Alexius Medical Center—DOS 8/15/18-3/5/19: $9,885.00
3. Radiological Consultants of Woodstock—DOS 8/15/18: $96.00
4. Midwest Emergency Associates—DOS 8/15/18: $1,197.00
5. Dr. Paul Lucas—DOS 8/28/18-6/11/19: $1,890.00 total, $80.00 paid by Petitioner
6. Elk Grove Radiology—DOS 9/1/18: $68.00

7. Resolute Anesthesia—DOS 9/1/18: $3,871.00

8. Alexian Brothers Medical Center—DOS 9/1/18-9/2/18: $42,074.70

Petitioner shall be reimbursed by the Respondents for $80.00 she paid out-of-pocket out of the awarded medical bills.

None of the bills presented in Petitioner's Exhibit 3 indicate that any payments were made by an insurance carrier. Several of them indicate that Petitioner was sent to collections. Neither employer claimed any credit under Section 8(j) of the Act. The Act requires that the Respondents pay the Petitioner for the above medical treatment pursuant to Sections 8(a) and 8.2. Petitioner testified that she was not aware of any charity deduction on her medical bills and had not filled out any paperwork to obtain such a reduction. (Tr., p. 44).

REGARDING DISPUTED ISSJUE K, "WHAT TEMPORARY BENEFITS ARE IN DISPUTE? TTD", THE ARBITRATOR FINDS:

The Petitioner claims that she is entitled to temporary total disability benefits for the period of October 1, 2018 through January 6, 2019, a period representing 14 weeks. The Respondents dispute liability for any TTD benefits. On September 27, 2018, Dr. Lucas reexamined Petitioner and kept her on the same restrictions of no weightbearing and elevation of the right ankle. (PX2). Petitioner's unrebutted testimony is that as of October 1, 2018, her employment with Respondents was terminated. Therefore, Respondents could not and did not accommodate her restrictions. From October 1, 2018 through January 6, 2019, Petitioner was on limited weight-bearing with her right ankle. She was off work until she began employment within her

restrictions with a new employer on January 7, 2019. Neither employer presented any evidence or testimony to contradict Petitioner's treating medical records or testimony.

The Arbitrator has reviewed the evidence and finds Petitioner is entitled to unpaid TTD benefits for 14 weeks, representing the period of October 1, 2018 through January 6, 2019.

REGARDING DISPUTED ISSUE L, "WHAT IS THE NATURE AND EXTENT OF THE INJURY?", THE ARBITRATOR FINDS:

Pursuant to Section 8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability ("PPD"), 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 regards to paragraph (i) of Section 8.1(b) of the Act:

i. The Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. This factor carries no weight in the permanency determination.

With regards to paragraph (ii) of Section 8.1(b) of the Act:

ii. Petitioner is now, and was at the time of injury, employed in a position that requires primarily desk work. She testified that her current employment does require significant amounts of walking which increases the symptoms in her right ankle. This factor carries minimal weight in the permanency determination

With regards to paragraph (iii) of Section 8.1(b) of the Act:

iii. Petitioner is 56 years old. The Arbitrator considers the Petitioner to be an older individual and will likely have greater disability than a younger individual with the same injuries. The Arbitrator gives this factor moderate weight.

With regards to paragraph (iv) of Section 8.1(b) of the Act:

iv. Petitioner returned to her full duty work and no evidence was presented which would indicate that she sustained any loss of earning capacity as a result of this accident. This factor carries some weight in the permanency determination.

With regards to paragraph (v) of Section 8.1(b) of the Act:

v. Evidence of Petitioner's injuries in the medical records show that she sustained a displaced trimalleolar fracture of her right ankle. On September 1, 2018, Petitioner underwent surgery performed by Dr. Lucas, including open reduction and internal fixation of the right ankle with placement of a plate and medial malleolar interfragmentary screw. She attended postoperative therapy at St. Alexius Rehab Services. At her exam with Dr. Lucas on June 11, 2019, Petitioner's right ankle continued to exhibit tenderness to palpation with some bruising present in the right ankle. PX1-PX2.

Prior to the accident, Petitioner was not having problems with her right foot or ankle. She currently notices pain, stiffness, and limited mobility, which become worse when she has to walk for over two blocks, drive for over an hour, or use stairs. She still has hardware in her right ankle, which the Arbitrator notes may require removal at a later date. The Arbitrator gives great weight to the Petitioner's current symptoms, corresponding to the treating medical records.

The determination of permanent partial disability is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of PPD, consideration is not given to any single enumerated factor as the sole determinant. Therefore, after applying Section 8.1b of the Act, 820 ILCS 305/8.1b and considering the relevance and weight of all the above factors, the Arbitrator concludes that Petitioner has sustained a 35% permanent loss of the right foot under Section 8(d)2, or 58.45 weeks of PPD benefits.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC027887
Case Name	CHAVEZ,BRAULIO v. TOTAL STAFFING SOLUTIONS
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0316
Number of Pages of Decision	41
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	Damian Flores
Respondent Attorney	Thomas Boyd

DATE FILED: 6/22/2021

/s/ Christopher Harris, Commissioner

Signature

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

BRAULIO CHAVEZ,

Petitioner,

vs.

NO: 18 WC 27887
19 WC 8620

TOTAL STAFFING SOLUTIONS, INC., and
BRIDGEVIEW MANUFACTURING, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical, and prospective medical, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 14, 2020 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired

without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $58,000.00. 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.

June 22, 2021

CAH/tdm
O: 6/17/21
052

Christopher A. Harris
Christopher A. Harris

Barbara N. Flores
Barbara N. Flores

Marc Parker
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

CHAVEZ, BRAULIO
Employee/Petitioner

Case# **18WC027887**
19WC008620

TOTAL STAFFING SOLUTIONS INC AND BRIDGEVIEW MANUFACTURING INC
Employer/Respondent

On 8/14/2020, 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 0.12% 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:

1922 STEVEN B SALK & ASSOC LTD
DAMIAN R FLORES
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

4866 KNELL O'CONNOR DANIELEWICZ PC
THOMAS RYAN BOYD
W JACKSON BLVD SUITE 301
CHICAGO, IL 60607

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
19(B)/8(A) ARBITRATION DECISION

BRAULIO CHAVEZ
Employee/Petitioner

v.

TOTAL STAFFING SOLUTIONS, INC., and BRIDGEVIEW MANUFACTURING, INC.
Employer/Respondent

Case # **18** WC **27887**

(consolidated with 19 WC 8620)

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 **December 12, 2019 and June 16, 2020**. 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. [ ] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [ ] TTD
L. [ ] What is the nature and extent of the injury?
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other: Prospective/additional medical treatment (8a)

FINDINGS

On **August 7, 2018** Respondents ***were*** operating under and subject to the provisions of the Act.

On that date, an employee-employer relationship ***did*** exist between Petitioner and Respondents.

Petitioner ***did*** sustain an accident that arose out of and in the course of employment with Respondents.

Timely notice of the accident was provided to Respondents.

For the reasons set forth in the attached decision, Petitioner established a causal connection between each work accident and his current lumbar spine condition of ill-being.

In the year preceding the injury, Petitioner earned $5,140.00; the average weekly wage was $395.38.

On the date of alleged accident, Petitioner was 47 years of age, ***married*** with **one** dependent child.

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

Respondent shall be given a credit of $0 for TTD, $**0** for TPD, $**0** for maintenance, and $0.00 for medical benefits under Section 8(j) of the Act, for a total credit of $0.00

ORDER

Medical Benefits
With the exception of the non-emergency transportation charges claimed by Lakeshore Surgery Center (PX 17) and the rental unit charges claimed by Windy City Medical Specialists (PX 31, 35), the Arbitrator awards the fee schedule charges set forth in PX 31. See the attached decision for further details concerning the medical award.

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner did not exceed the choices afforded by Section 8(a).

Prospective Medical (8a)
Respondents shall authorize and pay for prospective care in the form of the two-level lumbar fusion recommended by Dr. Salehi and ultimately certified by utilization review.

Penalties/Fees
For the reasons set forth in the attached decision, Respondents are liable for $10,000.00 in Section 19(l) penalties, $2,283.74 in Section 19(k) penalties and $913.49 in Section 16 attorney fees.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of

payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Molly C Mason

Signature of Arbitrator

8/13/20
Date

AUG 14 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

CHAVEZ, BRAULIO
Employee/Petitioner

Case# **19WC008620**

18WC027887

TOTAL STAFFING SOLUTIONS INC - LOANING EMPLOYER & UNIFIRST CORPORATION INC - BORROWING EMPLOYER
Employer/Respondent

On 8/14/2020, 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 0.12% 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.

1922 STEVEN B SALK & ASSOC LTD
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21IWCC0316

STATE OF ILLINOIS)
)
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
19(b)/8(a) ARBITRATION DECISION

Braulio Chavez
Employee/Petitioner

v.

Total Staffing Solutions, Inc.-loaning employer & Unifirst Corporation, Inc.-borrowing employer
Employer/Respondent

Case # 19 WC 08620

Consolidated cases: 18 WC 27887

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 IWCC, in the city of Chicago, on 12/12/19 & 6/16/20. 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 the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to the respondent?
F. ☒ Is the petitioner's present condition of ill-being causally related to the injury?
G. ☐ What were the petitioner's earnings?
H. ☐ What was the petitioner's age at the time of the accident?
I. ☐ What was the petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to petitioner reasonable and necessary? 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 the respondent?
N. ☐ Is the respondent due any credit?
O. Other Choice of Physicians and Future Medical

FINDINGS

- On 10/24/2018 , Respondents Total Staffing Solutions, Inc.& Unifirst Corporation, Inc. *were* operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship *did* exist between Petitioner and Respondents.
- On this date, Petitioner *did* sustain injuries 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, Petitioner established a causal connection between each of his work accidents and his current lumbar spine condition of ill-being.
- In the year preceding the injury, Petitioner earned **$8,908.76**; the average weekly wage was **$371.20**.
- On the date of accident, Petitioner was **47** years of age, ***married*** with **1** dependent child.
- Petitioner has in part received reasonable and necessary medical services.
- Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.
- Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, , and **$0** for other benefits, for a total credit of **$0**.
- Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

The Arbitrator awards the unpaid medical expenses under the case of 18 WC 27887.

The Arbitrator awards the proposed lumbar fusion surgery under the case of 18 WC 27887.

Petitioner did not exceed his choice of physicians.

The Arbitrator awards penalties under the case of 18 WC 27887.

Respondents agree that, pursuant to the "Staffing/Vendor Agreement" (Unifirst Exh 1) running between them, Total Staffing assumed full liability for any workers' compensation claims filed by employees loaned to Unifirst.

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

8/13/20
Date

AUG 14 2020

Braulio Chavez v. Total Staffing Solutions
and Bridgeview Manufacturing, Inc.
18 WC 27887 and 19 WC 8620 (consolidated)

Summary of Disputed Issues

Petitioner, a staffing agency employee, claims he injured his lower back on August 7, 2018, while working at Bridgeview Manufacturing, and on October 24, 2018 [as amended, T. 174-177], while working at Unifirst Uniform Services. The disputed issues in both cases include accident, notice, causal connection, medical expenses, penalties/fees and prospective treatment, with Petitioner seeking a lumbar fusion that was recommended by Dr. Salehi and ultimately certified by utilization review. Arb Exh 1, 3.

Arbitrator's Findings of Fact

Petitioner testified via a Spanish-speaking interpreter.

Records in PX 6 reflect that Petitioner underwent a lumbar spine MRI on November 6, 2008. A chiropractic radiologist interpreted this study as showing a 4 millimeter, left foraminal intervertebral disc protrusion at L4-L5 and an asymmetric, broad-based posterior annular bulge at L5-S1. PX 6.

Petitioner acknowledged injuring his low back on July 31, 2009. He filed a workers' compensation claim in connection with this injury. He settled this claim [09 WC 36880] on December 17, 2010. T. 26. Petitioner testified he underwent physical therapy and three injections following the July 31, 2009 injury. T. 27. Records in PX 10 document treatment at Concentra and MacNeal Hospital. A lumbar spine MRI performed on January 7, 2010 showed a 2-3 millimeter disc bulge/protrusion at L5-S1 indenting the thecal sac, without significant stenosis. PX 6.

Petitioner testified he resumed working after he settled the '09 claim. The jobs he performed after December 2010 included forklift operator, school maintenance worker and home remodeler. In 2017, he worked at Southern Glazer Wine & Spirit for about a year. The job he performed at Southern Glazer required lifting up to 30 pounds. He was able to perform his assigned duties at Southern Glazer. T. 29-30.

On direct examination, Petitioner denied undergoing any low back treatment between the time he settled his '09 claim, in December 2010, and 2017. T. 30. Records in PX 10, however, reflect he underwent a physical therapy evaluation at MacNeal Hospital on March 31, 2011, with the evaluating therapist noting a complaint of low back pain radiating down the right leg to the knee.

Petitioner testified he began working for Total Staffing in late April 2018, after he left Southern Glazer. T. 30. Total Staffing sent him to various locations, including Nestle. At Nestle,

he drove a forklift for two to three months. He sat for eight hours per day while operating the forklift. His back did not bother him during this period. He was "working fine." T. 33.

Petitioner testified that, in August 2018, he began working as a machine operator at Bridgeview Manufacturing for Total Staffing. The machine cut automobile parts. He had to periodically clean the machine to remove liquid and scrap metal that would otherwise interfere with the manufacturing process. T. 35-36. Two to three times per shift, he would place the liquid and scrap metal in a plastic box that was about 20 inches by 20 inches in size and take the box out to a garbage container. T. 37-38. The box, when full of scrap metal, could weigh up to 100 pounds "because it also has liquid that runs around it." T. 38.

Petitioner testified he arrived at work at 4 AM on August 7, 2018. He felt fine when he arrived. T. 39. He discovered that his assigned machine was still "dirty from the previous shift." T. 39. After he cleaned the machine, he began lifting the 100-lb. plastic box containing refuse off the floor, using both hands. His intention was to place the box on his right shoulder so that he could carry it. As he began lowering the box to his shoulder, he felt a strong pull in his lower back. He rated his initial pain at 6-7 on a scale of 1 to 10. T. 41. He did not report the injury at that time because no supervisor was present. He continued working. At the end of his shift, he reported the accident to Angela, the owner of the company. He does not know Angela's last name. T. 42. He was in a lot of pain by the time his shift ended. It was very difficult for him to get into his car. T. 42-43. After he got up the following morning, he went to Total Staffing's office and reported the accident to Leticia, the manager. At his request, Leticia completed a written accident report so that he could go to a clinic. T. 44. Petitioner identified RX 2 as the accident report. He completed the first page of the report, in Spanish. He did not complete the second page, which is in English. T. 45-46. The name "Andrea Koller" is printed on the report. Andrea Koller is the person at Bridgeview to whom he reported the accident on August 7, 2018. T. 46. Leticia arranged for him to go to LaGrange Medical. On August 8, 2018, he drove himself to this facility, underwent a drug screening and then saw Dr. Byrd. T. 46. [The screening results were negative.] He complained of 8-10/10 pain in his left buttock traveling into his left thigh. T. 47. He initially denied experiencing this kind of radiating pain prior to the August 7, 2018 accident. He then acknowledged experiencing some leg pain after his 2009 back injury. Between December 2010 and the August 7, 2018 accident, he did not experience pain traveling down his legs. T. 48.

Petitioner testified that Dr. Byrd prescribed medication and imposed work restrictions. T. 49.

A "work injury form" in PX 1 reflects that, on Petitioner complained of low back pain radiating to his left buttock and down his left leg after lifting an approximate 100-pound container at work the previous morning. Petitioner rated his pain at 8/10 when standing. He described having undergone treatment for a similar injury nine years earlier. On initial examination, Dr. Byrd noted a reduced lumbar spine range of motion and point tenderness over the left lumbar area and left lateral thigh. She administered a Toradol injection, prescribed Naproxen, ice applications and physical therapy and directed Petitioner to return to the facility

to undergo X-rays. She restricted Petitioner to seated work with no driving, kneeling, squatting or repetitive bending/twisting. The X-rays, performed two days later, showed mild spondylosis and Grade 1 retrolisthesis L5 over S1. PX 1.

Petitioner testified he did not resume working at Bridgeview after his initial visit to Dr. Byrd. Instead, he began performing light duty in Total Staffing's office. The light duty consisted of cleaning the office, doing applications and posting notices in the street. T. 49. He continued seeing Dr. Byrd during this period. T. 49. On August 13, 2018, Dr. Byrd added Tylenol #3 and continued the restrictions. PX 1.

Petitioner underwent physical therapy at Athletico between August 17, 2018 and October 10, 2018. T. 50. At the initial therapy evaluation, the therapist noted that Petitioner reported injuring his low back "while lifting heavy object from floor and placing it onto R shoulder." The therapist also noted that Petitioner's gait was abnormal and that he exhibited signs of left lumbar radiculopathy. PX 1.

On August 27, 2018, Dr. Byrd noted that Petitioner had attended six therapy sessions but was still rating his left-sided pain at 7/10. She prescribed Norco, a Medrol DosePak and a lumbar spine MRI. She imposed restrictions of no kneeling, squatting, driving or repetitive bending/twisting and recommended additional therapy. PX 1.

A CompCorePro "personal note" dated August 29, 2018 reflects that Dr. Khanna spoke with Dr. Byrd about Petitioner's care. The note indicates that Dr. Khanna felt Petitioner "should be improving . . . three weeks after his injury date" but that Dr. Byrd wanted to try an additional two weeks of therapy. The note goes on to state that the additional therapy should be approved and that an MRI would be indicated "to rule out a disc herniation" if Petitioner did not improve by September 10, 2018. PX 2.

On August 30, 2018, James Hernandez, a claims adjuster affiliated with Next Level Administrators, wrote to LaGrange Medical Center, authorizing six physical therapy sessions. PX 2, PX 34.

In a GENEX utilization review communication dated September 10, 2018, Dr. Wang, a physiatrist, recommended that eighteen physical therapy sessions between August 31 and November 4, 2018 be non-certified. In making this recommendation, Dr. Wang noted that Petitioner remained symptomatic after twelve therapy sessions and cited "evidence-based guidelines" recommending that patients suffering from sciatica undergo ten to twelve therapy sessions over an 8-week period. PX 2.

The MRI, performed without contrast on September 14, 2018, showed degenerative disc disease and degenerative facet disease at various levels, with the radiologist noting that the findings were "prominent at the L4-L5 level where there is a broad-based disc bulge which is asymmetrically extending into the left neural foramen" resulting in stenosis of the left lateral recess and moderate left neural foraminal narrowing. PX 1.

A OneCallCare Email dated September 17, 2018 documents authorization of additional therapy visits between September 4 and 14, 2018. PX 2.

Petitioner testified he last saw Dr. Byrd on September 18, 2018. T. 51. [Based on notes in PX 1, it appears Petitioner actually saw Dr. Khan at LaGrange Medical Center on September 18, 2018.] Dr. Khan noted that Petitioner was benefiting from therapy and did not want any steroid injections. Petitioner testified he declined to undergo injections because he "wanted another option." Dr. Khan recommended two more weeks of therapy and continued the previous restrictions. PX 1.

On September 21, 2018, Elida Garcia of Comp Core Pro sent an Email to adjuster James Hernandez asking him to authorize two more weeks of therapy at Athletico. PX 2.

Petitioner testified he began seeing a different physician, Dr. Bayran, on September 27, 2018. He did not choose Dr. Bayran. He does not know whether his previous attorney selected Dr. Bayran. Someone associated with LaGrange Medical Center telephoned him and told him he would be seeing Dr. Bayran on a specific date. He did not set up the appointment on his own. T. 53. He knows it was LaGrange that contacted him because he asked the person who called him where that person was calling from. T. 54.

Petitioner testified he provided a consistent history of the August 7, 2018 accident to Dr. Bayran. He did not tell Dr. Bayran about the 2009 accident because that accident occurred in the past and "there was no pain from that." T. 54. Dr. Bayran recommended that he continue attending therapy and performing light duty. T. 55. He also prescribed an epidural steroid injection.

Dr. Bayran's initial note of September 17, 2018 reflects, without further explanation, that Petitioner was "referred by Neema Bayran." The doctor recorded a consistent history of the lifting-related accident of August 7, 2018 and subsequent care. The doctor noted that Petitioner reported "very little improvement" of his left-sided radicular symptoms after fifteen therapy sessions. He described Petitioner as walking without assistive devices and "able to sit comfortably." On lumbar spine examination, he noted tenderness over the midline and paraspinal muscles bilaterally and decreased sensation to light touch over the left lateral thigh. He interpreted the MRI as showing "foraminal disc extrusion on the left side at L4-L5 and disc extrusion to the left at L5-S1." He recommended that Petitioner continue therapy, noting he had three sessions scheduled. He also recommended a lumbar epidural steroid injection on the left. He imposed restrictions of no lifting over 20 pounds, no pulling/pushing over 30 pounds and no frequent twisting or bending. PX 3.

Dr. Bayran administered a transforaminal steroid injection on October 5, 2018. PX 3-5. Petitioner testified he "felt a little better" after this injection. The injection helped only a little with respect to his leg pain. T. 56.

On October 8, 2018, GENEX wrote to Dr. Bayran, certifying the left L4-L5 and L5-S1 transforaminal epidural injection. PX 29.

Dr. Bayran's note of October 18, 2018 reflects that Petitioner was still experiencing sharp pain in his lower back in the morning but denied pain radiating to his legs. The doctor released Petitioner to full duty "on a trial basis." He directed Petitioner to return to him if he could not tolerate full duty. PX 3.

Petitioner testified that, following the injection, Dr. Bayran recommended he return to his normal activities but "with caution." The doctor directed him to avoid doing things too quickly. T. 56. After the doctor released him to full duty, he contacted Total Staffing. Total Staffing sent him to work at a commercial laundry service called "Unifirst." T. 57-58.

Petitioner testified he began working at Unifirst in October 2018. He worked there about three days. His job consisted of removing wet, dirty laundry from large containers, placing the laundry on a table that was about 2 ½ feet high, sorting the items by color, placing the sorted items in carts and pushing the carts into large elevators. T. 57-59. The carts, when full, weighed between 200 and 300 pounds. At the beginning of the process, he had to bend to remove the wet laundry from the large containers, which arrived via truck. T. 60-61. A scale registered the weight of the items that he placed in carts. T. 62. He filled the carts to the brim before pushing them to the elevator. T. 62. The process continued throughout his shift. He bent over to pick up piles of items between 50 and 80 times a day. T. 66.

Petitioner testified he reinjured his back on October 23, 2018, while working at Unifirst. He was lifting a bundle of wet clothing that was about three feet wide and three feet high when he felt pinching in his back. The pinching sensation was more intense than the pain he had previously experienced. T. 65. He did not report the accident to anyone at Unifirst. He reported it to Leticia [of Total Staffing] the following day and then called Dr. Bayran's office. He set up an appointment to return to Dr. Bayran on October 25, 2018. The doctor had instructed him to call if his back condition changed. T. 66-67. On October 25, 2018, he reported the October 23rd accident to Dr. Bayran and complained of low back pain radiating down to his foot. His foot symptoms started after the October 23, 2018 accident. T. 67. At no time between December 2010 and August 2018 did he seek treatment for low back pain traveling down to his foot. T. 67-68.

Dr. Bayran's note of October 25, 2018 sets forth the following interval history:

> "The patient comes back for a visit. He states that his pain got worse after he started working as full-duty with no restrictions. He states that he was pushing a cart full of clothes which weighs about 400 pounds and he was bending down to pick up heavy wet clothes when his pain got worse. He complains of pain on the left side of his lower back with radiation into his left buttock, left

> lateral thigh, leg and foot. He describes his pain has [sic] pinching, sharp pain. He states that he feels that his left leg is very heavy. He also complains of pain radiating into his left groin and medial thigh."

On re-examination, Dr. Bayran noted decreased sensation to light touch on the left in the distribution of the left L4 nerve root. After re-reviewing the MRI, the doctor recommended a spinal consultation and imposed restrictions of no lifting over 20 pounds and no pulling or pushing over 30 pounds. PX 3.

Petitioner testified that, as soon as Dr. Bayran gave him the restrictions, he went to Total Staffing's office. He presented the restrictions to Leticia and told her about the October 23, 2018 accident. Leticia told him she no longer had light work available for him and that his situation was now in the hands of attorneys. T. 69. After October 25, 2018, he never returned to work for Total Staffing. T. 70. He tried to find work elsewhere. T. 70.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Singh on November 21, 2018. Dr. Singh's report reflects he examined Petitioner in the presence of a Spanish-speaking interpreter. The report also reflects that Dr. Singh reviewed records from LaGrange Medical Center and Dr. Bayran, as well as the September 14, 2018 MRI images. Dr. Singh noted complaints of 7/10 lower back pain and left posterior thigh paraesthesias into the knee. On examination, the doctor noted a full range of lumbar spine motion, 5/5 strength and 5 out of 5 positive Waddell's signs. He interpreted the MRI images as revealing a left L4-L5 disc protrusion without evidence of any L4 exiting nerve root compression. He opined that Petitioner "sustained a soft tissue muscular strain which has resolved." He characterized the L4-L5 disc herniation as "incidental in nature." He did not find Petitioner's posterior thigh complaints to be consistent with an L4 nerve root compression. He indicated it would have been appropriate for Petitioner to undergo four weeks of physical therapy. He saw no need for an injection. He described Petitioner's prognosis as "guarded." He found Petitioner capable of full duty.

Petitioner testified he began working for Billet Specialties sometime in November 2018. He worked for this company for only a short period, until January 2019, when he began working for Illinois Staffing. T. 71-72. He believes he was off work for about three weeks before he started working at Billet Specialties. T. 71-72.

Petitioner testified he saw Dr. Bayran again on November 29, 2018. At that visit, he complained of 6/10 pain going down to his left foot. The doctor continued the previous restrictions and again recommended a surgical consultation. T. 73. PX 3.

Petitioner testified he last saw Dr. Bayran on December 27, 2018. At that point, he was still experiencing low back and leg pain. His back pain had not improved. T. 74. Dr. Bayran discharged him from care, telling him he could not do anything more because Dr. Singh had said he did not require any additional treatment. T. 74. Dr. Bayran released him to full duty. T. 76.

In his note of December 27, 2018, Dr. Bayran expressed awareness of Dr. Singh's opinions that the work accident resulted in a lumbar strain and that Petitioner was capable of full duty. Citing these opinions, Dr. Bayran indicated that Petitioner did not require a spinal consultation "at this point." He discharged Petitioner from care. PX 3.

Petitioner testified that, in January 2019, Illinois Staffing sent him to work at MD Metals. He is still working full-time at MD Metals. T. 77, 79. At this facility, he cuts pieces of wood and cleans offices and bathrooms. T. 77. He is on his feet most of the day. T. 77-78. The only items he lifts at MD Metals are 15-inch pieces of wood. The work is "very light" but his symptoms persisted. T. 78. Eventually, he sought another opinion at a clinic at 7200 North Western Avenue, where he saw Dr. Trebert. This doctor prescribed therapy and recommended he see a pain management specialist. T. 79. He underwent therapy, at two La Clinica facilities, between February 21, 2019 and March 2019. T. 80.

Records in PX 6 reflect that Petitioner saw Dr. Trebert, a chiropractor, at Delaware Physicians, LLC, on February 13, 2019. A "patient status form" in PX 6 reflects that Petitioner was referred by "GML." Dr. Trebert noted complaints of low back pain with associated radiation and numbness in the left leg secondary to a work accident of August 7, 2018. She also noted that Petitioner had attended twenty therapy sessions and described his symptoms as having worsened since the last session. She prescribed therapy and recommended a consultation with a pain management specialist. PX 6, 7.

On February 19, 2019, Petitioner saw Dr. Iavarone, a chiropractor, at La Clinica, S.C., in Cicero, Illinois. The doctor recorded a consistent history of the August 7, 2018 accident and subsequent care. He noted that Petitioner "has been working since the accident" but lasted only four days at UniStaff in October 2018 "due to the pain." He indicated that, in November and December 2018, Petitioner worked for "_____ Specialties" and that he was currently working at ASI Accurate, a door company, where he was painting and packing doors.

Dr. Iavarone noted that Petitioner complained of left-sided low back pain, rated 7/10, radiating to the bottom of his left foot. He also noted that Petitioner reported injuring his low back ten years earlier "with all symptoms resolved." He linked Petitioner's complaints to the August 7, 2018 accident. PX 7.

On February 21, 2019, Petitioner began a course of care with Dr. Zaragoza, a chiropractor, at La Clinica, S.C. PX 7.

Petitioner testified that, at Dr. Trebert's referral, he saw Dr. Vargas at the facility at 7200 North Western Avenue, on February 21, 2019. Petitioner denied having any new back injuries between his last visit to Dr. Bayran, in December 2018, and his first visit to Dr. Vargas. T. 81. He complained to Dr. Vargas of pain traveling down the back of his leg to his foot. He did not provide a history of the 2009 accident to Dr. Vargas because that accident did not result in any

lingering problems. T. 82. At the recommendation of Dr. Vargas, he underwent another MRI on February 25, 2019 and then two more epidural steroid injections. T. 82-83.

In his initial note of February 21, 2019, Dr. Vargas recorded a consistent history of the August 7, 2018 work accident and subsequent care. He did not mention the October 2018 accident. He indicated that Petitioner described his symptoms as persisting after he resumed regular work, following therapy and an epidural injection. He described Petitioner as currently working "assembling bathroom doors." He noted that Petitioner walked with a mild limp, favoring his left leg. He also noted that Petitioner was able to walk on his heels and toes but unable to squat. After examining Petitioner and reviewing the MRI, he diagnosed chronic low back pain syndrome, discogenic pain syndrome, L4-L5 and L5-S1 herniated discs and lumbar facet pain syndrome. He recommended a repeat lumbar spine MRI, therapy, a series of bilateral L4-L5 and L5-S1 epidural steroid injections, a back brace and various medications. He linked Petitioner's symptoms to the work injury. He imposed restrictions of no lifting, carrying, pushing or pulling over 20 pounds. PX 6, 7, 8.

Petitioner underwent the recommended repeat lumbar spine MRI on February 26, 2019. T. 82. Dr. Kuritza, the interpreting radiologist, indicated he compared the images with those obtained on November 6, 2008 and October 1, 2009. He indicated that "the current exam demonstrates again at the L5-S1 level a 1-2 millimeter posterior disc bulge which indents the thecal sac at this level." He also noted a "far left intraforaminal disc protrusion/herniation measuring 2-3 millimeters" at L4-L5. PX 7.

Petitioner returned to Dr. Vargas on February 27, 2019. The doctor interpreted the repeat MRI as confirming pathology at the L4-L5 and L5-S1 levels. He described Petitioner as still in mild to moderate distress. He recommended a series of left-sided L4-L5 transforaminal epidural steroid injections. He refilled the medication and took Petitioner off work. PX 6. [A "quick report" in PX 8 reflects that Dr. Vargas continued the previous 20-pound restriction.]

On February 28, 2019, Dr. Zaragoza noted that Petitioner "has not been working since his work told him that they have no work for him." He also noted that Petitioner was scheduled to undergo injections the following day. PX 7.

On March 1, 2019, Dr. Vargas prescribed a VascuTherm Cold Therapy rental unit for Petitioner. PX 35.

On March 1 and 15, 2019, Dr. Vargas administered left L4-L5 transforaminal epidural steroid injections and selective nerve root blocks. PX 6, 8. Petitioner testified that the first injection did not help at all and that his pain increased after the second injection. T. 83.

On March 21, 2019, Dr. Zaragoza noted that Petitioner reported improvement of his leg pain following the injections. He described Petitioner as saying that "his job does allow him to work at his pace." PX 7.

On March 21, 2019, Petitioner's current counsel filed an Amended Application in 18 WC 27887 and an Application in 19 WC 8620. PX 22-23.

Petitioner returned to Dr. Vargas on March 27, 2019 (T. 83), with the doctor noting "no tangible clinical improvement whatsoever." The doctor also noted an intervening records review by a rehabilitation physician, Dr. Jaspal Singh. He described Dr. Singh as using "outdated and controversial data" in diagnosing a lumbar strain and concluding that Petitioner did not require the care he had recommended. After re-examining Petitioner, he recommended a surgical consultation, noting he wanted to perform a CT discogram and then refer Petitioner to Dr. Erickson, a neurosurgeon. He continued the previous work restrictions. PX 6, 8.

In an addendum issued on April 3, 2019, Dr. Vargas noted that he had spoken with an unidentified physician earlier that day, "in response to a negative UR issued by a different physician, i.e., Dr. Singh, who was unavailable for a peer to peer discussion." He also noted that the physician with whom he spoke "was unaware that [Petitioner] had failed to respond" to care and was pending a CT discogram. PX 8.

Dr. Vargas performed a four-level lumbar discogram on April 5, 2019. In his report, he described Petitioner as cooperative. He deemed Petitioner's responses to be valid. He concluded that Petitioner had "unequivocal concordant" pain at L4-L5 and L5-S1, with controls at L2-L3 and L3-L4. Dr. Kuritza interpreted a post-discogram lumbar spine CT scan as showing a 3-4 millimeter left intraforaminal disc herniation at L4-L5 and a 3-4 millimeter posterior disc herniation at L5-S1 indenting the thecal sac. PX 6, 8.

Petitioner testified that, when he last saw Dr. Vargas, on April 16, 2019, the doctor told him the discogram "came out bad" and referred him to Dr. Salehi, a surgeon. T. 84-85. While Dr. Vargas' note mentions Dr. Erickson, and not Dr. Salehi, Dr. Vargas told him that Dr. Salehi was "better." Petitioner testified that the receptionist at Dr. Vargas's clinic told him that Dr. Salehi sees patients at that clinic. T. 86.

In his note of April 16, 2019, Dr. Vargas indicated he reviewed the CT discogram results with Petitioner. He refilled Petitioner's medication, prescribed therapy and referred Petitioner to Dr. Erickson, who he described as a "neurosurgeon in our group." He recommended that Petitioner remain off work. A separate "quick report," however, reflects both that the doctor found Petitioner unable to work and that he was capable of light duty with no lifting, carrying, pushing or pulling over 20 pounds. PX 6, 8.

Petitioner testified he first saw Dr. Salehi on May 7, 2019. The employees at Dr. Vargas's clinic set up this appointment. They "arranged everything." T. 86. The employees asked him whether he preferred to see Dr. Salehi at the Western Avenue location or at the doctor's clinic in Westchester. He opted for Westchester because he lives 20 minutes from that city. T. 87. He believes it was "Marisol" of Dr. Vargas's office who he spoke with. T. 87. When he first saw Dr. Salehi, he complained of 8/10 low back pain radiating down his left leg into his foot. He provided the doctor with copies of his 2018 and 2019 MRIs and the April 5, 2019 CT

discogram scans. The doctor examined him and recommended surgery. He wants to undergo this surgery. T. 89. The doctor also indicated he could continue working. T. 88-89.

Dr. Salehi described Petitioner as lifting a heavy container onto his left, rather than right, shoulder but his account of the August 7, 2018 accident is otherwise consistent with Petitioner's testimony. He described Petitioner as denying any history of back or leg pain prior to this accident. After examining Petitioner and reviewing the 2019 lumbar spine MRI and CT discogram, he diagnosed mechanical back pain secondary to annular tears at L4-L5 and L5-S1. He found this diagnosis to be "causally related to the work injury of 8/7/18." He recommended a L4-S1 transforaminal lumbar interbody fusion, noting that Petitioner wanted to proceed with this surgery. PX 9, pp. 1-4.

On May 8, 2019, Dr. Salehi's surgical coordinator wrote to Angie Suesz, a claims adjuster at Next Level Administrators, requesting authorization of the recommended fusion. Suesz wrote back the same day, denying authorization "per IME 11/21/18 and pending litigation of this matter." PX 9, PX 32.

On May 8, 2019, Petitioner's counsel sent Respondent Total Staffing's counsel an Email, demanding payment of various outstanding medical expenses totaling $40,032.60. PX 26.

On May 11, 2019, GENEX wrote to the adjuster, as well as Dr. Salehi and Petitioner's counsel, indicating it was non-certifying the recommended lumbar fusion. The reviewing physician, Dr. Marehbian, a board certified neurologist, found the request for this surgery to be "premature for this claimant" and "not medically appropriate at this time." Specifically, Dr. Marehbian noted that Petitioner had resumed light duty and that "there appeared to be no evidence of instability to warrant a fusion over possible discectomy/laminectomy procedures." RX 6.

On May 15, 2019, GENEX wrote to Petitioner's counsel, indicating that, in response to Dr. Salehi's appeal of May 13, 2019, it was certifying the recommended L4-S1 fusion. GENEX cited the opinions of Dr. Luke, a board certified orthopedic surgeon, and indicated that "the prior determination [i.e., non-certification] was not appropriate." PX 28.

On May 29, 2019, Petitioner's counsel sent updated medical bills from four providers to Respondent Total Staffing's counsel. Total Staffing's counsel responded the same day, indicating that the injections "were all denied per UR and IME." PX 27.

Petitioner testified he did not tell Dr. Salehi about his 2009 back treatment until after the initial visit because he was fine between December 2010 and the August 2018 accident. T. 89-90. On August 6, 2019, he provided Dr. Salehi with copies of the MRI scans he underwent in 2009 and 2010. Dr. Salehi continued to recommend surgery. T. 90.

Petitioner testified he sought Emergency Room treatment on September 23, 2019 because he was experiencing "a really intense pulsating pain" and this worried him. He denied

sustaining any new back injury prior to his Emergency Room visit. T. 91. He never sought Emergency Room care for similar care between December 2010 and the August 2018 accident. T. 91. At the Emergency Room, doctors observed him for two hours and gave him pain medication. They recommended that he return to the Emergency Room if his pain persisted. PX 21

On September 23, 2019, Emergency Room personnel noted that Petitioner reported injuring his back at work a year earlier. They also noted that Petitioner was waiting to undergo recommended back surgery and denied any new back injury or trauma. The examining physician's assistant noted generalized tenderness to palpation of the bilateral lumbar paraspinous muscles and some midline tenderness to palpation. She dispensed Norco, Decadron and Lidocaine patches and instructed Petitioner to avoid heavy lifting or twisting. PX 10, pp. 7-10.

Dr. Salehi testified by way of evidence deposition on October 1, 2019. PX 25. Dr. Salehi testified he did his internship and residency in neurosurgery at Northwestern. He became board certified in neurosurgery in 2004 and was recertified in 2015. PX 25, p. 5. Salehi Dep Exh 1.

Dr. Salehi testified he first saw Petitioner on May 7, 2019, with Petitioner providing a history of a lifting-related work accident of August 7, 2018. Dr. Salehi indicated that Petitioner told him he experienced left-sided low back and left leg pain on that date after lifting a 100-pound container onto his left shoulder and carrying that container to a dumpster three times. Dr. Salehi also indicated that Petitioner subsequently improved but experienced a return of his pain after resuming work. He noted that Petitioner rated his current pain level at 8/10. PX 25, pp. 7-8.

Dr. Salehi testified that his evaluation of Petitioner, nine or ten months out from the injury, was beyond the point where one could reasonably attribute his symptoms to a muscular strain. PX 25, p. 8. The fact that Petitioner had pain running down to his left foot was suggestive of some neural compression. PX 25, p. 8. The injections Petitioner underwent allowed his symptoms to abate to the point where he could return to work. On October 25, 2018, Dr. Bayran documented recent lifting activity at work, with this activity aggravating Petitioner's lumbar condition. PX 25, p. 10.

Dr. Salehi testified that his examination findings showed there was "a pathology going on within [Petitioner's] lumbar spine resulting particularly in the limitation of the range of motion and the sensory loss." PX 25, p. 11. Petitioner was still working, subject to restrictions.

Dr. Salehi testified that he observed no signs of symptom magnification when he examined Petitioner. PX 25, p. 11.

Dr. Salehi interpreted the February 25, 2019 lumbar spine MRI images as showing annular tears within the L4-L5 and L5-S1 discs. He interpreted the post-discogram CT scan as

showing an annular tear at L5-S1 and on the left side at the posterolateral aspects of L3-L4 and L4-L5. PX 25, p. 12. When the outer, tougher layer of a disc tears, that can cause back pain. PX 25, p. 12. The discogram showed that Petitioner had concordant pain at L4-L5 and L5-S1. PX 25, p. 14. The discogram results correlated with the MRI and CT scans. Dr. Salehi diagnosed annular tearing and mechanical back pain. Petitioner also appeared to have radicular symptoms such as left leg numbness but there was no anatomic basis for these symptoms. PX 25, p. 15. The annular tearing is a "degenerative condition with aggravation." PX 26, p. 16. It is possible for a person with annular tears to be asymptomatic. Trauma can cause previously asymptomatic tearing to become symptomatic. PX 25, pp. 16-17. A disc that is torn "picks up" an injury more readily than an intact disc. Trauma can also cause existing tearing to deepen. PX 25, p. 17. The August accident was the "main" aggravation but both accidents were aggravating. PX 25, p. 18. Petitioner had back pain in 2009 and 2010 but did not subsequently seek additional care until after the August 2018 accident. PX 25, pp. 18-19. Given that Petitioner had exhausted conservative care, he recommended a two-level fusion, at L4-L5 and L5-S1. PX 25, pp. 19-20. The purpose of a fusion is to stabilize discs. When you remove motion from a disc, the pain tends to improve. PX 25, p. 20. He would recommend a fusion even if Petitioner had no radicular symptoms. PX 25, p. 21. Lifting, bending and twisting are the three mechanisms that typically aggravate discs. PX 25, p. 22. The accidents described by Petitioner involved these mechanisms. PX 25, p. 22. Any one of the three mechanisms can cause disc aggravation. PX 25, p. 22.

Dr. Salehi testified that utilization review initially non-certified the fusion he recommended. He appealed the denial to GENEX, in writing (Salehi Dep Exh 2). GENEX has guidelines to deny fusions which do not follow the guidelines promulgated by the American Association of Neurological Surgeons. In his appeal, he cited a 2005 study authored by "big names" in neurosurgery. The American Association of Neurological Surgeons guidelines are not based solely on one study. They have taken "hundreds of studies into consideration." They came up with "class one evidence that surgery for annular tears and disc disease is beneficial in the improvement of low back pain." PX 25, p. 25. Insurance carriers tend to cite "arcane guidelines" that a fusion is only appropriate if there is slippage of bone on bone. They tend to "conveniently forget" the diagnosis of mechanical back pain due to annular tearing. PX 25, pp. 25-26. Micromotion, as opposed to actual slippage, can also cause a lot of back pain. PX 25, p. 26. Dr. Salehi testified that, post-appeal, he received a letter from GENEX certifying the fusion. Salehi Dep Exh 3. The post-appeal reviewer tended to focus on disc herniations, whereas he focused on annular tearing, but he got to the same result. Despite the certification, the fusion was not approved. PX 25, pp. 28-29.

Dr. Salehi testified he has continued treating Petitioner since May 2019. He has imposed restrictions to prevent aggravation of the disc disease at L4-L5 and L5-S1. In August of 2019, he reviewed additional lumbar spine MRIs, including images dating back to 2008. All of the studies were more or less the same in terms of pathologic findings at L4-L5 and L5-S1. PX 25, pp. 30-31. His causal connection opinion is not based on the anatomic changes in the discs. It is based on "the symptomatic aggravation of the pre-existing anatomic problems that [Petitioner] had at L4-L5 and L5-S1." The older MRI scans did not cause him to change his

causation opinion. The only factor that might have prompted such a change was if Petitioner had been symptomatic prior to the August 2018 accident but he saw no evidence of that. PX 25, p. 33.

Dr. Salehi testified he disagrees with Dr. Singh's opinion that the MRI and CT scans from 2018 and 2019 are normal. He also disagrees with the doctor's opinion that Petitioner does not need a fusion. PX 25, pp. 34-35. The injections that Drs. Bayran and Vargas performed were reasonable as part of a conservative care regimen. PX 25, p. 35. No one wants to jump into surgery without first exhausting conservative measures. PX 25, p. 35.

Under cross-examination, Dr. Salehi testified he does not know who referred Petitioner to him. He reviewed certain records but did not see records from Dr. Zaragoza or any Emergency Room. PX 25, p. 37. From a chronological standpoint, the earliest records he reviewed were from Dr. Bayran. PX 25, pp. 37-38. Dr. Bayran's initial note reflects that Petitioner finished his shift after the accident on August 7, 2018. PX 25, p. 38. He has seen no records reflecting that Petitioner had back treatment between 2010 and August 7, 2018. PX 25, p. 38. Annular tears can be wholly chronic in nature. PX 25, p. 39. Petitioner's annular tears pre-dated the August 7, 2018 accident. PX 25, p. 39. They dated back to 2008 or 2009. Based on the imaging he reviewed, Petitioner's lumbar spine did not anatomically change between 2008-2009 and the August 7, 2018 accident. There is no neural component to Petitioner's condition. PX 25, p. 40. Petitioner has partial annular tearing at L4-L5. Annular tears cannot repair themselves nonsurgically. Discs are avascular and acellular, which means they have no capacity to repair themselves. PX 25, p. 42. Scar tissue sometimes fills the gaps, however. PX 25, p. 42. Based on the MRI, the L5-S1 disc is slightly more degenerated than L4-L5 but both discs show evidence of annular degenerative disc disease. PX 25, p. 43. He completely disagrees with the first utilization review. The logic applied by the second reviewer is different from his own. PX 25, pp. 43-44. The second reviewer indicated that decompression is appropriate but he disagrees. He saw no evidence of significant neural compression. PX 25, p. 44. His causation opinion is based on the consistent mechanism of injury and the correlation of Petitioner's symptoms with the imaging. PX 25, p. 45. He recommended a fusion at Petitioner's first visit. PX 25, p. 47. That visit lasted about 40 minutes. He concluded that a fusion was necessary after he reviewed the history, examined Petitioner and saw the imaging. PX 25, p. 47. Three factors, i.e., the limited range of motion, the MRI findings and the concordant discogram, provide an objective basis for his causation opinion. PX 25, p. 47. He did not document Petitioner's BMI. A patient's BMI has to be 35 or less to lower the complication rates. PX 25, p. 48. Most patients with annular tears improve. Petitioner improved after 2008-2009. PX 25, pp. 48-49. Dr. Bayran found Petitioner capable of full duty in December 2018. PX 25, p. 51.

On redirect, Dr. Salehi testified that, in December 2018, Petitioner complained to Dr. Bayran of left-sided low back pain radiating to his buttocks. PX 25, p. 52. During the discogram, which is a blind study, Petitioner reported no pain with injections at L2-L3 and L3-L4. At L4-L5 and L5-S1, however, Petitioner complained of excruciating, 10/10 pain. That was concordant. A discogram is objective in the sense that the patient does not know which level is being

injected. PX 25, p. 55. He is not ruling out radiculopathy in Petitioner but he has no good explanation for Petitioner's radicular symptoms. PX 25, p. 55. Absent the annular tears, he would not have recommended a fusion. It is possible for Petitioner to have had baseline 2-4/10 pain during the interval between 2009 and the August 2018 accident and for the accident to have aggravated that pain. PX 25, p. 56.

Under re-cross, Dr. Salehi acknowledged that Dr. Vargas treated Petitioner prior to performing the discogram. He does not see the possibility of "confirmation bias" as a huge problem. It is an "ethics thing" for the physician. He is sure that Dr. Singh uses or relies on discograms from time to time. PX 25, p. 58. The insertion of a needle into a person's back can cause discordant pain. The test is true if the pain is concordant, i.e., it reproduces the patient's typical pain. PX 25, p. 59. A doctor should not use a discogram lightly. PX 25, pp. 59-60.

On further redirect, Dr. Salehi testified that, in Petitioner's case, the discogram was "right on" in terms of the MRI findings. He would not necessarily have recommended that Petitioner undergo a discogram but the discogram added "another layer of confirmation." PX 25, pp. 60-61.

Petitioner testified he has not returned to the Emergency Room since September 23, 2019 but he has thought about going. During the last few days he has experienced strong pain and weakness in his leg. T. 92.

Petitioner testified he reported right leg pain to Dr. Salehi on October 2, 2019. No specific incident brought the right leg pain on. Dr. Salehi prescribed a new medication and again recommended surgery. T. 93. He last saw Dr. Salehi on December 3, 2019. T. 93. The new medication helps with the pain. T. 94.

Dr. Singh testified by way of evidence deposition on November 6, 2019. RX 8. Dr. Singh is a fellowship-trained spine surgeon. He is board certified in orthopedic surgery. Singh Dep Exh 1.

Dr. Singh acknowledged he does not independently recall examining Petitioner on November 21, 2018. RX 1, p. 5. His report reflects that a Spanish-speaking interpreter was present at the time of the examination. Petitioner told him he injured his back at work on August 7, 2018. Petitioner did not mention any injury occurring in October. RX 1, p. 6. Petitioner had normal strength and sensation, as well as a full range of lumbar spine motion. He exhibited 5/5 positive Waddell's findings. RX 1, p. 7.

Dr. Singh testified he interpreted a September 14, 2018 lumbar spine MRI as showing a left-sided disc protrusion at L4-L5. He saw no evidence of nerve root compression. RX 1, p. 8. He concluded that Petitioner sustained a lumbar strain. He could not correlate this to the L4-L5 protrusion. He found no evidence of L4 nerve root pathology. Petitioner's complaint of posterior thigh pain does not correlate with L4 nerve root compression. RX 1, p. 8. In light of Petitioner's normal examination, he felt that Petitioner could resume full duty. He concluded

that Petitioner reached maximum medical improvement four weeks after his injury. This time frame would be "consistent with the resolution of a soft tissue strain." RX 1, p. 9. In his note of December 27, 2018, Dr. Bayran found Petitioner to be at maximum medical improvement and capable of returning to work. RX 1, p. 9. Singh Dep Exh 4.

Dr. Singh identified Singh Dep Exh 3 as an addendum he issued after reviewing additional records from Drs. Bayran, Vargas and Salehi and certain therapy and chiropractic notes. He also reviewed images of MRI scans performed in 2008 and 2009 and a CT scan performed in 2019. The pre-accident MRI scans show the same findings as those taken after the accident. The CT scan shows a disc protrusion on the left at L4-L5 consistent with the pre-accident MRIs. RX 1, p. 11. There are "no neurological findings." The CT discogram showed no extravasation of the dye. The new records and imaging studies confirmed his previous causation opinion. RX 1, pp. 11-12. It is his understanding that Dr. Salehi believes Petitioner is suffering from discogenic low back pain, not a disc herniation. RX 1, p. 13.

Dr. Singh opined that Petitioner does not require a two-level fusion. This surgery would not improve Petitioner's symptoms. It is not causally related to the accident. RX 1, p. 14.

Under cross-examination, Dr. Singh testified that, apart from the issue of causation, there is no medical need for a fusion. RX 1, p. 15. He has been performing examinations for twelve years. He authored two reports in this case. He has not reviewed any records generated after May 15, 2019. RX 1, p. 17. The only pre-accident records he reviewed were the 2008 and 2009 MRIs. Petitioner told him he did not undergo any back treatment prior to the accident. RX 1, p. 18. He has no information indicating that Petitioner had back problems during the weeks or months preceding the accident. RX 1, p. 18. Petitioner provided him with a description of his machine operator job duties. Petitioner also told him he was injured while lifting 100 pounds of scrap metal. That lifting was outside the description that Petitioner provided. It is his understanding that Petitioner worked for five months before the accident and was able to complete his duties during that time. RX 1, p. 20. He believes Petitioner sustained a lumbar strain. The symptoms of a strain can vary. A nonstructural strain can produce symptoms that typically last between four and six weeks. A lumbar strain cannot produce pain traveling down the posterior aspect of the leg to the foot. RX 1, p. 21. In his opinion, Petitioner reached maximum medical improvement by September 4, 2018. RX 1, p. 21. Petitioner complained to him of posterior, not lateral, thigh pain. If a patient complained to him of low back pain radiating down the legs, he would not necessarily perform a straight leg raise test. This test was performed prior to the advent of MRI imaging. The straightening of the knee was though to be indicative of a possible disc herniation. "We now know there are false positives associated with it." RX 1, p. 24. If the test produces solely back pain and no leg pain, it does not suggest neurological findings. RX 1, p. 25. He has no opinion concerning the radiologist's interpretation of the September 14, 2018 MRI. He disagrees with the radiologist's finding of foraminal material extrusion at L5-S1. RX 1, p. 28. There is no herniation at that level. He disagrees with Dr. Bayran's finding of a protrusion at L5-S1. He also disagrees with Dr. Bayran's diagnosis of lumbar radiculopathy. RX 1, p. 29. The report Dr. Bayran generated indicates he administered an injection on the right. It makes no sense to inject the opposite

side of the disc protrusion. RX 1, p. 30. Petitioner reported a new incident at work when he saw Dr. Bayran on October 25, 2018. He (Dr. Singh) could not identify this as a new accident. The symptoms Petitioner reported to Dr. Bayran are different from those he reported at the examination. RX 1, p. 32. Petitioner did not report any improvement of his pain at the examination. RX 1, p. 33. "Everything is inconsistent" about Petitioner. RX 1, p. 34. Even Dr. Salehi does not believe that Petitioner has a disc herniation. If Dr. Salehi believed this he would be recommending a discectomy. RX 1, p. 35. When Waddell's testing is used in isolation, it is has "very little value." He uses the results of such testing only in the context of the records, the examination and the imaging studies. To use them to conclude that an examinee is a malingerer is erroneous as there is "heightened anxiety at the time of examination." An independent medical examination is "by definition a confrontational event." RX 1, p. 36. He does not put much stake into Waddell's testing. RX 1, p. 36. To rely solely on such testing would be erroneous. RX 1, p. 37. He examined Petitioner on one occasion. RX 1, p. 37. When Dr. Bayran examined Petitioner on November 29, 2018, he noted complaints of pain in the posterior lateral thigh on the left. Posterior lateral refers to the back outside part of the thigh. It overlaps L5-S1. RX 1, p. 38. In his opinion, the CT discogram was not reasonable or necessary. He no longer uses discograms in his practice. A discogram is a blind test for the patient. The person performing the discogram should not be a treating physician and should not be aware of the working diagnosis. The patient should be blinded to the levels being tested. If the physician performing the discogram injects too much dye into a disc, the patient can experience pain, even though the disc is normal. RX 1, p. 40. In Petitioner's case, Dr. Vargas found concordant pain at L4-L5 and L5-S1 but the working diagnosis was always L4-L5. RX 1, p. 40. It was not until the date of the deposition that he learned that utilization review ultimately certified the fusion. RX 1, p. 41. He devotes 5 to 7% of his practice to records reviews, examinations and depositions. RX 1, p. 41. He sees between 150 and 200 patients per week and performs 4 to 6 independent examinations per week approximately 40 weeks out of the year. RX 1, p. 42. He charges approximately $1,200 per examination. This charge includes reviewing records and imaging studies and generating a report. RX 1, p. 42. Petitioner was still voicing left-sided complaints on the date Dr. Bayran released him. RX 1, p. 43. At the previous appointment, Dr. Bayran recommended a spine surgery consultation. RX 1, p. 43. His examination took place between that appointment and the date on which Dr. Bayran released Petitioner. RX 1, p. 44.

On November 13, 2019, Petitioner filed a Petition for Penalties and Fees, asserting that Respondent failed to pay injection-related expenses and failed to authorize the lumbar fusion, despite the utilization review certification. PX 34.

On December 2, 2019, Dr. Salehi re-examined Petitioner and again recommended a L4-S1 lumbar fusion. He refilled Petitioner's Mobic. PX 9.

Petitioner testified he wants to undergo the recommended surgery because he "cannot live like this," dependent on medication. He did not take any pain medication for his back between December 17, 2010 and the August 7, 2018 accident. T. 95. He is working despite his pain because he must support his family. T. 95, 97. His wife works but only part-time. T. 97-

98. On his best day, his pain level is between 5 and 6. T. 95. After an 8-hour shift at MD Metals, he feels a lot of pulsating pain. He would rate that pain "as high as eight." T. 96. He is supposed to take pain medication twice daily but tries to limit it to once a day because he does not want to be dependent on it. T. 97.

Petitioner testified that, at no time between December 2010 and his August 7, 2018 accident did any medical provider recommend back surgery. T. 98.

Under cross-examination, Petitioner testified he does not recall going to MacNeal Hospital's Emergency Room on March 31, 2011 and complaining of low back pain. PX 10, p. 34. He disputes that he went to the Emergency Room on that date. He is not familiar with the records concerning that visit. T. 102. He did not sustain a work injury in 2011. As of March 2011, he was working for a company called "I Remodel Your Home." At no time after December 2010 was he injured while performing maintenance or remodeling. T. 104. He denied telling Dr. Salehi he was injured on August 7, 2018 when he lifted a box and placed it on his left shoulder. He always told his providers that he put the box on his right shoulder. T. 105. On August 7, 2018, he arrived at work at 4 AM and began working at approximately 4:30 AM. He saw that workers from the previous shift had left the machine messy so he began cleaning. A person was in his vicinity, about 5 to 10 feet away, when he was injured but that person was not paying any attention to him. T. 107. He does not remember this person's name. T. 107. He did not mention his injury to this person. T. 107. Angela, the female owner at Bridgeview, was at work but she was not near where he was working. When he first began working at Bridgeview, he was told to report any work injury to Total Staffing. At the time of his injury, he had the phone number for Total Staffing's office. He first experienced pain around 4:30 AM. He was able to work his entire shift, which ended around noon. T. 110. After he lifted the 100-pound box, the only thing he had left to do was to put liquid in the machine. He remembers telling a physical therapist that, although he experienced pain, he continued carrying the box to the trash. He did this to fulfill his obligations. T. 111. He had to walk about 50 steps while carrying the box on his shoulder. T. 113. He is not sure whether he had to carry that box to the dumpster one or two more times after his injury. T. 113. He received his schedule the previous day. When he finished his shift at noon, he just left. He did not have to check in with anyone. T. 114. If he had left work earlier, at 10:30 AM for example, he would have gotten in trouble. People walk around and watch him. Plus there are video cameras right over him. T. 115. When he leaves work, at the end of his shift, he typically says goodbye to Angela, the owner. When he left work on August 7, 2018, he said goodbye to Angela. He also told Angela he was hurt. It was the following day that he reported the injury to Total Staffing. T. 116. It is his contention that he reported his injury to Angela Koller on August 7, 2018. He told Angela he had been injured at work that day. T. 119. He told Dr. Bayran he reported his injury right away. T. 120-121. He did not go back to Bridgeview on August 8th. Instead, he went to Total Staffing to formally report the accident. T. 121. He subsequently began performing light duty at Total Staffing's office. T. 121.

Petitioner testified he does not have a family physician. He first heard Dr. Bayran's name when "they" spoke to him and gave him the appointment date. T. 122. He does not

recall when he hired his first attorney. He saw Dr. Bayran because LaGrange Medical Center referred him to this physician. T. 124. He hired his first attorney in 2018, maybe in December. He does not recall the exact date. T. 126. On December 27, 2018, Dr. Bayran told him he could not do anything further for him since Dr. Singh had indicated he did not require more care. T. 127. Nevertheless, Dr. Bayran told him to "continue onward" with his treatment. T. 128. He decided to change attorneys because his first attorney "never wanted to see" him and told him to consult someone else. T. 130. A friend, Juan Lumbarras, referred him to Delaware Physicians. T. 131. Lumbarras was undergoing treatment at that facility. T. 133. In November and December 2018, he worked full-time cleaning tire rims. T. 133-134. He cannot recall whether he earned more doing that work than he earned at Bridgeview. T. 136. In January 2019, he briefly worked through Illinois Staffing, earning $12.50 per hour. He had earned $12.00 per hour at Total Staffing as of August 7, 2018. T. 137. He injured his back at work in July 2009, while carrying a container. T 140. The back pain he suffered after that accident traveled down his left leg. T. 138. He did not experience left leg symptoms between 2009 and 2018. T. 138. His current symptoms vary. On some days, his pain level is 6/10 but overall his current pain is "consistently more intense." T. 141. He does not believe that any particular activity during the past eleven months has caused his pain to worsen. He tries to live with his pain. T. 141. At Bridgeview, he worked for one or two weeks. At Unifirst, he worked a total of two days. He believes he worked on Monday, October 22nd, and Tuesday, October 23rd. The cart he pushed at Unifirst had wheels. Sometimes he pushed the cart on a smooth floor but sometimes he had to push it up a ramp. T. 143. On the day he was injured at Unifirst, he managed to finish his workday. T. 143. In November 2018, he worked at Billet, cleaning tire rims. In January 2019, he started working at MD Metals through Illinois Staffing. The "restrictions" he works under at MD Metals are not formal. They are "his own." He tries to take care of himself. He works on his feet, lifting wood. During the past year, the heaviest item he has lifted at MD Metals has weighed 15 pounds. He primarily performs cleaning but, when the need arises, he lifts pieces of wood weighing 10 to 15 pounds. T. 147. He went to the Emergency Room on September 23, 2019 because his existing pain intensified and his leg was becoming numb and weak. T. 147-148. During September 2019, his pain at work varied between 6 and 8 on a scale of 1 to 10. On September 23, 2019, at work, he performed cleaning and no lifting. At about noon, his pain intensified. He continued working until 3:20 PM. He did not tell anyone at MD Metals about his increased pain. After his Emergency Room visit, he continued working at MD Metals until November 2019, when he took some vacation time. T. 151. He told his physicians, including Dr. Salehi, about his Emergency Room visit. The physicians told him his increased pain was due to "inflammation of the sciatica." T. 152. The pain he experienced on September 23, 2019 was the worst pain he has ever experienced. He does not believe he injured himself at work in September 2019. T. 152.

Under additional cross-examination, Petitioner testified he did not inform anyone at Unifirst of his October 23, 2018 injury. At Unifirst, no one told him how much weight he was supposed to lift while lifting clothes. He and his co-workers were under pressure to lift the clothes quickly. T. 155. He was not given directions as to how many items of clothing to lift at one time. He just grabbed everything he could. T. 156-157.

On redirect, Petitioner explained that, when he used the Spanish word "costal" while testifying, he was referring to a cloth bag. He had to pull out "the whole bag" from the container and then put the bag on a table. A bag could be light or heavy, depending on its contents. T. 160. Regardless, he had to bend over to pick up the bags and put them on the table. T. 160. He would typically go to MacNeal Hospital's Emergency Room for treatment but he does not recall going there on December 31, 2011. It is possible he forgot he went there that day. T. 161-162. Between March 2011 and the accident of August 7, 2018, no one recommended he undergo back surgery. T. 162. When he left work at noon on August 7, 2018, he "told them that [he] was feeling bad." T. 165. On August 8, 2018, he reported his August 7, 2018 accident to Leticia of Total Staffing. T. 166. If a Unifirst document reflects he worked October 22nd through October 24th, he believes it is correct but he is not sure. T. 167. He went to Dr. Bayran on October 25, 2018. T. 167. He does not believe he worked at Unifirst the day after he was injured. T. 167. He was injured on the last day he worked at Unifirst. He saw Dr. Bayran the day after the injury. T. 169. [At this point in the hearing, the Arbitrator allowed Petitioner's counsel's oral motion to amend the Application on its face to change the accident date to October 24, 2018. Respondents' counsel originally objected to the amendment but ultimately withdrew their objections. T. 174-177.] At Illinois Staffing, he was not subject to formal restrictions. T. 178. He would agree with Dr. Salehi's records if they reflect he was working subject to restrictions as of May and December 2019. T. 178-179. On September 23, 2019, he experienced increased symptoms and worrisome numbness when he was sitting at work, eating. T. 179. He continued working after his Emergency Room visit of September 23, 2019. T. 180. He has continued to work despite his pain because he will lose his job if he fails to show up. T. 180.

Under re-cross, Petitioner testified it takes him about ten minutes to drive from his home to MacNeal Hospital. He goes to that hospital because he lives nearby and gets prompt attention there. T. 181. Between 2009 and his August 7, 2018 accident he sought care for back pain at MacNeal on one occasion. T. 182.

Martin Enciso testified on behalf of Respondent Total Staffing. He has worked as a production plant manager at Unifirst for about twelve years. Five supervisors and about eighty employees work under his direction. T. 186. The supervisors are supposed to immediately report any employee problem to him. T. 187. If an employee is injured on the job, that employee's shift supervisor must sit down with the employee and complete paperwork. Once the injury has been investigated, a phone call is made to the insurance carrier. T. 187.

Enciso testified that Petitioner worked in Unifirst's unloading dock area. Petitioner and another employee worked in an area that was about 10 by 35 feet in size. Soiled clothes arrived via truck. Petitioner and his co-worker separated pants and shirts and put them in large bags that were on a cart. T. 193. The area where Petitioner worked is visible to others. About ten to twelve people pass that area or work in adjacent areas. During the brief period that Petitioner worked at Unifirst, no one reported seeing an accident, as far as he is aware. T. 190. It was in March 2019, when he received a letter from a law firm, that he first learned of Petitioner's claimed accident. T. 191. No witness statement from the period of Petitioner's

employment exists. T. 191. Petitioner did not return to Unifirst after the alleged accident. T. 191. At Unifirst, an accident report is completed within minutes of the employee reporting an injury. T. 192. An Email is generated after Unifirst reports the accident to its insurance carrier. No such Email exists in this case. T. 192. Enciso testified that, based on his experience, an employee performing Petitioner's job could pick up about a dozen pants at one time. T. 193. He has picked up a pile of clothes. An unused pair of pants weighs under one pound. He would imagine that a soiled pair of pants would weigh no more than one pound. T. 195. A typical pile would consist of three bags of garments. Each bag would contain about 175 pairs of pants. If Petitioner picked up a dozen pairs of pants, that load would weigh about 12 to 14 pounds. T. 196. Petitioner would have been "constantly" picking up garments, emptying one "cage" after another. A "cage" is a large, 4 by 5 foot cart with wheels that swivel. T. 197. Based on Unifirst's attendance records, Petitioner worked three full days in October 2018. Those days were the 22nd, 23rd and 24th. Unifirst Exh 2. Petitioner showed up on a fourth day but did not sign in. Unifirst has a sign-in sheet. T. 198. To his knowledge, no accident report was generated on any of the days Petitioner worked. T. 198-199. On October 25th, Petitioner did not sign in and left before his shift ended. T. 199. Temporary employees such as Petitioner are required to sign in and out. T. 199-200. His (Enciso's) production manager typically provides him with a roster of employees. The production manager gives him that roster on a daily basis. Employees have to use a card to scan in to work. Temporary employees also have to sign a log sheet. He has no record to show Petitioner signed in on October 25, 2018 but Petitioner was assigned a task in the morning that day. T. 204. Unifirst has no cameras inside its facility. T. 205.

In response to questions posed by Unifirst's counsel, Enciso testified that Petitioner would not have lifted bags weighing 175 pounds. Based on his own work experience, Petitioner would have lifted twelve pairs of pants at one time, at the most. T. 206.

Under cross-examination, Enciso acknowledged he does not remember seeing Petitioner at work on the days in question. He is basing his testimony as to Petitioner's work activities on his own experience at Unifirst. T. 206-207. The tasks are pretty much the same from day to day. He does not personally recall Petitioner. He is "not that hands-on of a manager." T. 207. Unifirst maintains employee rosters for one month and then throws them away. T. 208. Petitioner would have lifted clothes "off the cage." A "cage" is about 3 ½ to 4 feet high. Petitioner would have lifted clothes constantly, moving from one "cage" to the next. Once Petitioner completed other assigned tasks, he would have been constantly lifting 12 to 14 pounds throughout the workday. T. 209.

On redirect, Enciso testified he does not recall ever seeing Petitioner. Unifirst does not have any file containing documents concerning Petitioner's conduct or any claimed incidents. T. 210.

At this point in the hearing, the Arbitrator granted Respondent Total Staffing's request for bifurcation, over Petitioner's objection. T. 211-213. Respondents Total Staffing and Unifirst

stipulated that Total Staffing has assumed the defense in the claim. T. 216. The Arbitrator denied Unifirst's request to be dismissed out of the claim. T. 216-217.

Petitioner returned to Dr. Salehi on January 21, 2020 and complained of worsening lower back pain radiating down both legs, "mostly on the left." He reported that he was continuing to perform light duty. On re-examination, the doctor noted lumbosacral tenderness, greater on the left, normal strength and decreased sensation in the left lateral thigh and left medial foot. He again recommended a L4-S1 lumbar fusion. PX 9.

Dr. Bayran testified by way of evidence deposition on February 20, 2020. RX 9. Dr. Bayran testified he attended medical school in Romania and then practiced in his native Iran before coming to the United States. He completed a one-year fellowship in pain medicine at the University of Illinois. He performs various procedures, including injections and ablations. RX 9, pp. 6-7. He is board certified in anesthesia and pain medicine. He currently practices at the Pain Center of Illinois, where he is the medical director. RX 9, pp. 7-8. He is a part-owner of the Illinois Back & Neck Institute and Ashland Medical, an anesthesia company. RX 9, p. 8. He oversees the billing performed by these entities. He assumes no payments have been made for the services he provided to Petitioner, based on Bayran Dep Exh 2. RX 9, p. 11.

Dr. Bayran acknowledged he is familiar with CompCorePro. He has seen patients referred by this company. The company "randomly" refers patients to him. He has known Dr. Khanna for many years. He receives maybe one or two cases from CompCorePro each month. RX 9, p. 12. He has seen patients referred by Dr. Khanna since 2009 or 2010. He does not remember whether CompCorePro referred Petitioner to him. Based on Bayran Dep Exh 3, which is dated September 21, 2018, CompCorePro probably referred Petitioner to him. RX 9, pp. 13, 17. He first saw Petitioner on September 27, 2018. He typically secures pre-approval prior to treating a workers' compensation patient. He also secures pre-approval for injections. RX 9, pp. 14-15. It is not his practice to administer an injection without pre-approval. RX 9, p. 16. Petitioner provided a history of his work accident and complained of left-sided lower back pain radiating to his left buttock and left posterior side. If a patient complains of radiating leg pain, you want to make sure there is no disc problem. RX 9, p. 17. Petitioner rated his pain at 7/10. He (Dr. Bayran) noted no positive Waddell's findings. Straight leg raising caused only back pain. That is really not a positive straight leg raising test. Petitioner reported decreased sensation over the left lateral thigh. That could indicate impingement of the L5 nerve root. RX 9, p. 19. There was "some inconsistency" between the pain Petitioner reported and the examination findings. He diagnosed radiculopathy. He attributed Petitioner's symptoms to the work accident, based on Petitioner's reporting. RX 9, p. 21. He recommended continued therapy and an epidural injection. He also recommended that Petitioner continue working with restrictions. Most likely his staff sent a request for pre-authorization of the injection. RX 9, p. 24. He identified Bayran Dep Exh 4 as the request form that was sent to adjuster James Hernandez. Hernandez approved the injection. His signature appears on the form, which is dated October 4, 2018. RX 9, pp. 26-27. He switched billing companies and EMRs because the EMR he was using did not allow him to bill in a timely fashion. That is probably why he has not received payment for the injection. RX 9, pp. 28-29. Bayran Dep Exh 5 shows that nothing has

been paid toward the injection, even though GENEX received the bill on July 30, 2019. RX 9, p. 29. Bayran Dep Exh 6 reflects that GENEX certified the injection. RX 9, p. 31. Some EOBs have not been entered in his system but as far as he knows, his bill for treating Petitioner has not been paid. RX 9, p. 32. At the visit following the injection, Petitioner reported 90% pain relief. He concluded that Petitioner was "cured" and he released Petitioner to a trial of full duty. RX 9, p. 36. He told Petitioner to return to him if he had problems with full duty. Petitioner returned to him a week later, on October 25, 2018, and indicated his pain had worsened while performing full duty. Specifically, Petitioner reported left-sided back pain radiating to his left buttock after bending to lift heavy clothing and pushing a cart full of clothes. RX 9, p. 37. Petitioner's pain was now in the L5 distribution. RX 9, p. 37. He cannot explain why Petitioner's pain switched to L5. That is why he recommended a consultation with a spine surgeon. RX 9, p. 39. He would consider the clothing-related full duty a "re-aggravation." RX 9, p. 39. He does not independently recall Petitioner but he remembers Petitioner reporting lifting the clothing on multiple occasions. RX 9, p. 41. Straight leg raising was positive. He continued to diagnose radiculopathy. RX 9, p. 42. He saw no signs of symptom magnification on either October 25 or November 29, 2018. RX 9, p. 43. On November 29th, he again recommended a consultation with a spine surgeon. RX 9, p. 43. He last saw Petitioner on December 27, 2018. The only thing that took place between November 29th and December 27th was Dr. Singh's IME. He met Dr. Singh at a conference. Petitioner's presentation in December was the same as in November, except he was complaining of back rather than leg pain on straight leg raising. He decided Petitioner was at maximum medical improvement. The injection had failed and Petitioner "wasn't a candidate for surgery." The injection provided relief for only one week. RX 9, p. 48. James Hernandez approved three injections but that does not mean he should necessarily expose Petitioner to three injections. ODG guidelines require that, "in order to do a second injection, you have to basically have a response of 60 days." RX 9, pp. 49-50. ODG also says you can release a patient to full duty when there is no radiculopathy, weakness or loss of reflexes. RX 9, p. 50.

Under cross-examination, Dr. Bayran testified he is not sure whether he reviewed the records from LaGrange Medical Center. RX 9, p. 51. He is not affiliated with that facility. He injected Petitioner on the left side, not the right. If the report says "right," it is a "clerical mistake." RX 9, p. 53. The accompanying photograph of the procedure shows that the injections were done on the left side. RX 9, p. 53. Petitioner originally reported decreased sensation over the lateral aspect of the left side. Later, the distribution was in L4. Thus, he believes there was an inconsistency. Petitioner did not report any 2008 or 2009 injury to him. In his note of December 27, 2018, he expressed his agreement with Dr. Singh's opinions. RX 9, pp. 57-58.

On redirect, Dr. Bayran testified that the injection photographs should have been produced along with his records, in response to a subpoena. RX 9, p. 59. His handwritten notes from Petitioner's initial visit reflect that Petitioner did in fact inform him he injured his back in 2008. RX 9, p. 62.

Under re-cross, Dr. Bayran testified his notes reflect that Petitioner's pain was "higher" in 2008. RX 9, p. 63. Bayran Dep Exh 9.

On further redirect, Dr. Bayran clarified that, by using the term "higher," he meant the pain was physically at a different level. RX 9, p. 63.

At the continued hearing, Elida Garcia, a referral coordinator employed by CompCorePro, testified pursuant to subpoena. Dr. Khanna, CompCorePro's medical director, also attended the hearing. Garcia acknowledged securing a consultation with Dr. Bayran, after discussing this with Dr. Khanna, but maintained she secured Petitioner's consent, via telephone, before providing him with information concerning the appointment.

Arbitrator's Credibility Assessment

Petitioner's testimony concerning his August 7, 2018 accident was detailed and consistent with the records from LaGrange Medical Center and Athletico. His account of his October 24, 2018 accident was also detailed and consistent with Dr. Bayran's note of October 25, 2018. Enciso, who testified on behalf of Respondents, acknowledged he did not personally observe Petitioner working in October 2018 but conceded that much of Petitioner's workday would have consisted of repeatedly lifting garments that arrived at Unifirst in bags weighing 175 pounds.

The fact that Petitioner has continued working, despite his persistent symptoms, enhances his overall credibility. His testimony about the relatively light nature of his current job at MD Metals was detailed and believable.

Petitioner's current treating surgeon, Dr. Salehi, testified he observed no signs of symptom magnification. PX 25, p. 11. Dr. Bayran noted 5/5 negative Waddell's signs when he examined Petitioner in September, October and November 2018. Respondent's examiner, Dr. Singh, documented 5/5 positive Waddell's signs in November 2018 but, under cross-examination, conceded that Waddell's testing, used in isolation, has "very little value." RX 1, pp. 35-36.

Much has been made about Petitioner's prior history of back problems and whether he revealed that history to his providers. The Arbitrator finds credible Petitioner's testimony that the back symptoms he experienced in 2008 and 2009 resolved and thus he did not attach much significance to them. The Arbitrator also notes that, on August 8, 2018, only one day after the claimed accident of August 7, 2018, Petitioner told personnel at LaGrange Medical Center that he had injured his back nine years earlier. PX 1. At his deposition, Dr. Bayran confirmed that, when he first saw Petitioner, in September 2018, Petitioner told him he had injured his back in 2008. RX 9, p. 62.

Under cross-examination, Petitioner denied going to the Emergency Room at MacNeal Hospital on March 31, 2011. Records in PX 10 reflect he did go to MacNeal Hospital on that

date but for a therapy evaluation, not Emergency Room care. It is not clear whether he pursued additional therapy after the evaluation. The Arbitrator does not view Petitioner's denial as undermining his overall credibility, given the passage of 7 ½ years between the evaluation and his testimony.

The Arbitrator noted some inconsistencies in Mario Enciso's testimony. Enciso's claim that he never noticed or had reason to notice Petitioner is at odds with his very specific testimony that Petitioner showed up at Unifirst on October 24, 2018 but failed to sign in.

Overall, the Arbitrator found Dr. Salehi more persuasive than Respondent's examiner, Dr. Singh. Dr. Salehi saw Petitioner on several occasions while Dr. Singh examined him once. Dr. Singh's opinion that Petitioner sustained a minor strain requiring four weeks of therapy conflicts with the opinions of Drs. Byrd and Bayran, neither of whom was selected by Petitioner.

Arbitrator's Conclusions of Law Relative to Both Cases

Did Petitioner sustain compensable work accidents on August 7, 2018 and October 24, 2018?

In 18 WC 27887, the Arbitrator finds that Petitioner sustained an accident arising out of and in the course of his employment on August 7, 2018. In so finding, the Arbitrator relies on Petitioner's detailed testimony concerning the mechanism of injury, the accident reports (RX 2), the LaGrange Medical Center "work injury form" of August 8, 2018 (PX 1) and the records from LaGrange Medical Center. Petitioner testified he was performing a work task, i.e., lifting a heavy container of scrap metal and liquid, up to his shoulder at the time of the accident.

In 19 WC 8620, the Arbitrator finds that Petitioner sustained an accident arising out of and in the course of his employment on October 24, 2018. [Petitioner originally alleged an accident date of October 23, 2018. On redirect, he clarified the accident took place the day before he returned to Dr. Bayran. That return visit occurred on October 25, 2018. The Arbitrator allowed his counsel to orally amend the Application to change the accident date to October 24, 2018. T. 174-175.] In so finding, the Arbitrator relies in part on Petitioner's detailed account of the lifting he performed at Unifirst. Petitioner credibly testified he was under pressure to work quickly while lifting wet clothing items out of containers. T. 155. He also testified he was required to push fully loaded carts up ramps. The Arbitrator also notes that the term "accident," as used in the Act, is "not a technical legal term." Rather, it is a "comprehensive term almost without boundaries in meaning as related to some untoward event." Ervin v. Industrial Commission, 364 Ill. 56 (1936). Moreover, there need be no external violence to the body to constitute an accidental injury. Compensation may be allowed where a worker's existing physical structure gives way under the stress of his usual labor. Laclede Steel Co. v. Industrial Commission, 6 Ill.2d 296 (1955).

Did Petitioner establish timely notice?

In 18 WC 27887, the Arbitrator finds that Petitioner provided timely notice of his August 7, 2018 accident. Petitioner credibly testified he notified "Andrea," Bridgeview's owner, of his injury while leaving work. Petitioner also credibly testified that, the following day, he went to Total Staffing's office and notified Leticia of the injury. Leticia arranged for him to be seen at LaGrange Medical Center, where Dr. Byrd prescribed physical therapy. Records in PX 2 and PX 34 reflect that adjuster James Hernandez approved six therapy sessions on August 30, 2018. That date falls well within the statutory 45-day notice period.

In 19 WC 8620, the Arbitrator finds that Petitioner provided timely notice of his October 24, 2018 accident. Petitioner credibly testified he notified Leticia of Total Staffing of the accident the day after it occurred. No one from Total Staffing refuted this testimony. Mario Enciso of Unifirst (the borrowing employer) testified that none of the supervisors working under him informed him of any accident during the period in question but he also acknowledged that Petitioner did not return to Unifirst after the accident.

Did Petitioner establish causal connection?

The Arbitrator finds that both of Petitioner's work accidents contributed to his current lumbar spine condition and the need for surgery. The Arbitrator relies on Dr. Salehi in finding that each accident aggravated Petitioner's underlying degenerative disc condition. Although Petitioner had a history of prior low back problems and treatment, that history was relatively remote. Based on the available records, it appears that, prior to the accident of August 7, 2018, Petitioner last underwent back treatment in March 2011, when he underwent a physical therapy evaluation at MacNeal Hospital. Petitioner credibly testified he was able to successfully work in various capacities between the time he settled his prior claim, in 2010, and the August 7, 2018 accident. That accident brought about an abrupt change in his ability to work. When Dr. Bayran released him to a trial of full duty, in October 2018, he was still symptomatic, although to a lesser degree. The lifting he performed at Unifirst on October 24, 2018 aggravated his condition and brought about the need for additional treatment. When Dr. Bayran again released him, in December 2018, it was due to Dr. Singh's findings and not because Petitioner was asymptomatic. Dr. Bayran acknowledged this at his deposition. RX 9, pp. 57-58.

In Illinois, it has long been held that an injured worker seeking benefits under the Act need only establish that an accident was a cause of his condition. He is not required to prove that the accident was the sole, or even a primary, cause. Nor is he required to exclude all other possible causes. Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193, 205 (2003). In Schroeder v. IWCC, 2017 IL App (4th) 160192WC, the Court explained that the "chain of events" principle does not apply solely to workers who are in perfect health. It also applies to workers whose pre-accident health is less than ideal. The Arbitrator finds persuasive Dr. Salehi's opinion that each accident aggravated an underlying degenerative condition, causing that condition to become symptomatic and disabling. The Arbitrator adopts Dr. Salehi's opinion that the first accident was more significant than the second.

The Arbitrator recognizes that, following both accidents, Petitioner worked at MD Metals from January 2019 through the initial hearing. Petitioner credibly testified that, at this job, he is not required to lift anything weighing more than 10 to 15 pounds. The Arbitrator also recognizes that Petitioner experienced an episode of intense back pain and leg numbness at work on September 23, 2019, with those symptoms prompting him to seek Emergency Room care. The Arbitrator does not view the episode as an intervening work accident. Petitioner credibly testified he was symptomatic prior to the episode and experienced the increased symptoms while eating during a work break.

Did Petitioner exceed his choices under Section 8(a) of the Act?

The Arbitrator finds that Petitioner did not exceed the physician choices afforded by Section 8(a) of the Act. Having considered the testimony of Petitioner, Elida Garcia and Dr. Bayran, along with the records produced by Compcore Pro (PX 34), the Arbitrator concludes that CompCorePro (an entity that Respondent Total Staffing adopted as its agent), rather than Petitioner, selected Dr. Bayran. Petitioner credibly testified he did not choose Dr. Bayran or set up an appointment to see him. He learned of the appointment via telephone. The records that Compcore Pro produced pursuant to subpoena reflect that, on September 17, 2018, Elida Garcia (whose job title, tellingly, is "referral coordinator") Emailed Dr. Khanna [CompCorePro's medical director, PX 34, p. 4], informed him that Petitioner's lumbar spine MRI results were not yet available and asked the following question: "Due to his [Petitioner's] continued pain should we recommend him to see Dr. Bayran?" In response, Dr. Khanna indicated he wanted to see the MRI report and "then . . . decide whether to send [Petitioner] to Dr. Bayran." PX 34, p. 30. On September 21, 2018, Garcia Emailed Dr. Khanna again, saying: "The adjuster finally responded after the 4th Email. Patient has been scheduled to see Dr. Bayran on 9/27/18." On October 16, 2018, Garcia sent yet another Email to Dr. Khanna, indicating that the last time she was in touch with Petitioner "was on 9/21/18 to give him his appointment details with Dr. Bayran." PX 34, p. 39. This Email meshes with Petitioner's testimony that he learned he was to see Dr. Bayran via a telephone call. At his deposition, Dr. Bayran confirmed he receives referrals from CompCorePro. He was also able to confirm that CompCorePro referred Petitioner to him. RX 9, pp. 11-13. Bayran Dep Exh 3.

The Arbitrator concludes that Dr. Trebart was Petitioner's first choice of physicians and that Drs. Vargas and Salehi were within the chain of referrals emanating from this choice. Petitioner credibly testified that Dr. Vargas mentioned two surgeons, i.e., Drs. Erickson and Salehi, to him, but described Dr. Salehi as "better." Petitioner also credibly testified that "Marisol" of Dr. Vargas's office arranged for him to see Dr. Salehi.

Is Petitioner entitled to reasonable and necessary medical expenses?

The Arbitrator has previously found in Petitioner's favor on the threshold issues of accident, notice and causation.

Petitioner seeks an award of $44,642.70 in fee schedule charges relating to the treatment he underwent between September 27, 2018 (the date of his initial visit to Dr. Bayran) and 2020. PX 31. The Arbitrator has reviewed the underlying records and bills, as well as the utilization review evidence and the treatment-related opinions rendered by Drs. Salehi and Singh. With the exception of $825.00 in non-emergency transportation charges claimed by Lakeshore Surgery Center (PX 17), in connection with the injections administered in March and April 2019, and the bill from Windy City Medical Specialists (see next paragraph), the Arbitrator awards the claimed fee schedule charges. The Arbitrator declines to award the non-emergency transportation charges because Petitioner did not establish the need for transportation to and from the facility where he underwent the injections.

The charges from Windy City Medical Specialists relate to the VascuTherm Cold Therapy rental unit that Dr. Vargas prescribed on March 1, 2019. PX 31, 35. The bill reflects a rather startling rental fee of $1,750.00 per week. Petitioner did not testify to using such a unit, let alone deriving any benefit from it. Respondent offered evidence indicating that, on March 22, 2019, GENEX non-certified cryotherapy. RX 7. The Arbitrator declines to award the Windy City Medical Specialists bill.

In reliance on Dr. Salehi, who stressed the significance of the first accident, the Arbitrator opts to make the award of medical expenses in the first case, 18 WC 27887.

In 19 WC 8620, is Total Staffing contractually liable to UniFirst?

UniFirst submitted a "Staffing/Vendor Agreement" running between it and Total Staffing whereby Total Staffing assumed full liability for any workers' compensation claims filed by employees loaned to UniFirst. Unifirst Exh 1. Total Staffing did not object to the admission of the agreement and stipulated to the nature of its liability. The Arbitrator notes, however, that, under the Act, loaning and borrowing employers remain jointly and severally liable.

Is Petitioner entitled to prospective care?

The Arbitrator has previously found in Petitioner's favor on the issues of accident, notice and causal connection. The Arbitrator has elected to rely on Petitioner's treating surgeon, Dr. Salehi, rather than the Section 12 examiner, Dr. Singh, with respect to treatment recommendations. The Arbitrator awards prospective care in the form of the two-level lumbar fusion prescribed by Dr. Singh. The Arbitrator again notes that GENEX, the utilization reviewer, ultimately certified this surgery, although the certifying physician applied somewhat different reasoning than Dr. Salehi.

Are Respondents liable for penalties and fees?

Petitioner seeks penalties and fees on awarded, unpaid medical expenses. Petitioner offered a list of the unpaid fee schedule charges from various providers. PX 31. The Arbitrator

has found in Petitioner's favor on the issues of accident and causation and has awarded certain medical expenses. [See above.]

The Arbitrator notes that certain of the unpaid awarded medical expenses relate to treatment rendered by Dr. Bayran. The Arbitrator has previously found that it was CompCorePro, and not Petitioner, who selected this physician. The Arbitrator also notes that, while an adjuster pre-approved the injection that Dr. Bayran administered on October 5, 2018 (Bayran Dep Exh 4), and while GENEX certified that injection, the expenses stemming from that injection remain unpaid. Dr. Bayran confirmed this at his February 20, 2020, deposition. [Dr. Bayran also clarified that the report concerning the injection contained a typographical error. He injected Petitioner on the left, not the right.] On this record, and given the passage of more than a year between the treatment at issue and the initial hearing, the Arbitrator finds it appropriate to award $10,000.00 [the statutory maximum] in Section 19(l) penalties, $2,283.74 in Section 19(k) penalties and $913.49 in Section 16 attorney fees. Section 19(l) penalties are in the nature of a mandatory late fee [McMahan v. Industrial Commission, 183 Ill.2d 499, 515 (1998)] while Section 19(k) penalties and fees are to be awarded when an employer acts in an objectively unreasonable manner, under all of the existing circumstances, in denying payment [Oliver v. IWCC, 2015 IL App (1st) 143836WC]. In Oliver, the Court emphasized that "the burden of proving a reasonable basis for the denial of benefits falls solely on the employer." In the instant case, Respondent Total Staffing failed to meet that burden. Given that Petitioner did not select Dr. Bayran, that adjuster James Hernandez pre-approved the October 5, 2018 injection and that a utilization review provider of said Respondent's choice certified the injection, the Arbitrator concludes that Respondent acted in an objectively unreasonable manner in declining to pay the injection-related expenses. The $2,283.74 Section 19(k) award represents 50% of the combined fee schedule charges of $4,567.49 from Illinois Back & Neck Institute and Ashland Medical Specialists relating to the October 5, 2018 injection. The $913.49 Section 16 fee award represents 20% of those same combined charges. PX 31.

The Arbitrator further finds that Respondents acted in an objectively unreasonable manner in declining to authorize the recommended fusion. Dr. Marehbian, the physician who originally recommended non-certification of this surgery, on behalf of GENEX, is not a surgeon. After Dr. Salehi filed an appeal, a second physician, Dr. Luke, a board certified orthopedic surgeon, recommended that the procedure be certified. PX 28. The Arbitrator recognizes, however, that under current Illinois law, an employer cannot be held liable for penalties and fees for failing to approve treatment. Hollywood Casino-Aurora v. IWCC, 2012 IL App (2d) 110426WC.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC008620
Case Name	CHAVEZ,BRAULIO v. UNIFIRST CORPORATION D/B/A
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0317
Number of Pages of Decision	41
Decision Issued By	Christopher Harris, Commissioner

Petitioner Attorney	Damian Flores
Respondent Attorney	Amelia Schwingle, Thomas Boyd

DATE FILED: 6/22/2021

/s/ Christopher Harris, Commissioner

Signature

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

BRAULIO CHAVEZ,

Petitioner,

vs.

NO: 19 WC 8620
18 WC 27887

TOTAL STAFFING SOLUTIONS, INC., and
UNIFIRST CORPORATION, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical, and prospective medical, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 14, 2020 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired

without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

Bond has been assigned in this case as detailed in consolidated case 18 WC 27887. 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.

June 22, 2021

CAH/tdm
O: 6/17/21
052

Christopher A. Harris
Christopher A. Harris

Barbara N. Flores
Barbara N. Flores

Marc Parker
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

CHAVEZ, BRAULIO
Employee/Petitioner

Case# **18WC027887**
19WC008620

TOTAL STAFFING SOLUTIONS INC AND BRIDGEVIEW MANUFACTURING INC
Employer/Respondent

On 8/14/2020, 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 0.12% 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:

1922 STEVEN B SALK & ASSOC LTD
DAMIAN R FLORES
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

4866 KNELL O'CONNOR DANIELEWICZ PC
THOMAS RYAN BOYD
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CHICAGO, IL 60607

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
19(B)/8(A) ARBITRATION DECISION

BRAULIO CHAVEZ
Employee/Petitioner
v.
TOTAL STAFFING SOLUTIONS, INC., and BRIDGEVIEW MANUFACTURING, INC.
Employer/Respondent

Case # **18** WC **27887**
(consolidated with 19 WC 8620)

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 **December 12, 2019 and June 16, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☐ What is the nature and extent of the injury?
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other: Prospective/additional medical treatment (8a)

FINDINGS

On **August 7, 2018** Respondents ***were*** operating under and subject to the provisions of the Act.

On that date, an employee-employer relationship ***did*** exist between Petitioner and Respondents.

Petitioner ***did*** sustain an accident that arose out of and in the course of employment with Respondents.

Timely notice of the accident was provided to Respondents.

For the reasons set forth in the attached decision, Petitioner established a causal connection between each work accident and his current lumbar spine condition of ill-being.

In the year preceding the injury, Petitioner earned $5,140.00; the average weekly wage was $395.38.

On the date of alleged accident, Petitioner was 47 years of age, ***married*** with **one** dependent child.

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

Respondent shall be given a credit of $0 for TTD, $**0** for TPD, $**0** for maintenance, and $0.00 for medical benefits under Section 8(j) of the Act, for a total credit of $0.00

ORDER

Medical Benefits
With the exception of the non-emergency transportation charges claimed by Lakeshore Surgery Center (PX 17) and the rental unit charges claimed by Windy City Medical Specialists (PX 31, 35), the Arbitrator awards the fee schedule charges set forth in PX 31. See the attached decision for further details concerning the medical award.

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner did not exceed the choices afforded by Section 8(a).

Prospective Medical (8a)
Respondents shall authorize and pay for prospective care in the form of the two-level lumbar fusion recommended by Dr. Salehi and ultimately certified by utilization review.

Penalties/Fees
For the reasons set forth in the attached decision, Respondents are liable for $10,000.00 in Section 19(l) penalties, $2,283.74 in Section 19(k) penalties and $913.49 in Section 16 attorney fees.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of

payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Molly C Mason

Signature of Arbitrator

8/13/20
Date

AUG 14 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

CHAVEZ, BRAULIO
Employee/Petitioner

Case# **19WC008620**

18WC027887

TOTAL STAFFING SOLUTIONS INC - LOANING EMPLOYER & UNIFIRST CORPORATION INC - BORROWING EMPLOYER
Employer/Respondent

On 8/14/2020, 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 0.12% 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.

1922 STEVEN B SALK & ASSOC LTD
DAMIAN R FLORES
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

1120 BRADY CONNOLLY & MASUDA PC
AMELIA A SCHWINGLE
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

21IWCC0317

STATE OF ILLINOIS)
)
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
19(b)/8(a) ARBITRATION DECISION

Braulio Chavez
Employee/Petitioner

Case # 19 WC 08620

v.

Consolidated cases: 18 WC 27887

Total Staffing Solutions, Inc.-loaning employer & Unifirst Corporation, Inc.-borrowing employer
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 Molly Mason, arbitrator of the IWCC, in the city of Chicago, on 12/12/19 & 6/16/20. 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 the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to the respondent?
F. ☒ Is the petitioner's present condition of ill-being causally related to the injury?
G. ☐ What were the petitioner's earnings?
H. ☐ What was the petitioner's age at the time of the accident?
I. ☐ What was the petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to petitioner reasonable and necessary? 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 the respondent?
N. ☐ Is the respondent due any credit?
O. Other Choice of Physicians and Future Medical

FINDINGS

- On 10/24/2018 , Respondents Total Staffing Solutions, Inc.& Unifirst Corporation, Inc. *were* operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship *did* exist between Petitioner and Respondents.
- On this date, Petitioner *did* sustain injuries 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, Petitioner established a causal connection between each of his work accidents and his current lumbar spine condition of ill-being.
- In the year preceding the injury, Petitioner earned **$8,908.76**; the average weekly wage was **$371.20**.
- On the date of accident, Petitioner was **47** years of age, ***married*** with **1** dependent child.
- Petitioner has in part received reasonable and necessary medical services.
- Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.
- Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, , and **$0** for other benefits, for a total credit of **$0**.
- Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

The Arbitrator awards the unpaid medical expenses under the case of 18 WC 27887.

The Arbitrator awards the proposed lumbar fusion surgery under the case of 18 WC 27887.

Petitioner did not exceed his choice of physicians.

The Arbitrator awards penalties under the case of 18 WC 27887.

Respondents agree that, pursuant to the "Staffing/Vendor Agreement" (Unifirst Exh 1) running between them, Total Staffing assumed full liability for any workers' compensation claims filed by employees loaned to Unifirst.

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

8/13/20
Date

AUG 14 2020

Braulio Chavez v. Total Staffing Solutions
and Bridgeview Manufacturing, Inc.
18 WC 27887 and 19 WC 8620 (consolidated)

Summary of Disputed Issues

Petitioner, a staffing agency employee, claims he injured his lower back on August 7, 2018, while working at Bridgeview Manufacturing, and on October 24, 2018 [as amended, T. 174-177], while working at Unifirst Uniform Services. The disputed issues in both cases include accident, notice, causal connection, medical expenses, penalties/fees and prospective treatment, with Petitioner seeking a lumbar fusion that was recommended by Dr. Salehi and ultimately certified by utilization review. Arb Exh 1, 3.

Arbitrator's Findings of Fact

Petitioner testified via a Spanish-speaking interpreter.

Records in PX 6 reflect that Petitioner underwent a lumbar spine MRI on November 6, 2008. A chiropractic radiologist interpreted this study as showing a 4 millimeter, left foraminal intervertebral disc protrusion at L4-L5 and an asymmetric, broad-based posterior annular bulge at L5-S1. PX 6.

Petitioner acknowledged injuring his low back on July 31, 2009. He filed a workers' compensation claim in connection with this injury. He settled this claim [09 WC 36880] on December 17, 2010. T. 26. Petitioner testified he underwent physical therapy and three injections following the July 31, 2009 injury. T. 27. Records in PX 10 document treatment at Concentra and MacNeal Hospital. A lumbar spine MRI performed on January 7, 2010 showed a 2-3 millimeter disc bulge/protrusion at L5-S1 indenting the thecal sac, without significant stenosis. PX 6.

Petitioner testified he resumed working after he settled the '09 claim. The jobs he performed after December 2010 included forklift operator, school maintenance worker and home remodeler. In 2017, he worked at Southern Glazer Wine & Spirit for about a year. The job he performed at Southern Glazer required lifting up to 30 pounds. He was able to perform his assigned duties at Southern Glazer. T. 29-30.

On direct examination, Petitioner denied undergoing any low back treatment between the time he settled his '09 claim, in December 2010, and 2017. T. 30. Records in PX 10, however, reflect he underwent a physical therapy evaluation at MacNeal Hospital on March 31, 2011, with the evaluating therapist noting a complaint of low back pain radiating down the right leg to the knee.

Petitioner testified he began working for Total Staffing in late April 2018, after he left Southern Glazer. T. 30. Total Staffing sent him to various locations, including Nestle. At Nestle,

he drove a forklift for two to three months. He sat for eight hours per day while operating the forklift. His back did not bother him during this period. He was "working fine." T. 33.

Petitioner testified that, in August 2018, he began working as a machine operator at Bridgeview Manufacturing for Total Staffing. The machine cut automobile parts. He had to periodically clean the machine to remove liquid and scrap metal that would otherwise interfere with the manufacturing process. T. 35-36. Two to three times per shift, he would place the liquid and scrap metal in a plastic box that was about 20 inches by 20 inches in size and take the box out to a garbage container. T. 37-38. The box, when full of scrap metal, could weigh up to 100 pounds "because it also has liquid that runs around it." T. 38.

Petitioner testified he arrived at work at 4 AM on August 7, 2018. He felt fine when he arrived. T. 39. He discovered that his assigned machine was still "dirty from the previous shift." T. 39. After he cleaned the machine, he began lifting the 100-lb. plastic box containing refuse off the floor, using both hands. His intention was to place the box on his right shoulder so that he could carry it. As he began lowering the box to his shoulder, he felt a strong pull in his lower back. He rated his initial pain at 6-7 on a scale of 1 to 10. T. 41. He did not report the injury at that time because no supervisor was present. He continued working. At the end of his shift, he reported the accident to Angela, the owner of the company. He does not know Angela's last name. T. 42. He was in a lot of pain by the time his shift ended. It was very difficult for him to get into his car. T. 42-43. After he got up the following morning, he went to Total Staffing's office and reported the accident to Leticia, the manager. At his request, Leticia completed a written accident report so that he could go to a clinic. T. 44. Petitioner identified RX 2 as the accident report. He completed the first page of the report, in Spanish. He did not complete the second page, which is in English. T. 45-46. The name "Andrea Koller" is printed on the report. Andrea Koller is the person at Bridgeview to whom he reported the accident on August 7, 2018. T. 46. Leticia arranged for him to go to LaGrange Medical. On August 8, 2018, he drove himself to this facility, underwent a drug screening and then saw Dr. Byrd. T. 46. [The screening results were negative.] He complained of 8-10/10 pain in his left buttock traveling into his left thigh. T. 47. He initially denied experiencing this kind of radiating pain prior to the August 7, 2018 accident. He then acknowledged experiencing some leg pain after his 2009 back injury. Between December 2010 and the August 7, 2018 accident, he did not experience pain traveling down his legs. T. 48.

Petitioner testified that Dr. Byrd prescribed medication and imposed work restrictions. T. 49.

A "work injury form" in PX 1 reflects that, on Petitioner complained of low back pain radiating to his left buttock and down his left leg after lifting an approximate 100-pound container at work the previous morning. Petitioner rated his pain at 8/10 when standing. He described having undergone treatment for a similar injury nine years earlier. On initial examination, Dr. Byrd noted a reduced lumbar spine range of motion and point tenderness over the left lumbar area and left lateral thigh. She administered a Toradol injection, prescribed Naproxen, ice applications and physical therapy and directed Petitioner to return to the facility

to undergo X-rays. She restricted Petitioner to seated work with no driving, kneeling, squatting or repetitive bending/twisting. The X-rays, performed two days later, showed mild spondylosis and Grade 1 retrolisthesis L5 over S1. PX 1.

Petitioner testified he did not resume working at Bridgeview after his initial visit to Dr. Byrd. Instead, he began performing light duty in Total Staffing's office. The light duty consisted of cleaning the office, doing applications and posting notices in the street. T. 49. He continued seeing Dr. Byrd during this period. T. 49. On August 13, 2018, Dr. Byrd added Tylenol #3 and continued the restrictions. PX 1.

Petitioner underwent physical therapy at Athletico between August 17, 2018 and October 10, 2018. T. 50. At the initial therapy evaluation, the therapist noted that Petitioner reported injuring his low back "while lifting heavy object from floor and placing it onto R shoulder." The therapist also noted that Petitioner's gait was abnormal and that he exhibited signs of left lumbar radiculopathy. PX 1.

On August 27, 2018, Dr. Byrd noted that Petitioner had attended six therapy sessions but was still rating his left-sided pain at 7/10. She prescribed Norco, a Medrol DosePak and a lumbar spine MRI. She imposed restrictions of no kneeling, squatting, driving or repetitive bending/twisting and recommended additional therapy. PX 1.

A CompCorePro "personal note" dated August 29, 2018 reflects that Dr. Khanna spoke with Dr. Byrd about Petitioner's care. The note indicates that Dr. Khanna felt Petitioner "should be improving . . . three weeks after his injury date" but that Dr. Byrd wanted to try an additional two weeks of therapy. The note goes on to state that the additional therapy should be approved and that an MRI would be indicated "to rule out a disc herniation" if Petitioner did not improve by September 10, 2018. PX 2.

On August 30, 2018, James Hernandez, a claims adjuster affiliated with Next Level Administrators, wrote to LaGrange Medical Center, authorizing six physical therapy sessions. PX 2, PX 34.

In a GENEX utilization review communication dated September 10, 2018, Dr. Wang, a physiatrist, recommended that eighteen physical therapy sessions between August 31 and November 4, 2018 be non-certified. In making this recommendation, Dr. Wang noted that Petitioner remained symptomatic after twelve therapy sessions and cited "evidence-based guidelines" recommending that patients suffering from sciatica undergo ten to twelve therapy sessions over an 8-week period. PX 2.

The MRI, performed without contrast on September 14, 2018, showed degenerative disc disease and degenerative facet disease at various levels, with the radiologist noting that the findings were "prominent at the L4-L5 level where there is a broad-based disc bulge which is asymmetrically extending into the left neural foramen" resulting in stenosis of the left lateral recess and moderate left neural foraminal narrowing. PX 1.

A OneCallCare Email dated September 17, 2018 documents authorization of additional therapy visits between September 4 and 14, 2018. PX 2.

Petitioner testified he last saw Dr. Byrd on September 18, 2018. T. 51. [Based on notes in PX 1, it appears Petitioner actually saw Dr. Khan at LaGrange Medical Center on September 18, 2018.] Dr. Khan noted that Petitioner was benefiting from therapy and did not want any steroid injections. Petitioner testified he declined to undergo injections because he "wanted another option." Dr. Khan recommended two more weeks of therapy and continued the previous restrictions. PX 1.

On September 21, 2018, Elida Garcia of Comp Core Pro sent an Email to adjuster James Hernandez asking him to authorize two more weeks of therapy at Athletico. PX 2.

Petitioner testified he began seeing a different physician, Dr. Bayran, on September 27, 2018. He did not choose Dr. Bayran. He does not know whether his previous attorney selected Dr. Bayran. Someone associated with LaGrange Medical Center telephoned him and told him he would be seeing Dr. Bayran on a specific date. He did not set up the appointment on his own. T. 53. He knows it was LaGrange that contacted him because he asked the person who called him where that person was calling from. T. 54.

Petitioner testified he provided a consistent history of the August 7, 2018 accident to Dr. Bayran. He did not tell Dr. Bayran about the 2009 accident because that accident occurred in the past and "there was no pain from that." T. 54. Dr. Bayran recommended that he continue attending therapy and performing light duty. T. 55. He also prescribed an epidural steroid injection.

Dr. Bayran's initial note of September 17, 2018 reflects, without further explanation, that Petitioner was "referred by Neema Bayran." The doctor recorded a consistent history of the lifting-related accident of August 7, 2018 and subsequent care. The doctor noted that Petitioner reported "very little improvement" of his left-sided radicular symptoms after fifteen therapy sessions. He described Petitioner as walking without assistive devices and "able to sit comfortably." On lumbar spine examination, he noted tenderness over the midline and paraspinal muscles bilaterally and decreased sensation to light touch over the left lateral thigh. He interpreted the MRI as showing "foraminal disc extrusion on the left side at L4-L5 and disc extrusion to the left at L5-S1." He recommended that Petitioner continue therapy, noting he had three sessions scheduled. He also recommended a lumbar epidural steroid injection on the left. He imposed restrictions of no lifting over 20 pounds, no pulling/pushing over 30 pounds and no frequent twisting or bending. PX 3.

Dr. Bayran administered a transforaminal steroid injection on October 5, 2018. PX 3-5. Petitioner testified he "felt a little better" after this injection. The injection helped only a little with respect to his leg pain. T. 56.

On October 8, 2018, GENEX wrote to Dr. Bayran, certifying the left L4-L5 and L5-S1 transforaminal epidural injection. PX 29.

Dr. Bayran's note of October 18, 2018 reflects that Petitioner was still experiencing sharp pain in his lower back in the morning but denied pain radiating to his legs. The doctor released Petitioner to full duty "on a trial basis." He directed Petitioner to return to him if he could not tolerate full duty. PX 3.

Petitioner testified that, following the injection, Dr. Bayran recommended he return to his normal activities but "with caution." The doctor directed him to avoid doing things too quickly. T. 56. After the doctor released him to full duty, he contacted Total Staffing. Total Staffing sent him to work at a commercial laundry service called "Unifirst." T. 57-58.

Petitioner testified he began working at Unifirst in October 2018. He worked there about three days. His job consisted of removing wet, dirty laundry from large containers, placing the laundry on a table that was about 2 ½ feet high, sorting the items by color, placing the sorted items in carts and pushing the carts into large elevators. T. 57-59. The carts, when full, weighed between 200 and 300 pounds. At the beginning of the process, he had to bend to remove the wet laundry from the large containers, which arrived via truck. T. 60-61. A scale registered the weight of the items that he placed in carts. T. 62. He filled the carts to the brim before pushing them to the elevator. T. 62. The process continued throughout his shift. He bent over to pick up piles of items between 50 and 80 times a day. T. 66.

Petitioner testified he reinjured his back on October 23, 2018, while working at Unifirst. He was lifting a bundle of wet clothing that was about three feet wide and three feet high when he felt pinching in his back. The pinching sensation was more intense than the pain he had previously experienced. T. 65. He did not report the accident to anyone at Unifirst. He reported it to Leticia [of Total Staffing] the following day and then called Dr. Bayran's office. He set up an appointment to return to Dr. Bayran on October 25, 2018. The doctor had instructed him to call if his back condition changed. T. 66-67. On October 25, 2018, he reported the October 23rd accident to Dr. Bayran and complained of low back pain radiating down to his foot. His foot symptoms started after the October 23, 2018 accident. T. 67. At no time between December 2010 and August 2018 did he seek treatment for low back pain traveling down to his foot. T. 67-68.

Dr. Bayran's note of October 25, 2018 sets forth the following interval history:

> "The patient comes back for a visit. He states that his pain got worse after he started working as full-duty with no restrictions. He states that he was pushing a cart full of clothes which weighs about 400 pounds and he was bending down to pick up heavy wet clothes when his pain got worse. He complains of pain on the left side of his lower back with radiation into his left buttock, left

> lateral thigh, leg and foot. He describes his pain has [sic] pinching, sharp pain. He states that he feels that his left leg is very heavy. He also complains of pain radiating into his left groin and medial thigh."

On re-examination, Dr. Bayran noted decreased sensation to light touch on the left in the distribution of the left L4 nerve root. After re-reviewing the MRI, the doctor recommended a spinal consultation and imposed restrictions of no lifting over 20 pounds and no pulling or pushing over 30 pounds. PX 3.

Petitioner testified that, as soon as Dr. Bayran gave him the restrictions, he went to Total Staffing's office. He presented the restrictions to Leticia and told her about the October 23, 2018 accident. Leticia told him she no longer had light work available for him and that his situation was now in the hands of attorneys. T. 69. After October 25, 2018, he never returned to work for Total Staffing. T. 70. He tried to find work elsewhere. T. 70.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Singh on November 21, 2018. Dr. Singh's report reflects he examined Petitioner in the presence of a Spanish-speaking interpreter. The report also reflects that Dr. Singh reviewed records from LaGrange Medical Center and Dr. Bayran, as well as the September 14, 2018 MRI images. Dr. Singh noted complaints of 7/10 lower back pain and left posterior thigh paraesthesias into the knee. On examination, the doctor noted a full range of lumbar spine motion, 5/5 strength and 5 out of 5 positive Waddell's signs. He interpreted the MRI images as revealing a left L4-L5 disc protrusion without evidence of any L4 exiting nerve root compression. He opined that Petitioner "sustained a soft tissue muscular strain which has resolved." He characterized the L4-L5 disc herniation as "incidental in nature." He did not find Petitioner's posterior thigh complaints to be consistent with an L4 nerve root compression. He indicated it would have been appropriate for Petitioner to undergo four weeks of physical therapy. He saw no need for an injection. He described Petitioner's prognosis as "guarded." He found Petitioner capable of full duty.

Petitioner testified he began working for Billet Specialties sometime in November 2018. He worked for this company for only a short period, until January 2019, when he began working for Illinois Staffing. T. 71-72. He believes he was off work for about three weeks before he started working at Billet Specialties. T. 71-72.

Petitioner testified he saw Dr. Bayran again on November 29, 2018. At that visit, he complained of 6/10 pain going down to his left foot. The doctor continued the previous restrictions and again recommended a surgical consultation. T. 73. PX 3.

Petitioner testified he last saw Dr. Bayran on December 27, 2018. At that point, he was still experiencing low back and leg pain. His back pain had not improved. T. 74. Dr. Bayran discharged him from care, telling him he could not do anything more because Dr. Singh had said he did not require any additional treatment. T. 74. Dr. Bayran released him to full duty. T. 76.

In his note of December 27, 2018, Dr. Bayran expressed awareness of Dr. Singh's opinions that the work accident resulted in a lumbar strain and that Petitioner was capable of full duty. Citing these opinions, Dr. Bayran indicated that Petitioner did not require a spinal consultation "at this point." He discharged Petitioner from care. PX 3.

Petitioner testified that, in January 2019, Illinois Staffing sent him to work at MD Metals. He is still working full-time at MD Metals. T. 77, 79. At this facility, he cuts pieces of wood and cleans offices and bathrooms. T. 77. He is on his feet most of the day. T. 77-78. The only items he lifts at MD Metals are 15-inch pieces of wood. The work is "very light" but his symptoms persisted. T. 78. Eventually, he sought another opinion at a clinic at 7200 North Western Avenue, where he saw Dr. Trebert. This doctor prescribed therapy and recommended he see a pain management specialist. T. 79. He underwent therapy, at two La Clinica facilities, between February 21, 2019 and March 2019. T. 80.

Records in PX 6 reflect that Petitioner saw Dr. Trebert, a chiropractor, at Delaware Physicians, LLC, on February 13, 2019. A "patient status form" in PX 6 reflects that Petitioner was referred by "GML." Dr. Trebert noted complaints of low back pain with associated radiation and numbness in the left leg secondary to a work accident of August 7, 2018. She also noted that Petitioner had attended twenty therapy sessions and described his symptoms as having worsened since the last session. She prescribed therapy and recommended a consultation with a pain management specialist. PX 6, 7.

On February 19, 2019, Petitioner saw Dr. Iavarone, a chiropractor, at La Clinica, S.C., in Cicero, Illinois. The doctor recorded a consistent history of the August 7, 2018 accident and subsequent care. He noted that Petitioner "has been working since the accident" but lasted only four days at UniStaff in October 2018 "due to the pain." He indicated that, in November and December 2018, Petitioner worked for "_____ Specialties" and that he was currently working at ASI Accurate, a door company, where he was painting and packing doors.

Dr. Iavarone noted that Petitioner complained of left-sided low back pain, rated 7/10, radiating to the bottom of his left foot. He also noted that Petitioner reported injuring his low back ten years earlier "with all symptoms resolved." He linked Petitioner's complaints to the August 7, 2018 accident. PX 7.

On February 21, 2019, Petitioner began a course of care with Dr. Zaragoza, a chiropractor, at La Clinica, S.C. PX 7.

Petitioner testified that, at Dr. Trebert's referral, he saw Dr. Vargas at the facility at 7200 North Western Avenue, on February 21, 2019. Petitioner denied having any new back injuries between his last visit to Dr. Bayran, in December 2018, and his first visit to Dr. Vargas. T. 81. He complained to Dr. Vargas of pain traveling down the back of his leg to his foot. He did not provide a history of the 2009 accident to Dr. Vargas because that accident did not result in any

lingering problems. T. 82. At the recommendation of Dr. Vargas, he underwent another MRI on February 25, 2019 and then two more epidural steroid injections. T. 82-83.

In his initial note of February 21, 2019, Dr. Vargas recorded a consistent history of the August 7, 2018 work accident and subsequent care. He did not mention the October 2018 accident. He indicated that Petitioner described his symptoms as persisting after he resumed regular work, following therapy and an epidural injection. He described Petitioner as currently working "assembling bathroom doors." He noted that Petitioner walked with a mild limp, favoring his left leg. He also noted that Petitioner was able to walk on his heels and toes but unable to squat. After examining Petitioner and reviewing the MRI, he diagnosed chronic low back pain syndrome, discogenic pain syndrome, L4-L5 and L5-S1 herniated discs and lumbar facet pain syndrome. He recommended a repeat lumbar spine MRI, therapy, a series of bilateral L4-L5 and L5-S1 epidural steroid injections, a back brace and various medications. He linked Petitioner's symptoms to the work injury. He imposed restrictions of no lifting, carrying, pushing or pulling over 20 pounds. PX 6, 7, 8.

Petitioner underwent the recommended repeat lumbar spine MRI on February 26, 2019. T. 82. Dr. Kuritza, the interpreting radiologist, indicated he compared the images with those obtained on November 6, 2008 and October 1, 2009. He indicated that "the current exam demonstrates again at the L5-S1 level a 1-2 millimeter posterior disc bulge which indents the thecal sac at this level." He also noted a "far left intraforaminal disc protrusion/herniation measuring 2-3 millimeters" at L4-L5. PX 7.

Petitioner returned to Dr. Vargas on February 27, 2019. The doctor interpreted the repeat MRI as confirming pathology at the L4-L5 and L5-S1 levels. He described Petitioner as still in mild to moderate distress. He recommended a series of left-sided L4-L5 transforaminal epidural steroid injections. He refilled the medication and took Petitioner off work. PX 6. [A "quick report" in PX 8 reflects that Dr. Vargas continued the previous 20-pound restriction.]

On February 28, 2019, Dr. Zaragoza noted that Petitioner "has not been working since his work told him that they have no work for him." He also noted that Petitioner was scheduled to undergo injections the following day. PX 7.

On March 1, 2019, Dr. Vargas prescribed a VascuTherm Cold Therapy rental unit for Petitioner. PX 35.

On March 1 and 15, 2019, Dr. Vargas administered left L4-L5 transforaminal epidural steroid injections and selective nerve root blocks. PX 6, 8. Petitioner testified that the first injection did not help at all and that his pain increased after the second injection. T. 83.

On March 21, 2019, Dr. Zaragoza noted that Petitioner reported improvement of his leg pain following the injections. He described Petitioner as saying that "his job does allow him to work at his pace." PX 7.

On March 21, 2019, Petitioner's current counsel filed an Amended Application in 18 WC 27887 and an Application in 19 WC 8620. PX 22-23.

Petitioner returned to Dr. Vargas on March 27, 2019 (T. 83), with the doctor noting "no tangible clinical improvement whatsoever." The doctor also noted an intervening records review by a rehabilitation physician, Dr. Jaspal Singh. He described Dr. Singh as using "outdated and controversial data" in diagnosing a lumbar strain and concluding that Petitioner did not require the care he had recommended. After re-examining Petitioner, he recommended a surgical consultation, noting he wanted to perform a CT discogram and then refer Petitioner to Dr. Erickson, a neurosurgeon. He continued the previous work restrictions. PX 6, 8.

In an addendum issued on April 3, 2019, Dr. Vargas noted that he had spoken with an unidentified physician earlier that day, "in response to a negative UR issued by a different physician, i.e., Dr. Singh, who was unavailable for a peer to peer discussion." He also noted that the physician with whom he spoke "was unaware that [Petitioner] had failed to respond" to care and was pending a CT discogram. PX 8.

Dr. Vargas performed a four-level lumbar discogram on April 5, 2019. In his report, he described Petitioner as cooperative. He deemed Petitioner's responses to be valid. He concluded that Petitioner had "unequivocal concordant" pain at L4-L5 and L5-S1, with controls at L2-L3 and L3-L4. Dr. Kuritza interpreted a post-discogram lumbar spine CT scan as showing a 3-4 millimeter left intraforaminal disc herniation at L4-L5 and a 3-4 millimeter posterior disc herniation at L5-S1 indenting the thecal sac. PX 6, 8.

Petitioner testified that, when he last saw Dr. Vargas, on April 16, 2019, the doctor told him the discogram "came out bad" and referred him to Dr. Salehi, a surgeon. T. 84-85. While Dr. Vargas' note mentions Dr. Erickson, and not Dr. Salehi, Dr. Vargas told him that Dr. Salehi was "better." Petitioner testified that the receptionist at Dr. Vargas's clinic told him that Dr. Salehi sees patients at that clinic. T. 86.

In his note of April 16, 2019, Dr. Vargas indicated he reviewed the CT discogram results with Petitioner. He refilled Petitioner's medication, prescribed therapy and referred Petitioner to Dr. Erickson, who he described as a "neurosurgeon in our group." He recommended that Petitioner remain off work. A separate "quick report," however, reflects both that the doctor found Petitioner unable to work and that he was capable of light duty with no lifting, carrying, pushing or pulling over 20 pounds. PX 6, 8.

Petitioner testified he first saw Dr. Salehi on May 7, 2019. The employees at Dr. Vargas's clinic set up this appointment. They "arranged everything." T. 86. The employees asked him whether he preferred to see Dr. Salehi at the Western Avenue location or at the doctor's clinic in Westchester. He opted for Westchester because he lives 20 minutes from that city. T. 87. He believes it was "Marisol" of Dr. Vargas's office who he spoke with. T. 87. When he first saw Dr. Salehi, he complained of 8/10 low back pain radiating down his left leg into his foot. He provided the doctor with copies of his 2018 and 2019 MRIs and the April 5, 2019 CT

discogram scans. The doctor examined him and recommended surgery. He wants to undergo this surgery. T. 89. The doctor also indicated he could continue working. T. 88-89.

Dr. Salehi described Petitioner as lifting a heavy container onto his left, rather than right, shoulder but his account of the August 7, 2018 accident is otherwise consistent with Petitioner's testimony. He described Petitioner as denying any history of back or leg pain prior to this accident. After examining Petitioner and reviewing the 2019 lumbar spine MRI and CT discogram, he diagnosed mechanical back pain secondary to annular tears at L4-L5 and L5-S1. He found this diagnosis to be "causally related to the work injury of 8/7/18." He recommended a L4-S1 transforaminal lumbar interbody fusion, noting that Petitioner wanted to proceed with this surgery. PX 9, pp. 1-4.

On May 8, 2019, Dr. Salehi's surgical coordinator wrote to Angie Suesz, a claims adjuster at Next Level Administrators, requesting authorization of the recommended fusion. Suesz wrote back the same day, denying authorization "per IME 11/21/18 and pending litigation of this matter." PX 9, PX 32.

On May 8, 2019, Petitioner's counsel sent Respondent Total Staffing's counsel an Email, demanding payment of various outstanding medical expenses totaling $40,032.60. PX 26.

On May 11, 2019, GENEX wrote to the adjuster, as well as Dr. Salehi and Petitioner's counsel, indicating it was non-certifying the recommended lumbar fusion. The reviewing physician, Dr. Marehbian, a board certified neurologist, found the request for this surgery to be "premature for this claimant" and "not medically appropriate at this time." Specifically, Dr. Marehbian noted that Petitioner had resumed light duty and that "there appeared to be no evidence of instability to warrant a fusion over possible discectomy/laminectomy procedures." RX 6.

On May 15, 2019, GENEX wrote to Petitioner's counsel, indicating that, in response to Dr. Salehi's appeal of May 13, 2019, it was certifying the recommended L4-S1 fusion. GENEX cited the opinions of Dr. Luke, a board certified orthopedic surgeon, and indicated that "the prior determination [i.e., non-certification] was not appropriate." PX 28.

On May 29, 2019, Petitioner's counsel sent updated medical bills from four providers to Respondent Total Staffing's counsel. Total Staffing's counsel responded the same day, indicating that the injections "were all denied per UR and IME." PX 27.

Petitioner testified he did not tell Dr. Salehi about his 2009 back treatment until after the initial visit because he was fine between December 2010 and the August 2018 accident. T. 89-90. On August 6, 2019, he provided Dr. Salehi with copies of the MRI scans he underwent in 2009 and 2010. Dr. Salehi continued to recommend surgery. T. 90.

Petitioner testified he sought Emergency Room treatment on September 23, 2019 because he was experiencing "a really intense pulsating pain" and this worried him. He denied

sustaining any new back injury prior to his Emergency Room visit. T. 91. He never sought Emergency Room care for similar care between December 2010 and the August 2018 accident. T. 91. At the Emergency Room, doctors observed him for two hours and gave him pain medication. They recommended that he return to the Emergency Room if his pain persisted. PX 21

On September 23, 2019, Emergency Room personnel noted that Petitioner reported injuring his back at work a year earlier. They also noted that Petitioner was waiting to undergo recommended back surgery and denied any new back injury or trauma. The examining physician's assistant noted generalized tenderness to palpation of the bilateral lumbar paraspinous muscles and some midline tenderness to palpation. She dispensed Norco, Decadron and Lidocaine patches and instructed Petitioner to avoid heavy lifting or twisting. PX 10, pp. 7-10.

Dr. Salehi testified by way of evidence deposition on October 1, 2019. PX 25. Dr. Salehi testified he did his internship and residency in neurosurgery at Northwestern. He became board certified in neurosurgery in 2004 and was recertified in 2015. PX 25, p. 5. Salehi Dep Exh 1.

Dr. Salehi testified he first saw Petitioner on May 7, 2019, with Petitioner providing a history of a lifting-related work accident of August 7, 2018. Dr. Salehi indicated that Petitioner told him he experienced left-sided low back and left leg pain on that date after lifting a 100-pound container onto his left shoulder and carrying that container to a dumpster three times. Dr. Salehi also indicated that Petitioner subsequently improved but experienced a return of his pain after resuming work. He noted that Petitioner rated his current pain level at 8/10. PX 25, pp. 7-8.

Dr. Salehi testified that his evaluation of Petitioner, nine or ten months out from the injury, was beyond the point where one could reasonably attribute his symptoms to a muscular strain. PX 25, p. 8. The fact that Petitioner had pain running down to his left foot was suggestive of some neural compression. PX 25, p. 8. The injections Petitioner underwent allowed his symptoms to abate to the point where he could return to work. On October 25, 2018, Dr. Bayran documented recent lifting activity at work, with this activity aggravating Petitioner's lumbar condition. PX 25, p. 10.

Dr. Salehi testified that his examination findings showed there was "a pathology going on within [Petitioner's] lumbar spine resulting particularly in the limitation of the range of motion and the sensory loss." PX 25, p. 11. Petitioner was still working, subject to restrictions.

Dr. Salehi testified that he observed no signs of symptom magnification when he examined Petitioner. PX 25, p. 11.

Dr. Salehi interpreted the February 25, 2019 lumbar spine MRI images as showing annular tears within the L4-L5 and L5-S1 discs. He interpreted the post-discogram CT scan as

showing an annular tear at L5-S1 and on the left side at the posterolateral aspects of L3-L4 and L4-L5. PX 25, p. 12. When the outer, tougher layer of a disc tears, that can cause back pain. PX 25, p. 12. The discogram showed that Petitioner had concordant pain at L4-L5 and L5-S1. PX 25, p. 14. The discogram results correlated with the MRI and CT scans. Dr. Salehi diagnosed annular tearing and mechanical back pain. Petitioner also appeared to have radicular symptoms such as left leg numbness but there was no anatomic basis for these symptoms. PX 25, p. 15. The annular tearing is a "degenerative condition with aggravation." PX 26, p. 16. It is possible for a person with annular tears to be asymptomatic. Trauma can cause previously asymptomatic tearing to become symptomatic. PX 25, pp. 16-17. A disc that is torn "picks up" an injury more readily than an intact disc. Trauma can also cause existing tearing to deepen. PX 25, p. 17. The August accident was the "main" aggravation but both accidents were aggravating. PX 25, p. 18. Petitioner had back pain in 2009 and 2010 but did not subsequently seek additional care until after the August 2018 accident. PX 25, pp. 18-19. Given that Petitioner had exhausted conservative care, he recommended a two-level fusion, at L4-L5 and L5-S1. PX 25, pp. 19-20. The purpose of a fusion is to stabilize discs. When you remove motion from a disc, the pain tends to improve. PX 25, p. 20. He would recommend a fusion even if Petitioner had no radicular symptoms. PX 25, p. 21. Lifting, bending and twisting are the three mechanisms that typically aggravate discs. PX 25, p. 22. The accidents described by Petitioner involved these mechanisms. PX 25, p. 22. Any one of the three mechanisms can cause disc aggravation. PX 25, p. 22.

Dr. Salehi testified that utilization review initially non-certified the fusion he recommended. He appealed the denial to GENEX, in writing (Salehi Dep Exh 2). GENEX has guidelines to deny fusions which do not follow the guidelines promulgated by the American Association of Neurological Surgeons. In his appeal, he cited a 2005 study authored by "big names" in neurosurgery. The American Association of Neurological Surgeons guidelines are not based solely on one study. They have taken "hundreds of studies into consideration." They came up with "class one evidence that surgery for annular tears and disc disease is beneficial in the improvement of low back pain." PX 25, p. 25. Insurance carriers tend to cite "arcane guidelines" that a fusion is only appropriate if there is slippage of bone on bone. They tend to "conveniently forget" the diagnosis of mechanical back pain due to annular tearing. PX 25, pp. 25-26. Micromotion, as opposed to actual slippage, can also cause a lot of back pain. PX 25, p. 26. Dr. Salehi testified that, post-appeal, he received a letter from GENEX certifying the fusion. Salehi Dep Exh 3. The post-appeal reviewer tended to focus on disc herniations, whereas he focused on annular tearing, but he got to the same result. Despite the certification, the fusion was not approved. PX 25, pp. 28-29.

Dr. Salehi testified he has continued treating Petitioner since May 2019. He has imposed restrictions to prevent aggravation of the disc disease at L4-L5 and L5-S1. In August of 2019, he reviewed additional lumbar spine MRIs, including images dating back to 2008. All of the studies were more or less the same in terms of pathologic findings at L4-L5 and L5-S1. PX 25, pp. 30-31. His causal connection opinion is not based on the anatomic changes in the discs. It is based on "the symptomatic aggravation of the pre-existing anatomic problems that [Petitioner] had at L4-L5 and L5-S1." The older MRI scans did not cause him to change his

causation opinion. The only factor that might have prompted such a change was if Petitioner had been symptomatic prior to the August 2018 accident but he saw no evidence of that. PX 25, p. 33.

Dr. Salehi testified he disagrees with Dr. Singh's opinion that the MRI and CT scans from 2018 and 2019 are normal. He also disagrees with the doctor's opinion that Petitioner does not need a fusion. PX 25, pp. 34-35. The injections that Drs. Bayran and Vargas performed were reasonable as part of a conservative care regimen. PX 25, p. 35. No one wants to jump into surgery without first exhausting conservative measures. PX 25, p. 35.

Under cross-examination, Dr. Salehi testified he does not know who referred Petitioner to him. He reviewed certain records but did not see records from Dr. Zaragoza or any Emergency Room. PX 25, p. 37. From a chronological standpoint, the earliest records he reviewed were from Dr. Bayran. PX 25, pp. 37-38. Dr. Bayran's initial note reflects that Petitioner finished his shift after the accident on August 7, 2018. PX 25, p. 38. He has seen no records reflecting that Petitioner had back treatment between 2010 and August 7, 2018. PX 25, p. 38. Annular tears can be wholly chronic in nature. PX 25, p. 39. Petitioner's annular tears pre-dated the August 7, 2018 accident. PX 25, p. 39. They dated back to 2008 or 2009. Based on the imaging he reviewed, Petitioner's lumbar spine did not anatomically change between 2008-2009 and the August 7, 2018 accident. There is no neural component to Petitioner's condition. PX 25, p. 40. Petitioner has partial annular tearing at L4-L5. Annular tears cannot repair themselves nonsurgically. Discs are avascular and acellular, which means they have no capacity to repair themselves. PX 25, p. 42. Scar tissue sometimes fills the gaps, however. PX 25, p. 42. Based on the MRI, the L5-S1 disc is slightly more degenerated than L4-L5 but both discs show evidence of annular degenerative disc disease. PX 25, p. 43. He completely disagrees with the first utilization review. The logic applied by the second reviewer is different from his own. PX 25, pp. 43-44. The second reviewer indicated that decompression is appropriate but he disagrees. He saw no evidence of significant neural compression. PX 25, p. 44. His causation opinion is based on the consistent mechanism of injury and the correlation of Petitioner's symptoms with the imaging. PX 25, p. 45. He recommended a fusion at Petitioner's first visit. PX 25, p. 47. That visit lasted about 40 minutes. He concluded that a fusion was necessary after he reviewed the history, examined Petitioner and saw the imaging. PX 25, p. 47. Three factors, i.e., the limited range of motion, the MRI findings and the concordant discogram, provide an objective basis for his causation opinion. PX 25, p. 47. He did not document Petitioner's BMI. A patient's BMI has to be 35 or less to lower the complication rates. PX 25, p. 48. Most patients with annular tears improve. Petitioner improved after 2008-2009. PX 25, pp. 48-49. Dr. Bayran found Petitioner capable of full duty in December 2018. PX 25, p. 51.

On redirect, Dr. Salehi testified that, in December 2018, Petitioner complained to Dr. Bayran of left-sided low back pain radiating to his buttocks. PX 25, p. 52. During the discogram, which is a blind study, Petitioner reported no pain with injections at L2-L3 and L3-L4. At L4-L5 and L5-S1, however, Petitioner complained of excruciating, 10/10 pain. That was concordant. A discogram is objective in the sense that the patient does not know which level is being

injected. PX 25, p. 55. He is not ruling out radiculopathy in Petitioner but he has no good explanation for Petitioner's radicular symptoms. PX 25, p. 55. Absent the annular tears, he would not have recommended a fusion. It is possible for Petitioner to have had baseline 2-4/10 pain during the interval between 2009 and the August 2018 accident and for the accident to have aggravated that pain. PX 25, p. 56.

Under re-cross, Dr. Salehi acknowledged that Dr. Vargas treated Petitioner prior to performing the discogram. He does not see the possibility of "confirmation bias" as a huge problem. It is an "ethics thing" for the physician. He is sure that Dr. Singh uses or relies on discograms from time to time. PX 25, p. 58. The insertion of a needle into a person's back can cause discordant pain. The test is true if the pain is concordant, i.e., it reproduces the patient's typical pain. PX 25, p. 59. A doctor should not use a discogram lightly. PX 25, pp. 59-60.

On further redirect, Dr. Salehi testified that, in Petitioner's case, the discogram was "right on" in terms of the MRI findings. He would not necessarily have recommended that Petitioner undergo a discogram but the discogram added "another layer of confirmation." PX 25, pp. 60-61.

Petitioner testified he has not returned to the Emergency Room since September 23, 2019 but he has thought about going. During the last few days he has experienced strong pain and weakness in his leg. T. 92.

Petitioner testified he reported right leg pain to Dr. Salehi on October 2, 2019. No specific incident brought the right leg pain on. Dr. Salehi prescribed a new medication and again recommended surgery. T. 93. He last saw Dr. Salehi on December 3, 2019. T. 93. The new medication helps with the pain. T. 94.

Dr. Singh testified by way of evidence deposition on November 6, 2019. RX 8. Dr. Singh is a fellowship-trained spine surgeon. He is board certified in orthopedic surgery. Singh Dep Exh 1.

Dr. Singh acknowledged he does not independently recall examining Petitioner on November 21, 2018. RX 1, p. 5. His report reflects that a Spanish-speaking interpreter was present at the time of the examination. Petitioner told him he injured his back at work on August 7, 2018. Petitioner did not mention any injury occurring in October. RX 1, p. 6. Petitioner had normal strength and sensation, as well as a full range of lumbar spine motion. He exhibited 5/5 positive Waddell's findings. RX 1, p. 7.

Dr. Singh testified he interpreted a September 14, 2018 lumbar spine MRI as showing a left-sided disc protrusion at L4-L5. He saw no evidence of nerve root compression. RX 1, p. 8. He concluded that Petitioner sustained a lumbar strain. He could not correlate this to the L4-L5 protrusion. He found no evidence of L4 nerve root pathology. Petitioner's complaint of posterior thigh pain does not correlate with L4 nerve root compression. RX 1, p. 8. In light of Petitioner's normal examination, he felt that Petitioner could resume full duty. He concluded

that Petitioner reached maximum medical improvement four weeks after his injury. This time frame would be "consistent with the resolution of a soft tissue strain." RX 1, p. 9. In his note of December 27, 2018, Dr. Bayran found Petitioner to be at maximum medical improvement and capable of returning to work. RX 1, p. 9. Singh Dep Exh 4.

Dr. Singh identified Singh Dep Exh 3 as an addendum he issued after reviewing additional records from Drs. Bayran, Vargas and Salehi and certain therapy and chiropractic notes. He also reviewed images of MRI scans performed in 2008 and 2009 and a CT scan performed in 2019. The pre-accident MRI scans show the same findings as those taken after the accident. The CT scan shows a disc protrusion on the left at L4-L5 consistent with the pre-accident MRIs. RX 1, p. 11. There are "no neurological findings." The CT discogram showed no extravasation of the dye. The new records and imaging studies confirmed his previous causation opinion. RX 1, pp. 11-12. It is his understanding that Dr. Salehi believes Petitioner is suffering from discogenic low back pain, not a disc herniation. RX 1, p. 13.

Dr. Singh opined that Petitioner does not require a two-level fusion. This surgery would not improve Petitioner's symptoms. It is not causally related to the accident. RX 1, p. 14.

Under cross-examination, Dr. Singh testified that, apart from the issue of causation, there is no medical need for a fusion. RX 1, p. 15. He has been performing examinations for twelve years. He authored two reports in this case. He has not reviewed any records generated after May 15, 2019. RX 1, p. 17. The only pre-accident records he reviewed were the 2008 and 2009 MRIs. Petitioner told him he did not undergo any back treatment prior to the accident. RX 1, p. 18. He has no information indicating that Petitioner had back problems during the weeks or months preceding the accident. RX 1, p. 18. Petitioner provided him with a description of his machine operator job duties. Petitioner also told him he was injured while lifting 100 pounds of scrap metal. That lifting was outside the description that Petitioner provided. It is his understanding that Petitioner worked for five months before the accident and was able to complete his duties during that time. RX 1, p. 20. He believes Petitioner sustained a lumbar strain. The symptoms of a strain can vary. A nonstructural strain can produce symptoms that typically last between four and six weeks. A lumbar strain cannot produce pain traveling down the posterior aspect of the leg to the foot. RX 1, p. 21. In his opinion, Petitioner reached maximum medical improvement by September 4, 2018. RX 1, p. 21. Petitioner complained to him of posterior, not lateral, thigh pain. If a patient complained to him of low back pain radiating down the legs, he would not necessarily perform a straight leg raise test. This test was performed prior to the advent of MRI imaging. The straightening of the knee was though to be indicative of a possible disc herniation. "We now know there are false positives associated with it." RX 1, p. 24. If the test produces solely back pain and no leg pain, it does not suggest neurological findings. RX 1, p. 25. He has no opinion concerning the radiologist's interpretation of the September 14, 2018 MRI. He disagrees with the radiologist's finding of foraminal material extrusion at L5-S1. RX 1, p. 28. There is no herniation at that level. He disagrees with Dr. Bayran's finding of a protrusion at L5-S1. He also disagrees with Dr. Bayran's diagnosis of lumbar radiculopathy. RX 1, p. 29. The report Dr. Bayran generated indicates he administered an injection on the right. It makes no sense to inject the opposite

side of the disc protrusion. RX 1, p. 30. Petitioner reported a new incident at work when he saw Dr. Bayran on October 25, 2018. He (Dr. Singh) could not identify this as a new accident. The symptoms Petitioner reported to Dr. Bayran are different from those he reported at the examination. RX 1, p. 32. Petitioner did not report any improvement of his pain at the examination. RX 1, p. 33. "Everything is inconsistent" about Petitioner. RX 1, p. 34. Even Dr. Salehi does not believe that Petitioner has a disc herniation. If Dr. Salehi believed this he would be recommending a discectomy. RX 1, p. 35. When Waddell's testing is used in isolation, it is has "very little value." He uses the results of such testing only in the context of the records, the examination and the imaging studies. To use them to conclude that an examinee is a malingerer is erroneous as there is "heightened anxiety at the time of examination." An independent medical examination is "by definition a confrontational event." RX 1, p. 36. He does not put much stake into Waddell's testing. RX 1, p. 36. To rely solely on such testing would be erroneous. RX 1, p. 37. He examined Petitioner on one occasion. RX 1, p. 37. When Dr. Bayran examined Petitioner on November 29, 2018, he noted complaints of pain in the posterior lateral thigh on the left. Posterior lateral refers to the back outside part of the thigh. It overlaps L5-S1. RX 1, p. 38. In his opinion, the CT discogram was not reasonable or necessary. He no longer uses discograms in his practice. A discogram is a blind test for the patient. The person performing the discogram should not be a treating physician and should not be aware of the working diagnosis. The patient should be blinded to the levels being tested. If the physician performing the discogram injects too much dye into a disc, the patient can experience pain, even though the disc is normal. RX 1, p. 40. In Petitioner's case, Dr. Vargas found concordant pain at L4-L5 and L5-S1 but the working diagnosis was always L4-L5. RX 1, p. 40. It was not until the date of the deposition that he learned that utilization review ultimately certified the fusion. RX 1, p. 41. He devotes 5 to 7% of his practice to records reviews, examinations and depositions. RX 1, p. 41. He sees between 150 and 200 patients per week and performs 4 to 6 independent examinations per week approximately 40 weeks out of the year. RX 1, p. 42. He charges approximately $1,200 per examination. This charge includes reviewing records and imaging studies and generating a report. RX 1, p. 42. Petitioner was still voicing left-sided complaints on the date Dr. Bayran released him. RX 1, p. 43. At the previous appointment, Dr. Bayran recommended a spine surgery consultation. RX 1, p. 43. His examination took place between that appointment and the date on which Dr. Bayran released Petitioner. RX 1, p. 44.

On November 13, 2019, Petitioner filed a Petition for Penalties and Fees, asserting that Respondent failed to pay injection-related expenses and failed to authorize the lumbar fusion, despite the utilization review certification. PX 34.

On December 2, 2019, Dr. Salehi re-examined Petitioner and again recommended a L4-S1 lumbar fusion. He refilled Petitioner's Mobic. PX 9.

Petitioner testified he wants to undergo the recommended surgery because he "cannot live like this," dependent on medication. He did not take any pain medication for his back between December 17, 2010 and the August 7, 2018 accident. T. 95. He is working despite his pain because he must support his family. T. 95, 97. His wife works but only part-time. T. 97-

98. On his best day, his pain level is between 5 and 6. T. 95. After an 8-hour shift at MD Metals, he feels a lot of pulsating pain. He would rate that pain "as high as eight." T. 96. He is supposed to take pain medication twice daily but tries to limit it to once a day because he does not want to be dependent on it. T. 97.

Petitioner testified that, at no time between December 2010 and his August 7, 2018 accident did any medical provider recommend back surgery. T. 98.

Under cross-examination, Petitioner testified he does not recall going to MacNeal Hospital's Emergency Room on March 31, 2011 and complaining of low back pain. PX 10, p. 34. He disputes that he went to the Emergency Room on that date. He is not familiar with the records concerning that visit. T. 102. He did not sustain a work injury in 2011. As of March 2011, he was working for a company called "I Remodel Your Home." At no time after December 2010 was he injured while performing maintenance or remodeling. T. 104. He denied telling Dr. Salehi he was injured on August 7, 2018 when he lifted a box and placed it on his left shoulder. He always told his providers that he put the box on his right shoulder. T. 105. On August 7, 2018, he arrived at work at 4 AM and began working at approximately 4:30 AM. He saw that workers from the previous shift had left the machine messy so he began cleaning. A person was in his vicinity, about 5 to 10 feet away, when he was injured but that person was not paying any attention to him. T. 107. He does not remember this person's name. T. 107. He did not mention his injury to this person. T. 107. Angela, the female owner at Bridgeview, was at work but she was not near where he was working. When he first began working at Bridgeview, he was told to report any work injury to Total Staffing. At the time of his injury, he had the phone number for Total Staffing's office. He first experienced pain around 4:30 AM. He was able to work his entire shift, which ended around noon. T. 110. After he lifted the 100-pound box, the only thing he had left to do was to put liquid in the machine. He remembers telling a physical therapist that, although he experienced pain, he continued carrying the box to the trash. He did this to fulfill his obligations. T. 111. He had to walk about 50 steps while carrying the box on his shoulder. T. 113. He is not sure whether he had to carry that box to the dumpster one or two more times after his injury. T. 113. He received his schedule the previous day. When he finished his shift at noon, he just left. He did not have to check in with anyone. T. 114. If he had left work earlier, at 10:30 AM for example, he would have gotten in trouble. People walk around and watch him. Plus there are video cameras right over him. T. 115. When he leaves work, at the end of his shift, he typically says goodbye to Angela, the owner. When he left work on August 7, 2018, he said goodbye to Angela. He also told Angela he was hurt. It was the following day that he reported the injury to Total Staffing. T. 116. It is his contention that he reported his injury to Angela Koller on August 7, 2018. He told Angela he had been injured at work that day. T. 119. He told Dr. Bayran he reported his injury right away. T. 120-121. He did not go back to Bridgeview on August 8th. Instead, he went to Total Staffing to formally report the accident. T. 121. He subsequently began performing light duty at Total Staffing's office. T. 121.

Petitioner testified he does not have a family physician. He first heard Dr. Bayran's name when "they" spoke to him and gave him the appointment date. T. 122. He does not

recall when he hired his first attorney. He saw Dr. Bayran because LaGrange Medical Center referred him to this physician. T. 124. He hired his first attorney in 2018, maybe in December. He does not recall the exact date. T. 126. On December 27, 2018, Dr. Bayran told him he could not do anything further for him since Dr. Singh had indicated he did not require more care. T. 127. Nevertheless, Dr. Bayran told him to "continue onward" with his treatment. T. 128. He decided to change attorneys because his first attorney "never wanted to see" him and told him to consult someone else. T. 130. A friend, Juan Lumbarras, referred him to Delaware Physicians. T. 131. Lumbarras was undergoing treatment at that facility. T. 133. In November and December 2018, he worked full-time cleaning tire rims. T. 133-134. He cannot recall whether he earned more doing that work than he earned at Bridgeview. T. 136. In January 2019, he briefly worked through Illinois Staffing, earning $12.50 per hour. He had earned $12.00 per hour at Total Staffing as of August 7, 2018. T. 137. He injured his back at work in July 2009, while carrying a container. T 140. The back pain he suffered after that accident traveled down his left leg. T. 138. He did not experience left leg symptoms between 2009 and 2018. T. 138. His current symptoms vary. On some days, his pain level is 6/10 but overall his current pain is "consistently more intense." T. 141. He does not believe that any particular activity during the past eleven months has caused his pain to worsen. He tries to live with his pain. T. 141. At Bridgeview, he worked for one or two weeks. At Unifirst, he worked a total of two days. He believes he worked on Monday, October 22nd, and Tuesday, October 23rd. The cart he pushed at Unifirst had wheels. Sometimes he pushed the cart on a smooth floor but sometimes he had to push it up a ramp. T. 143. On the day he was injured at Unifirst, he managed to finish his workday. T. 143. In November 2018, he worked at Billet, cleaning tire rims. In January 2019, he started working at MD Metals through Illinois Staffing. The "restrictions" he works under at MD Metals are not formal. They are "his own." He tries to take care of himself. He works on his feet, lifting wood. During the past year, the heaviest item he has lifted at MD Metals has weighed 15 pounds. He primarily performs cleaning but, when the need arises, he lifts pieces of wood weighing 10 to 15 pounds. T. 147. He went to the Emergency Room on September 23, 2019 because his existing pain intensified and his leg was becoming numb and weak. T. 147-148. During September 2019, his pain at work varied between 6 and 8 on a scale of 1 to 10. On September 23, 2019, at work, he performed cleaning and no lifting. At about noon, his pain intensified. He continued working until 3:20 PM. He did not tell anyone at MD Metals about his increased pain. After his Emergency Room visit, he continued working at MD Metals until November 2019, when he took some vacation time. T. 151. He told his physicians, including Dr. Salehi, about his Emergency Room visit. The physicians told him his increased pain was due to "inflammation of the sciatica." T. 152. The pain he experienced on September 23, 2019 was the worst pain he has ever experienced. He does not believe he injured himself at work in September 2019. T. 152.

Under additional cross-examination, Petitioner testified he did not inform anyone at Unifirst of his October 23, 2018 injury. At Unifirst, no one told him how much weight he was supposed to lift while lifting clothes. He and his co-workers were under pressure to lift the clothes quickly. T. 155. He was not given directions as to how many items of clothing to lift at one time. He just grabbed everything he could. T. 156-157.

On redirect, Petitioner explained that, when he used the Spanish word "costal" while testifying, he was referring to a cloth bag. He had to pull out "the whole bag" from the container and then put the bag on a table. A bag could be light or heavy, depending on its contents. T. 160. Regardless, he had to bend over to pick up the bags and put them on the table. T. 160. He would typically go to MacNeal Hospital's Emergency Room for treatment but he does not recall going there on December 31, 2011. It is possible he forgot he went there that day. T. 161-162. Between March 2011 and the accident of August 7, 2018, no one recommended he undergo back surgery. T. 162. When he left work at noon on August 7, 2018, he "told them that [he] was feeling bad." T. 165. On August 8, 2018, he reported his August 7, 2018 accident to Leticia of Total Staffing. T. 166. If a Unifirst document reflects he worked October 22nd through October 24th, he believes it is correct but he is not sure. T. 167. He went to Dr. Bayran on October 25, 2018. T. 167. He does not believe he worked at Unifirst the day after he was injured. T. 167. He was injured on the last day he worked at Unifirst. He saw Dr. Bayran the day after the injury. T. 169. [At this point in the hearing, the Arbitrator allowed Petitioner's counsel's oral motion to amend the Application on its face to change the accident date to October 24, 2018. Respondents' counsel originally objected to the amendment but ultimately withdrew their objections. T. 174-177.] At Illinois Staffing, he was not subject to formal restrictions. T. 178. He would agree with Dr. Salehi's records if they reflect he was working subject to restrictions as of May and December 2019. T. 178-179. On September 23, 2019, he experienced increased symptoms and worrisome numbness when he was sitting at work, eating. T. 179. He continued working after his Emergency Room visit of September 23, 2019. T. 180. He has continued to work despite his pain because he will lose his job if he fails to show up. T. 180.

Under re-cross, Petitioner testified it takes him about ten minutes to drive from his home to MacNeal Hospital. He goes to that hospital because he lives nearby and gets prompt attention there. T. 181. Between 2009 and his August 7, 2018 accident he sought care for back pain at MacNeal on one occasion. T. 182.

Martin Enciso testified on behalf of Respondent Total Staffing. He has worked as a production plant manager at Unifirst for about twelve years. Five supervisors and about eighty employees work under his direction. T. 186. The supervisors are supposed to immediately report any employee problem to him. T. 187. If an employee is injured on the job, that employee's shift supervisor must sit down with the employee and complete paperwork. Once the injury has been investigated, a phone call is made to the insurance carrier. T. 187.

Enciso testified that Petitioner worked in Unifirst's unloading dock area. Petitioner and another employee worked in an area that was about 10 by 35 feet in size. Soiled clothes arrived via truck. Petitioner and his co-worker separated pants and shirts and put them in large bags that were on a cart. T. 193. The area where Petitioner worked is visible to others. About ten to twelve people pass that area or work in adjacent areas. During the brief period that Petitioner worked at Unifirst, no one reported seeing an accident, as far as he is aware. T. 190. It was in March 2019, when he received a letter from a law firm, that he first learned of Petitioner's claimed accident. T. 191. No witness statement from the period of Petitioner's

employment exists. T. 191. Petitioner did not return to Unifirst after the alleged accident. T. 191. At Unifirst, an accident report is completed within minutes of the employee reporting an injury. T. 192. An Email is generated after Unifirst reports the accident to its insurance carrier. No such Email exists in this case. T. 192. Enciso testified that, based on his experience, an employee performing Petitioner's job could pick up about a dozen pants at one time. T. 193. He has picked up a pile of clothes. An unused pair of pants weighs under one pound. He would imagine that a soiled pair of pants would weigh no more than one pound. T. 195. A typical pile would consist of three bags of garments. Each bag would contain about 175 pairs of pants. If Petitioner picked up a dozen pairs of pants, that load would weigh about 12 to 14 pounds. T. 196. Petitioner would have been "constantly" picking up garments, emptying one "cage" after another. A "cage" is a large, 4 by 5 foot cart with wheels that swivel. T. 197. Based on Unifirst's attendance records, Petitioner worked three full days in October 2018. Those days were the 22nd, 23rd and 24th. Unifirst Exh 2. Petitioner showed up on a fourth day but did not sign in. Unifirst has a sign-in sheet. T. 198. To his knowledge, no accident report was generated on any of the days Petitioner worked. T. 198-199. On October 25th, Petitioner did not sign in and left before his shift ended. T. 199. Temporary employees such as Petitioner are required to sign in and out. T. 199-200. His (Enciso's) production manager typically provides him with a roster of employees. The production manager gives him that roster on a daily basis. Employees have to use a card to scan in to work. Temporary employees also have to sign a log sheet. He has no record to show Petitioner signed in on October 25, 2018 but Petitioner was assigned a task in the morning that day. T. 204. Unifirst has no cameras inside its facility. T. 205.

In response to questions posed by Unifirst's counsel, Enciso testified that Petitioner would not have lifted bags weighing 175 pounds. Based on his own work experience, Petitioner would have lifted twelve pairs of pants at one time, at the most. T. 206.

Under cross-examination, Enciso acknowledged he does not remember seeing Petitioner at work on the days in question. He is basing his testimony as to Petitioner's work activities on his own experience at Unifirst. T. 206-207. The tasks are pretty much the same from day to day. He does not personally recall Petitioner. He is "not that hands-on of a manager." T. 207. Unifirst maintains employee rosters for one month and then throws them away. T. 208. Petitioner would have lifted clothes "off the cage." A "cage" is about 3 ½ to 4 feet high. Petitioner would have lifted clothes constantly, moving from one "cage" to the next. Once Petitioner completed other assigned tasks, he would have been constantly lifting 12 to 14 pounds throughout the workday. T. 209.

On redirect, Enciso testified he does not recall ever seeing Petitioner. Unifirst does not have any file containing documents concerning Petitioner's conduct or any claimed incidents. T. 210.

At this point in the hearing, the Arbitrator granted Respondent Total Staffing's request for bifurcation, over Petitioner's objection. T. 211-213. Respondents Total Staffing and Unifirst

stipulated that Total Staffing has assumed the defense in the claim. T. 216. The Arbitrator denied Unifirst's request to be dismissed out of the claim. T. 216-217.

Petitioner returned to Dr. Salehi on January 21, 2020 and complained of worsening lower back pain radiating down both legs, "mostly on the left." He reported that he was continuing to perform light duty. On re-examination, the doctor noted lumbosacral tenderness, greater on the left, normal strength and decreased sensation in the left lateral thigh and left medial foot. He again recommended a L4-S1 lumbar fusion. PX 9.

Dr. Bayran testified by way of evidence deposition on February 20, 2020. RX 9. Dr. Bayran testified he attended medical school in Romania and then practiced in his native Iran before coming to the United States. He completed a one-year fellowship in pain medicine at the University of Illinois. He performs various procedures, including injections and ablations. RX 9, pp. 6-7. He is board certified in anesthesia and pain medicine. He currently practices at the Pain Center of Illinois, where he is the medical director. RX 9, pp. 7-8. He is a part-owner of the Illinois Back & Neck Institute and Ashland Medical, an anesthesia company. RX 9, p. 8. He oversees the billing performed by these entities. He assumes no payments have been made for the services he provided to Petitioner, based on Bayran Dep Exh 2. RX 9, p. 11.

Dr. Bayran acknowledged he is familiar with CompCorePro. He has seen patients referred by this company. The company "randomly" refers patients to him. He has known Dr. Khanna for many years. He receives maybe one or two cases from CompCorePro each month. RX 9, p. 12. He has seen patients referred by Dr. Khanna since 2009 or 2010. He does not remember whether CompCorePro referred Petitioner to him. Based on Bayran Dep Exh 3, which is dated September 21, 2018, CompCorePro probably referred Petitioner to him. RX 9, pp. 13, 17. He first saw Petitioner on September 27, 2018. He typically secures pre-approval prior to treating a workers' compensation patient. He also secures pre-approval for injections. RX 9, pp. 14-15. It is not his practice to administer an injection without pre-approval. RX 9, p. 16. Petitioner provided a history of his work accident and complained of left-sided lower back pain radiating to his left buttock and left posterior side. If a patient complains of radiating leg pain, you want to make sure there is no disc problem. RX 9, p. 17. Petitioner rated his pain at 7/10. He (Dr. Bayran) noted no positive Waddell's findings. Straight leg raising caused only back pain. That is really not a positive straight leg raising test. Petitioner reported decreased sensation over the left lateral thigh. That could indicate impingement of the L5 nerve root. RX 9, p. 19. There was "some inconsistency" between the pain Petitioner reported and the examination findings. He diagnosed radiculopathy. He attributed Petitioner's symptoms to the work accident, based on Petitioner's reporting. RX 9, p. 21. He recommended continued therapy and an epidural injection. He also recommended that Petitioner continue working with restrictions. Most likely his staff sent a request for pre-authorization of the injection. RX 9, p. 24. He identified Bayran Dep Exh 4 as the request form that was sent to adjuster James Hernandez. Hernandez approved the injection. His signature appears on the form, which is dated October 4, 2018. RX 9, pp. 26-27. He switched billing companies and EMRs because the EMR he was using did not allow him to bill in a timely fashion. That is probably why he has not received payment for the injection. RX 9, pp. 28-29. Bayran Dep Exh 5 shows that nothing has

been paid toward the injection, even though GENEX received the bill on July 30, 2019. RX 9, p. 29. Bayran Dep Exh 6 reflects that GENEX certified the injection. RX 9, p. 31. Some EOBs have not been entered in his system but as far as he knows, his bill for treating Petitioner has not been paid. RX 9, p. 32. At the visit following the injection, Petitioner reported 90% pain relief. He concluded that Petitioner was "cured" and he released Petitioner to a trial of full duty. RX 9, p. 36. He told Petitioner to return to him if he had problems with full duty. Petitioner returned to him a week later, on October 25, 2018, and indicated his pain had worsened while performing full duty. Specifically, Petitioner reported left-sided back pain radiating to his left buttock after bending to lift heavy clothing and pushing a cart full of clothes. RX 9, p. 37. Petitioner's pain was now in the L5 distribution. RX 9, p. 37. He cannot explain why Petitioner's pain switched to L5. That is why he recommended a consultation with a spine surgeon. RX 9, p. 39. He would consider the clothing-related full duty a "re-aggravation." RX 9, p. 39. He does not independently recall Petitioner but he remembers Petitioner reporting lifting the clothing on multiple occasions. RX 9, p. 41. Straight leg raising was positive. He continued to diagnose radiculopathy. RX 9, p. 42. He saw no signs of symptom magnification on either October 25 or November 29, 2018. RX 9, p. 43. On November 29th, he again recommended a consultation with a spine surgeon. RX 9, p. 43. He last saw Petitioner on December 27, 2018. The only thing that took place between November 29th and December 27th was Dr. Singh's IME. He met Dr. Singh at a conference. Petitioner's presentation in December was the same as in November, except he was complaining of back rather than leg pain on straight leg raising. He decided Petitioner was at maximum medical improvement. The injection had failed and Petitioner "wasn't a candidate for surgery." The injection provided relief for only one week. RX 9, p. 48. James Hernandez approved three injections but that does not mean he should necessarily expose Petitioner to three injections. ODG guidelines require that, "in order to do a second injection, you have to basically have a response of 60 days." RX 9, pp. 49-50. ODG also says you can release a patient to full duty when there is no radiculopathy, weakness or loss of reflexes. RX 9, p. 50.

Under cross-examination, Dr. Bayran testified he is not sure whether he reviewed the records from LaGrange Medical Center. RX 9, p. 51. He is not affiliated with that facility. He injected Petitioner on the left side, not the right. If the report says "right," it is a "clerical mistake." RX 9, p. 53. The accompanying photograph of the procedure shows that the injections were done on the left side. RX 9, p. 53. Petitioner originally reported decreased sensation over the lateral aspect of the left side. Later, the distribution was in L4. Thus, he believes there was an inconsistency. Petitioner did not report any 2008 or 2009 injury to him. In his note of December 27, 2018, he expressed his agreement with Dr. Singh's opinions. RX 9, pp. 57-58.

On redirect, Dr. Bayran testified that the injection photographs should have been produced along with his records, in response to a subpoena. RX 9, p. 59. His handwritten notes from Petitioner's initial visit reflect that Petitioner did in fact inform him he injured his back in 2008. RX 9, p. 62.

Under re-cross, Dr. Bayran testified his notes reflect that Petitioner's pain was "higher" in 2008. RX 9, p. 63. Bayran Dep Exh 9.

On further redirect, Dr. Bayran clarified that, by using the term "higher," he meant the pain was physically at a different level. RX 9, p. 63.

At the continued hearing, Elida Garcia, a referral coordinator employed by CompCorePro, testified pursuant to subpoena. Dr. Khanna, CompCorePro's medical director, also attended the hearing. Garcia acknowledged securing a consultation with Dr. Bayran, after discussing this with Dr. Khanna, but maintained she secured Petitioner's consent, via telephone, before providing him with information concerning the appointment.

Arbitrator's Credibility Assessment

Petitioner's testimony concerning his August 7, 2018 accident was detailed and consistent with the records from LaGrange Medical Center and Athletico. His account of his October 24, 2018 accident was also detailed and consistent with Dr. Bayran's note of October 25, 2018. Enciso, who testified on behalf of Respondents, acknowledged he did not personally observe Petitioner working in October 2018 but conceded that much of Petitioner's workday would have consisted of repeatedly lifting garments that arrived at Unifirst in bags weighing 175 pounds.

The fact that Petitioner has continued working, despite his persistent symptoms, enhances his overall credibility. His testimony about the relatively light nature of his current job at MD Metals was detailed and believable.

Petitioner's current treating surgeon, Dr. Salehi, testified he observed no signs of symptom magnification. PX 25, p. 11. Dr. Bayran noted 5/5 negative Waddell's signs when he examined Petitioner in September, October and November 2018. Respondent's examiner, Dr. Singh, documented 5/5 positive Waddell's signs in November 2018 but, under cross-examination, conceded that Waddell's testing, used in isolation, has "very little value." RX 1, pp. 35-36.

Much has been made about Petitioner's prior history of back problems and whether he revealed that history to his providers. The Arbitrator finds credible Petitioner's testimony that the back symptoms he experienced in 2008 and 2009 resolved and thus he did not attach much significance to them. The Arbitrator also notes that, on August 8, 2018, only one day after the claimed accident of August 7, 2018, Petitioner told personnel at LaGrange Medical Center that he had injured his back nine years earlier. PX 1. At his deposition, Dr. Bayran confirmed that, when he first saw Petitioner, in September 2018, Petitioner told him he had injured his back in 2008. RX 9, p. 62.

Under cross-examination, Petitioner denied going to the Emergency Room at MacNeal Hospital on March 31, 2011. Records in PX 10 reflect he did go to MacNeal Hospital on that

date but for a therapy evaluation, not Emergency Room care. It is not clear whether he pursued additional therapy after the evaluation. The Arbitrator does not view Petitioner's denial as undermining his overall credibility, given the passage of 7 ½ years between the evaluation and his testimony.

The Arbitrator noted some inconsistencies in Mario Enciso's testimony. Enciso's claim that he never noticed or had reason to notice Petitioner is at odds with his very specific testimony that Petitioner showed up at Unifirst on October 24, 2018 but failed to sign in.

Overall, the Arbitrator found Dr. Salehi more persuasive than Respondent's examiner, Dr. Singh. Dr. Salehi saw Petitioner on several occasions while Dr. Singh examined him once. Dr. Singh's opinion that Petitioner sustained a minor strain requiring four weeks of therapy conflicts with the opinions of Drs. Byrd and Bayran, neither of whom was selected by Petitioner.

Arbitrator's Conclusions of Law Relative to Both Cases

Did Petitioner sustain compensable work accidents on August 7, 2018 and October 24, 2018?

In 18 WC 27887, the Arbitrator finds that Petitioner sustained an accident arising out of and in the course of his employment on August 7, 2018. In so finding, the Arbitrator relies on Petitioner's detailed testimony concerning the mechanism of injury, the accident reports (RX 2), the LaGrange Medical Center "work injury form" of August 8, 2018 (PX 1) and the records from LaGrange Medical Center. Petitioner testified he was performing a work task, i.e., lifting a heavy container of scrap metal and liquid, up to his shoulder at the time of the accident.

In 19 WC 8620, the Arbitrator finds that Petitioner sustained an accident arising out of and in the course of his employment on October 24, 2018. [Petitioner originally alleged an accident date of October 23, 2018. On redirect, he clarified the accident took place the day before he returned to Dr. Bayran. That return visit occurred on October 25, 2018. The Arbitrator allowed his counsel to orally amend the Application to change the accident date to October 24, 2018. T. 174-175.] In so finding, the Arbitrator relies in part on Petitioner's detailed account of the lifting he performed at Unifirst. Petitioner credibly testified he was under pressure to work quickly while lifting wet clothing items out of containers. T. 155. He also testified he was required to push fully loaded carts up ramps. The Arbitrator also notes that the term "accident," as used in the Act, is "not a technical legal term." Rather, it is a "comprehensive term almost without boundaries in meaning as related to some untoward event." Ervin v. Industrial Commission, 364 Ill. 56 (1936). Moreover, there need be no external violence to the body to constitute an accidental injury. Compensation may be allowed where a worker's existing physical structure gives way under the stress of his usual labor. Laclede Steel Co. v. Industrial Commission, 6 Ill.2d 296 (1955).

Did Petitioner establish timely notice?

In 18 WC 27887, the Arbitrator finds that Petitioner provided timely notice of his August 7, 2018 accident. Petitioner credibly testified he notified "Andrea," Bridgeview's owner, of his injury while leaving work. Petitioner also credibly testified that, the following day, he went to Total Staffing's office and notified Leticia of the injury. Leticia arranged for him to be seen at LaGrange Medical Center, where Dr. Byrd prescribed physical therapy. Records in PX 2 and PX 34 reflect that adjuster James Hernandez approved six therapy sessions on August 30, 2018. That date falls well within the statutory 45-day notice period.

In 19 WC 8620, the Arbitrator finds that Petitioner provided timely notice of his October 24, 2018 accident. Petitioner credibly testified he notified Leticia of Total Staffing of the accident the day after it occurred. No one from Total Staffing refuted this testimony. Mario Enciso of Unifirst (the borrowing employer) testified that none of the supervisors working under him informed him of any accident during the period in question but he also acknowledged that Petitioner did not return to Unifirst after the accident.

Did Petitioner establish causal connection?

The Arbitrator finds that both of Petitioner's work accidents contributed to his current lumbar spine condition and the need for surgery. The Arbitrator relies on Dr. Salehi in finding that each accident aggravated Petitioner's underlying degenerative disc condition. Although Petitioner had a history of prior low back problems and treatment, that history was relatively remote. Based on the available records, it appears that, prior to the accident of August 7, 2018, Petitioner last underwent back treatment in March 2011, when he underwent a physical therapy evaluation at MacNeal Hospital. Petitioner credibly testified he was able to successfully work in various capacities between the time he settled his prior claim, in 2010, and the August 7, 2018 accident. That accident brought about an abrupt change in his ability to work. When Dr. Bayran released him to a trial of full duty, in October 2018, he was still symptomatic, although to a lesser degree. The lifting he performed at Unifirst on October 24, 2018 aggravated his condition and brought about the need for additional treatment. When Dr. Bayran again released him, in December 2018, it was due to Dr. Singh's findings and not because Petitioner was asymptomatic. Dr. Bayran acknowledged this at his deposition. RX 9, pp. 57-58.

In Illinois, it has long been held that an injured worker seeking benefits under the Act need only establish that an accident was a cause of his condition. He is not required to prove that the accident was the sole, or even a primary, cause. Nor is he required to exclude all other possible causes. Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193, 205 (2003). In Schroeder v. IWCC, 2017 IL App (4th) 160192WC, the Court explained that the "chain of events" principle does not apply solely to workers who are in perfect health. It also applies to workers whose pre-accident health is less than ideal. The Arbitrator finds persuasive Dr. Salehi's opinion that each accident aggravated an underlying degenerative condition, causing that condition to become symptomatic and disabling. The Arbitrator adopts Dr. Salehi's opinion that the first accident was more significant than the second.

The Arbitrator recognizes that, following both accidents, Petitioner worked at MD Metals from January 2019 through the initial hearing. Petitioner credibly testified that, at this job, he is not required to lift anything weighing more than 10 to 15 pounds. The Arbitrator also recognizes that Petitioner experienced an episode of intense back pain and leg numbness at work on September 23, 2019, with those symptoms prompting him to seek Emergency Room care. The Arbitrator does not view the episode as an intervening work accident. Petitioner credibly testified he was symptomatic prior to the episode and experienced the increased symptoms while eating during a work break.

Did Petitioner exceed his choices under Section 8(a) of the Act?

The Arbitrator finds that Petitioner did not exceed the physician choices afforded by Section 8(a) of the Act. Having considered the testimony of Petitioner, Elida Garcia and Dr. Bayran, along with the records produced by Compcore Pro (PX 34), the Arbitrator concludes that CompCorePro (an entity that Respondent Total Staffing adopted as its agent), rather than Petitioner, selected Dr. Bayran. Petitioner credibly testified he did not choose Dr. Bayran or set up an appointment to see him. He learned of the appointment via telephone. The records that Compcore Pro produced pursuant to subpoena reflect that, on September 17, 2018, Elida Garcia (whose job title, tellingly, is "referral coordinator") Emailed Dr. Khanna [CompCorePro's medical director, PX 34, p. 4], informed him that Petitioner's lumbar spine MRI results were not yet available and asked the following question: "Due to his [Petitioner's] continued pain should we recommend him to see Dr. Bayran?" In response, Dr. Khanna indicated he wanted to see the MRI report and "then . . . decide whether to send [Petitioner] to Dr. Bayran." PX 34, p. 30. On September 21, 2018, Garcia Emailed Dr. Khanna again, saying: "The adjuster finally responded after the 4th Email. Patient has been scheduled to see Dr. Bayran on 9/27/18." On October 16, 2018, Garcia sent yet another Email to Dr. Khanna, indicating that the last time she was in touch with Petitioner "was on 9/21/18 to give him his appointment details with Dr. Bayran." PX 34, p. 39. This Email meshes with Petitioner's testimony that he learned he was to see Dr. Bayran via a telephone call. At his deposition, Dr. Bayran confirmed he receives referrals from CompCorePro. He was also able to confirm that CompCorePro referred Petitioner to him. RX 9, pp. 11-13. Bayran Dep Exh 3.

The Arbitrator concludes that Dr. Trebart was Petitioner's first choice of physicians and that Drs. Vargas and Salehi were within the chain of referrals emanating from this choice. Petitioner credibly testified that Dr. Vargas mentioned two surgeons, i.e., Drs. Erickson and Salehi, to him, but described Dr. Salehi as "better." Petitioner also credibly testified that "Marisol" of Dr. Vargas's office arranged for him to see Dr. Salehi.

Is Petitioner entitled to reasonable and necessary medical expenses?

The Arbitrator has previously found in Petitioner's favor on the threshold issues of accident, notice and causation.

Petitioner seeks an award of $44,642.70 in fee schedule charges relating to the treatment he underwent between September 27, 2018 (the date of his initial visit to Dr. Bayran) and 2020. PX 31. The Arbitrator has reviewed the underlying records and bills, as well as the utilization review evidence and the treatment-related opinions rendered by Drs. Salehi and Singh. With the exception of $825.00 in non-emergency transportation charges claimed by Lakeshore Surgery Center (PX 17), in connection with the injections administered in March and April 2019, and the bill from Windy City Medical Specialists (see next paragraph), the Arbitrator awards the claimed fee schedule charges. The Arbitrator declines to award the non-emergency transportation charges because Petitioner did not establish the need for transportation to and from the facility where he underwent the injections.

The charges from Windy City Medical Specialists relate to the VascuTherm Cold Therapy rental unit that Dr. Vargas prescribed on March 1, 2019. PX 31, 35. The bill reflects a rather startling rental fee of $1,750.00 per week. Petitioner did not testify to using such a unit, let alone deriving any benefit from it. Respondent offered evidence indicating that, on March 22, 2019, GENEX non-certified cryotherapy. RX 7. The Arbitrator declines to award the Windy City Medical Specialists bill.

In reliance on Dr. Salehi, who stressed the significance of the first accident, the Arbitrator opts to make the award of medical expenses in the first case, 18 WC 27887.

In 19 WC 8620, is Total Staffing contractually liable to UniFirst?

UniFirst submitted a "Staffing/Vendor Agreement" running between it and Total Staffing whereby Total Staffing assumed full liability for any workers' compensation claims filed by employees loaned to UniFirst. Unifirst Exh 1. Total Staffing did not object to the admission of the agreement and stipulated to the nature of its liability. The Arbitrator notes, however, that, under the Act, loaning and borrowing employers remain jointly and severally liable.

Is Petitioner entitled to prospective care?

The Arbitrator has previously found in Petitioner's favor on the issues of accident, notice and causal connection. The Arbitrator has elected to rely on Petitioner's treating surgeon, Dr. Salehi, rather than the Section 12 examiner, Dr. Singh, with respect to treatment recommendations. The Arbitrator awards prospective care in the form of the two-level lumbar fusion prescribed by Dr. Singh. The Arbitrator again notes that GENEX, the utilization reviewer, ultimately certified this surgery, although the certifying physician applied somewhat different reasoning than Dr. Salehi.

Are Respondents liable for penalties and fees?

Petitioner seeks penalties and fees on awarded, unpaid medical expenses. Petitioner offered a list of the unpaid fee schedule charges from various providers. PX 31. The Arbitrator

has found in Petitioner's favor on the issues of accident and causation and has awarded certain medical expenses. [See above.]

The Arbitrator notes that certain of the unpaid awarded medical expenses relate to treatment rendered by Dr. Bayran. The Arbitrator has previously found that it was CompCorePro, and not Petitioner, who selected this physician. The Arbitrator also notes that, while an adjuster pre-approved the injection that Dr. Bayran administered on October 5, 2018 (Bayran Dep Exh 4), and while GENEX certified that injection, the expenses stemming from that injection remain unpaid. Dr. Bayran confirmed this at his February 20, 2020, deposition. [Dr. Bayran also clarified that the report concerning the injection contained a typographical error. He injected Petitioner on the left, not the right.] On this record, and given the passage of more than a year between the treatment at issue and the initial hearing, the Arbitrator finds it appropriate to award $10,000.00 [the statutory maximum] in Section 19(l) penalties, $2,283.74 in Section 19(k) penalties and $913.49 in Section 16 attorney fees. Section 19(l) penalties are in the nature of a mandatory late fee [McMahan v. Industrial Commission, 183 Ill.2d 499, 515 (1998)] while Section 19(k) penalties and fees are to be awarded when an employer acts in an objectively unreasonable manner, under all of the existing circumstances, in denying payment [Oliver v. IWCC, 2015 IL App (1st) 143836WC]. In Oliver, the Court emphasized that "the burden of proving a reasonable basis for the denial of benefits falls solely on the employer." In the instant case, Respondent Total Staffing failed to meet that burden. Given that Petitioner did not select Dr. Bayran, that adjuster James Hernandez pre-approved the October 5, 2018 injection and that a utilization review provider of said Respondent's choice certified the injection, the Arbitrator concludes that Respondent acted in an objectively unreasonable manner in declining to pay the injection-related expenses. The $2,283.74 Section 19(k) award represents 50% of the combined fee schedule charges of $4,567.49 from Illinois Back & Neck Institute and Ashland Medical Specialists relating to the October 5, 2018 injection. The $913.49 Section 16 fee award represents 20% of those same combined charges. PX 31.

The Arbitrator further finds that Respondents acted in an objectively unreasonable manner in declining to authorize the recommended fusion. Dr. Marehbian, the physician who originally recommended non-certification of this surgery, on behalf of GENEX, is not a surgeon. After Dr. Salehi filed an appeal, a second physician, Dr. Luke, a board certified orthopedic surgeon, recommended that the procedure be certified. PX 28. The Arbitrator recognizes, however, that under current Illinois law, an employer cannot be held liable for penalties and fees for failing to approve treatment. Hollywood Casino-Aurora v. IWCC, 2012 IL App (2d) 110426WC.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC026045
Case Name	ROSE, KIMBRUEL v. AGENCY FOR COMMUNITY TRANSIT
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0319
Number of Pages of Decision	19
Decision Issued By	Barbara Flores, Commissioner

Petitioner Attorney	David Galanti
Respondent Attorney	R. Mark Cosimini

DATE FILED: 6/22/2021

/s/ Barbara Flores, Commissioner

Signature

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KIMBRUEL ROSE,

Petitioner,

vs. NO: 19 WC 26045

AGENCY FOR COMMUNITY TRANSIT,

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, medical expenses, prospective medical care, and temporary total disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator with the changes noted herein, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill. 2d 327 (1980).

The Commission writes additionally solely to note that the Arbitrator awarded temporary total disability benefits for the period from December 19, 2019 through October 14, 2020, which is a period of 43 weeks rather than the 42 and 4/7ths weeks stated in the Decision of the Arbitrator.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on December 7, 2020 is hereby affirmed and adopted with the change stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $451.60 per week for the period from December 19, 2019 through October 14, 2020, for a period of 43 weeks, that being the period of temporary total incapacity for work under §8(b)

of the Act. Respondent shall be given a credit for benefits already paid.

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.

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 is hereby fixed at the sum of $74,200.00. 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.

June 22, 2021

/s/ *Barbara N. Flores*
Barbara N. Flores

o: 6/17/21
BNF/kcb
045

/s/ *Deborah J. Baker*
Deborah J. Baker

/s/ *Christopher A. Harris*
Christopher A. Harris

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

21IWCC0319

ROSE, KIMBRUEL
Employee/Petitioner

Case# **19WC026045**

AGENCY FOR COMMUNITY TRANSIT
Employer/Respondent

On 12/7/2020, 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 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0000 RUSIN & MACIOROWSKI LTD
KYLEE J JORDAN
231 W MAIN ST SUITE 2E
CARBONDALE, IL 62901

STATE OF ILLINOIS)
)SS.
COUNTY OF **Madison**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Kimbruel Rose
Employee/Petitioner

v.

Agency for Community Transit
Employer/Respondent

Case # **19** WC **26045**

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 **Jeanne AuBuchon**, Arbitrator of the Commission, in the city of **Collinsville**, on **October 28, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **6/16/19**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**35,224.80**; the average weekly wage was $**677.40**.

On the date of accident, Petitioner was **48** 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 $**3,423.24** for TTD, $**N/A** for TPD, $**N/A** for maintenance, and $**N/A** for other benefits, for a total credit of $**3,423.24**.

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

ORDER

The Respondent shall pay reasonable and necessary services, pursuant to the fee schedule of $1,047.60 to Dr. Gornet, $7,324.00 to Dr. Blake, $20,688.69 to The Orthopedic Ambulatory Surgery Center, $45.25 to Maryville Radiology, $25,217.36 to Multicare Specialists, $410.35 to Gateway Occupational, $1,400.00 to Dr. Solman, $1,964.47 to SSM Health Physical Therapy, and 35.00 to SIHF, as provided in Sections 8(a) and 8.2 of the Act.

With respect to future medical care, the Petitioner is entitled to the viscosupplementation and biologics as recommended by Dr. Solman as well as a professional weight loss program as recommended by Dr. Farley. Further, the Petitioner is entitled to additional physical therapy if recommended by Dr. Solman.

The Petitioner is awarded TTD benefits from December 19, 2019 through October 14, 2020, a period of 42 and 4/7 weeks.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Signature of Arbitrator

12/3/2020
Date

ICArbDec19(b)

DEC 7 - 2020

PROCEDURAL HISTORY

This matter proceeded to trial on October 28, 2020, pursuant to Sections 19(b) and 8(a) of the Illinois Workers' Compensation Act (hereinafter "the Act"). The issues in dispute are: 1) the causal connection between the accident and the Petitioner's bilateral knee condition and certain aspects of her lumbar spine condition; 2) payment of medical bills; 3) entitlement to prospective medical care to the Petitioner's knees and lumbar spine; 4) entitlement to TTD benefits from December 19, 2019 through October 28, 2020.

FINDINGS OF FACT

At the time of the accident, the Petitioner was employed by the Respondent, Agency for Community Transit, as a bus driver. (T. 15) On June 16, 2019, she was driving a bus and making a left turn when a speeding truck struck the bus near the driver's seat. (T. 15-16) She testified that her knees hit the steering column and she felt a jolt in her back. (T. 17).

The Arbitrator reviewed the video of the accident and saw that at the time of impact, the Petitioner jolted to the left and right in her seat. (RX1) It was apparent that her knees did, in fact strike the steering column between her legs and the fare box to her right. (Id.) After the accident, the Petitioner did step on and off the bus and walked around the bus. (Id.) She can be heard groaning as she gets back on the bus and several times stated that her knee hurt. (Id.)

The same day, the Petitioner went to the emergency room at Anderson Hospital, where she complained of pain in her left wrist and both of her knees. (PX1) She denied having back pain. (Id.) X-rays showed osteoarthritis but no acute injury. (Id.) She was instructed to use ice and heat, take anti-inflammatories and follow up with her primary care doctor. (Id.) In addition to general patient and motor-vehicle accident instructions, hospital staff gave the Petitioner patient instructions for contusion in adults. (Id.)

On July 9, 2019, the Petitioner followed up with her primary care providers at Southern Illinois Healthcare Foundation, where she saw Nurse Practitioner Monique Manderson. (PX2) The Petitioner reported pain in her lower back and both knees. (Id.) She was diagnosed with osteoarthritis in her knees and was referred to physical therapy for both her back and knees. (Id.)

The Petitioner began physical therapy at SSMHealth Physical Therapy on July 29, 2019, at which time, she reported that her knee pain was 10/10 and her low back pain was 8/10. (PX4) She had additional physical therapy sessions on July 31, 2019; August 6, 2019; August 7, 2019; August 15, 2019; August 27, 2019; and August 29, 2019. (Id.) She was discharged from physical therapy on September 23, 2019, after having missed five out of her 12 prescribed sessions and being late for others. (Id.)

On August 26, 2019, the Petitioner underwent a Section 12 evaluation of her knees by Dr. Christopher Knapp at Gateway Regional Occupational Health Services. (PX3) The Petitioner rated her pain as 10/10 but walked into the office without assistance. (Id.) Dr. Knapp took x-rays of the Petitioner's knees and found significant degenerative osteoarthritis. (Id.) He stated that the mechanism of injury did not support any significant risk of internal derangement of the knees, but rather a contusion. (Id.) he did not believe that her current symptoms were the result of the accident, noting that the accident had occurred two months prior. (Id.) Dr. Knapp stated that there was insufficient evidence that the symptoms were work related and recommended the Petitioner be referred back to her primary care doctor for further evaluation and management of her pre-existing conditions. (Id.)

On September 3, 2019, the Petitioner went to Multicare Specialists and saw Dr. Ashley Eavenson, a chiropractor, and Corey Voss, a physical therapist. Again, she rated her knee pain at 10/10 and her low back pain at 8/10. (Id., PX8) After a physical examination and radiographs,

Dr. Eavenson diagnosed a lumbar disc protrusion and bilateral internal knee derangement. (Id.) Recommended treatment included electrical stimulation and ultrasound followed by manual mobilization and stretching and exercises. (Id.) Dr. Eavenson placed restrictions on the Petitioner's activity of no lifting greater than 10 pounds and no pushing, pulling or climbing. (Id.)

The Petitioner underwent MRIs of her lumbar spine and both knees on September 14, 2019. (Id.) Dr. Eavenson reported a likely annular tear or fissure at L4-5 as well as severe facet and ligamentum flavum hypertrophy and moderate right foraminal and central canal stenosis. (Id.) At L3-4, Dr. Eavenson reported posterior element hypertrophy resulting in moderate central canal stenosis but no foraminal stenosis. (Id.) At L5-S1, she noted facet arthropathy without significant stenosis. (Id.)

In the right knee MRI, Dr. Eavenson saw moderate grade 3 chondral thinning with surface contour irregularity in scattered subcortical marrow edema, grade 4 chondral fissuring and calcified lose bodies. (Id.) In the left knee, she found a probable meniscus tear, mixed grade 3 and 4 chondrosis with scattered underlying subcortical marrow edema and spurring. (Id.) Her diagnosis was unchanged, and she referred the Petitioner to Dr. Matthew Gornet for the lumbar spine. She spoke to Dr. George Paletta informally about the knees, and he recommended physical therapy, NSAIDs and injection. (Id.)

The Petitioner's symptoms appeared to improve when she consistently attended physical therapy but worsened when there were lapses in therapy. (PX8) She also experienced relief with rest and using a hot tub and pool. (Id.) For the first few months of physical therapy at Multicare Specialists, the notes show occasional improvement but a day or so later, her condition worsened. (Id.) In 2019, the Petitioner attended seven sessions in September, one in October, none in November and three in December. (Id.) In 2020, she attended 11 sessions in January, 10 in

February, 13 each month in March and April, 11 in May, 13 in June and seven in July, with the last session occurring July 15, 2020. (Id.)

More improvement occurred starting in March 2020. (Id.) It appears that the combination of injections and consistent physical therapy helped the Petitioner the most throughout her treatment. As it stood in July 2020, the Petitioner had significantly less back pain than when she started treatment. Her knees improved as well but less so than her back.

The Petitioner underwent another Section 12 evaluation – this time for her lower back – on December 3, 2019, with Dr. David Robson at Comprehensive Spine Care. (RX9) The Petitioner reported her back pain to be 9/10. (Id.) Dr. Robson reviewed the Petitioner's medical records from the ER visit, Dr. Knapp's evaluation, Dr. Eavenson's notes, physical therapy records from SSM and the MRI of the Petitioner's lumbar spine. (Id.) Dr. Robson diagnosed a bulging disc at L4-5 with facet arthropathy and stated that the bus accident was the aggravating factor in the development of the Petitioner's condition. (Id.) He recommended an epidural steroid injection and opined that if that did not provide relief, the Petitioner may ultimately require surgery. (Id.)

On January 7, 2020, the Petitioner saw Dr. Matthew Gornet at the Orthopedic Center of St. Louis for continuing low back pain. (PX5) Dr. Gornet ordered radiographs and found osteoarthritis of the facet joints at L4-5, L5-S2 and potentially L3-4. (Id.) In reviewing the MRI from September 14, 2019, he found a right-sided annular tear at T2 that was encroaching on the nerve. (Id.) also found mild to moderate bilateral facet changes at L3-4, more significant changes at L4-5 and potential changes at L5-S2. (Id.) Dr. Gornet diagnosed the Petitioner with potential aggravation of her preexisting arthropathy at L3-4, L4-5 and L5-S1 and stated that it was causally connected to the accident. (Id.) He recommended medial branch blocks and facet rhizotomies at L3 to S1 bilaterally and an epidural steroid injection at L4-5. (Id.) He gave the Petitioner oral

medications and ordered her to work light duty with a 10-pound lifting limit, as well as no repetitive bending or lifting and alternating between sitting and standing as needed. (Id.)

The Petitioner received injections from Dr. Helen Blake on February 4, 2020, February 18, 2020, and March 10, 2020. (Id.) (PX10) She received facet rhizotomies (radiofrequency ablations) from Dr. Blake on March 26, 2020, and June 30, 2020. (PX5, PX12) The Petitioner testified that the procedures provided some relief from her symptoms. (T. 20) She reported the same to Dr. Gornet on July 16, 2020, stating that she still had a low level of pain. (PX5) Dr. Gornet released her to full duty on July 16, 2020, but did not place her at maximum medical improvement. (Id.) He asked her to follow up with him in six months. (Id.)

For her knee pain, the Petitioner saw Dr. Corey Solman at the Orthopedic and Spine Institute of St. Louis on February 5, 2020. (PX6) Dr. Solman took x-rays and reviewed MRIs of both knees. (Id.) He identified chondromalacia of the patellofemoral joint in both knees as well as significant osteoarthritis in those joints with spurring on the medial and lateral femoral condyles. (Id.) He found no significant narrowing of the medial or lateral joint lines nor any evidence of medial or lateral meniscus tears or ACL, PCL, MCL or LCL tears. (Id.) He also noted that the Petitioner's knees showed no weakness nor instability. (Id.) Dr. Solman diagnosed the Petitioner with bilateral knee osteoarthritis, worse in the patellofemoral joints. (Id.) He stated that the Petitioner's preexisting arthritis became symptomatic and caused dysfunction of both knees as a result of the accident. (Id.) In his report, Dr. Solman mentioned various courses or treatment – corticosteroid injections, arthroscopies for debridement, meniscectomy and synovectomy or total knee arthroplasties. (Id.) He stated that the arthroplasties would be the most predictable course of treatment that would bring the Petitioner back to close baseline and allow her to return to gainful employment. (Id.) Dr. Solman ordered the Petitioner to be off work. (Id.)

The Petitioner followed up with Dr. Solman on October 14, 2020. (Id.) At that time, his diagnosis and recommended treatment remained unchanged. (Id.) He also recommended viscosupplementation or biologic injections in the Petitioner's knees. (Id.) He released the Petitioner to full duty. (Id.)

The arbitrator viewed the surveillance video from January and February 2020. (RX5) The Petitioner can be seen standing, walking, getting in and out of her car and walking a dog. (Id.) Sometimes she walked with a cane, and at other times she walked without it. (Id.) At no time did she do anything inconsistent with her injuries, i.e. running, jumping, kneeling, squatting or walking up or down more than a step or two. (Id.)

On January 28, 2020, Dr. Timothy Farley of Motion Orthopaedics conducted a Section 12 evaluation of the Petitioner – specifically regarding her knees. (RX6) At that time, the Petitioner rated her knee pain at 9/10. (Id.) Dr. Farley examined the Petitioner, took x-rays and reviewed her medical records and video footage of the accident. (Id.) He noted that the accident footage did not show the Petitioner limping, nor was there demonstrable evidence of the Petitioner having pain in her knees. (Id.) Dr. Farley diagnosed the Petitioner as having bilateral osteoarthritis in both of her knees and stated that her condition was preexisting and not causally related to the bus accident but rather was exacerbated by her obesity. (Id.) He recommended a weight loss program and episodic injections. (Id.) He also noted signs of symptom magnification and malingering. (Id.)

On February, 13, 2020, Dr. Farley issued another report based on his review x-rays and video surveillance footage from January 2020. (RX7) He described the Petitioner's activities in the video and noted that he saw no signs of pain or limping. (Id.) His opinion did not change. (Id.)

Dr. Solman testified by way of deposition on September 22, 2020. (PX7) His testimony was consistent with his reports. (Id., PX6) Prior to the deposition, Dr. Solman reviewed the video footage of the accident but said that did not change his opinions as stated in his reports. (PX7 at 9-10) He also reviewed Dr. Farley's report – specifically where Dr. Farley described the video surveillance footage. (Id. at 10) Dr. Solman stated that people will have waxing and waning pain with either traumatic or chronic osteoarthritis. (Id. at 11) He also said that many patients have good motion, stability and strength but have a lot of pain, for which knee replacement surgery would be a solution. (Id. at 37)

When confronted with the evidence of the Petitioner's prior treatment for knee pain, Dr. Solman reaffirmed his opinion that the bus accident was a mechanism that could certainly accelerate or exacerbate the preexisting pain. (Id. at 16) However, Dr. Solman admitted later in his deposition that his causation findings were based on the Petitioner not having pre-accident treatment for her knees and based on her relating that she struck her knees in the accident. (Id. at 29) Dr. Solman testified that he saw no acute injuries on the Petitioner's MRIs and that it was possible for someone with solely chronic osteoarthritis to have the same symptoms as the Petitioner. (Id. at 18-19) During his deposition, Dr. Solman was given a scenario wherein a person was symptomatic prior to a trauma but subjectively stated that their pain was worse after the trauma, while their imaging studies were the same before and after the trauma. (Id. at 38-39) In response to being asked how he would determine whether the accident was a causative factor, Dr. Solman replied: "..(I)f the patient is actively seeking treatment for arthritis because they have pain, but they're not having surgery, then the conservative management options that they've been undergoing have been successful in treating their pain, and then after the accident, they become unsuccessful, then that's the information that we have to go on." (Id. at 39)

Dr. Solman also stated that, considering that it had been several months since the Petitioner's visit, he would want to see her again and would consider whether further injections would be beneficial as opposed to surgery. (Id. at 25) He stated that in cases like the Petitioner's – where there is mild and moderate osteoarthritis – injections could be helpful. (Id. at 25-27) He also testified that weight loss would also be an option. (Id. at 27-28)

Dr. Farley testified by way of deposition on September 29, 2020, and his testimony was consistent with his reports. (RX6, RX7, RX8) In support of his opinion that he saw no evidence that the bus accident aggravated the Petitioner's underlying osteoarthritis, Dr. Farley said he saw no evidence in the accident video that the Petitioner's legs hit anything when the accident occurred and that the Petitioner's movements afterwards demonstrated absolutely no findings of any pain-related behaviors. (RX8 at 18). During questioning regarding his review of records from the prior knee complaints in February 2018 and May 2019, Dr. Farley acknowledged that the records did not show that there was any follow-up treatment nor referrals for further treatment for those complaints. (Id. at 30-31) Dr. Farley also fielded a question about the notation in the emergency room records on the day of the bus accident regarding contusion. (Id. at 43) He stated that a contusion would necessitate some sort of direct blow. (Id.)

Throughout her visits to healthcare providers since the accident, the Petitioner reported no prior issues with her knees or lower back, and her descriptions of the accident were consistent. However, she did have prior knee issues. On February 24, 2018, the Petitioner went to Anderson Hospital after a fall, complaining of pain in her left knee and hip. (RX3) The Petitioner was instructed to apply ice, then heat and to follow up with her doctor. (Id.) On May 28, 2019 – less than three weeks before the bus accident – the Petitioner went to Anderson Hospital complaining of right knee pain for a day due to frequent use of the clutch while driving a bus. (Id.) She again

was instructed to use ice and follow up with her doctor. (Id.) The records for these visits did not contain any pain ratings. (Id.)

The Petitioner testified at arbitration that she was not having problems with her knees just before the accident, that she was never referred for additional treatment for her knees after the hospital visits in February 2018 and May 2019 and that she never missed time from work due to knee problems before the accident. (T. 23-24) She also stated that she would be open to having injections before seeing if surgery was necessary. (Id. at 33)

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law as set forth below.

Issue (F): Is Petitioner's current condition of ill-being, specifically her bilateral knee injuries and low back pain experienced after December 3, 2019, causally related to the accident?

An accident need not be the sole or primary cause as long as employment is a cause of a claimant's condition. *Sisbro, Inc. v. Industrial Comm'n,* 207 Ill. 2d 193, 205 (2003). An employer takes its employees as it finds them. *St. Elizabeth's Hospital v. Illinois Workers' Compensation Comm'n,* 371 ILL. App. 3d 882, 888 (2007). A claimant with a preexisting condition may recover where employment aggravates or accelerates that condition. *Caterpillar Tractor Co. v. Industrial Comm'n,* 92 Ill. 2d 30, 36 (1982).

The medical records show that the Petitioner had osteoarthritis and prior complaints regarding her knees before the accident on June 16, 2019. The question is whether the accident was a cause or aggravation of her condition.

The video of the accident shows that the Petitioner's knees appeared to strike the steering column and fare box. The Petitioner can be heard on the footage complaining that her knee hurt. Further, Dr. Knapp and Anderson Hospital staff believed the Petitioner suffered contusions, and even Dr. Farley acknowledged that a contusion would signify that there was a blow to the Petitioner's knees.

The video surveillance footage of the Petitioner revealed nothing out of the ordinary for someone experiencing waxing and waning knee pain, as Dr. Solman described. This is confirmed by the physical therapy records showing that on some days the Petitioner's symptoms were better than on others.

The most persuasive evidence regarding a causal relationship between the accident and the Petitioner's knee issues was in Dr. Solman's final statement in his deposition as quoted above. Although the Arbitrator believes the Petitioner magnifies her symptoms – specifically the reports of 10/10 pain – the records show that any knee problems the Petitioner had prior to the bus accident did not cause any lasting problems for which follow-up treatment was necessary. However, after the accident, the Petitioner required additional treatment.

The Respondent stipulated to the causal connection between the accident the Petitioner's low back pain up until Dr. Robson's exam on December 3, 2019. However, on that date Dr. Robson diagnosed a bulging disc at L4-5 with facet arthropathy and stated that the bus accident was the aggravating factor in the development of the Petitioner's condition. He recommended an epidural steroid injection and opined that if that did not provide relief, the Petitioner may ultimately require surgery. Therefore, the Petitioner still required treatment for her condition after December 3, 2019.

Therefore, the Arbitrator finds that the Petitioner's current bilateral knee condition and her low back condition after December 3, 2019, are causally related to the accident of June 16, 2019.

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 right to be compensated for medical costs associated with work-related injuries is at the very heart of the Workers' Compensation Act. *Hagene v. Derek Polling Const.*, 388 Ill. App. 3d 380, 383, 902 N.E.2d 1269, 1273 (2009).

In light of the findings above and review of the medical records, the medical costs for the evaluation, diagnosis and treatment were reasonable and necessary. This is especially apparent in reviewing the physical therapy records, which showed the Petitioner's condition improved with consistent physical therapy. The same can be said of the injections to the Petitioner's back.

The Arbitrator orders the Respondent to pay the medical expenses contained in Petitioner's Exhibit 11 pursuant to Section 8(a) of the Act and in accordance with medical fee schedules. The Respondent shall have credit for any amounts already paid or paid through its group carrier. Respondent shall indemnify and hold Petitioner harmless from any claims arising out of the expenses for which it claims credit.

Issue (K): Is Petitioner entitled to any prospective medical care?

Upon establishing causal connection and the reasonableness and the necessity of recommended medical treatment, employers are responsible for necessary prospective medical care required by their employees. *Plantation Mfg. Co. v. Indus. Comm'n*, 294 Ill.App.3d 705, 691 N.E.2d. 13 (1997). This includes treatment required to diagnose, relieve, or cure the effects of claimant's injury. *F & B Mfg. Co. v. Indus. Comm'n*, 325 Ill. App. 3d 527, 758 N.E.2d 18 (2001).

Although the Arbitrator disagrees with Dr. Farley regarding the causal relationship between the accident and the Petitioner's knee issues, I agree with his conservative treatment approach – especially considering that the Petitioner is suffering from mild to moderate osteoarthritis in her knees. The Arbitrator also agrees with Dr. Farley that the Petitioner's weight is a contributing factor to her knee problems. For the recommended treatment to be successful and to avoid possibly unnecessary surgery, the Petitioner should participate in a weight loss program.

Regarding the Petitioner's back condition, Dr. Gornet did not find the Petitioner had reached maximum medical improvement, although he did release her to full duty. Therefore, further evaluation and treatment for the Petitioner's low back is still in order.

The Arbitrator finds that the Petitioner is entitled to prospective medical care, specifically further evaluations, injections and physical therapy as recommended by Drs. Gornet and Solman and a weight loss program as recommended by Dr. Farley. The Respondent shall authorize and pay for such.

Issue (L): What temporary benefits are in dispute? (TTD)

According to the Request for Hearing (AX1), the parties dispute temporary total disability benefits for the period of December 19, 2019, through October 28, 2020. However, the Petitioner has since conceded in her proposed decision that the end date should be October 14, 2020 – when she was released to full duty by Dr. Solman.

An employee is temporarily totally incapacitated from the time an injury incapacitates him for work until such time as he is as far recovered or restored as the permanent character of his injury will permit. *Archer Daniels Midland Co. v. Indus. Comm'n*, 138 Ill.2d 107, 118 (1990).

Regarding the Petitioner's lower back, Dr. Gornet released the Petitioner to full duty work on July 16, 2020. As to the Petitioner's knees, Dr. Solman released the Petitioner for full duty

work on October 14, 2020. Therefore, the Petitioner is entitled to temporary total disability benefits pursuant to Section 8(b) of the Act for 42 and 4/7 weeks, from December 19, 2019 through October 14, 2020.

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.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	12WC002359
Case Name	ACEVEDO, DOUGLAS v. MCDONALDS
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0320
Number of Pages of Decision	38
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	John Eliasik
Respondent Attorney	Daniel Ugaste

DATE FILED: 6/24/2021

/s/ Thomas Tyrrell, Commissioner

Signature

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

Douglas Acevedo,

Petitioner,

vs. NO: 12 WC 2359

McDonalds,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 17, 2018, is hereby affirmed and adopted.

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

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

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

June 24, 2021

o: 6/8/21
TJT/jds
51

/s/ *Thomas J. Tyrrell*
Thomas J. Tyrrell

/s/ *Stephen J. Mathis*
Stephen J. Mathis

/s/ *Kathryn A. Doerries*
Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ACEVEDO, DOUGLAS
Employee/Petitioner

Case# **12WC002359**

McDONALDS
Employer/Respondent

On 9/17/2018, 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 2.26% 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:

4239 LAW OFFICES OF JOHN S ELIASIK
180 N LASALLE ST
SUITE 3700
CHICAGO, IL 60601

2461 NYHAN BAMBRICK KINZIE & LOWRY
DANIEL J UGASTE
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

DOUGLAS ACEVEDO,
Employee/Petitioner

Case # **12 WC 02359**

v.

McDONALDS,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **BRIAN T. CRONIN**, Arbitrator of the Commission, in the city of **CHICAGO**, on **November 30, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS OF FACT AND CONCLUSIONS OF LAW

As Petitioner did not provide live testimony in this matter, the Arbitrator finds that he has failed to prove his case. The Arbitrator did not have the opportunity to observe, first hand, the demeanor of Petitioner or to completely assess his credibility. Petitioner argued that in civil court, under certain circumstances when the plaintiff is unavailable, the judge allows the lawyers to take an evidence deposition of the plaintiff. However, in this case, particularly since the identity of Petitioner has been at issue, the Arbitrator found it imperative that he appear in person to be viewed by the Arbitrator, the lawyers, and any potential witness.

The last date of treatment in evidence is April 26, 2013, which was about 4½ years before this trial.

Absent Petitioner's testimony, the Arbitrator cannot make Findings of Fact and Conclusions of Law on, among other issues, causation and the nature and extent of the injury, when he does not know (1) if Petitioner has undergone additional medical care for a body part or parts at issue here, (2) if he sustained an intervening injury, and (3) what his physical condition is as of the date of trial.

Without Petitioner's testimony, the Arbitrator is unable to corroborate, or not, statements attributed to him by the medical providers, detectives, and Section 12 physicians.

ORDER

All claims for compensation and other benefits under the Act 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

9-16-2018
Date

ICArbDec19(b)

SEP 17 2018

STATE OF ILLINOIS)
)
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DOUGLAS ACEVEDO,	)	
	)	
Petitioner,	)	
	)	
vs.	)	Case No. 12 WC 2359
	)	
McDONALDS,	)	
	)	
Respondent.	)	

MEMORANDUM OF DECISION OF ARBITRATOR

PRE-TRIAL MOTIONS

On February 12, 2012, Petitioner filed a motion for immediate hearing under Section 19(b) of the Act.

On October 10, 2012, Petitioner filed a second motion for immediate hearing under Section 19(b) of the Act.

On March 3, 2014 and March 12, 2015, Petitioner filed a "Motion for Dedimus Potestatem." The Arbitrator has never ruled on this motion.

In Geneva, Illinois, on October 6, 2015 and November 18, 2015, the Arbitrator held a hearing on "Petitioner's Motion for petitioner to testify by deposition or telephone." During the hearing, the Arbitrator and two attorneys discussed the possibility of testimony received via live remote video. The subject of the hearing was Petitioner's inability to be present for a trial on the merits. Petitioner left the U.S., has not been not allowed to return for perhaps 10 years due to issues regarding his immigration status, and currently resides in El Salvador. Petitioner argued that in civil court, under certain

circumstances when the plaintiff is unavailable, the judge allows the lawyers to take an evidence deposition of the plaintiff. Petitioner argued that in the interest of justice, his client should be allowed to testify via deposition, phone deposition or live remote video. Respondent objected to this motion and argued that Petitioner should be required to provide live testimony; otherwise, it would be a violation of Respondent's due process rights. Furthermore, he argued that because Petitioner has been prohibited from re-entering this country for such a long period of time, Petitioner would be unavailable to undergo a current examination by a Section 12 physician or an AMA impairment examination, as is Respondent's right. The Arbitrator denied Petitioner's motion. A record was made of the October 6, 2015 hearing.

On September 29, 2016, Respondent filed a motion to reassign the case to the undersigned Arbitrator because he had been transferred from Geneva to Chicago. As he made a substantive evidentiary ruling in this case, the undersigned Arbitrator granted the motion that same day.

On November 30, 2017, Respondent presented their "Motion to Dismiss." The basis of this motion was that when Petitioner filed the Application for Adjustment of Claim for this case, he did so by using a name and a date of birth that were not his own. Petitioner objected to this motion and argued that Respondent was well aware that the man who filed this Application was their employee and that he had fallen from a ladder at work on January 7, 2012. Petitioner also pointed out that Respondent initially accepted the claim.

Section 1(b)2 of the Act defines an "employee" as "(2) [e]very person in the service of another under any contract of hire, express or implied, oral or written … including aliens …"

In *Economy Packing v. Illinois Workers' Comp. Comm'n*, 387 Ill. App. 3d 283 (1st Dist. 2008), the claimant, who was born in Mexico, admitted that she did not have the necessary paperwork to legally obtain employment in the United States and that when she applied for her position at Economy Packing, "she presented documents that she received from a source other than the government."

The Arbitrator denied Respondent's motion.

EVIDENCE AT TRIAL

On November 30, 2017, this case proceeded to trial on all issues.

Petitioner Douglas Acevedo did not appear or testify at trial.

Petitioner presented his case through counsel by way of medical records, evidence deposition transcripts of Petitioner's treating physicians (PX 1, PX 2), cross-examination of Respondent's witnesses and submission of police investigation reports into evidence.

Respondent offered into evidence the deposition transcripts of their Section 12 physicians (RX 1, RX 2), as well as the testimony of two detectives from the Aurora Police Department.

According to the medical records from Provena Mercy Medical Center in Aurora, IL, Petitioner was seen at the emergency room on January 7, 2012, the day of the injury. (PX 3). There is no medical record for this visit. The first record is dated January 9, 2012, at which time Charles G. Woodward, M.D., saw Petitioner at Provena

Occupational Health Services, in Aurora, IL. On that date, Dr. Woodward recorded that Petitioner was previously seen at the emergency room for an injury he sustained at work on January 7, 2012. He wrote that Petitioner was attempting to change a light bulb on a stepladder and fell from a height of approximately three feet onto a concrete surface. He fell onto both knees, and his left foot and ankle were caught in the ladder when he fell. His complaints consisted of bilateral knee pain with some mild ankle pain and swelling. X-rays of his right hip, left and right foot and left ankle were taken at the emergency room and that they were negative for fractures. (PX 3)

Dr. Woodward's impression was multiple contusions secondary to fall. He gave Petitioner Aleve and released him to return to work with restrictions. The medical records list Petitioner's employer and medical guarantor as McDonalds, with Keith Kasanova listed as the contact person. (PX 3) Kasanova was present at the hearing for Respondent but did not testify.

Petitioner returned to Provena Occupational Health Services on January 12, 2012. William M. Zander, D.O., wrote that Petitioner states he feels no better. Petitioner reported bilateral knee pain, right worse than left, and bilateral ankle pain. Petitioner reported that Respondent could not accommodate his restrictions, and so, he had been off work. Dr. Zander noted a past medical history of an old shoulder injury from three months ago, with which he still has issues, and apparently some bulging disk in his lower cervical region. On examination, Petitioner rated his pain as 9/10, but Dr. Zander wrote that he appears more comfortable than that. Dr. Zander's examination revealed no thoracic or lumbar spine tenderness and very minimal effusion over the right knee suprapatellar area, along with tenderness to the medial and lateral collateral ligaments.

However, with stressing these ligaments, Dr. Zander wrote, there is neither pain nor laxity. Range of motion was smooth without "crepitence" from 180° to 75°. For the left knee, he found tenderness both at the medial and lateral collateral ligaments. He found very minimal tenderness over the right lateral malleolus and mild tenderness over the left medial malleolus. Dr. Zander recommended knee and ankle supports and heat treatment, continued him on restricted duty, and requested that Petitioner return on January 17, 2010 for reevaluation. (PX 3)

On January 17, 2012, Petitioner sought treatment on his own at Chicago Pain & Orthopedic Institute, 467 W. Erie St., Chicago, IL. (PX 4) He was examined on that date by Christopher Morgan, M.D., a physical medicine and rehabilitation specialist. Petitioner reported to Dr. Morgan that he slipped and fell five feet from a ladder at work to the ground. He reported twisting both ankles and landing on his knee. Dr. Morgan also wrote: "Patient states he also felt immediate lower back pain." Dr. Morgan also wrote that Petitioner is known to Chicago Pain and Ortho for a previous work injury. On examination, Petitioner demonstrated tenderness to both ankles and both knees, limited range of motion to the knees bilaterally and a positive Tinel's sign to the left ankle. He had visible bruising to the left knee. He also demonstrated a limited range of motion of his lumbar spine on flexion and extension. Straight leg testing was positive on the right and negative on the left for low back pain. Dr. Morgan diagnosed Petitioner with a lumbar sprain/strain, ankle sprain/strain and knee pain. He recommended that Petitioner start physical therapy, stay off work and get an orthopedic evaluation. (PX 4)

Petitioner started physical therapy at Rehab Dynamix on January 18, 2012 and continued therapy three days a week for approximately two months through March 29, 2012. (PX17).

On January 23, 2012, Petitioner saw orthopedic surgeon Steven Sclamberg, M.D., for an evaluation of his bilateral knee condition. (PX4). Petitioner reported the same mechanism of injury – falling off a ladder and landing on his knees on the floor. Dr. Sclamberg reviewed MRI films of Petitioner's right and left knee. The right knee was normal, but the left knee MRI showed a meniscal tear. Dr. Sclamberg recommended medication and physical therapy, which he was already getting at Rehab Dynamix. (PX4).

Petitioner continued to follow up with Dr. Sclamberg and reported no improvement with therapy and medication. (PX 4) On May 25, 2012, Petitioner again reported no improvement and Dr. Sclamberg recommended arthroscopic surgery. Dr. Sclamberg performed medical meniscal repair surgery on June 15, 2012.

Petitioner returned for a second round of post-surgical physical therapy at Rehab Dynamix starting July 11, 2012 through November 21, 2012. (PX 17)

On October 19, 2012, Petitioner returned to Dr. Sclamberg. (PX 4) He was doing well with the left knee. Dr. Sclamberg recommended four more weeks of physical therapy, with anticipation of discharge and an FCE at that time. This was Petitioner's last visit with Dr. Sclamberg and his last treatment for his left knee. There is no FCE in evidence.

During this time, Petitioner also continued to see Dr. Morgan for his lumbar complaints. (PX 4) On February 14, 2012, in addition to physical therapy and medication,

Dr. Morgan ordered a lumbar MRI. On February 21, 2012, Petitioner had a lumbar MRI at Advantage Imaging. According to the radiologist, the MRI revealed a herniated disc at L4-L5. (RX 1, Deposition of Dr. Andreshak, pp. 36-37).

On March 13, 2012, Dr. Morgan reviewed Petitioner's lumbar MRI and continued Petitioner on medications and physical therapy. (PX 4) On March 27, 2012, when Petitioner reported no improvement, Dr. Morgan recommended lumbar epidural injections. Dr. Morgan gave Petitioner his first lumbar epidural injection on April 24, 2012

Petitioner had an EMG of his lumbar spine at Chicago Pain & Orthopedics on May 2, 2012. (PX 4) He returned to Dr. Morgan on May 22, 2012 and Dr. Morgan reviewed the EMG, which showed L5-S1 radiculopathy. He recommended another round of epidural steroid injections.

On June 1, 2012, pursuant to Section 12 of the Act, Petitioner presented to John L. Andreshak, M.D., for an examination of his lumbar spine. (RX 1, p. 6)

Neeraj Jain, M.D., an anesthesiologist and pain management specialist, administered injections to Petitioner's low back on June 5, 2012, July 17, 2012 and July 31, 2012. When Petitioner reported no improvement, Dr. Morgan recommended a lumbar discogram, which was performed by Dr. Jain on August 28, 2012. The discogram showed a pain response at L4-L5, with the other levels being normal.

Petitioner returned to Dr. Morgan on August 14, 2012, with Petitioner still reporting no improvement. (PX 4) Dr. Morgan recommended lumbar nerve block injections. Dr. Morgan's note indicates cervical instead of lumbar, but this appears to be an error. The nerve block was performed by Dr. Jain, M.D., on August 28, 2012.

On September 11, 2012, pursuant to Section 12 of the Act, Petitioner presented to Steven J. Mash, M.D., for an examination of his knees and ankles. (RX 2, Dep. Ex. 2)

On September 19, 2012, Demetrios Louis, M.D, an anesthesiologist and pain management specialist, took over care of Petitioner's lumbar spine at Chicago Pain & Orthopedics. (PX 4) Dr. Louis recommended another nerve block, which he performed on September 19, 2012. On October 30, 2012, Petitioner reported no improvement with the injections, and Dr. Louis recommended that Petitioner suspend all conservative treatment and get a surgical consultation with Mark Lorenz, M.D., an orthopedic spine surgeon.

On October 29, 2012, Petitioner saw Dr. Lorenz at Hinsdale Orthopedics for a surgical consultation for his lumbar spine. (PX 15) Dr. Lorenz recommended an L4-L5 lumbar fusion surgery. On October 30, 2012, Petitioner returned to Dr. Louis, who suspended further injections for Petitioner's lumbar spine pending surgery with Dr. Lorenz, but continued medications and physical therapy.

Also, during this time, Petitioner was under medical care at Chicago Pain & Orthopedics for his feet and ankles with podiatrist David Charnota, D.P.M. (PX 4) Petitioner first saw Dr. Charnota on April 18, 2012. Petitioner complained of pain in the ankles bilaterally, left greater than right. Dr. Charnota diagnosed Petitioner with tenosynovitis bilaterally, performed an epidural injection and recommended MRIs. The MRIs were done at Hawthorne Works on April 27, 2012. The MRI films of the right and left foot were normal, the right ankle showed mild tenosynovitis and effusion, and the left ankle showed severe tendonitis, fluid in the tendon sheath and fraying of the tendon. Dr.

Charnota continued to recommend conservative treatment and another injection, which he performed on that date.

Petitioner returned to Dr. Charnota on June 13, 2012. (PX 4) Petitioner reported some improvement with his foot and ankle symptoms with the injections. Dr. Charnota recommended continued physical therapy, as well as orthotics, which Dr. Charnota gave to Petitioner on a return visit of August 1, 2012.

On September 5, 2012, Petitioner returned to see Dr. Charnota. (PX 4) Petitioner reported improvement to his right ankle symptoms with injections and the use of orthotics, but his left ankle continued to be painful. Dr. Charnota recommended an adjustment to the orthotics and performed another round of injections to the left ankle. Dr. Charnota advised Petitioner to return in four weeks. On October 3, 2012, Petitioner returned to Dr. Charnota and at that point, in addition to the prior diagnosis of bilateral tendonitis, he diagnosed Petitioner with tarsal tunnel syndrome of the left foot. He recommended more frequent injections to avoid an open release surgery of the nerve.

On January 17, 2013, Petitioner switched his medical care to Illinois Orthopedic Network. (PX 5) On that date, Petitioner saw Krishna Chunduri, M.D., an anesthesiologist and pain management specialist, for his lumbar spine. Petitioner reported the same mechanism of injury of falling off a ladder at work. Dr. Chunduri reviewed the medical records, examined Petitioner and recommended that Petitioner see a neurosurgeon for his lumbar spine.

Petitioner then saw podiatrist Joel Anderson, D.P.M., on January 14, 2013. (PX 5, PX 7) Dr. Anderson examined Petitioner, reviewed the medical records, and diagnosed him with tarsal tunnel syndrome of the left foot, nerve entrapment left foot, and double-

crush injury involving the lumbar spine. Dr. Anderson recommended tarsal tunnel release surgery. Dr. Anderson performed the nerve decompression surgery on Petitioner's left foot on February 6, 2013

Petitioner continued to follow up with Dr. Anderson after surgery. (PX 5, PX 7)

On March 6, 2013, Petitioner reported significant improvement of his left foot pain, but increased pain to the medial aspect of the ankle and along the tibial tendon. Dr. Anderson diagnosed his ongoing problems as a nerve entrapment and neuritis of the tibial nerve and the distal branches at the laciniate ligament. He felt that Petitioner may require future surgery for this condition. This is Dr. Anderson's last medical record. There is no evidence that Petitioner underwent the recommended left ankle surgery.

Petitioner started another course of post-surgical physical therapy for his foot and ankle at Nuestra Clinica on March 15, 2013 and continued through April 26, 2013. (PX 9)

At various times in the medical records, Petitioner is referred to as Douglas Acevedo, Douglas Garcia Acevedo, or Douglas Acevedo Garcia.

Respondent called Scott Reid as a witness. He testified that as of October of 2012, he has been a detective for the Aurora Police Department. Around that time, the Aurora Crimestoppers received an "anonymous tip" that someone was working for Respondent under the name Douglas Acevedo, but that his real name was Hector Acevedo. As a result of the tip, Reid completed an Incident Report and started an investigation.

First, Reid testified, he went to Respondent's location to interview Zaira Fonseca, the general manager. Fonseca provided Reid with a copy of an employment file and

medical records for Douglas Acevedo, who she confirmed as an employee of Respondent.

Reid testified that the crime that he was investigating was identity theft, and the victim would be the person whose identity was being used, not Respondent. There is no crime of using false credentials to obtain employment of which he was aware or that he was investigating. Reid also confirmed that he would not be able to obtain a suspects medical records without a grand jury subpoena due to HIPPA privacy laws.

Reid testified that he reviewed the investigation records obtained by Respondent via subpoena. (PX 26). Reid confirmed that he reviewed the records prior to giving his testimony. Reid confirmed that the medical records provided to him by Fonseca were in the investigation file, and they were all for Douglas Acevedo. These consisted of records from Provena Mercy Medical Center and Chicago Pain and Orthopedics. She also provided the Application for Adjustment of Claim, the First Report of injury and his personnel file, which included hiring documents for Douglas Acevedo, an employee record for Douglas Acevedo and payroll records for Douglas Acevedo. Reid testified that some records came from Fonseca and some from the owner of the McDonalds' franchise, Keith Kazanova.

Reid testified that he returned to the McDonalds on another day with a photo array, which included a photograph of Hector Acevedo from the Aurora Police Department database. Fonseca identified the photograph of Hector Acevedo as the person she knew as Douglas Acevedo, who was employed by Respondent, was injured on January 7, 2012 after falling off a ladder during his employment with Respondent, and did hurt his knees, ankle and lower back.

Reid testified that he next called Hector Acevedo into the police station for an interview on October 30, 2012. During that interview, Hector Acevedo confirmed that he was working for Respondent under the name Douglas Acevedo, that his real name was Hector Acevedo, and that he was injured as a result of working for Respondent. He confirmed that he was receiving off work benefits and medical benefits from Respondent. Hector Acevedo was not charged with any crime.

Respondent also called Michael DeValdivielso as a witness. DeValdivielso was also employed as a police officer for the Aurora Police Department. He assisted Reid with Petitioner's interview, and confirmed that Petitioner admitted in his interview that he was hired by and worked for Respondent under the name of Douglas Acevedo, but that his real name was Hector Acevedo. Petitioner confirmed that he worked for Respondent, that he was injured after falling off a ladder while working for Respondent, that he filed for workers compensation benefits as a result of the injury, and that he received benefits under the name of Douglas Acevedo.

Petitioner submitted the Aurora Police Department records, which were obtained by Respondent, into evidence. (PX 26). The records include an Incident Report, which has a Report Title of "FRAUD." The Incident Report indicates that the Adult Suspect is Hector Antonio Crispin Acevedo with a DOB of 09/11/1985 a/k/a Douglas Garcia Acevedo with a stated DOB of 04/19/1985, the Adult Witness is Zaira Fonseca, General Manager of the McDonalds, and the Property is listed as McDonalds' Employee records for Douglas Garcia Acevedo. (PX 24, PX 26)

The first paragraph of the Narrative Information section of such Incident Report states the following:

> "Aurora Area Crimestoppers received a tip reference Suspect ACEVEDO using a fake name (Douglas Acevedo Garcia) to work at McDonalds (New York St./Union St.). The caller indicated that Suspect ACEVEDO was currently on Workman's Comp due to an injury that he sustained while work- at McDonalds. The caller indicated that ACEVEDO had been bragging about faking injuries in order to file a workman's comp. claim and receive the money." (PX 24, PX 26)

The Narrative Information section of the report goes on to indicate that Reid went to Respondent's McDonalds location and interviewed Fonseca. (PX 26) Fonseca confirmed that she had an employee named Douglas Acevedo, and that he was receiving workers compensation benefits from them due to injuries sustained when he fell off a ladder at work. Fonseca provided Petitioner's employment file to Reid, which indicated that he was hired under the name Douglas Acevedo. She provided Reid with Petitioner's employment application, his "first report of injury", his Application for Adjustment of Claim, medical records from Provena Mercy Hospital and Chicago Pain & Orthopedic Institute, as well as Acevedo's payroll report from 7/30/11 to 11/16/12 and a list of TTD payments from 3/14/12 through 9/12/12. The name on all of the records was Douglas Acevedo. (PX 24, PX 26)

The next report by Reid addressed a repeat visit to Fonseca at the McDonalds on October 22, 2012. (PX 24, PX 26) As Reid had testified, he obtained a photograph of Hector Acevedo, which he included in the photo lineup as photograph #5. Fonseca identified photograph #5 as the person she knew as Douglas Acevedo.

The next report prepared by Reid was of his interview with Hector Acevedo on October 30, 2012. (PX 26) Reid was assisted in translation by DeValdivielso. Hector Acevedo told Reid that he only used the name Douglas Acevedo, DOB, and SSN to work. He also stated that he made a workers' compensation claim to Respondent using

the name of Douglas Acevedo. Douglas Acevedo was his cousin who lives in El Salvador. When asked what Social Security Number he used, he stated 543-95-0326. He further told Reid that he had the Social Security Card made with his cousin's name and the Social Security Number. Petitioner stated that he remembers signing his real signature, Hector Acevedo, on the forms for employee withholding allowance, property receipt, and Application for workers' comp. benefits.

The next report by Reid, dated November 27, 2012, includes a summary of Petitioner's salary history and workers' compensation payment history, as faxed to him by Keith Kazanova. (PX 26)

The final report by Reid, dated December 3, 2012, states the following:

> "R/I was contacted by Kane Co. A.S.A. Christina Wascher reference (sic) this offense. R/I explained to A.S.A. Wascher the facts of the case. After reviewing the facts of the case, A.S.A. Wascher advised that she would not authorize charges due to the social security number that was used by Suspect Acevedo was a made-up number and did not belong to anyone. A.S.A. Wascher advised that based off this fact, there is no victim. This offense is CLEARED/LACK OF PROSECUTION." (PX 26)

In the application for employment with Respondent, Petitioner indicated that he is legal to work in the U.S. (PX 26)

There is no evidence that Respondent verified Petitioner's Social Security Number before hiring him.

Petitioner is claiming unpaid medical bills in the amount of $172,187.93. (AX 1, PX 3, PX 4, PX 5, PX 7, PX 8, PX 9, PX 10, PX 11, PX 12, PX 13, PX 14, PX 15, PX 16, PX 17, PX 18, PX 19, PX 20, PX 21, PX 22, PX 23)

Among the many bills is one from Gray Medical, Inc. for $42,725.00. This total is comprised, in part, of numerous rental charges for a GAME READY COLD THERAPY unit, which Gray rented out to Petitioner for $1,575.00 per week. (PX 19)

Treating physician Mark Lorenz, M.D., testified via deposition on February 13, 2013. He first saw Petitioner, Douglas Acevedo-Garcia, on October 25, 2012. (PX 15, PX 2) Upon examining Petitioner, Dr. Lorenz found that Petitioner had difficulty with forward bending (flexion) and evidence of tripoding (extension). He also exhibited positive straight leg raising on the right and difficulty with heel walking. Regarding diagnostic studies, Dr. Lorenz noted that the discogram showed an abnormality at L4-L5, as well as concordant pain produced at that level. Also, the MRI of September 25, 2012, demonstrated an abnormality at the L4-L5 level. Furthermore, he continued, the MRI of February 21, 2012 showed a posterior central disc herniation at L4-L5. Plus, the dynamic flexion and extension views of lumbar spine x-rays show excessive motion at one segment: L4-L5. Dr. Lorenz diagnosed Petitioner with L4-L5 axial low back pain, likely secondary to some instability and spondylosis, and right leg radiculopathy. Dr. Lorenz opined that Petitioner's fall from a ladder is a competent cause to create the pathology and subsequent dysfunction that he has diagnosed. He recommended that Petitioner either live with the pain or undergo decompression surgery at L4-L5, on the right side primarily. In addition, Petitioner may need a stabilizing fusion at that level. Dr. Lorenz opined that the need for surgery is based on his diagnosis, and his diagnosis is related to Petitioner's fall. Dr. Lorenz also opined that the conservative treatment rendered to Petitioner for this pathology, which included epidural steroid injections, was reasonable for a period of time up to three months. (PX 2)

On cross-examination, Dr. Lorenz testified that he was not aware that Petitioner had another accident in 2011 since Petitioner did not provide that history and he does not have any records to have such opinion. The surgery he is recommending will primarily address his significant dysfunction with regard to leg pain and will stabilize the spine and improve his back pain to some degree. Dr. Lorenz did not review the EMG study that Petitioner had. Rather than testing straight leg raising in the supine position, he goes to the Waddell's type test and extends the leg in a seated position. The doctor opined Petitioner's nerve root impingement is caused by lateral gutter stenosis and also from the central disc herniation that's been reported on the same segment on a different MRI. He further opined that both the February 12, 2012 MRI and the September 25, 2012 MRI show this disc herniation. Dr. Lorenz personally interprets the x-rays taken in his office. Dr. Lorenz's Physician's Assistant, Thomas Pittman, P.A., conducts examinations under the doctor's supervision. In addition to P.A. Pittman's examination, Petitioner underwent an examination by Dr. Lorenz. At the first patient visit, in addition to P.A. Pittman's exam, Dr. Lorenz conducts an examination of the patient. (PX 2)

Treating physician Joel Anderson, D.P.M., testified via deposition, on April 29, 2013. (PX 1) He testified that he is board-certified in podiatry and that probably 25% of his practice is devoted to performing foot and ankle surgeries, which works out to be 5-6 a week. Dr. Anderson first saw Petitioner on January 14, 2013. The history Petitioner gave him was that he fell from a ladder at work (McDonalds) and injured his back, his left knee and his left ankle. Petitioner also reported to him that he had recent surgery for a meniscal tear, and that he had been treating with another podiatrist, Dr. Charnota, for tendinopathy, tendinitis, and tarsal tunnel syndrome. Dr. Charnota provided injections

and physical therapy, which was appropriate treatment, but did not help. Petitioner reported continued pain in his ankle with any standing or walking. Dr. Anderson noted that the report of the MRI of the left ankle from Hawthorne Imaging was consistent with posterior tibialis tenosynovitis. Upon examination, Dr. Anderson found that Petitioner had pain at the medial aspect under pressure to the tarsal tunnel region as well as pain along the posterior tibial tendon. Based on the history, physical examination and diagnostics, he diagnosed Petitioner with tarsal tunnel syndrome and posterior tibial tendinitis. Tarsal tunnel syndrome is nerve compression at the medial ankle that causes pain, numbness, tingling, and shooting pain. Dr. Anderson also diagnosed Petitioner with tenosynovitis, which is an inflammation of the tendon sheath. He found it unusual that Petitioner's tenosynovitis lasted more than one year after the accident. At the time he saw Petitioner, Petitioner had undergone an exhaustive amount physical therapy and multiple injections without any success. So, he recommended tarsal tunnel decompression surgery, and performed it on February 6, 2013. During surgery, Dr. Anderson observed that the nerve was compressed and swollen and had fatty deposits on it. Dr. Anderson testified that the surgery was successful. On March 6, 2013, Petitioner reported to him that he was about 40% better overall since the surgery. Petitioner still had tendon pain and nerve pain. The doctor discussed the possible need for an MRI and possible need for further surgical procedures for the tendinopathy. Such surgery consisted of a tenosynovectomy, which involves cleaning, examining, and possibly repairing the tendon if tears are noted. Dr. Anderson continues to recommend a left ankle MRI and this surgery. He has recommended that Petitioner continue to wear the boot. Dr. Anderson opined that the left ankle complaints with which Petitioner presented to

him were causally related to the January 7, 2012 accident. He further opined that the need for the surgery he has performed, as well as the need for the one he is recommending, were related to the accident. He continues to keep Petitioner off work, and stated that he has kept Petitioner off work from the time Petitioner began treating with him. Such off-work restriction, Dr. Anderson testified, is related to the January 7, 2012 accident. (PX 1)

On cross-examination, Dr. Anderson testified that "outside of just from today", he has only seen Dr. Mash's IME report. He also saw a one-page, November 28, 2012 note from Dr. Charnota, the first page of P.A. Pittman's report, the April 27, 2012 left ankle MRI report, and the EMG/NCV study of May 2, 2012. Dr. Anderson did testify that all the physical therapy, injections and orthotics was appropriate, yet he has not seen the records outlining such treatment. He based his opinion on the appropriateness of the injections on Petitioner's demonstration of the general area where he received the injections. Dr. Anderson reviewed the orthotics at the first visit. Dr. Anderson did not know why Petitioner switched his treatment to him from Dr. Charnota. Dr. Anderson then testified that Petitioner told him "that the other guy wasn't doing the surgery." When Petitioner first came to see him, he had a working diagnosis of tarsal tunnel syndrome. On examination, the pain was noted on mainly the tarsal tunnel initially and discomfort on palpation of the tendon itself. Petitioner had a positive Tinel and Below sign. Dr. Anderson noted that the pain went up his leg and into his foot. The doctor did note, in Dr. Charnota's one record, complaints of pain into the plantar aspect of the foot. Dr. Anderson agreed that someone suffering from tarsal tunnel syndrome for a year would be expected to have complaints going into the sole. He also agreed that the EMG did not

support the diagnosis of tarsal tunnel syndrome, but they don't always, and the EMG was done mainly to check for radiculopathy of the lumbar spine. Dr. Anderson had recommended another EMG/NCV to determine whether or not there was tarsal tunnel syndrome, but it was not done. He was comfortable moving forward with the surgery without the EMG/NCV that he recommended. The history of accident Petitioner recollected was that he fell four feet from a ladder - - Petitioner did not recall the mechanism of injury - - and that after he fell, had pain in his back, left knee, left ankle, and left foot. Without Dr. Anderson knowing the mechanism of injury, he rendered a causation opinion and an opinion on the necessity of surgery. As to the cause of Petitioner's condition, Dr. Anderson relied the one note from Dr. Charnota and the one page from P.A. Pittman. Dr. Anderson had no idea what the treatment was other than the history Petitioner gave him. The doctor did not know the exact date Petitioner's complaints of foot and ankle pain began. He agreed that the area of the foot about which Petitioner complained would have an impact on his causation opinion. Dr. Anderson has not seen the results of the September 2012 FCE that Petitioner took. Full recovery time from a tarsal tunnel surgery is 8-12 weeks. Dr. Anderson is now recommending surgery on the posterior tibial tendon. If the MRI of the posterior tibial tendon shows no problem, then he would have to reconsider surgery. Petitioner did not tell him of any left foot or ankle problems he had prior to January 7, 2012. Dr. Anderson mentioned in his report "double crush syndrome," but he did not examine Petitioner for this condition because that is outside of his area of expertise. He is relying on the first page of P.A. Pittman's report. Dr. Anderson agreed that double crush syndrome refers to nerve entrapment at two levels with the same extremity. Dr. Anderson agreed that he operated

on the left side, and that Petitioner had complaints to the right lower extremity, so it is not double crush. It is generally accepted in orthopedic literature that three cortisone injections are sufficient, and if there is no response, the doctor should discontinue them. Petitioner had 4-5 such injections before he came to see Anderson. (PX 1)

On redirect examination, Dr. Anderson testified that if Petitioner had started treating with him shortly after the accident, he would proceeded with conservative, non-surgical treatment. Dr. Anderson did not find in Petitioner any other condition that would cause tarsal tunnel syndrome such as arthritis, diabetes, varicosities, ganglion cysts, tendinitis, or bone spurs. Dr. Anderson did not recall Petitioner describing a traumatic mechanism other than his fall that would be responsible for his tarsal tunnel syndrome. Other potential causes of tendinopathy are flat feet, long-term injury, biomechanical fault of the foot, or any other kind of bone spurring or arthritic condition. Other than the accident, Dr. Anderson did not find any other potential cause of his tendinopathy. The two reasons for doing the proposed surgery are to clean the tendon and to check to see if there is any tendon damage. Even if he did not find tendon damage, he would still find this surgery to be appropriate treatment. (PX 1)

On recross examination, Dr. Anderson testified that he was not aware of an accident that Petitioner had in September of 2011. Sports, such as soccer, with the repetitive stress and strain could possibly be associated with the development of tarsal tunnel syndrome. (PX 1)

Section 12 examining physician John L. Andreshak, M.D., testified via deposition on April 17, 2013. (RX 1) Dr. Andreshak testified that he is a board-certified orthopedic surgeon whose practice is completely devoted to treatment of the spine. He examined

Petitioner on June 1, 2012. Petitioner provided the history in a several-page document. He also spoke with Petitioner about what had happened. Petitioner's wife did much of the translating. He told Dr. Andreshak that he was injured on January 7, 2012 when he fell off a ladder while changing lights due to grease on his feet. He slipped and landed on his knees and ankles and also landed on his back. At this examination, Petitioner said that he had pain mostly in his back on the right side mostly around the lumbosacral junction. He stated that both standing and sitting are uncomfortable, but sitting is worse, especially when changing positions. He complained of pain in his right leg in his groin along with the medial aspect of the leg, and that standing causes more of the leg symptoms. He also complained of swelling in his knees and swelling in his ankles. When Dr. Andreshak started the initial interview of Petitioner, he observed that Petitioner seemed to be comfortable. Upon examination, Petitioner started grimacing and groaning and posturing in regard to the pain. The significance of the finding is that the Petitioner is obviously trying to let him know that he is having pain. He had some tenderness of the spine. He was markedly restricted in his range of motion because of these pain responses but had more movement when he was just sitting, talking, being interviewed. Petitioner also exhibited give away weakness. He had sensation changes in non-dermatomal patterns. His reflexes were normal; he did not display any spasticity or clonus, which are signs of abnormal neurologic reflex findings. Dr. Andreshak testified that these non-anatomic findings are clustered in a list of exam findings called Waddell's signs. There are five or six Waddell's Signs. Give away weakness is a non-anatomic finding and suggests that a patient is not cooperating or trying to symptom magnify. Patients cannot fake their reflexes because a reflex is an involuntary motor response. Dr. Andreshak

concluded that based on the examination, despite all these non-anatomic findings, he had an essentially normal examination. Dr. Andreshak's interpretation of the films of the lumbar spine MRI of the February 21, 2012 was that they were normal appearing for someone his age. The doctor noted some degenerative disk disease at the L3-L4 and L4-L5 levels, but no disk herniation, no central disk bulging, no stenosis, no compression of the nerves, and no inflammation around the muscles, bones, ligaments or joints. Dr. Andreshak reviewed a stack of medical records from the following providers: Provena Mercy Medical Center, Chicago Pain & Orthopedic Institute where he saw Doctors Morgan, Sclamberg, Markarian, and Charnota, and Advantage Imaging. After hearing the history and current complaints from Petitioner, conducting an examination of Petitioner, and reviewing the records and films, Dr. Andreshak opined Petitioner was not having any problems except his pre-existing degenerative disk disease. The basis of such opinion was the examination results, the MRI, and that most strains resolve within 30 days to 2 months. So, the most Petitioner could have possibly had after the fall was a lumbar strain since he did not have this problem when Dr. Andreshak saw him. Dr. Andreshak noted that it was not until a couple of days after the fall that he began to complain of some back pain, which is very consistent with a lumbar strain. Dr. Andreshak opined that as of the day he examined Petitioner, he did not need any further treatment with regard to his low back. The basis of such opinion is that he had already done therapy for his back and that he just needed to continue with his home exercises to get his degenerative disc problem back to its normal asymptomatic condition. Dr. Andreshak further opined Petitioner should be able to return to full-duty work with no restrictions. He felt that the treatment Petitioner received from January 7, 2012 through June 1, 2012 was reasonable and

necessary, and then he stated that the treatment was a little bit excessive - - Petitioner was undergoing a lot of chiropractic modalities. Dr. Andreshak interpreted the September 25, 2012 MRI as showing some minor degenerative disc disease with a loss of signal at L3-L4 and L4-L5. At L4-L5, there seemed to be a slightly newer finding in regard to some left-sided bulging that was not seen on the previous MRI. The doctor also interpreted the x-rays from Hinsdale Orthopaedics. No real signs of degenerative disc disease, disc spaces pretty well maintained, flexion and extension views appear to have normal motion with normal opening and closing of the disks. Dr. Andreshak interpreted the post-discogram CT scan as relatively unremarkable with degenerative disc disease at mostly L3-L4 and L4-L5. The L5-S1 level showed signs of degeneration. There was no annular tear or extravasation of the dye into the canal at any level. Dr. Andreshak noted that the doctor's opinion in the discogram report is not consistent with the post-discogram CT scan. Dr. Andreshak did not see the annular tear that the doctor described, and the L3-L4 level, which the doctor also described, was not on the discogram CT. After reviewing these additional studies as well as Dr. Lorenz's reports, Dr. Andreshak stated that none of his opinions have changed. Dr. Andreshak sees 40 to 55 or 60 patients a week, and 2-3 IMEs a week. Of the IMEs he conducts, 20% are from the plaintiff's side and 80% are from the defense side, but he has no preference. (RX 1)

On cross-examination, Dr. Andreshak testified that before his former practice was bought out by Cadence, they used to charge $1,200.00 - $1,300.00 for an IME, which would include reviewing the records, examining the patient and writing the report. That is a flat fee. On average, he gives 4-6 depositions a year. Before Cadence, they would initially charge $900.00/hour for a deposition, but that went up to $1,200.00 -

$1,300.00/hour. For an injury that occurred in 2010, Petitioner was scheduled to have an IME by Dr. Andreshak, but Petitioner never showed so the adjuster requested that Andreshak do a record review instead. Dr. Andreshak drafted a report following the record review. (RX 1, Dep. Ex. 2) Dr. Andreshak testified that he did not review Dep. Ex. 2 before rendering his opinions in this case. He received a letter from Zurich asking him to do the IME or record review for Petitioner's injury of November 15, 2010. (RX 1, Dep. Ex. 3) Dr. Andreshak reiterated that the February 21, 2012 MRI was extremely normal-appearing. He agreed that the radiologist who interpreted that MRI came to a slightly different conclusion in that he identified a disk herniation at L4-L5. Dr. Andreshak also agreed that Dr. Lorenz concluded, after reviewing the October 25, 2012 MRI film that at L4-L5, there was disk desiccation and spondylosis and right foraminal narrowing. Dr. Andreshak disagreed with Dr. Lorenz's conclusion. Before testifying today, Dr. Andreshak agreed that he reviewed Dr. Jain's discogram report of August 28, 2012. Dr. Andreshak agreed that Dr. Jain found it to be a valid discogram that was positive for concordant pain at L4-L5, but negative at all other levels. Dr. Andreshak did not disagree with Dr. Jain's findings. Dr. Andreshak opined that the painful disk at L4-L5 would have been the result of degenerative disk disease and not of any traumatic injuries that occurred in the accident Petitioner described to him. The doctor's basis for such opinion was that he had a progression of degeneration at the L4-L5 level as shown on the MRIs and that the degeneration started prior to the accident at bar. Dr. Andreshak agreed that someone could have a degenerative disc condition and be asymptomatic. Prior to the accident at bar, Dr. Andreshak testified, he did not know when Petitioner had symptoms in his lumbar spine. In his report (RX 1, Dep. Ex. 2), Dr. Andreshak stated

that Petitioner had a significant previous history of back problems, but that did not include the previous injury for which he did a prior record review. With regard to his significant previous history statement, Dr. Andreshak testified that he did not know at the time he wrote it what he meant by it. Dr. Andreshak then testified, in the records he reviewed, that a chiropractor commented that he had previously seen Petitioner for his back problem. So, Dr. Andreshak testified, that's probably why he wrote that Petitioner had a significant previous history of back problems. Dr. Andreshak then pointed to the second page of his IME report for the case at bar in which Petitioner reported, perhaps through his wife, that he went to a chiropractic clinic where they had treated him in the past for back problems. However, such prior back problems did not have anything to do with his prior evaluation for Zurich. Dr. Andreshak did not agree with Dr. Lorenz's conclusion that the flexion and extension x-rays showed instability at L4-L5. Dr. Andreshak opined that a patient can exhibit Waddell's Signs and still have valid complaints of pain. When he examines each patient, he will note any inconsistency. During an examination, Dr. Andreshak would write down impressions of his observations, such as whether or not a patient grimaces. In answer to the question relating to how an Arbitrator may determine the veracity of Andreshak's conclusions as they relate to Waddell's Signs, Dr. Andreshak testified that the Arbitrator would have to basically rely on his report and all of the different tests he performed. Dr. Andreshak agreed that there was no indication in the other medical records that any treating physician felt that Petitioner was exaggerating his complaints. Dr. Andreshak also agreed that Dr. Lorenz concluded that Petitioner had axial back pain at L4-L5, and that the appropriate treatment for such condition would include therapy, possible injections, a

positive concordant discogram that showed mechanical back pain with normal control levels, and a fusion. (RX 1)

On redirect examination, Dr. Andreshak opined that Petitioner would be a potential candidate for fusion surgery. However, given that Petitioner displayed all these abnormal findings during his exam, Dr. Andreshak would not offer the surgery to him. Although there can be consistent verifiable findings hidden underneath the abnormal findings, Dr. Andreshak did not find any consistent verifiable findings when he examined Petitioner. Dr. Andreshak "didn't find any accurate findings that he actually was having terrible pain in his back." Dr. Andreshak concluded that Petitioner had degenerative disk disease that was possibly causing his pain, then possibly right after the injury he sustained a simple strain but no objective findings for the cause of his pain. He knows Petitioner had degenerative disk disease because as we age, our disks start to lose water and darken on MRI images. Dr. Andreshak did not find anything in the records or films he reviewed or the history given that would have represented an aggravation or acceleration of that condition by the January 7, 2012 accident. For this opinion he relies, in part, on his 17 years of practice treating these types of patients. Dr. Andreshak testified that his use of the word "normal" when used to describe an MRI or x-rays refers to a comparison with someone of that same age. Dr. Andreshak opined that the flexion and extension x-rays from Hinsdale Orthopaedics do not show any significant findings, were normal for his age, and did not show any instability. (RX 1)

On recross examination, Dr. Andreshak testified that it would be unusual for someone 26 years of age at the time of the accident to have symptomatic degenerative disk in his lower back. Then, Dr. Andreshak testified that it would not be unusual for a

26-year-old to have that condition. He testified that 26-year-old people, men more than women, will probably have about 20% of the findings of degenerative disease or herniations.

Section 12 examining physician Steven J. Mash, M.D., testified via deposition on May 4, 2017. (RX 2) He testified that he is a board-certified orthopedic surgeon whose practice focuses on sports medicine and general orthopedics. Dr. Mash ahs performed a tarsal tunnel syndrome surgery, and is aware of the medical indications for same. Dr. Mash does not concentrate on any specific body part. He examined Petitioner on September 11, 2012 with the assistance of a professional interpreter. (RX 2, Dep. Ex. 2) Petitioner gave a history of injuring himself on January 7, 2012 when he slipped from a ladder due to oil on his shoes. He reported falling about three ladder rungs, or four feet, and injured both knees, both ankles and his back. Petitioner then related to Dr. Mash his history of complaints and medical chronology. Dr. Mash testified that whoever arranged his Section 12 examination asked him to examine only Petitioner's ankles and knees. He examined the knees. He noted, upon palpation, tenderness along the medial joint line of the left knee. Other than that, everything was normal with the knees. He then examined the ankles. On the left, Petitioner complained of some tenderness to palpation along the posterior tibial tendon chief. Otherwise, the exam was normal on the left side. He had a full range of motion and did not have positive nerve findings in the tarsal tunnel on the left. His neurovascular was reported as normal at that time and his ligaments were intact as well. Dr. Mash also reviewed records, which included the records of Dr. Andreshak, the records of Mercy emergency room, the records of Dr. Sclamberg, including his operative report of the left knee, the records of Dr. Charnota, the records of Provena

Mercy Medical Center, and the MRI report of Petitioner's knee. After taking a history, conducting an examination of Petitioner, and reviewing the medical records, Dr. Mash diagnosed Petitioner with status post arthroscopic meniscectomy left knee, contusion or strain of the right knee and right ankle resolved, and posterior tibial tendinopathy of the left ankle. Dr. Mash opined that the condition of Petitioner's right knee and left knee, and subsequent left knee surgery, were causally related to the alleged accident of January 7, 2012. Dr. Mash also opined that the condition of Petitioner's right ankle and foot had resolved at the time he saw Petitioner. Dr. Mash opined that Petitioner left ankle condition that he diagnosed as tibial tendinopathy of the left ankle was causally related to the alleged injury. At the time he examined Petitioner, he did not believe he was a candidate for further medical care for his left or right knee or his left or right ankle, other than instruction and home exercise and perhaps an elastic brace for the ankle (for posterior tibial tendon discomfort). He based his opinion on his examination, outside records, diagnostics, and experience treating patients with similar conditions every day in his practice. Dr. Mash opined that there was quite a bit of chiropractic treatment (the length of time) rendered to Petitioner. Dr. Mash testified that he thought Petitioner could have returned to work without restriction as of September 2012. At Respondent's counsel's request, Dr. Mash reviewed additional records that consisted of the records of Dr. Anderson, a podiatrist, an operative report relating to the left ankle dated February 6, 2013, an MRI of April 27, 2012, and an EMG report dated May 2, 2012. After reviewing these records, Dr. Mash prepared a report, dated July 1, 2013, which stated that none of the records he reviewed affected any of the opinions that previously rendered. (RX 2, Dep. Ex. 3) Dr. Mash testified that he disagrees with Dr. Anderson's decision to operate

on Petitioner for tarsal tunnel syndrome. His basis is several-fold. His examination of Petitioner revealed posterior tibial tendinitis, but did not reveal positive physical findings for tarsal tunnel syndrome. Furthermore, the May 2012 EMG does not demonstrate any findings referable to an injury to the posterior tibial nerve in the tarsal tunnel. Also, the complaints Petitioner offered to Dr. Mash were different than those offered to Dr. Anderson. Also, the MRI findings supported his opinion. The EMG, although conducted for difficulties in the low back, is expected to look at compression syndromes all the way to the toes. Dr. Mash opined that tarsal tunnel syndrome can be caused by a number of problems. (RX 2)

On cross-examination, Dr. Mash testified that back in 2013, he conducted 200-300 IMEs a year. Of those, 75% are for respondents and 25% are for petitioners. In 2012, he charged $1,000.00/hour for an IME. In this case, he charged $3,000.00 for the initial IME, and $900.00 for the addendum report. Today's deposition is being charged at $1,500.00, which is $1,200.00 for the hour and a quarter hour of prep time before the deposition. Dr. Mash agreed that in the letter requesting the IME for this case, he was not asked to address whether or not an accident occurred, but, in fact, the person from CCM who drafted the letter provided a description of the accident. (RX 2, Dep. Ex. 4) When Dr. Mash took a history from Petitioner, through the interpreter, Petitioner indicated to Mash that he was employed by McDonalds and that he suffered an injury on January 7, 2012 that occurred when he slipped off a ladder and fell a number of feet causing his injury. Nothing that was provided to Dr. Mash disputed Petitioner's employment by Respondent or that this incident occurred. Petitioner indicated to Mash that he had injured both knees, both ankles, and lower back. At the time Dr. Mash interviewed

Petitioner, Petitioner complained of lower back pain, radiating pain down the right leg, ongoing pain in his left ankle, and non-specific, post-surgical pain in his left knee. Dr. Mash opined that a meniscectomy, whether done to one or both sides, comes with the risk of developing some degenerative arthritic change in the future. Dr. Mash performs impairment ratings. He opined that most of the time, both the medial and lateral meniscus will end up with a higher percentage of the lower extremity, but generally the same percentage of the whole person. When Dr. Mash wrote his first report, he found that Petitioner was MMI for his left knee, right knee, right ankle, and left ankle. Dr. Mash testified that he then reviewed the EMG of May 2, 2012, which was found to be positive for L5-S1 lumbar spine radiculopathy. Dr. Mash's second report should be changed to say: "that the evidence was on the left side, not the right side for his radicular findings and the AMG (sic) from the L5-S1 level." The EMG is telling us that the problem is not related to a nerve problem that goes through the peroneal or tibial nerves into the foot. It is possible to have a negative EMG even when there is some nerve involvement. Tibial tendinitis is an inflammatory process, and tarsal tunnel syndrome results from compression of the nerves. Dr. Mash testified on direct that he felt the chiropractic treatment was excessive. His concern was with the length of time. He agreed that some chiropractic treatment is appropriate. Petitioner was still receiving chiropractic care when he came to see Dr. Mash in September, but he cannot give an exact start date for the chiropractic care. He knows that Petitioner saw a chiropractor after Dr. Sclamberg performed surgery. After reading his report, Dr. Mash was comfortable in stating that Petitioner was getting chiropractic treatment for both knees

and ankles for many months before seeing Dr. Mash, and also at the time he saw Dr. Mash. (RX 2)

FINDINGS OF FACT AND CONCLUSIONS OF LAW

As Petitioner did not provide live testimony in this matter, the Arbitrator finds that he has failed to prove his case. The Arbitrator did not have the opportunity to observe, first hand, the demeanor of Petitioner or to completely assess his credibility. Petitioner argued that in civil court, under certain circumstances when the plaintiff is unavailable, the judge allows the lawyers to take an evidence deposition of the plaintiff. However, in this case, particularly since the identity of Petitioner has been at issue, the Arbitrator found it imperative that he appear in person to be viewed by the Arbitrator, the lawyers, and any potential witness.

The last date of treatment in evidence is April 26, 2013, which was about 4½ years before this trial.

Absent Petitioner's testimony, the Arbitrator cannot make Findings of Fact and Conclusions of Law on, among other issues, causation and the nature and extent of the injury, when he does not know (1) if Petitioner has undergone additional medical care for a body part or parts at issue here, (2) if he sustained an intervening injury, and (3) what his physical condition is as of the date of trial.

Without Petitioner's testimony, the Arbitrator is unable to corroborate, or not, statements attributed to him by the medical providers, detectives, and Section 12 physicians.

Brian T. Cronin
Arbitrator

9-16-2018
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC024430
Case Name	RODRIGUEZ, LAURA v. LITTLE LADY FOODS
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0321
Number of Pages of Decision	11
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Peter Schlax
Respondent Attorney	Miles Cahill

DATE FILED: 6/28/2021

/s/Marc Parker, Commissioner

Signature

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Laura Rodriguez,

Petitioner,

vs. NO: 18 WC 24430

Little Lady Foods,

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 permanent partial disability, causal connection, medical expenses, wage calculations, benefit rates, 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 9, 2020, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $47,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

June 28, 2021

/s/ *Marc Parker*
Marc Parker

MP:yl
o 6/17/21
68

/s/ *Barbara N. Flores*
Barbara N. Flores

/s/ *Christopher A. Harris*
Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0321
NOTICE OF ARBITRATOR DECISION

RODRIGUEZ, LAURA
Employee/Petitioner

Case# **18WC024430**

LITTLE LADY FOODS
Employer/Respondent

On 4/9/2020, 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 0.16% 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:

0013 DUDLEY & LAKE LLC
PETER M SCHLAX
325 N MILWAUKEE AVE SUITE 202
LIBERTYVILLE, IL 60048

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

STATE OF ILLINOIS)
)SS.
COUNTY OF **Lake**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Laura Rodriguez
Employee/Petitioner

v.

Little Lady Foods
Employer/Respondent

Case # **18** WC **24430**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Waukegan**, on **01/06/2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **06/04/2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**28,392.00**; the average weekly wage was $**546.00**.

On the date of accident, Petitioner was **42** years of age, ***single*** with **4** dependent children.

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

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

Respondent shall be given a credit of $**12,102.86** for TTD, for a total credit of $**12,102.86**.

ORDER

- Respondent shall be given a credit for all medical bills proven hereinafter to have been paid by Respondent per Petitioner's Stipulation on the records, as well as $12,102.86.
- Respondent shall pay reasonable and necessary medical services of $19,246.43, as provided in Section 8(a) of the Act.
- Respondent shall pay Petitioner temporary total disability benefits of $364.00/week for 28 3/7 weeks, commencing 06/05/18 through 12/20/18, as provided in Section 8(b) of the Act.
- Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 06/05/18 through 01/06/20, and shall pay the remainder of the award, if any, in weekly payments.
- Respondent shall be given a credit of $12,102.86 for temporary total disability benefits that have been paid.
- Based on the statutory factors (see attached Addendum) and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 20% loss of use of man as a whole pursuant to §8(d)(2) of the Act. The Arbitrator also notes at the time of the accident Petitioner was single with 4 dependent children and therefore qualifies for the minimum applicable permanent partial disability rate at the time of the accident of $330.00 per week of compensation.

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.

Susan C. Mgatz

Signature of Arbitrator

4-7-2020
Date

ICArbDec p. 2

APR 9 - 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

LAURA RODRIGUEZ,	)	
	)	
Petitioner,	)	
	)	
v.	)	Case No. 18 WC 24430
	)	
LITTLE LADY FOODS,	)	
	)	
Respondent.	)	

ADDENDUM TO THE DECISION OF THE ARBITRATOR

Statement of Facts

Petitioner's Testimony

Petitioner testified (with the aid of an interpreter) that on June 4, 2018, she worked as a machine operator in Respondent's food company. As she was moving from one station to another, she tripped over a cable that was on the floor. As she began falling to her knees, her hand caught on another cable. (Trans. p. 7). As her left hand caught, she felt a lot of pain in her left shoulder. (Trans. P. 8).

Petitioner reported the accident and went immediately to Condell Hospital and was referred to Dr. Hamming. She underwent surgical repair followed by a period of physical therapy. She was restricted by Dr. Hamming from working from June 5, 2018 to December 20, 2018. (Trans. pp. 8-9).

Petitioner was released by Dr. Hamming with restrictions on July 26, 2019 but those restrictions fell within her regular job demands. (Trans. p. 10). Nonetheless, while performing her regular work activities "at the speed the line is going" she experienced pain in her left shoulder and numbness in her left hand. (Trans. p. 10). At Respondent's factory, she makes pizzas. Petitioner grabs the pizzas and puts them on the line and performs "a lot of movement and repetitive work in any part of the line you are in." (Trans. p. 11). "We don't do exactly the same thing all day but the movement and everything, the repetitive work is the same." (Trans. p. 11). The work includes carrying plain pizza crusts from boxes, putting the crusts on a table and then working with the crusts putting things on, but you are doing it fast." She testified, "the boxes and you put it on the table and from there, and then you have periods of one hour in every station. Regardless of what station you are in during the day, it is the same repetitive work." (Trans. p. 12).

Petitioner testified that at the end of the working day she is very tired. Her shoulder also hurts when she is pushing a shopping cart and carrying grocery bags. She has difficulty dressing because by the end of the work day, her shoulder is tired. (Trans. p. 13).

Petitioner testified that she worked mandatory overtime. Although the overtime hours vary – working five days some weeks, six days the next – she is not afforded a choice. The overtime hours are mandatory. (Trans. p. 14).

On cross-examination, Petitioner testified she reported the accident to her second shift supervisor, "Main" (ph). (Trans. p. 15). Her co-worker, Jorgina Cruz was in front of her when the accident happened. She described the accident to Dr. Hamming and thinks she reported to him what she noticed about herself. (Trans. pp. 16-17) She stated, however, she was working with restrictions at the time and not doing the same work she

performs now, and therefore may not have told him about the left hand problems she experiences now. (Trans. p. 6). There are "H and C lines" at Little Lady Foods. Petitioner was injured while working on the "C" line at the time of the accident, but now works the "H" line. She described six different stations he rotates through in order to assemble, wrap and box the pizzas. (Trans. pp. 17-19). Petitioner testified the weight she is required to lift is somewhat more than a can of soda but less than a gallon of milk. (Trans. pp. 20-21). She feels pain when she is at stations requiring her to grab the pizzas with both hands. (Trans. p. 21). She believes she reported the problems she is experiencing at work to Dr. Hamming although she does not recall the exact dates of her appointments and whether she was still working with restrictions at those times. (Trans. p. 22).

Petitioner recalled Dr. Hamming released her with a 50 pound lifting restriction on July 3, 2019. (Trans. pp. 22-23). She admitted taking personal time off sometime before the June 4, 2018 accident. (Trans. p. 23). She testified she is considered a full-time employee. The employer gives her a schedule depending upon when work is available. Petitioner works whenever that work is available and no one asks to change their schedules. She testified that when the company has work available for a six day work week that six day work week is mandatory. (Trans. pp. 24-26).

Petitioner testified she gave all of her medical bills to her lawyer and does not recall receiving any bills from a doctor saying money is still due. (Trans. p. 26).

Medical Records

Petitioner was evaluated at Advocate Immediate Care on June 4, 2018 at 3:15 p.m. The chief complaint noted, "states she was at work and tripped over a cable and as she started to fall left arm got tangled in another cable hanging from the ceiling and pulled her arm as she fell to her knees; complained of pain to left shoulder and right knee." (Resp. Ex. 4, p. 2). She was evaluated, underwent x-rays and was released with a diagnosis of "sprain of left shoulder, contusion of right knee." She was referred for orthopedic evaluation to doctors at Illinois Bone & Joint and given light duty work restrictions. (Resp. Ex. 4 and Pet. Ex. 3).

Petitioner came under the care of Dr. Hamming at Illinois Bone & Joint shortly thereafter. A left shoulder arthrogram was obtained which showed: "a large full thickness tear involving the supraspinatus tendon as well as partial thickness tear of the surrounding articular surface as well. She was found to have a Hill-Sachs impaction deformity, as well as disruption of the anterior-inferior labrum, and osseus sleeve avulsion." (Resp. Ex. 3, Pet. Ex. 1, pp. 43-44).

Petitioner underwent surgical repair performed by Dr. Hamming on July 30, 2018. "Operative indications" ascribe the need for surgery to Petitioner's trip and fall work accident of June 2018. Intra-articular findings including "extensive tearing of the anterior superior, as well as posterior labrum", and "full-thickness tear of the supraspinatus tendon." Repairs were performed both arthroscopically with the use of an Arthrex SpeedBridge construct and both medial and lateral row anchors, as well as an "open subpectoral biceps tenodesis component. (Pet. Ex. 1, pp. 37-40).

Petitioner underwent post-surgical physical therapy and followed up with Dr. Hamming on July 3, 2017. At that time, she reported difficulty lifting heavy objects and fatiguing easily despite being back to work with restrictions. In a follow up visit on July 26, 2019, Petitioner reported "she is feeling a little better at work; however, she still does have some discomfort with repetitive motions. She states that after a long day of work, her arm feels tired and heavy. She states that she can do everything that involves front work of her shoulder; however, the repetitive motion is what is causing her pain." (Pet. Ex. 1, p. 32). An FCE was ordered and lifting restrictions ranging between 10 to 45 pounds were imposed depending upon level of the lift - floor versus overhead. (Trans. Pet. 1, pp. 32 & 46).

IME-Cole

Petitioner was evaluated at Respondent's request by Dr. Cole on May 30, 2019. She reported to Dr. Cole that subsequent to her surgery "there has been some improvement of the left shoulder pain, but she still fatigues very easily and still has pain and weakness in her left shoulder. Laura notes the right shoulder is getting better overall but still hurts at an intermittent level of 4/10. She takes Advil almost every day with some improvement. She says, regarding her goals for the shoulder, she "would like to recover full motion of her arm like I had so I can handle working." She is working light duty now." (Resp. Ex. 5). Dr. Cole diagnosed "left shoulder 10+ months status post rotator cuff repair for work-related purposes, approaching MMI." He forecasts an excellent prognosis for recovery and felt that she could "segue" to a home exercise program, continue working light duty and forecast her ability to advance to full-duty work as of June 4, 2019. He expected that she would reach maximum medical improvement by that date. He stated unequivocally: "yes, I do find claimant's onset of symptoms in June 2018 were the direct result of the injury in question and the claimant's need for care resulted promptly as a result of the left shoulder injury in question." (Resp. Ex. 5). Dr. Cole did not comment regarding what, if any residual pain or fatigue Petitioner might otherwise anticipate despite her ultimate ability to resume her full-duty work activities.

CONCLUSIONS OF LAW

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "F" (CAUSAL CONNECTION), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Both Dr. Hamming and Dr. Cole agree that Petitioner's condition of ill being relates to the June 4, 2018 work accident described by the Petitioner at trial and documented in the immediate care records of that same date. Accordingly, the Arbitrator does find that Petitioner's current condition of ill being is causally connected to her June 4, 2018 work accident.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "G" (EARNINGS), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

The Arbitrator notes Petitioner's unrebutted and credible testimony that the overtime she worked as indeed mandatory. Petitioner's wage statement (Resp. Ex. 6), shows, in addition, that overtime hours were, in fact, regularly worked. In reviewing the wage statement, the Arbitrator finds it is appropriate to delete week/pay date 03/30/2018 (a two week pay period) wherein the Petitioner worked only a total of 9.6 hours - an anomalous week. Deducting those hours from the total combined regular and overtime hours, leaves net total hours worked of 2,277.8 during a total of 25 two week pay periods, or an average of 45.5 hours a week. At a $12.00 straight time rate, the Arbitrator finds that Petitioner's average weekly wage calculates to $546.00 per week.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "J" (MEDICAL SERVICES), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

In evidence are medical bills from Illinois Bone & Joint totaling $19,246.43. (Pet. Ex. 1 & 2). Petitioner stipulated that Respondent is entitled to a full credit for any payments hereinafter proven to have been made toward medical expense. The Arbitrator reiterates her findings regarding causal connection and therefore awards medical expenses totaling $19,246.43 limited only by the Medical Fee Schedule, with Respondent to receive full credit for any medical payments made per Petitioner's stipulation.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "K" (TTD), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

The Arbitrator reiterates her findings regarding average weekly wage above and therefore TTD paid during the stipulated period of temporary total disability from June 5, 2018 through December 20, 2018, a period of 28 3/7 weeks as stipulated by the parties on the Request for Hearing form but at a TTD rate of $364.00 per week. Respondent shall receive credit for TTD paid of $12,102.86 as stipulated by the parties on the Request for Hearing form.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "L" (NATURE AND EXTENT OF THE INJURY), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

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 givens *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 she *is* able to return to work in her prior capacity as a result of said injury. The Arbitrator notes Petitioner's job duties do not, in fact, require lifting beyond the restrictions imposed by Dr. Hamming on July 23, 2019 and that she is, in fact, able to fulfil her full job duties. However, the Petitioner's credible testimony, consistent with the information set forth in Dr. Hamming's office notes (as well as Dr. Cole's IME report) that Petitioner does report ongoing pain and fatigue with the admittedly repetitive nature of her job including repetitive use of her left shoulder. Because Petitioner continues to fulfill her full job duties but with a degree of pain and fatigue, the Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 42 years old at the time of the accident. Because Petitioner has a substantial continuing work life expectancy, 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 there is no evidence that Petitioner's earning capacity has been adversely affected. 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's complaints of ongoing pain and fatigue in connection with her work activities are documented both by Dr. Hamming in his last two office notes as well as by Dr. Cole, which complaints are consistent with Petitioner's trial testimony. The Arbitrator notes the substantial intra-operative findings regarding the extent of tearing to both Petitioner's labrum and supraspinatus tendon which required extensive arthroscopic and open repair. The Arbitrator notes Dr. Cole's excellent prognosis but his failure to otherwise dispute Petitioner's ongoing difficulties of pain and fatigue experienced in fulfilling her regular job duties. Because the evidence of disability is corroborated by the treating medical records, 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 20% loss of use of man as a whole pursuant to §8(d)(2) of the Act. The Arbitrator also notes at the time of the accident Petitioner was single with 4 dependent children and therefore qualifies for the minimum applicable permanent partial disability rate at the time of the accident of $330.00 per week of compensation.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC011560
Case Name	OWENS, CHARLES v. NATION PIZZA
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0323
Number of Pages of Decision	15
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Gerald Connor
Respondent Attorney	James Jannisch

DATE FILED: 6/28/2021

/s/Kathryn Doerries, Commissioner
Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHARLES OWENS,

Petitioner,

vs. NO: 19 WC 11560

NATION PIZZA,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 28, 2020, 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.

June 28, 2021

o-6/22/21
KAD/jsf

/s/*Kathryn A. Doerries*
Kathryn A. Doerries

/s/*Maria E. Portela*
Maria E. Portela

/s/*Thomas J. Tyrrell*
Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0323
NOTICE OF ARBITRATOR DECISION

OWENS, CHARLES Case# **19WC011560**
Employee/Petitioner

NATION PIZZA PRODUCTS
Employer/Respondent

On 1/28/2020, 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:

6184 LAW OFFICES OF GERALD F CONNOR
222 W MERCHANDISE MART #1225
SUITE 1225
CHICAGO, IL 60654

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

STATE OF ILLINOIS)

)SS.

COUNTY OF)

☐ Injured Workers' Benefit Fund (§4(d))

☐ Rate Adjustment Fund (§8(g))

☐ Second Injury Fund (§8(e)18)

☒ None of the above

IN THE WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Charles Owens,)
Employee/Petitioner,)
)
vs.) Case #: 19WC11560
)
Nation Pizza Products,)
Employer/Respondent.)

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert M. Harris, Arbitrator of the Commission, in the city of Chicago, on December 18, 2019. 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 **4/12/19**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**18,999.75**; the average weekly wage was $**387.75**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **2** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

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

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

ORDER

The Arbitrator finds and concludes Petitioner failed to prove by a preponderance of the credible evidence that an accident occurred which arose out of and in the course of Petitioner's employment with Respondent on the date alleged, April 12, 2019. Accordingly, 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.

Robert M. Harris

Signature of Arbitrator Robert M. Harris

January 15, 2020
Date

ICArbDec p. 2

JAN 28 2020

Charles Owen v. Nation Pizza
19 WC 11560

Memorandum of Decision of Arbitrator

Statement of Facts:

Charles Owen (hereinafter "Petitioner") testified that he was employed on April 12, 2019 at Nation Pizza (hereinafter "Respondent") and that he worked on the production line. On that date around 2:30 a.m. Petitioner testified he was standing next to boxes, stacking the boxes when a co-employee threw a box from 7 to 10 feet and it hit him in the neck and the back. Petitioner then experienced pain in the neck and back so he went the ER at St. Anthony Hospital on April 17th, 2019. (Transcript 9,10) At the hospital x-rays were taken and Petitioner then sought further treatment at La Clinica on April 18th 2019. Petitioner testified he was taken off of work and eventually referred to Dr. Memon of Pinnacle Pain on May 2, 2019. Petitioner testified he underwent an MRI of the lumbar spine on May 10, 2019. Petitioner was discharged from therapy by La Clinica on May 27, 2019. (T 11) Petitioner testified he was off of work from April 13, 2019 until May 27, 2019 without pay. At the time of trial he was working as a cook at Angelo's Market. Petitioner testified he still experiences pain in the back and neck. Petitioner testified under direct examination that he never had those neck or back symptoms prior to April 12, 2019. (T 12)

Under cross examination, Petitioner testified he worked third shift while he worked for Respondent. Petitioner testified he was positive that he was injured on April 12, 2019 between 2:30 am to 2:45 am. (T 13) Petitioner further testified that his shifts started at 9:00 pm and ended on 5:00 am the next day. Petitioner then confirmed that the shift in which he would have been working at 2:30 am on April 12, 2019 would have started on April 11, 2019 at 9:00 pm. (T 14)

Petitioner confirmed he sought medical treatment in the emergency room five days later on April 17, 2019 when the accident was still fresh in his mind. When Petitioner presented in the emergency room and he testified that they asked him why he was there and that he told them the truth about how he was injured. (T 15) Petitioner testified he told the emergency room that that accident occurred on April 12, 2019. Petitioner agreed that he treated at La Clinica but he could not recall if they asked him why he was there. Petitioner testified he did not recall going to Pinnacle Pain Management for the first time. (T 17)

Petitioner initially testified that after the accident occurred he returned to work for another shift, but could not recall if that was the last shift he worked for Respondent. Petitioner then testified he recalled meeting with someone from Respondent to fill out an injury report. (T 18) Petitioner was shown Respondent's Exhibit # 1 ("Injury Report") and he recognized it as the injury report he filled out. Petitioner completed and signed this form on April 16, 2019. Petitioner testified that the report had spaces to check so as to designate which body parts were injured. Petitioner testified at trial he was unable to see the report because he needed glasses. (T 19) When questioned about the report, Petitioner testified that is seemed correct to him that only the right hand was checked as the body part injured on the first page. Petitioner testified that it seemed correct to him that the second page only indicated that the right hand and right shoulder were injured. Petitioner confirmed that the report was signed by him on April 16, 2019. (T 20) The "Injury Report" indicates the accident was reported on **April 11**, 2019 and the accident occurred on **April 9**, 2019.

Petitioner confirmed through testimony that he presented to the emergency room on April 17, 2019 around 4:20 pm. Petitioner testified that he did not meet with his attorney that day and he could not recall if he filled out the Application for Adjustment of Claim (which is Arbitrator's exhibit # 2). The Application for Adjustment of Claim indicates that Petitioner claimed the accident occurred on April 12, 2019 and that the Application was signed on April 17, being five days later. The Application was filed at the Commission on April 18, 2019.

When he presented to the emergency room on April 17, 2019, Petitioner testified that he reported his pain level was 10 out of 10 or the most extreme pain he could be in. Petitioner testified that the pain started three days after the accident. Petitioner asserted he was experiencing 10 out of 10 pain at the time he filled out the injury report on April 16, 2019. (T 22)

Petitioner testified he presented to La Clinica the day after he went to the emergency room upon a referral from his attorney. Petitioner could not recall during cross-examination whether or not he told La Clinica his pain was 8 out of 10. Petitioner testified he could recall that he started treatment with Pinnacle Pain Management on May 2, 2019, but could not recall if they asked him about prior back injuries. (T 23) Petitioner confirmed that he testified under direct examination that he did not have any back injuries prior to April 12, 2019. Petitioner then testified that he did have a motor vehicle accident several years ago that resulted in back pain. Petitioner testified that he reported his pain level to Pinnacle Pain Management as 10 out of 10 on May 2, 2019 and they referred him for an MRI and told him to return in two weeks. (T 24) Petitioner testified he underwent the MRI. (T 25)

Petitioner testified he could not recall being examined by Dr. Mark Levin at the request of the insurance company. (T 25) During re-direct testimony Petitioner again confirmed the accident occurred on April 12, 2019. (T 27)

Alejandro Parra testified he is employed by Respondent as a safety and security manager. Parra testified that his job duties include OSHA compliance, injury investigation, and workers' compensation claim management. Parra testified he is familiar with Petitioner from his investigation of this matter. (T 30) Parra testified he reviewed time cards and security footage for the room where the injury was reported. Parra is familiar with the video set up at Respondent's facility because he manages the system. (T 31) Parra testified that video of the property, production rooms, and the exterior of the building are stored. Parra was not able to find video of Petitioner working on April 12, 2019 at 2:30 am to 2:45 am. Parra testified there was no video of this date and time because Petitioner did not work that day. Parra was able to locate video of Petitioner working on April 13 at 2:30 am. Parra testified he watched all eight hours of the video for that shift and was able to identify Petitioner in the video from his work photo (ID badge) and his appearance in the video. (T 33, 35) Parra testified he did not observe any occurrences such as Petitioner has alleged. Parra testified there was no video evidence of an accident occurring between 2:30 am and 2:45 am during that shift. (T 33)

The emergency room records from St. Anthony Hospital reflect that Petitioner presented for treatment at 4:20 pm on April 17, 2019. Petitioner complained of right shoulder, neck and back pain. This history contained in the records reflects a pain level of 10 out of 10 pain. The date of accident is documented as April 12, 2019. (PX 1) (There is one entry on page 9/10 under "Nursing Assessment: Back" that indicates "Patient states he was hurt at work April 5, 2019." The "onset of pain" was April 12, 2019. In his Section 12 report, Dr. Levin placed all of his emphasis on this entry.)

The records from La Clinica reflect Petitioner reported an accident date of April 12, 2019. (PX 2)

The records from Pinnacle Pain Management on May 2, 2019 reflect a date of accident as April 12, 2019. A history of a prior work-related low back injury is also documented. (PX 3)

The injury report, which Petitioner testified he filled out, reflects the accident occurring on April 9, 2019. The report also reflects that the accident was reported on April 11, 2019. The report was completed and signed by Petitioner on April 16, 2019. (RX 1)

The IME report of Dr. Levin from June 13, 2019 (two months after the alleged accident) reflects a history provided by Petitioner which includes an accident occurring on April 12, 2019. The report also includes the results of the Pain Disability Questionnaire the Petitioner completed. Petitioner scored 60 out of 140 on the questionnaire. Dr. Levin noted Petitioner has difficulty explaining the mechanism of injury because Petitioner indicated the box hit him in the back of the right shoulder and then struck his **left hand**. The doctor recorded his attempts to understand the mechanism of injury through questioning of Petitioner. Eventually the doctor noted, **"He then stated he did not know how he actually got hit on the back and his hand got caught by the box."** Petitioner told Dr. Levin that he

reported the accident on **April 14**, 2019. Dr. Levin's physical examination revealed Petitioner walking with an exaggerated gait while being examined but a normal gait while leaving the examination room. Dr. Levin determined there was no objective evidence from an orthopedic standpoint that a work injury occurred on April 12, 2019. The doctor also noted Petitioner had subjective complaints that were not substantiated to be truly related to the alleged work accident. (RX 2) Dr. Levin also noted in his report that Petitioner told him "he was fired a few days after the injury." Dr. Levin further noted in his report that Petitioner also told him, "He made a report on April 14, 219, that he was having pain going from his neck to his low back and they told him to go rest in the cafeteria. At that time, his supervisor came in with termination papers." Petitioner did not challenge this history in his post-hearing submissions.

The security video of the area in which Petitioner worked during the shift that began on April 12, 2019 and continued into April 13, 2019 contains no evidence that Petitioner was injured in the manner in which he alleged during his testimony. (PX 3)

Disputed Issues:

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

The burden lies with the claimant to establish the elements of his right to compensation. *Nabisco Brands, Inc. v. Industrial Comm'n,* 266 Ill. App.3d 1103, 1106, 204 Ill.Dec.354, 641 N.E. 2d 578, 581 (1994). The Arbitrator finds and concludes Petitioner has not met his burden in this matter based on the evidence presented at trial. Petitioner has failed to prove by a preponderance of the credible evidence that an accident occurred arising out of and in the course of his employment with Respondent on April 12, 2019.

Petitioner testified during direct and cross examination that he was certain he was injured between 2:30 am and 2:45 am on April 12, 2019. Petitioner reported this date of injury (April 12, 2019) to all of his medical providers (except for the note shown above, "Nursing Assessment: Back", which may be a typo) as well as Dr. Levin, the Section 12 examiner. This would seem to support Petitioner's assertions and claims.

However, the Arbitrator finds Petitioner's trial testimony is not supported by - but rather is contradicted by - other very persuasive and credible evidence presented at trial, which is significant.

First and foremost is the "Injury Report", (RX 1), which Petitioner admitted he completed and signed which indicates an accident date of **April 9, 2019**. In addition, and quite inexplicably, the injury report reflects the accident date was reported on **April 11, 2019 – a date which was the day before Petitioner alleges the accident occurred. This report was completed by Petitioner on April 16, 2019 which is just a few days after the alleged occurrence.**

Petitioner offered no explanation or reason as to why this "Injury Report", created only 4 days after the alleged accident, should not be accepted as correct, other than offering that maybe it was a mistake. But the form

would necessarily contain multiple mistakes in order to match his asserted date of accident, which is not believable. Petitioner offered no evidence he ever attempted to correct the multiple "errors" in the "Injury Form" or otherwise advise Respondent that it was mistaken. The issue that the "Injury Report" had "mistakes" apparently did not arise until trial.

Also, there are certain other facts or scenarios that further undermine Petitioner's credibility and lead to negative credibility inferences. Petitioner was unable to identify the co-employee who threw the box at him, nor did that co-employee, or any other, offer any evidence or testimony on Petitioner's behalf to support his accident claims. Respondent, on the other hand, offered surveillance video and a witness to use in its defense, which did support its defense claims.

The timing of the alleged accident also places credibility into question. Petitioner apparently was discharged from his employment (per Dr. Levin's report history) on or about April 14, 2019, a mere two days after the alleged accident date. (This history is confirmed in the records from La Clinica dated April 18, 2019, where it is recorded Petitioner stated [one or two days after the alleged accident] that he was called back into the office and was then informed that he as being fired. Further confirmation is noted in the records from Pinnacle Pain Management on May 2, 2019, when Petitioner reported that two days after the accident, he notified the supervisor and the patient ended up getting fired.") However, inexplicably, Petitioner never challenged nor denied these reported histories, during or after trial. Then, on April 17, a mere three days after his discharge and five days after the alleged accident, Petitioner filed his Application for Adjustment of Claim. It is unclear whether Petitioner was fired before or after he signed and completed the "Injury Report" on April 16, 2019. The speed of this Application filing raises both negative credibility and motive questions.

The "Injury Report", medical records and Petitioner's testimony do not match regarding where the box fell and hit Petitioner. It is significant and inexplicable that Petitioner **did not** indicate on the "Injury Report" that his back was injured **despite his testimony that he had 10 out of 10 pain at the time he filled out the report**. The "Injury Report" clearly and specifically indicates Petitioner claimed injury **only** to his right shoulder and right hand (but only used actual words to describe the hand injury - "hit my hand very and smashing between the other box" and "drop a box on top of his hand"). Petitioner presented in the emergency room the day following his completion of the "Injury Report" (April 17) and related a history of accident occurring on April 12, 2019 injuring his "right shoulder, mid neck and lower back" **but no mention of his right hand. These hospital records also clearly indicate the box landed on his right shoulder – however, the "Injury Report" clearly indicates the box landed "on top of his hand" and the box "hit my hand very and smashing between the other box." (sic) The "Injury Report" makes no mention of the box hitting his shoulder (or neck or back). No neck or back pain was indicated on the "Injury Report." However, at trial Petitioner testified the box landed on his "neck and back" – but not the shoulder or hand**. Lastly, highlighting again the disagreeing factual histories, the "History" record from La Clinica,

dated April 18, 2019, only indicates that the box struck Petitioner "on his right upper extremity." **The incongruences are striking, unavoidable and significant.**

These inconsistences and contradictions regarding the reported mechanism of injury are quire glaring and are significant, leading directly to the conclusion Petitioner is not credible. The Arbitrator finds Petitioner's claims implausible and the logical inconsistencies and contradictions undermine Petitioner's credibility.

Lastly, the Arbitrator notes Petitioner made no effort at trial, nor in his post-trial submissions, to explain, clarify or remedy these obvious serious, factual inconsistencies and contradictions regarding his reporting the mechanism of injury. In fact, in his post-trial submission, Petitioner asserts his testimony is supported by the medical records and is credible, an assertion that fails to take into account, and avoids discussing, the conflicting and varying histories and implausible dates.

Next, Petitioner confirmed that the shift in which he would have been working at 2:30 am on April 12, 2019 would have started on April 11, 2019. Respondent's witness Alex Parra credibly testified at trial that he investigated the reported accident on behalf of Respondent. As part of his investigation, Parra reviewed Petitioner's time cards. Parra testified that Petitioner did not work the shift that began on April 11, 2019 and included 2:30 am on April 12, 2019. . Parra also reviewed the security camera footage of the next shift which began on April 12, 2019 and continued into April 13, 2019. Petitioner was observed in the video and there is no evidence that an accident occurred at any time during that shift. The Arbitrator has reviewed the video from 2:30 am to 2:45 am and there is no evidence of an accident as described by Petitioner. **Petitioner, inexplicably, did not offer any rebuttal testimony after Parra testified. Accordingly, the Arbitrator finds Parra's testimony credible and adopts it.**

The Arbitrator notes Petitioner's lack of recall as to certain facts related to this matter, especially under cross examination. Petitioner could not recall the history he gave to several of his medical providers and could not even recall attending the independent medical examination of Dr. Levin on June 13, 2019 – a dubious claim. The Arbitrator further notes Petitioner denied any prior back injuries under direct examination but admitted to a prior back injury under cross examination. A history of a prior back injury is also documented in the medical records from Pinnacle Pain Management on May 2, 2019 ("The patient has had a prior injury, a work-related lo back injury…") **but the history Petitioner provided to Dr. Levin contradicts this – "He denies any previous low back pain"** (RX 2, p. 3). The Arbitrator finds that Petitioner's lack of recall and inconsistent and contradictory testimony undermines his credibility.

Additionally, the Arbitrator notes Petitioner's Application for Adjustment of Claim was signed by Petitioner on April 17, 2019. Petitioner also presented to the emergency room at 4:20 pm that day and was not discharged until after 8:00 pm. The Application was filed the next day. While in the emergency room Petitioner reported a pain level of 10 out of 10. Petitioner was discharged with no significant recommendations for medical treatment and the pursuant to a referral from his attorney sought treatment with a chiropractor the following day.

Based on a review of all of the evidence, including Petitioner's testimony, the medical records, the injury report, the IME report of Dr. Levin and the security video, the Arbitrator finds and concludes Petitioner was not credible. The Arbitrator finds there is sufficient and persuasive evidence that fully contradicts and rebuts Petitioner's testimony, which testimony is given very little weight. Accordingly, Petitioner has not met his burden of proof.

Therefore, the Arbitrator finds and concludes Petitioner' failed to prove he sustained accidental injuries arising out of and in the course of his employment with Respondent. Accordingly, Petitioner's claim for compensation is denied.

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

The Arbitrator adopts and incorporates the findings under Disputed Accident Issue Section C above. Accordingly, the issue of notice is moot.

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

The Arbitrator adopts and incorporates the findings under Disputed Accident Issue Section C above. Accordingly, the issue of causal connection is moot. In addition, the Arbitrator finds Dr. Levin's opinions persuasive based on a review of medical records, and the physical examination the doctor performed on Petitioner. Specifically, Dr. Levin opined that there was no objective evidence to support a causal connection between Petitioner's reported subjective complaints at the time of the Section 12 examination and the alleged work accident.

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

The Arbitrator adopts and incorporates the findings under Disputed Accident Issue Section C above. Accordingly, the issue of medical benefits is moot.

K. What temporary benefits are in dispute? TTD

The Arbitrator adopts and incorporates the findings under Disputed Accident Issue Section C above. Accordingly, the issue of temporary benefits is moot.

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

The Arbitrator adopts and incorporates the findings under Disputed Accident Issue Section C above. Accordingly, the issue of nature and extent is moot.

Robert M. Harris

Arbitrator Robert M. Harris
Dated: January 13, 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	12WC044567
Case Name	DIAZ, BARBARA MAYTE v. VICTOR'S PRODUCE INC
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0324
Number of Pages of Decision	17
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Alexandra Broderick
Respondent Attorney	Charlene Copeland

DATE FILED: 6/28/2021

/s/Kathryn Doerries, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BARBARA MAYTE DIAZ,

Petitioner,

vs. NO: 12 WC 44567

VICTOR'S PRODUCE, INC. &
MICHAEL FRERICHS, ILLINOIS
STATE TREASURER &
EX-OFFICIO CUSTODIAN OF THE
INJURED WORKERS' BENEFIT FUND (IWBF),

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent, IWBF, herein, and notice given to all parties, the Commission, after considering the issue of 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, with the changes noted herein.

The Commission corrects a scrivener's error in the Arbitrator's decision, Findings section, page 3, to reflect a total TTD credit of $800.00 (not $0 as stated).

The Commission corrects a scrivener's error in the Arbitrator's decision, Findings of Fact section, page 11, to reflect the correct number of weeks awarded regarding the 35% loss of use of the right index finger, to 15.05 weeks (not 22 weeks as stated), and to 106.75 total weeks (not 113.7 total weeks as stated).

The Commission corrects a scrivener's error in the Arbitrator's decision, Order section, page 3, to reflect the correct total number of weeks of permanent partial disability awarded to 106.75 total weeks (not 113.7 total weeks as stated).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 28, 2020 is, otherwise, hereby affirmed and adopted.

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

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

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Sections 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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.

June 28, 2021

/s/*Kathryn A. Doerries*
Kathryn A. Doerries

KAD/jsf

/s/*Maria E. Portela*
Maria E. Portela

/s/*Thomas J. Tyrrell*
Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0324

DIAZ, BARBARA MAYTE
Employee/Petitioner

Case# **12WC044567**

VICTOR'S PRODUCE INC AND MICHAEL FRERICHS ILLINOIS STATE TREASURER AND EX OFFICIO CUSTODIAN OF THE ILLINOIS INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 4/28/2020, 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 0.15% 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.

1922 STEVEN B SALK & ASSOC LTD
ALEXANDRA BRODERICK
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

0000 VICTOR'S PRODUCE INC
3410 W 31ST ST
CHICAGO, IL 60623

0639 ASSISTANT ATTORNEY GENERAL
CHARLENE C COPELAND
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Barbara Mayte Diaz
Employee/Petitioner

v.

Case # **12 WC 44567**

Consolidated cases: _____

Victor's Produce, Inc., and Michael Frerichs
Illinois State Treasurer and *ex officio* custodian of the Illinois Injured Workers' Benefit Fund
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **8/19/2019**. 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: Was the Respondent, Victor's Produce, Inc., an uninsured employer on the date of the accident and given notice of the hearing?

FINDINGS

On **12/4/2012**, 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 **$18,633.16**; the average weekly wage was **$358.33**.

On the date of accident, Petitioner was **42** years of age, ***single*** with **1** dependent child.

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

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

Respondent shall be given a credit of **$800** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

ORDER

Respondent shall pay reasonable and necessary medical services of $80,273.94, as provided in §8(a) of the Act, to be adjusted in accord with the medical fee schedule provided in §8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $253/week for 79 weeks, commencing 12/5/2012 through 6/10/2014, as provided in §8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $253/week for 113.7 weeks, because the injuries sustained caused 100% loss of the right little finger, 50% of the right ring finger, 40% loss of the right middle finger, 35% of the right index finger and 20% of the right hand as provided in §8(e)(l) of the Act.

The Illinois State Treasurer, *ex-officio* custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to §5(b) and §4(d) of this Act. Respondent/Employer/Owner/Officer shall

reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

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

Signature of Arbitrator

April 15, 2020
Date

APR 28 2020

Barbara Mayte Diaz v. Victor's Produce, IC, & IWBF
12 WC 44567

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: *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 accident?; *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? TTD; *L:* What is the nature and extent of the injury?; *N:* Was the Respondent, Victor's Produce, Inc., due any credit?; ***O:*** Was the Respondent, Victor's Produce, Inc., an uninsured employer on the date of the accident and given notice of the date of hearing?

This matter proceeded to hearing on August 19, 2019. Respondent Victor's Produce, Inc., was served with proper notice and personally served with correspondence (PX #20 A & B). The correspondence indicated this case was proceeding to arbitration on August 19, and also indicated that if the Respondent failed to appear, this matter would proceed *ex parte*. The National Council of Compensation Insurance Certification having certified that Respondent Victor's Produce, Inc., did not applicable Workers' Compensation insurance coverage on December 4, 2012 (PX #18), and the Illinois State Treasurer and Custodian of the Injured Workers Benefit Fund having been added as a party, and having appeared being duly represented by counsel.

Petitioner testified through a Spanish language translator.

FINDINGS OF FACT

On December 4, 2012, Petitioner Barbara Mayte Diaz was employed by Respondent Victor's Produce Inc. Respondent was engaged in the business of selling cactus. Petitioner used sharp cutting tools, including sharp knives, to cut and remove the spines of the cactus. She testified that during her employment

with Victor's Produce, Inc., she was required to use electric machines including a conveyor belt. On the date of the accident, December 4, 2012, the Petitioner was 42 old, and single with one child under 18.

Petitioner started her employment with Victor's Produce, Inc., approximately one year before December 4, 2012. Victor, the owner of Victor's Produce, hired Petitioner, assigned her tasks, and supplied Petitioner with the tools necessary to complete the assigned tasks. Petitioner testified she was paid by Victor's wife, Carmen, who was also Petitioner's supervisor. Victor hired Petitioner at a rate of $350.00 per week. Two months before the December 4, 2012 accident, pay was increased to $400.00 per week. Petitioner was always paid in cash by Carmen. She worked from 5:00 a.m. to 6:30 p.m., 6 days a week.

Prior to December 4, 2012, Petitioner had not injured her right hand. Up through the date of the accident, Petitioner was fully capable of performing her normal job duties for the Respondent, which included regularly lifting up to 25 pounds and cleaning the conveyor belt. On December 4, 2012, Petitioner reported to work at approximately 5:00 a.m. At approximately 3:30 p.m., Petitioner was cleaning the conveyor belt using a rag, when the rag as well as Petitioner's right hand got caught between sharp blades and the conveyor belt. She felt a strong pain in her arm, and had a hand full of blood. She reported the incident immediately to Carmen and Carmen called for an ambulance. Petitioner was taken by ambulance to Mt. Sinai Hospital.

Petitioner was seen that day in the emergency department of Mt. Sinai Hospital. Petitioner gave a history of her hand being caught in the conveyor belt and complained of right-hand pain. She underwent emergency surgery at Mt. Sinai the same day. Dr. Kaymakcalan diagnosed a right-hand crush injury and performed a right little finger amputation and revision, nail bed repairs of the right middle and ring fingers, right ring finger extensor tendon repair with tendon graft from little finger, and open reduction with internal fixation. Dr. Kaymakcalan placed "K" wire in the ring finger. Petitioner was discharged with restrictions of no heavy lifting. Petitioner testified that she presented herself with restrictions to Victor and was informed that Victor's Produce, Inc., could not accommodate her restrictions.

Petitioner sought a second opinion with Rehab Dynamix and reported her accident history and complaints. Petitioner was referred for an orthopedic consultation. Petitioner returned to Dr. Kaymakcalan December 20, 2012, at which time he removed the sutures and recommended therapy. Therapy began at

Rehab Dynamix on January 7, 2013, at which time she was also taken off work. An MRI of the right wrist was performed upon referral by Rehab Dynamix, which demonstrated the complete amputation of the 5th finger, and fractures of the middle and ring fingers.

Petitioner saw Dr. Sclamberg at Chicago Pain & Orthopedic on February 22, 2013, upon referral by Rehab Dynamix. Dr. Sclamberg opined that she needed more therapy, possibly another surgery, and should remain off work. He also recommended that she return to Dr. Kaymakcalan. She was also seen at Chicago Pain in follow up on March 1, 2013, by Dr. Jain, complaining of right sided neck pain and shoulder pain that radiated and noted occipital numbness. She was diagnosed with neuropathic pain in the right upper extremity, referred for a cervical MRI and physical therapy. Dr. Jain opined that her symptoms were directly related to the work injury.

Petitioner was seen by Dr. Kaymakcalan on March 19, 2013, complaining of tingling on the right 5th finger and ring finger Dr. Kaymakcalan recommended another surgery as her range of motion was limited at 10%. Petitioner underwent another surgery at Mt. Sinai Hospital on May 20, 2013. Dr. Kaymakcalan performed a ring finger extensor tendon and collateral ligaments mobilization using sharp dissection, and an A1 pulley release and tenolysis as well as a right small finger distal amputation revision, and nail debridement of right index finger, middle finger, and ring finger. The head of the metacarpal was removed, and the edges of the bone were trimmed. The next day, Petitioner was seen at Rehab Dynamix, when it was recommended that she remain off work.

Petitioner was referred for physical therapy at Schwab Rehab Hospital, which she began on May 30, 2013. She returned to Dr. Kaymakcalan July 9, 2013, who recommended a third surgery. She underwent the procedure on July 29, 2013, in which Dr. Kaymakcalan performed debridement of the right middle and ring fingernails and nail beds for nail deformities. On August 6, 2013, Dr. Kaymakcalan recommended occupational therapy, which was performed at Schwab. He also recommended Petitioner may benefit from a prosthesis and discharged her from care on June 10, 2014.

Petitioner offered 6 photographs of her right and left hand, (PX #21) in evidence. She also displayed her right hand to the Arbitrator.

Petitioner is currently working as a cashier, earning $200 per week. Petitioner testified that following her accident she received two $400 money orders from Respondent.

Petitioner testified she wears a bandage on her right-hand every day, and that she continues to have pain in the right hand. She testified that her life has completely changed, and she has trouble doing the activities of daily living she previously was able to perform with ease. The Petitioner can no longer take a shower completely, can't brush her hair, or do housework. She has constant pain in her right hand.

CONCLUSIONS OF LAW

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

The Arbitrator finds that on December 4, 2012 Respondent Victor's Produce, Inc. was operating under the Illinois Workers' Compensation Act automatically without election pursuant to §3(8) of the Act. Petitioner used sharp edged cutting tools (knives), and pursuant to §3(15), in that electric equipment was used (electric conveyor belt).

B: Was there an employee-employer relationship?

The Arbitrator finds that based on the undisputed testimony of Petitioner, on December 4, 2012, she was an employee Respondent. She received direction from Respondent on how to perform her job and was supplied tools by Respondent to perform her job.

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

The Arbitrator finds that Petitioner proved that she was injured in an accident on December 4, 2012 that arose out of and in the course of her employment with Respondent. Petitioner was cleaning the electric conveyor belt when her hand and the rag she was using to clean the machine were caught on the machine. This was a risk connected to the Petitioner's employment, and the accident arose out of and occurred in the course of the same.

D: What was the date of the accident?

The Arbitrator finds, based on the testimony of Petitioner and the medical records, that the date of accident was December 4, 2012. The Arbitrator relies on the undisputed testimony of Petitioner and the medical records.

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

The Arbitrator finds that Petitioner proved that timely notice of accident was given to Respondent. Petitioner testified that she reported the incident immediately that same day to Carmen, her supervisor and wife of the owner. She also testified that Carmen called the ambulance.

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

The Arbitrator finds that Petitioner proved that as a result of the accident of December 4, 2012, she suffered a right-hand crush injury, loss of metacarpal, complete amputation of the right little finger, and injuries to the right middle ring and index finger. The circumstantial evidence of the chain of events demonstrates that immediately following the work-related accident, Petitioner had pain and discomfort in her right hand. Based on the medical records and Petitioner's testimony, the Arbitrator finds that Petitioner sustained a right-hand crush injury, loss of metacarpal, complete amputation of the right little finger, and injuries to the right middle ring and index finger that were causally related to her work accident.

G: What were Petitioner's earnings?

The Arbitrator finds that Petitioner's proved her average weekly wage, calculated pursuant to §10 of the Act, was $358.33 per week. Petitioner testified that she was earning $350 per week, until the two months prior to the accident in which her salary was increased to $400 per week. Averaging these two rates (10 months $350/week + 2 months $400/week /12 months) is an AWW of $358.33.

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

The Arbitrator finds that the Petitioner's age at the time of the accident was 42 years of age.

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

The Arbitrator finds that Petitioner proved that she was single, with one child under the age of 18.

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

The Arbitrator finds that Petitioner proved that all the medical care and treatment provided by Petitioner's treating physicians was reasonable and necessary. The Arbitrator relies on the unrebutted testimony of Petitioner, the record as a whole, and the credible opinions of Drs. Kaymakcalan and Sclamberg. There was no evidence to rebut their opinions.

As such, the Arbitrator finds all of the charges admitted in evidence and attached to the Request for Hearing (ArbX #1), as reasonable and necessary and that Petitioner has incurred said medical expenses pursuant to §8(a) of the Act in the amount of $80,273.94. All of said charges were reasonable and necessary to cure or relieve the effects of Petitioner's accidental injuries. All charges are to be adjusted in accord with the medical fee schedule provided in §8.2 of the Act.

K: What temporary benefits are in dispute? TTD

Based upon Petitioner's unrebutted testimony and credible opinions of Rehab Dynamix, Dr. Sclamberg, Dr Kaymakcalan & Dr. Jain, the Arbitrator finds that the amount of compensation due for temporary total disability is 79 weeks from December 5, 2012, through June 10, 2014, when she obtained new employment. Therefore, the Arbitrator awards TTD for 79 weeks at the rate of $253/week, for a total of $19,987.

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

Petitioner's permanent partial disability was evaluated in accord with §8.1b(b) of the Act:

i) No AMA Impairment Rating was offered in evidence. The Arbitrator cannot give any weight to this factor

ii) The record demonstrates that the Petitioner was employed as laborer cutting cactuses at the time of her injury. Due to the nature of her injuries Petitioner was not able to return to her former job. The Arbitrator gives great weight to this factor.

iii) Petitioner was 42 years old at the time of her accident. At that time, she had a statistical life expectancy of 43 years. Petitioner's injuries caused substantial instead significant disability which will affect her for the remainder of her life. The Arbitrator gives great weight to this factor.

iv) Petitioner was earning $400 per week at the time of her injury. She now is earning $200 per week, a substantial reduction in earning capacity. The Arbitrator gives great weight to this factor.

v) The Arbitrator finds that the Petitioner sustained losses to her right hand. Petitioner's medical records document severe and significant injuries, namely right little finger was amputated, right middle and ring fingernail beds were removed, and damage to the nail plates was extensive and flapped up. The nail plates of both fingers were later removed and quite decayed, as well as both nails removed. A piece of the FDB of the little finger was used as a tendon graft for the ring finger, and a K wire was placed in the finger, the extensor tendon and collateral ligaments were later mobilized using sharp dissection, an A1 pulley release and tenolysis were performed and later nail removal. The head of the metacarpal was removed, and the edges of the bone were trimmed. Fractures of the middle and ring fingers were noted in the MRI. The Arbitrator observed significant disfigurement and limitation at the trial. The Arbitrator gives great weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 100% loss of the right little finger (22 weeks), 50% of the right ring finger (13.5 weeks), 40% loss of the right middle finger (15.2 weeks), 35% of the right index finger (22 weeks), and 20% of the right hand (41 weeks) pursuant to §8 (e) 1 of the Act, equaling 113.7 weeks of compensation at the rate of $253/week.

N: Was the Respondent, Victor's Produce, Inc., due any credit?

Petitioner testified that she was paid her full salary for two weeks, and two checks were submitted in the amount of $400.00 each. Respondent is, therefore, due a credit of $800.00

O: Was the Respondent, Victor's Produce, Inc., an uninsured employer on the date of the accident and given notice of the date of hearing?

Based on Petitioner's Exhibit #18, the National Council of Compensation Insurance Certification, the Arbitrator finds that Respondent Victor's Produce, Inc. did not have Workers' Compensation insurance coverage on the date of accident and that the Injured Workers Benefit Fund is the proper party. Due

notice of the hearing was given to Respondent via certified and regular mail (PX #20 A & B).

Steven J. Fruth, Arbitrator

April 15, 2020
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC010749
Case Name	MESSEX, PATRICK v. THE VILLAGE OF MATTESON
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0325
Number of Pages of Decision	17
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Mark DePaolo
Respondent Attorney	Anthony Ulm

DATE FILED: 6/28/2021

/s/Marc Parker, Commissioner

Signature

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

Patrick Messex,

Petitioner,

vs. No. 15 WC 10749

The Village of Matteson,

Respondent.

DECISION AND OPINION ON REVIEW

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

On May 10, 2012, Petitioner, a 50-year-old automotive mechanic, was working on a car when a spark caused a flash explosion in a nearby 55-gallon waste fluid container which was filled with used engine oil, antifreeze and other automotive fluids. The explosion splashed some of the liquid onto Petitioner's skin. He was treated initially at St. James Hospital for first degree burns to his face and neck, and from there was transferred to the burn unit at Loyola Medical Center, where he remained overnight. Following his discharge from Loyola Medical Center on May 11, 2012, Petitioner made two follow-up visits at Ingalls Occupational Health over the next week, after which he was released from care.

Petitioner testified that following the accident, his face appeared somewhat red and he had some blistering on the sides of his cheeks. He testified that after the redness faded from the areas

where he had been burned, his skin developed a greyish-blue tint. Petitioner's medical records reported that his skin redness went away about one week after the accident. Those records, however, did not document any tint or discoloration to Petitioner's skin.

Petitioner claimed the greyish-blue discoloration to his face is permanent, and that it was caused by exposure to silver. Petitioner testified that silver was a component in one or more of the automotive fluids which had splashed onto his face. He also admitted that he was familiar with colloidal silver, a health supplement reputed to be an alternative method of healing, though he denied ever taking any supplements or products containing colloidal silver.

At arbitration, Gordon Hardin testified that he worked for Respondent as the Superintendent of Public Works, and his duties in that position included supervising the mechanics. He has known Petitioner since 2005, and often ate lunch with him. Mr. Hardin testified that Petitioner told him that a dark-colored, tea-like drink Petitioner would have at lunch included a form of silver, like colloidal silver. Mr. Hardin further testified that around 2011, when his wife had been diagnosed with cancer, Petitioner gave him literature about colloidal silver and suggested it as a possible remedy. Mr. Hardin did some research on colloidal silver, but read that among other things, consuming it could cause one's skin to become bluish-grey.

The Commission affirms the Arbitrator's finding that Petitioner failed to prove that the greyish-blue tint to his skin was caused by his work accident of May 10, 2012. Petitioner's claim that the liquid which splashed onto his skin contained silver was not supported by other credible evidence. Further, Petitioner offered no evidence of how long an automotive fluid containing silver would need to remain in contact with skin in order to cause a permanent tint or discoloration.

Petitioner's testimony that his skin developed a bluish-grey tint as soon as the redness from his burns went away was contradicted by his medical records from Ingalls Occupational Health. Those records reported on May 14, 2012 that Petitioner's skin was, "negative for rash, skin redness, abrasions. On exam of head the skin appears pale looking." Four days later, his medical records again reported that Petitioner's face had no skin redness, and that, "Face appears normal presently." No mention of any bluish-grey tint was noted at that time, or in any of Petitioner's other medical records – until 15 months after his accident, on August 26, 2013. A report of that date stated simply, "Blue tinge to face notable," without stating a cause. Petitioner offered no medical records to show that his skin discoloration developed soon after his accident, and he offered no medical opinions that it was caused by his accident.

After Petitioner presented testimony at arbitration, he offered into evidence six photographs of himself taken on different dates prior to his accident. Those photographs purported to show he had normal facial skin coloration prior to May 10, 2012. The Arbitrator denied admission of those photographs based upon a lack of foundation. The Arbitrator also denied Petitioner's request to recall a witness, to attempt to rectify the lack of foundation.

The Commission finds the Arbitrator did not err in rejecting Petitioner's photographs; a proper foundation was not laid. Petitioner offered no testimony that the photographs were fair and accurate representations of what was depicted in them. The Commission also finds that the Arbitrator did not abuse his discretion by refusing Petitioner's request to recall a witness to attempt to lay a proper foundation. Finally, the Commission notes that even if Petitioner's photographs had been admitted into evidence, the Commission would have placed little weight upon them. While showing Petitioner did not have skin discoloration on the pre-accident dates those photographs were taken, they do not prove it developed soon after, or as a result of, his accident. The Commission notes that no post-accident photographs were offered by Petitioner to support his claim that his condition developed shortly after the accident.

The Commission does find, however, that Petitioner's accident caused burns which left permanent blisters and scars on his head and face. At the hearing, the Arbitrator examined Petitioner from one foot away, and gave a description of Petitioner's appearance on the record. The Arbitrator noted that Petitioner displayed after effects of five blisters on the left side of his face and four on his right side, along with one blister on his left ear. While the Arbitrator did not believe that condition amounted to serious and permanent disfigurement, the Commission considers that evidence of Petitioner's appearance, differently. The Commission therefore awards Petitioner 10 weeks of disfigurement pursuant to §8(c), for the visible after effects of blisters on his face and left ear.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 2, 2020, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner a total of 10 weeks of compensation at the rate of $636.00 per week as provided in §8(c) of the Act, for the reason that the accident caused serious and permanent disfigurement to the head and face.

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

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

Under §19(f)(2) of the Act, 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.

June 28, 2021

/s/ *Marc Parker*
Marc Parker

MP/mcp
o-06/03/21
068

/s/ *Barbara N. Flores*
Barbara N. Flores

/s/ *Christopher A. Harris*
Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0325

MESSEX, PATRICK
Employee/Petitioner

Case# **15WC010749**

THE VILLAGE OF MATTESON
Employer/Respondent

On 3/2/2020, 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 1.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0233 DePAOLO & ZADEIKIS
MARK A DePAOLO
309 W WASHINGTON ST SUITE 550
CHICAGO, IL 60606

2337 INMAN & FITZGIBBONS LTD
ANTHONY ULM
33 N DEARBORN ST SUITE 1825
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

Patrick Messex
Employee/Petitioner

v.

The Village of Matteson
Employer/Respondent

Case # **15** WC **10749**

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 **Thomas L. Ciecko**, Arbitrator of the Commission, in the city of **Chicago**, on **December 4, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **May 10, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**55,120.00**; the average weekly wage was $**1,060.00**.

On the date of accident, Petitioner was **50** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit of $**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

Permanent Partial Disability: Disfigurement

No permanent partial disability benefits are awarded as any disfigurement is neither serious nor permanent as required by Section 8(c) of the Act.

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

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

Signature of Arbitrator

3/2/2020
Date

MAR 2 - 2020

Patrick Messex v. The Village of Matteson, No 15 WC 10749

Preface

The parties proceeded to hearing December 4, 2019, on a Request for Hearing indicating the following issues in dispute: whether Petitioner sustained accidental injuries that arose out of and in the course of employment; whether Petitioner's current condition of ill-being is causally connected to the injury; and what is the nature and extent of the injury. Patrick Messex v. The Village of Matteson, No. 15 WC 10749 Transcript of Evidence on Arbitration (hereinafter cited as T) at 4; Arbitrator's Exhibit 1. Petitioner's Application for Adjustment of Claim, filed April 1, 2015, nearly three years after the accident represented the accident occurred when an oil tank exploded and Petitioner suffered face and chest burns. Arbitrator's Exhibit 2. That turned out to be not entirely true.

Findings of Fact

Petitioner testified that he resides in Steger, Illinois, and that he is employed by the Respondent, Village of Matteson. On May 10, 2012, Petitioner was employed as an automotive mechanic by the Respondent. (T. 9-10).

Petitioner testified that on May 10, 2012, he was working on a blown differential on a squad car and he was in the process of taking it apart. He stated that this involved a synthetic based fluid in the car that was put into a waste oil container. He testified that the waste container decided to flash and blow up in his face. Petitioner stated that he was standing over the waste container taking bolts out of the rear end and his face was about 2 feet above the top of it. He further testified that when the waste container blew up, his face had some type of liquid on it, so he went to the bathroom and tried to wash it off with cold water. This fluid went across petitioner's glasses, cheeks and forehead. He did not think it went on his neck. (T. 13-18)

Petitioner's story changed over time. He told the paramedics who arrived at the scene and took him to St James Hospital that he was welding and there was a minor combustion. He told medical personnel at St. James that he was working on a car and an oil tank flashed over. He told the burn unit at Loyola University Medical Center he was working on a fuel line of an automobile when it suddenly ignited and flashed in his face. He told medical providers at Ingalls Occupational Health Program he was using a torch heating something and a waste oil can full of engine oil ignited and exploded next to him. He told Dr. John Kotis that engine oil ignited and a waste tank blew up. Petitioner's Exhibit 1; Petitioner's Exhibit 2; Petitioner's Exhibit 3; Petitioner's Exhibit 5; Respondent's Exhibit 4. Petitioner's testimony at trial seemed to attempt to line up with the theory Petitioner's attorney seemed to want to advance during the deposition of Dr. Kotis, rather than what he told medical providers who sought to treat him on the day of the accident.

Petitioner testified that someone called the paramedics, who then showed up, and took him to St. James Hospital. While at the hospital, some type of cream was applied to his face and

"everything else". He stated that his airway was checked because his nose hair was burned. He was then taken to Loyola Medical Center by ambulance. He said he stayed two days at Loyola, after which he was released. Petitioner testified that he was feeling well when he was released from Loyola. (T. 18-20). The records from Loyola contradict Petitioner on the length of his stay.

Petitioner testified that upon his discharge from Loyola, he was given some "medicine and stuff" to put on his face. This medicine included a salve and a cream. (T. 20).

Petitioner further testified that the fluids normally in the waste container were engine oil, gear lube, transmission fluid, and antifreeze. He stated, without objection from Respondent, that he learned from a co-worker that someone had poured gasoline into the tank as well. (T. 15, 21).

Petitioner testified that when he went back to work, his face was somewhat red, and there was also a funny greyish-blue tint to parts of his face. He said, without objection from Respondent, a couple of people told him he looked different. He noticed that the redness on his face faded, but the bluish color appeared on his face after the redness was gone. (T. 22).

Petitioner testified that motor oil and some hydraulic oil can contain silver. He further testified that transmission fluid typically does not have silver in it. However, the transmission itself does have silver in it because of silver soldering. Petitioner further stated that synthetic differential oils may have copper, a silver-based material. Petitioner further stated that antifreeze has silver in it. Petitioner stated that as far as he knew, those materials were in the subject waste container on the date of the alleged accident. (T. 26-28).

Petitioner testified that prior to the alleged accident, his face had never been discolored. Since the date of the alleged accident, some people have noticed his bluish skin and have made comments about it. The Petitioner testified that the current discoloration to his face has remained mostly consistent. (T. 28-30).

After the completion of Petitioner's attorney's direct examination of Petitioner, this Arbitrator viewed Petitioner's face and stated what I saw for the record. This Arbitrator stated that what he saw on Petitioner's face included the blisters/aftereffects of blisters. On the left side of Petitioner's face, there were maybe three, four or five, and one on the ear. On the right side of Petitioner's face, this Arbitrator saw four blisters/aftereffects of blisters. This Arbitrator further stated that the coloration of Petitioner's face was slightly bluish-grey from the hairline and I could see this color everywhere on Petitioner's face except where he had facial hair. This Arbitrator also compared the color of Petitioner's face to the color of his right hand. This Arbitrator stated that Petitioner's right hand was typical of a white Caucasian male, and when the hand was placed next to Petitioner's face, it emphasized the bluish-grey nature of Petitioner skin on his face. Respondent's attorney stated that he agreed with the Arbitrator's description of Petitioner's face. (T. 32-34).

Petitioner testified that the bluish-grey discoloration to his face did not appear until after May 10, 2012. He further stated that he is claiming the discoloration to his face was due to the accident on May 10, 2012. (T. 36).

The Petitioner said he was seen at St. James Hospital on May 10, 2012, and that paramedics took him to that hospital. Petitioner testified that he reported redness and singed facial hair and nasal hair when he was seen at St. James Hospital. (T. 38-39).

Petitioner testified that he was seen at Loyola Medical Center Friday through Sunday. He stated that after he was discharged from Loyola on May 11, 2012, he was next seen at Ingalls Occupational Health on May 14, 2012. Petitioner stated that he recalled telling the doctor at Ingalls that he considered his symptoms to be mild. Petitioner further testified that the records from Ingalls from May 14, 2012, indicated that the only visible signs of burns on that date were to his eyelashes, eyebrows and frontal hair. (T. 37-40).

Petitioner testified that he returned to Ingalls Occupational Health on May 18, 2012. The doctor told him on that date that his facial burns had healed, and he had no redness or blisters. Petitioner also told the doctors that he did not have any pain or any other concerns on that date, and that he was back to work for Respondent performing his full work duties. (T. 41-42).

Petitioner testified that he was released from care on May 18, 2012 and he has not sought any additional medical treatment related to the alleged accident after that date. He further testified that he has never treated at a hospital or received any other medical treatment for any lung damage due to the accident. (T. 42-43).

Petitioner testified that on the date of the alleged accident, he did not swallow or inhale any flames, and he has never treated at any hospital or with any other medical provider for an ingestion of toxic chemicals allegedly occurring on the date of the accident. Incredibly, he testified that he has never seen a dermatologist or any other medical specialist relating to his facial discoloration after the date of the alleged accident. (T. 43-44).

Petitioner testified that he did not file his Application for Adjustment of Claim for this case until April 1, 2015. Petitioner testified that he has continued to work full duty for the Respondent since May 14, 2012. (T. 43-44).

Petitioner testified that he has heard of colloidal silver, but he has never taken it. He said that he has never taken any type of silver health supplement before, unless it would be contained in his regular natural vitamins that he takes every day. The Petitioner testified that he worked with another individual who had talked about using colloidal silver in the past. (T. 44-47).

Petitioner testified that he told Dr. John A. Kotis, an independent medical evaluator in this case, that he did not know what was in the oil container on the date of the alleged accident. Petitioner further testified that he did not ask the Respondent for the residue to be tested. The Petitioner further testified that he did not know for sure whether the oil container had any silver in it at the time. He is also not aware of any laboratory tests that showed whether there was any silver in the container. He further testified that he was not treated for exposure to chemicals related to the alleged accident. Lastly, he stated that he was not treated for the ingestion of toxic chemicals related to the alleged accident. (T. 48-50).

Petitioner testified that he did not know exactly what was in the waste container when it exploded. He does know that it was filled with materials that had been drained from "various aspects of his work." (T. 50-51).

Petitioner testified that he has never taken any silver supplements, whether orally, through injections, or via creams. Petitioner testified that he was not prescribed any medications related to this matter that contained silver. He was prescribed Zinc Bacitracin at Loyola. (T. 51-52).

Gordon Hardin testified he is the Supervisor of Public Works for Respondent, and he has worked for Respondent since August 2005. His first position with Respondent was in park maintenance. His job duties in that position included maintaining the parks, the Village building, municipal buildings, and right of ways. He held that position for one year. (T. 65-66). Hardin testified that his next position with the Respondent was in public works maintenance. This job entailed trimming trees, and working with concrete, asphalt, aprons, and checking water. He held his position with public works maintenance for the respondent until 2009. (T. 66). Hardin testified that his next position with the Respondent was that of crew leader/foreman, and he started that job in 2009. In this position, he would give work assignments to employees of the respondent and he would send them out to do certain jobs throughout the Village. The types of employees he would supervise would be people working in public works and mechanics. Hardin testified that he was still in this position as crew leader/foreman in May 2012. (T. 66-67).

Hardin testified that he is familiar with Petitioner and indicated that Petitioner was in the court room on the date of the hearing. Mr. Hardin further testified that Petitioner is the village mechanic for Respondent. Petitioner started working for Respondent 2005. Mr. Hardin stated that after both he and Petitioner started working for Respondent in the year 2005, Mr. Hardin would periodically see Petitioner. He would see Petitioner when he would get fuel for the lawnmowers. He would also see Petitioner when he walked through the public works garage. Also, if Hardin needed something to be worked on, such as a vehicle or something with a motor, he would see Petitioner. (T. 68-69).

Mr. Hardin testified that from approximately 2006 going forward, he would see Petitioner approximately 3 to 4 times a week, and he would see him with this frequency all the way up through 2012. Mr. Hardin stated that when he would eat lunch with Petitioner, Petitioner had a dark colored beverage in a container. The drink looked kind of yellowish. Mr. Hardin testified that he periodically had conversations with Petitioner about this drink. He said other workers in the break room would be present during these conversations. Hardin testified that Petitioner told him and the other workers that his drink was like a colloidal silver. Mr. Hardin testified that he frequently saw Petitioner drinking the colloidal silver. He stated that he first noticed Petitioner's facial area having a bluish-grey tint to it beginning in 2005. (T. 70-72).

Mr. Hardin testified that he would make comments to Petitioner about his skin color prior to May 2012. He said that he and other employees of Respondent would call Petitioner "Papa Smurf" or a member of the "Blue Man Group", and these comments occurred prior to May 2012. Mr. Hardin said that these jokes about Petitioner's skin color started in around 2005 or 2006, and they continued up through May 2012. Mr. Hardin stated that Petitioner's skin color was a topic of

conversation at lunch or during other gatherings with public works employees, and the Petitioner was present for these conversations. Mr. Hardin testified that there was no doubt in his mind that these conversations took place prior to May 2012. (T. 72-76).

Mr. Hardin testified that Petitioner provided him with brochures and literature regarding colloidal silver. Mr. Hardin stated that Petitioner gave him this literature around 2011 because his wife was diagnosed with breast cancer. He stated that Petitioner was trying to offer him a remedy for his wife, and that Petitioner encouraged him to look into colloidal silver as a remedy. Mr. Hardin stated that he conducted his own research on colloidal silver any found that it had some negative aspects to it, one being that it could cause a person's skin to turn bluish-grey. (T. 76-78).

Mr. Hardin also testified that in 2010, he and Petitioner and other employees of the respondent were discussing the incident involving the Chilean miners when they were trapped in a mine in August 2010. Mr. Hardin stated that during the conversation regarding this incident, he and the other employees were joking around about what they would say if miked up and what they would do if they ran out of food, who would they eat, and that they wouldn't eat Petitioner because he was blue. (T. 79-80).

Mr. Hardin testified that Petitioner never told him that he was exposed to silver soldering from working on any vehicles owned by Respondent. (T. 86).

Mr. Hardin testified that Petitioner never told him that he thought the alleged accident changed the color of his skin. Mr. Hardin further stated that Petitioner never asked him if he could seek medical attention for any skin discoloration due to a work-related incident. (T. 86-87).

Mr. Hardin stated that he voluntarily appeared to testify at the hearing in this case. He further testified that he was absolutely certain that Petitioner had bluish-grey discoloration to his face prior to May 10, 2012, and he was also absolutely certain that Petitioner regularly talked about using colloidal silver prior to May 10, 2012. He said that his certainty in this regard was based on what he saw and based on his conversations with Petitioner. (T. 87-88).

Mr. Hardin testified that, with respect to the vehicles owned by Respondent, he was not aware of any recalls or defects associated with there being any silver in the fuel tanks of the vehicles made after 1973. (T. 88).

Mr. Hardin testified that from approximately 2006 going forward, he saw Petitioner at work approximately every day up through the date of the alleged occurrence in 2012. He further stated that Petitioner had a bluish discoloration to his face during this time period. (T. 89-90).

Mr. Hardin testified that he first saw Petitioner consuming colloidal silver during lunch while at work for the Respondent, and that would have been in approximately 2006. Mr. Hardin testified that he and other employees of the respondent often remarked about the blue color to Petitioner's face, in Petitioner's presence, prior to the alleged occurrence in 2010. (T. 92-95).

Petitioner's wife sat in the hearing room through the entire testimony of Petitioner and Harden. Respondent failed to move to exclude witnesses and there was no indication she would be a witness. Mary Messex testified that she has been married to Petitioner since September 16, 2006.

Messex testified that Petitioner's primary medical group is Marcotte Medical Group. (T. 110,112,114-115). Messex testified that since she's been married to Petitioner, she has never known him to take colloidal silver. She further stated that when she got married to Petitioner in September 2006, his face was a natural color. She said that his face color remained the same until he got burned in 2012. She stated that after the redness went away, he started to become blue. (T. 113-118).

Medical records of the accident and treatment of Petitioner were introduced at the hearing.

The records of South Cook EMS indicate they responded to Petitioner May 10, 2012. He told them he was welding and there was a minor combustion and his face was burned. They noted redness on his face and no swelling or airway obstruction. Petitioner was transported to St. James Hospital. Petitioner's Exhibit 1.

The records of St James Hospital indicate Petitioner was seen that day, and he told then he was working on a car and an oil tank flashed over. He had some facial pain, like a heavy sunburn, and redness from the neck up and the burnt smell of singed hair. Blisters were noted on the left facial area, he was dressed and given medication. Their impression was a facial burn. Petitioner was taken that day to Loyola Medical Center. Petitioner's Exhibit 2.

The records of Loyola University Medical Center indicate he was seen May 10, 2012, and discharged May 11, 2012. 0% flash burn to the face was noted. Petitioner told them he was working on a fuel line of an automobile when it suddenly ignited and flashed in his face. He said no part of his person or clothes was ever on fire. Loyola noted no appreciable blistering, bullae, or skin breakdown on Petitioner's face. They noted singed nasal and facial hair. Petitioner was diagnosed with first degree burns to his face and anterior neck, with singed nasal and facial hairs. Treatment was given to his wounds.

The records of Ingalls Occupational Health indicate Petitioner was seen May 14, 2012. He told them he was using a torch cleaning something and a waste oil can full of engine oil ignited and exploded next to him and burned his face and neck. There were visible areas of burns to his eyelashes, eyebrows, and facial hair. He was diagnosed with facial burn and placed on restricted duty encouraging clean working conditions. Petitioner returned four days later without swelling or redness. His facial wounds and burn were resolved. His face appeared normal and he was returned to work full duty. Petitioner's Exhibit 5.

Petitioner submitted to an independent medical examination by Dr. John Kotis, a board certified plastic and reconstructive surgeon, on July 6, 2016. Kotis testified via evidence deposition. That deposition was marked by sarcasm, incivility, and interruptions on the part of counsel \that severely compromised portions of the testimony. The behavior exhibited in that deposition would not ever have been tolerated in a hearing had the testimony been live.

Dr. Kotis testified Petitioner told him engine oil ignited and a waste tank blew up. Petitioner was unsure as to the substances that were in the waste reservoir. For the first time anywhere, Petitioner told Kotis the explosion melted the safety glasses he was wearing. Petitioner falsely told Kotis he spent four days in a burn unit. Petitioner claimed to have blood work done, but Kotis did not have it and was unable to evaluate it. He testified Petitioner was concerned with discoloration concerning his face, saying people say his face looks blue or gray. There is nothing in Kotis's testimony or report

indicating Petitioner sought any treatment or explanation for the discoloration in the four years since the accident. That was noted by Kotis. Nor was there any testimony or anything in the report indicating exactly when the discoloration began. Kotis did a physical examination and reviewed medical records of Petitioner's treatment. He saw no burn scars to the face or discoloration to the neck or ears. He noted the records from Loyola indicated Petitioner was discharged within 24 hours. Petitioner was diagnosed with first degree burns, that is superficial to the epidermis. Petitioner was treated with topical ointment and pain medications. That condition usually resolves in seven days. Petitioner's facial wound resolved and he had no treatment after May 18, 2012. He diagnosed Petitioner with facial discoloration and dischromatia. He could not establish a causal connection between the discoloration and the work accident without further work up. Petitioner, he said had no functional impairment from the incident. Kotis was not able to ascertain what may have blown up in Petitioner's face, and nothing in the medical records indicating Petitioner used any silver creams for the burn. He noted Petitioner was treated for flash burns, not chemical burns. Petitioner's Exhibit 4.

CONCLUSIONS OF LAW

Disputed issue **C** is whether Petitioner sustained accidental injuries that arose out of and in the course of employment.

There is clear evidence, essential unrebutted, that Petitioner suffered accidental injuries that arose out of and in the course of his employment as a mechanic for Respondent. The "how" of it, or what happened is confusing because of Petitioner's shifting stories. The most likely comes from the Petitioner's history when at the burn unit at Loyola, his comprehensive treatment location, when he told medical provider's he was working on the fuel line of an automobile when it suddenly ignited and flashed. The medical treatment given Petitioner solidly supports this. I find as a conclusion of law, Petitioner sustained accidental injuries that arose out of and in the course of his employment.

Disputed issue **F** is, is Petitioner's current condition of ill-being causally connected to the accidental injury of May10, 2012. To obtain compensation under the Act, an employee must establish by a preponderance of the evidence, a causal connection between a work related injury and the employee's condition of ill-being. Vogel v. Illinois Worker's Compensation Commission, 354 Ill. App. 3d 780, 786 (2005).

Here, Petitioner contends he has a facial disfigurement, a blueish grey discoloration. Petitioner goes to great lengths, without any credible evidence of any kind, let alone a preponderance, to contend fluids containing silver blew up in his face. Why? Because Petitioner's condition is Argyria, a blueish gray discoloration of the skin. A fact of which I take judicial notice. Illinois Rules of Evidence 201 (b); (c); (f).

Here, Petitioner failed to meet this burden of proof in that he did not establish, by a preponderance of the evidence, that his current condition of ill-being, namely his bluish-grey skin discoloration, is causally related to the alleged accident of May 10, 2012. Conjecture, speculation, and suggestion are not evidence.

The Petitioner has not offered any medical evidence whatsoever to indicate or establish that his current condition of ill-being; that is, his bluish-grey skin discoloration, is causally related to the

alleged accident. Petitioner received very little treatment following the alleged accident, from May 10 through May 18, 2012, at St. James Hospital, Loyola University Medical Center, and Ingalls Occupational Health, and there is no indication in any of these records that Petitioner's current condition of ill-being is causally related to the alleged accident. He was treated for a first degree flash burn, not a chemical burn. It resolved in a week. He never even testified precisely when the discoloration began.

Dr. Kotis testified that he was unable to reach an opinion, based upon a reasonable degree of medical certainty, as to whether there was a causal relationship between his diagnoses of petitioner and Petitioner's alleged work accident, because the doctor indicated Petitioner needed to undergo a lab workup in order to determine all potential medical/dermatologic causes of Petitioner's discoloration.

This Arbitrator cites the testimony of Petitioner in support of his findings. Specifically, Petitioner is alleging that his bluish-grey skin discoloration was caused by silver being contained in certain fluids which he alleges blew up in his face on the date of the accident. However, Petitioner testified that he did not know with certainty whether these fluids had silver in them, nor was he aware of any test results establishing that the aforementioned fluids contained any silver in them. (T. 48-50). Accordingly, there is no credible evidence that there was any silver contained in the fluids which allegedly caught fire and caused Petitioner's flash burn. Petitioner's allegations concerning the causation of his condition of ill-being are based only on supposition and conjecture, and they are not supported by any medical or scientific evidence. They are not even consistent.

This Arbitrator also finds it significant that despite Petitioner's apparent concern with his skin discoloration, he has not sought or received any additional medical treatment or even an explanation related to the discoloration subsequent to being released from treatment on May 18, 2012. (T. 42-43). If Petitioner was genuinely concerned with his skin discoloration, as he told Dr Kotis, and wanted to determine the cause of it, he could have sought treatment or explanation for it. There is strong evidence to reason he did not do so because he knew the cause, and it had nothing to do with the accident.

I rely on the testimony of Gordon Hardin, who proved to be a credible, consistent, and unflappable witness. Hardin testified that he has worked with Petitioner at the Village of Matteson from 2005 through the hearing, and from approximately 2006 through the alleged date of accident, he would see Petitioner at work at least 3 to 4 times per week. (T. 70-72). Hardin testified that Petitioner's skin had a noticeable bluish-grey tint to it beginning in approximately 2005, and this skin discoloration was well known to Hardin and Petitioner's co-workers, and the skin discoloration was openly discussed in Petitioner's presence many times prior to the alleged date of accident. (T. 72-76). Furthermore, it was well known to Hardin and Petitioner's co-workers that Petitioner regularly consumed colloidal silver for many years, and consumption was the likely cause of Petitioner's bluish-grey skin discoloration. (T. 70-76). Hardin testified that Petitioner has never told him that he thought the alleged accident changed the color of his skin, nor did Petitioner ever ask him if he could seek medical attention for any skin discoloration due to a work-related accident. (T. 86-87). Simply look at the story about discussing the Chilean miners two years before the accident. Who makes that stuff up? Anyone who has worked among men in that type of environment recognizes the conversation.

I do not find the testimony of Petitioner's wife, who sat in the hearing room through the testimony of the other witnesses, before popping up as a rebuttal witness, to be credible on this issue.

The evidence in this matter strongly suggests that Petitioner had bluish-grey skin discoloration well before the alleged date of accident of May 10, 2012, and it is in no way the result of the flash burn. Additionally, Petitioner could have simply offered medical evidence he sought treatment or explanation for the condition, and those findings. He didn't.

Disputed issue L is what is the nature and extent of the injury. Petitioner suffered first degree burns to his face and anterior neck with singed facial and nasal hair while working on a fuel line when the line suddenly ignited and flashed. His condition resolved in eight days.

Petitioner contends he is disfigured. Pursuant to Section 8 (c) of the Act, disfigurement must be both serious and permanent. Having seen the Petitioner, I find no serious or permanent disfigurement to Petitioner and so deny compensation under that Section.

Arbitrator

3/2/2020
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	14WC013550
Case Name	VALES, ARCELIA v. CITY OF CHICAGO
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0326
Number of Pages of Decision	13
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Tyler Berberich
Respondent Attorney	Donald Chittick

DATE FILED: 6/28/2021

/s/Marc Parker, Commissioner

Signature

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 Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Arcelia Vales,
Petitioner,

vs.

No. 14 WC 013550
(Consolidated case: 14 WC 015303)

City of Chicago,
Respondent.

DECISION AND OPINION ON REVIEW

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

Prior to arbitration, the parties stipulated that Petitioner was entitled to 13-1/7 weeks of temporary total disability. Respondent claimed that it had paid Petitioner $9,111.49 in temporary total disability benefits. In his decision, the Arbitrator acknowledged Respondent's credit for the amount paid but omitted in his findings any reference to Petitioner's entitlement to 13-1/7 weeks of benefits for the period commencing October 4, 2013 through January 3, 2014. Therefore, the Commission modifies the Arbitrator's Decision and, consistent with the parties' stipulation, awards Petitioner 13-1/7 weeks of benefits for the period commencing October 4, 2013 through January 3, 2014.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 1, 2019, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $518.51 per week for 13-1/7 weeks for the period commencing October 4, 2013 through January 3, 2014 as total temporary disability, pursuant to §8(b) of the Act .

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

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

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.

June 28, 2021

/s/ *Marc Parker*
Marc Parker

mp/dak
o-6/17/21
068

/s/ *Barbara N. Flores*
Barbara N. Flores

/s/ *Christopher A. Harris*
Christopher A. Harris

NOTICE OF ARBITRATOR DECISION

VALES, ARCELIA
Employee/Petitioner

Case# **14WC013550**
14WC015303

CITY OF CHICAGO
Employer/Respondent

On 11/1/2019, 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 1.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0274 HORWITZ & HORWITZ & ASSOC LTD
TYLER BERBERICH
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

0010 CITY OF CHICAGO DEPT OF LAW
D TAYLOR CHITTICK
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF **COOK**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Arcelia Vales
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **14** WC **13550**

Consolidated cases: **14 WC 15303**

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 **08-07-19**. 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 **Overpayment of TTD**

FINDINGS

On **10-02-13**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$28,225.32**; the average weekly wage was **$777.77**.

On the date of accident, Petitioner was **43** 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 **$9,111.49** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$9,111.49**.

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

ORDER

The Arbitrator finds that Respondent is entitled to a credit for a TTD overpayment in the amount of $2,296.79, which may be applied to the award on permanency.

As Petitioner returned to work for only a brief period before re-injuring the same body part (right shoulder), the Arbitrator will address the award on permanency in his decision on the latter claim.

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

10-31-19
Date

NOV - 1 2019

Arcelia Vales v. City of Chicago

14 WC 13550 & 14 WC 15303

Statement of Facts

1st Accident:

On 10/2/13, Petitioner was employed as a Laborer for the Department of Streets and Sanitation – Forestry Operations. On 10/2/13, Petitioner was 42 years of age and had been employed by Respondent since 2012. According to VocaMotive records, her legal name is Arcelia Vale.

On 10/2/13, Petitioner was on duty and was tasked with pruning trees. As Petitioner lifted the pruner overhead she felt a "snap" in her right shoulder. Petitioner reported this incident and sought initial treatment at MercyWorks.

On 10/2/13, Petitioner sought consultation with Dr. Homer Diadula of MercyWorks, who assessed Petitioner with a right shoulder strain (Px6). On 10/4/13, Petitioner returned to Dr. Diadula, who recommended Petitioner for a right shoulder MRI.

On 10/10/13, Petitioner underwent a right shoulder MRI at Skan National Radiology Services (Px8). On 10/15/13, Petitioner returned to Dr. Diadula, who reviewed Petitioner's imaging and assessed Petitioner with a positive proximal rupture of the long head of the biceps tendon with distal refraction of the tendon. On 10/15/13, Dr. Diadula referred Petitioner to Dr. William Heller of Midland Orthopedics for further treatment.

On 10/21/13, Petitioner presented to Dr. Heller, who diagnosed Petitioner with an isolated long head biceps tendon rupture and administered a subacromial injection (Px2). On 10/21/13, Dr. Heller recommended Petitioner complete a course of physical therapy for her right shoulder. Petitioner continued to follow up with Dr. Heller and performed a course of physical therapy followed by work conditioning

On 1/3/14, Petitioner returned to Dr. Heller, who released Petitioner to return to work full duty to her position as a Laborer (Px2). Petitioner testified that she did, in fact, return to work full duty with no restrictions to her usual and customary position following Dr. Heller's release.

2nd Accident:

On 2/7/14, Petitioner was back to work as a Laborer for the Department of Streets and Sanitation. On 2/7/14, Petitioner was 42 years of age and had been employed by Respondent since 2012.

On 2/7/14, Petitioner was in a bucket and was attempting to start a chainsaw when she felt a "snap" in her right shoulder. Petitioner continued working. Later that day, Petitioner was

exiting a work truck when her foot slipped and her right shoulder struck the truck. Petitioner reported this incident and sought initial treatment at MercyWorks before referral to Dr. Heller of Midland Orthopedics.

On 3/18/14, Petitioner presented to Dr. Heller, who recommended additional physical therapy for Petitioner's right shoulder (Px2). Petitioner continued to follow up at Midland Orthopedics. On 4/21/14, Petitioner returned to Dr. Heller, who noted worsening function and recommended Petitioner for right shoulder surgery.

On 6/25/14, Petitioner presented to Dr. Scott Rubenstein for a second opinion (Px1). Dr. Rubenstein agreed with Dr. Heller's surgical recommendation, and Petitioner elected to have Dr. Rubenstein perform the surgery. Petitioner continued to follow up with Dr. Rubenstein and performed a course of physical therapy for her lower back.

On 2/7/15, Petitioner underwent surgery performed by Dr. Rubenstein consisting of right shoulder arthroscopy with debridement of partial-thickness rotator cuff tear and mini open biceps tenotomy (Px1). Following surgery, Petitioner continued to follow up with Dr. Rubenstein and performed a course of post-operative physical therapy.

On 8/26/15, Petitioner returned to Dr. Rubenstein, who recommended Petitioner undergo a Functional Capacity Evaluation (FCE) to determine her restrictions (Px1). On 9/14/15, Petitioner underwent an FCE at ATI, which placed at the Light Physical Demand Level. However, Petitioner's pre-injury capabilities are uncertain. Many of her FCE limitations were related to lumbar pain, which is unrelated to these claims. Finally, it is unclear if the assessment was conducted by a certified physical therapist (PT) or a person with a master's degree (MS) with an athletic trainer's certificate (ATC) (Px 10)

On 9/21/15, Petitioner returned to Dr. Rubenstein, who found Petitioner to have reached maximum medical improvement, and released her to return to work with restrictions consistent with the FCE's findings (Px1).

Respondent was unable to accommodate Petitioner's permanent restrictions and Petitioner was, subsequently, referred to Vocamotive for a vocational rehabilitation program.

On 12/22/16, Petitioner attended her initial appointment with Vocamotive (Px12). On 1/5/16, Petitioner attended a vocational testing appointment. Thereafter, Petitioner began a program with Vocamotive that included typing and computer skills training, along with job seeking skills instruction and vocational counseling.

On 3/8/16, Vocamotive issued a Progress report, which documented Petitioner's desire to return to work in Real Estate, a field in which she had extensive prior experience (Px12). On 4/17/16,

Vocamotive issued a Progress Report, which noted Petitioner's applications to Real Estate positions as well as Petitioner's inquiry regarding obtaining her Real Estate License.

On 6/19/16, Vocamotive issued a Progress Report that noted that Petitioner reported to Vocamotive staff that she was only interested in pursuing positions as a Real Estate agent or Property Claims Adjustor (Px12). The 6/19/16 Progress Report notes Petitioner's failure to follow up on a number of positions that fell outside of these self-imposed parameters.

On 7/20/16, Vocamotive issued a Progress Report that included a Labor Market Survey of the Real Estate Broker positions (Rx1). According to wage information obtained from Occupation Employment Statistical Data of the State of Illinois, the average annual salary for a Real Estate Broker in Illinois was reported as $78,950.00, and the average hourly salary was $37.96 with a median of $25.34. For the Chicago Metropolitan area, the average annual salary was reported as $79,950.00, with an average hourly salary of $38.44 and a median of $25.05.

Under the analysis portion of the 7/20/16 Progress Report, it is noted "[Petitioner] does not follow up with employers with whom she interviews until she is requested to do so (Rx1). She has not sent thank you letters voluntarily even though she has been instructed to do so. She does not place follow up phone calls or complete letters of interest when she does not hear back from employers."

Additionally included in the analysis portion of the 7/20/16 report is a note confirming that Petitioner's resume had, up until this point, falsely included past work experience as a Real Estate Agent (Rx1). As this was, in fact, untrue, Petitioner would need a semester long course rather than an abbreviated program to obtain her Broker's License.

With Vocamotive's assistance, Petitioner eventually obtained her Broker's License. On 4/14/17, Vocamotive issued a Final Report, which noted that all fees had been paid on behalf of Petitioner for her to pursue her career as a Realtor, and, furthermore, that Petitioner had obtained employment with Chicago Premier Realty (Px12).

At hearing, Petitioner submitted evidence and testimony indicating that, in the over-two-year-period that she has been employed as a Real Estate Broker, she has earned a total of $34,252.25. Petitioner testified that, since returning to work as a Broker, she has recently changed companies from Premier to Classic Realty Group on account of a higher commission percentage and greater networking support (Transcript at p. 50-52). Petitioner testified that, with further experience in the industry, she anticipates that her earnings will continue to rise (Transcript at p. 52).

Petitioner testified that, when she worked in Real Estate prior to 2008, she earned approximately $40,000 to $50,000 annually (Transcript at p. 56). Petitioner further testified that she felt she could return to that salary range with additional time spent working in the field (Transcript at p. 57).

At hearing, Petitioner's co-worker, Yanis Lebron, also offered testimony on behalf of Petitioner. On cross-examination, Ms. Lebron stated that her flexible schedule as a Realtor enables her to work another job part-time to supplement her income (Transcript at p. 73). Ms. Lebron also testified that she would not expect someone re-entering the field of Real Estate to have reached his or her true earning potential after only two or three years on the job (Transcript at p. 74). Ms. Lebron also stated that the approximately $78,000 average annual salary included in Vocamotive's Labor Market Survey would be a realistic figure for some of the more experienced Brokers in her office (Transcript at p. 78).

Conclusions on Law

To be compensable under the Workers Compensation Act, the injury complained of must be one "arising out of and in the course of the employment." *Ill.Rev.Stat.1991, ch. 48, par. 138.2.* The claimant has the burden of establishing both requirements. *Castaneda v. Indus. Comm'n (1983), 97 Ill.2d 338, 341, 73 Ill.Dec. 535, 454 N.E.2d 632.* 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. Indus. Comm'n (1974), 57 Ill.2d 38, 40, 310 N.E.2d 12.*

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

In this case, Petitioner's right shoulder condition is causally connected to her accidents on 10/2/13 and 2/7/14.

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

The Arbitrator finds that Respondent has paid all appropriate charges for all reasonable and necessary medical services.

In the alternative, to the extent that the Arbitrator finds that appropriate charges for reasonable and necessary medical services remain outstanding, the parties agreed that Respondent is entitled to an 8(j) credit for all bills processed under Petitioner's group health insurance plan and Respondent will hold Petitioner harmless with respect to these bills.

L) What is the nature and extent of the injury?, O) Other Issues: Wage Differential

In determining the level of Petitioner's disability, the Arbitrator considers five factors:

1) In this case, neither party entered an impairment rating into evidence; however, this alone does not preclude an award for permanent partial disability.

2) Petitioner was employed as a Laborer and, following her course of treatment, she was released with permanent restrictions that precluded her return to work in her usual and customary

position. Following participation in a vocational rehabilitation program, Petitioner secured employment as a Real Estate Broker. The Arbitrator places great weight on this factor.

3) Petitioner was 42 years of age on the dates of her accidents and, accordingly, is entering the latter half of her work life. The Arbitrator places some weight on this factor.

4) Petitioner's future earning capacity is indeterminate as Petitioner has failed to earn any wage even remotely approximating the typical earnings for an individual in her profession.

According to the evidence submitted at trial, Petitioner has earned $34,252.25 in the 2-3 year period since becoming a Broker. The Arbitrator notes that, using this figure, Petitioner has earned approximately $15,000 per year since returning to work as a Broker. At hearing, Petitioner acknowledged that the current minimum wage in the City of Chicago is $12.00 per hour (Transcript at p. 48). Therefore, in order for the Arbitrator to conclude that Petitioner's infrequent and sporadic commission checks accurately reflect her wage-earning *capacity*, the Arbitrator would be required to find that Petitioner is unable to earn the minimum wage ($12.00 X 40 hrs/week = $480.00; $480 X 52 weeks/year = $24,960.00 annually). Nothing in the records suggest that Petitioner is incapable of acquiring light-duty minimum wage work, and, therefore, Petitioner's contention that she is entitled to a wage differential based on the $34,252.25 figure is untenable on its face.

As the Arbitrator has concluded that the $34,252.25 figure does not accurately reflect Petitioner's wage-earning *capacity*, the issue becomes whether or not there is other evidence of wage-earning capacity that can be applied to a wage differential analysis. The only other evidence that provides specific wage-earning information is contained Vocamotive's Labor Market Survey, which found that the average annual salary for a Real Estate Broker in Illinois was reported as $78,950.00, and the average hourly salary was $37.96 with a median of $25.34. For the Chicago Metropolitan area, the average annual salary was reported as $79,950.00, with an average hourly salary of $38.44 with a median of $25.05. Using these figures, Petitioner has not sustained a loss of wage-earning capacity but, instead, has the potential to earn much more than she did as a Laborer.

Petitioner, for her part, testified that her wage-earning prospects have risen recently as she transitioned to a new company and, furthermore, she expects that her wage-earning capacity will continue to rise going forward. Specifically, Petitioner testified that she believes herself to be capable of returning to the $40,000 to $50,000 salary range that she had achieved in her Real Estate work prior to 2008.

Ms. Lebron likewise testified that, with additional experience and networking, Brokers at their company can reach salary ranges consistent with Labor Market Survey's findings.

As Petitioner's future earning capacity is indeterminate, the Arbitrator places less weight on this factor.

5) The treating medical records in this case corroborate Petitioner's right shoulder injuries. The Arbitrator places some weight on this factor.

As a result of the injuries sustained, Petitioner is entitled to have and receive from Respondent 175 weeks at a rate of $468.00 per week because she sustained 20% loss of use of her right arm (biceps tendon rupture, mini-biceps tenotomy) and 25% loss of the person as a whole (partial rotator cuff tear with job loss).

Is Petitioner entitled to penalties/attorney's fees under Sections 19(k), 19(l) and/or 16.

In this case, Respondents' refusal to issue wage differential benefits was neither unreasonable nor vexatious as there existed a legitimate and good-faith dispute as to what, if any, wage differential benefits were due. Calculation of benefits was further complicated by the fact that Petitioner's earnings were infrequent and sporadic. Furthermore, as Respondent's contention that Petitioner sustained no loss in earning capacity is supported by its Labor Market Survey, its position cannot be construed as unreasonable or vexatious. Accordingly, Petitioner's request for penalties and attorney's fees is denied.

O) Other Issues: Overpayment of TTD on 13 WC 13550.

With respect to Petitioner's 10/2/13 accident, the parties stipulated to Petitioner's AWW of $777.77, TTD entitlement for 13 & 1/7 weeks, and Respondent's total TTD credit of $9,111.49. Therefore, the Arbitrator's calculations are as follows:

$777.77 X 2/3 = $518.51 (TTD rate)

13.14 weeks X $518.51 = $6,814.70 (TTD due)

$9,111.49 - $6,814.70 = $2,296.79

Accordingly, the Arbitrator finds that Respondent is entitled to a credit for a TTD overpayment in the amount of $2,296.79, which may be applied to the award on permanency.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	14WC015303
Case Name	VALES, ARCELIA v. CITY OF CHICAGO
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0327
Number of Pages of Decision	13
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Tyler Berberich
Respondent Attorney	Donald Chittick

DATE FILED: 6/28/2021

/s/Marc Parker, Commissioner
Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Arcelia Vales,
Petitioner,

vs.

No. 14 WC 015303
(Consolidated case: 14 WC 013550)

City of Chicago,
Respondent.

DECISION AND OPINION ON REVIEW

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

Prior to arbitration, the parties stipulated that Petitioner was entitled to 83 weeks of temporary total disability and 87-4/7 weeks of maintenance. Respondent claimed that it had paid Petitioner $43,973.39 in temporary total disability benefits and $44,720.00 in maintenance. In his decision, the Arbitrator acknowledged Respondent's credit for the amounts paid but omitted any reference in his findings to Petitioner's entitlement to 83 weeks of temporary total disability benefits for the period commencing February 18, 2014 through September 21, 2015 and 87-4/7 weeks of maintenance for the period commencing September 22, 2015 through May 26, 2017. Therefore, the Commission modifies the Arbitrator's Decision and, consistent with the parties' stipulation, awards Petitioner 83 weeks of temporary total disability benefits for the period commencing February 18, 2014 through September 21, 2015 and 87-4/7 weeks of maintenance for the period commencing September 22, 2015 through May 26, 2017, pursuant to §8(b) of the Act.

Additionally, Petitioner claimed that Respondent was liable for certain outstanding medical bills. Respondent demanded strict proof thereof. The Arbitrator found that Petitioner had received

all reasonable and necessary medical services and that Respondent had paid all appropriate charges for those services. However, one related reasonable and necessary bill remained outstanding at the time of arbitration. The Commission orders the Respondent to pay to Petitioner the $65.33 bill for services rendered by Midland Orthopedics, pursuant to §8(a) and §8.2 of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 1, 2019, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $518.51 per week for 83 weeks of temporary total disability benefits for the period commencing February 18, 2014 through September 21, 2015 and 87-4/7 weeks of maintenance for the period commencing September 22, 2015 through May 26, 2017, pursuant to §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner, pursuant to §8(a) and §8.2 of the Act, the $65.33 bill of Midland Orthopedics.

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.

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.

June 28, 2021

/s/ *Marc Parker*
Marc Parker

mp/dak
o-6/17/21
068

/s/ *Barbara N. Flores*
Barbara N. Flores

/s/ *Christopher A. Harris*
Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0327

VALES, ARCELIA
Employee/Petitioner

Case# **14WC015303**

14WC013550

CITY OF CHICAGO
Employer/Respondent

On 11/1/2019, 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 1.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0274 HORWITZ HORWITZ & ASSOC LTD
TYLER BERBERICH
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

0010 CITY OF CHICAGO DEPT OF LAW
D TAYLOR CHITTICK
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF **COOK**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Arcelia Vales
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **14** WC **15303**

Consolidated cases: **14 WC 13550**

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 **08-07-19**. 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 **Wage Differential**

FINDINGS

On **02-17-14**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**40,560.00**; the average weekly wage was $**780.00**.

On the date of accident, Petitioner was **43** 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 $**43,979.39** for TTD, $**0** for TPD, $**44,720.00** for maintenance, and $**0** for other benefits, for a total credit of $**88,699.39**.

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

ORDER

As a result of the injuries sustained, Petitioner is entitled to have and receive from Respondent 175.6 weeks at a rate of $468.00 per week because she sustained a 20% loss of her right arm (50.6) and 25% (125) loss of use of a person as a whole.

Petitioner's request for penalties and attorney's fees is denied.

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

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

Signature of Arbitrator

10-31-19
Date

NOV - 1 2019

Arcelia Vales v. City of Chicago

14 WC 13550 & 14 WC 15303

Statement of Facts

1st Accident:

On 10/2/13, Petitioner was employed as a Laborer for the Department of Streets and Sanitation – Forestry Operations. On 10/2/13, Petitioner was 42 years of age and had been employed by Respondent since 2012. According to VocaMotive records, her legal name is Arcelia Vale.

On 10/2/13, Petitioner was on duty and was tasked with pruning trees. As Petitioner lifted the pruner overhead she felt a "snap" in her right shoulder. Petitioner reported this incident and sought initial treatment at MercyWorks.

On 10/2/13, Petitioner sought consultation with Dr. Homer Diadula of MercyWorks, who assessed Petitioner with a right shoulder strain (Px6). On 10/4/13, Petitioner returned to Dr. Diadula, who recommended Petitioner for a right shoulder MRI.

On 10/10/13, Petitioner underwent a right shoulder MRI at Skan National Radiology Services (Px8). On 10/15/13, Petitioner returned to Dr. Diadula, who reviewed Petitioner's imaging and assessed Petitioner with a positive proximal rupture of the long head of the biceps tendon with distal refraction of the tendon. On 10/15/13, Dr. Diadula referred Petitioner to Dr. William Heller of Midland Orthopedics for further treatment.

On 10/21/13, Petitioner presented to Dr. Heller, who diagnosed Petitioner with an isolated long head biceps tendon rupture and administered a subacromial injection (Px2). On 10/21/13, Dr. Heller recommended Petitioner complete a course of physical therapy for her right shoulder. Petitioner continued to follow up with Dr. Heller and performed a course of physical therapy followed by work conditioning

On 1/3/14, Petitioner returned to Dr. Heller, who released Petitioner to return to work full duty to her position as a Laborer (Px2). Petitioner testified that she did, in fact, return to work full duty with no restrictions to her usual and customary position following Dr. Heller's release.

2nd Accident:

On 2/7/14, Petitioner was back to work as a Laborer for the Department of Streets and Sanitation. On 2/7/14, Petitioner was 42 years of age and had been employed by Respondent since 2012.

On 2/7/14, Petitioner was in a bucket and was attempting to start a chainsaw when she felt a "snap" in her right shoulder. Petitioner continued working. Later that day, Petitioner was

exiting a work truck when her foot slipped and her right shoulder struck the truck. Petitioner reported this incident and sought initial treatment at MercyWorks before referral to Dr. Heller of Midland Orthopedics.

On 3/18/14, Petitioner presented to Dr. Heller, who recommended additional physical therapy for Petitioner's right shoulder (Px2). Petitioner continued to follow up at Midland Orthopedics. On 4/21/14, Petitioner returned to Dr. Heller, who noted worsening function and recommended Petitioner for right shoulder surgery.

On 6/25/14, Petitioner presented to Dr. Scott Rubenstein for a second opinion (Px1). Dr. Rubenstein agreed with Dr. Heller's surgical recommendation, and Petitioner elected to have Dr. Rubenstein perform the surgery. Petitioner continued to follow up with Dr. Rubenstein and performed a course of physical therapy for her lower back.

On 2/7/15, Petitioner underwent surgery performed by Dr. Rubenstein consisting of right shoulder arthroscopy with debridement of partial-thickness rotator cuff tear and mini open biceps tenotomy (Px1). Following surgery, Petitioner continued to follow up with Dr. Rubenstein and performed a course of post-operative physical therapy.

On 8/26/15, Petitioner returned to Dr. Rubenstein, who recommended Petitioner undergo a Functional Capacity Evaluation (FCE) to determine her restrictions (Px1). On 9/14/15, Petitioner underwent an FCE at ATI, which placed at the Light Physical Demand Level. However, Petitioner's pre-injury capabilities are uncertain. Many of her FCE limitations were related to lumbar pain, which is unrelated to these claims. Finally, it is unclear if the assessment was conducted by a certified physical therapist (PT) or a person with a master's degree (MS) with an athletic trainer's certificate (ATC) (Px 10)

On 9/21/15, Petitioner returned to Dr. Rubenstein, who found Petitioner to have reached maximum medical improvement, and released her to return to work with restrictions consistent with the FCE's findings (Px1).

Respondent was unable to accommodate Petitioner's permanent restrictions and Petitioner was, subsequently, referred to Vocamotive for a vocational rehabilitation program.

On 12/22/16, Petitioner attended her initial appointment with Vocamotive (Px12). On 1/5/16, Petitioner attended a vocational testing appointment. Thereafter, Petitioner began a program with Vocamotive that included typing and computer skills training, along with job seeking skills instruction and vocational counseling.

On 3/8/16, Vocamotive issued a Progress report, which documented Petitioner's desire to return to work in Real Estate, a field in which she had extensive prior experience (Px12). On 4/17/16,

Vocamotive issued a Progress Report, which noted Petitioner's applications to Real Estate positions as well as Petitioner's inquiry regarding obtaining her Real Estate License.

On 6/19/16, Vocamotive issued a Progress Report that noted that Petitioner reported to Vocamotive staff that she was only interested in pursuing positions as a Real Estate agent or Property Claims Adjustor (Px12). The 6/19/16 Progress Report notes Petitioner's failure to follow up on a number of positions that fell outside of these self-imposed parameters.

On 7/20/16, Vocamotive issued a Progress Report that included a Labor Market Survey of the Real Estate Broker positions (Rx1). According to wage information obtained from Occupation Employment Statistical Data of the State of Illinois, the average annual salary for a Real Estate Broker in Illinois was reported as $78,950.00, and the average hourly salary was $37.96 with a median of $25.34. For the Chicago Metropolitan area, the average annual salary was reported as $79,950.00, with an average hourly salary of $38.44 and a median of $25.05.

Under the analysis portion of the 7/20/16 Progress Report, it is noted "[Petitioner] does not follow up with employers with whom she interviews until she is requested to do so (Rx1). She has not sent thank you letters voluntarily even though she has been instructed to do so. She does not place follow up phone calls or complete letters of interest when she does not hear back from employers."

Additionally included in the analysis portion of the 7/20/16 report is a note confirming that Petitioner's resume had, up until this point, falsely included past work experience as a Real Estate Agent (Rx1). As this was, in fact, untrue, Petitioner would need a semester long course rather than an abbreviated program to obtain her Broker's License.

With Vocamotive's assistance, Petitioner eventually obtained her Broker's License. On 4/14/17, Vocamotive issued a Final Report, which noted that all fees had been paid on behalf of Petitioner for her to pursue her career as a Realtor, and, furthermore, that Petitioner had obtained employment with Chicago Premier Realty (Px12).

At hearing, Petitioner submitted evidence and testimony indicating that, in the over-two-year-period that she has been employed as a Real Estate Broker, she has earned a total of $34,252.25. Petitioner testified that, since returning to work as a Broker, she has recently changed companies from Premier to Classic Realty Group on account of a higher commission percentage and greater networking support (Transcript at p. 50-52). Petitioner testified that, with further experience in the industry, she anticipates that her earnings will continue to rise (Transcript at p. 52).

Petitioner testified that, when she worked in Real Estate prior to 2008, she earned approximately $40,000 to $50,000 annually (Transcript at p. 56). Petitioner further testified that she felt she could return to that salary range with additional time spent working in the field (Transcript at p. 57).

At hearing, Petitioner's co-worker, Yanis Lebron, also offered testimony on behalf of Petitioner. On cross-examination, Ms. Lebron stated that her flexible schedule as a Realtor enables her to work another job part-time to supplement her income (Transcript at p. 73). Ms. Lebron also testified that she would not expect someone re-entering the field of Real Estate to have reached his or her true earning potential after only two or three years on the job (Transcript at p. 74). Ms. Lebron also stated that the approximately $78,000 average annual salary included in Vocamotive's Labor Market Survey would be a realistic figure for some of the more experienced Brokers in her office (Transcript at p. 78).

Conclusions on Law

To be compensable under the Workers Compensation Act, the injury complained of must be one "arising out of and in the course of the employment." *Ill.Rev.Stat.1991, ch. 48, par. 138.2.* The claimant has the burden of establishing both requirements. *Castaneda v. Indus. Comm'n (1983), 97 Ill.2d 338, 341, 73 Ill.Dec. 535, 454 N.E.2d 632.* 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. Indus. Comm'n (1974), 57 Ill.2d 38, 40, 310 N.E.2d 12.*

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

In this case, Petitioner's right shoulder condition is causally connected to her accidents on 10/2/13 and 2/7/14.

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

The Arbitrator finds that Respondent has paid all appropriate charges for all reasonable and necessary medical services.

In the alternative, to the extent that the Arbitrator finds that appropriate charges for reasonable and necessary medical services remain outstanding, the parties agreed that Respondent is entitled to an 8(j) credit for all bills processed under Petitioner's group health insurance plan and Respondent will hold Petitioner harmless with respect to these bills.

L) What is the nature and extent of the injury?, O) Other Issues: Wage Differential

In determining the level of Petitioner's disability, the Arbitrator considers five factors:

1) In this case, neither party entered an impairment rating into evidence; however, this alone does not preclude an award for permanent partial disability.

2) Petitioner was employed as a Laborer and, following her course of treatment, she was released with permanent restrictions that precluded her return to work in her usual and customary

position. Following participation in a vocational rehabilitation program, Petitioner secured employment as a Real Estate Broker. The Arbitrator places great weight on this factor.

3) Petitioner was 42 years of age on the dates of her accidents and, accordingly, is entering the latter half of her work life. The Arbitrator places some weight on this factor.

4) Petitioner's future earning capacity is indeterminate as Petitioner has failed to earn any wage even remotely approximating the typical earnings for an individual in her profession.

According to the evidence submitted at trial, Petitioner has earned $34,252.25 in the 2-3 year period since becoming a Broker. The Arbitrator notes that, using this figure, Petitioner has earned approximately $15,000 per year since returning to work as a Broker. At hearing, Petitioner acknowledged that the current minimum wage in the City of Chicago is $12.00 per hour (Transcript at p. 48). Therefore, in order for the Arbitrator to conclude that Petitioner's infrequent and sporadic commission checks accurately reflect her wage-earning *capacity*, the Arbitrator would be required to find that Petitioner is unable to earn the minimum wage ($12.00 X 40 hrs/week = $480.00; $480 X 52 weeks/year = $24,960.00 annually). Nothing in the records suggest that Petitioner is incapable of acquiring light-duty minimum wage work, and, therefore, Petitioner's contention that she is entitled to a wage differential based on the $34,252.25 figure is untenable on its face.

As the Arbitrator has concluded that the $34,252.25 figure does not accurately reflect Petitioner's wage-earning *capacity*, the issue becomes whether or not there is other evidence of wage-earning capacity that can be applied to a wage differential analysis. The only other evidence that provides specific wage-earning information is contained Vocamotive's Labor Market Survey, which found that the average annual salary for a Real Estate Broker in Illinois was reported as $78,950.00, and the average hourly salary was $37.96 with a median of $25.34. For the Chicago Metropolitan area, the average annual salary was reported as $79,950.00, with an average hourly salary of $38.44 with a median of $25.05. Using these figures, Petitioner has not sustained a loss of wage-earning capacity but, instead, has the potential to earn much more than she did as a Laborer.

Petitioner, for her part, testified that her wage-earning prospects have risen recently as she transitioned to a new company and, furthermore, she expects that her wage-earning capacity will continue to rise going forward. Specifically, Petitioner testified that she believes herself to be capable of returning to the $40,000 to $50,000 salary range that she had achieved in her Real Estate work prior to 2008.

Ms. Lebron likewise testified that, with additional experience and networking, Brokers at their company can reach salary ranges consistent with Labor Market Survey's findings.

As Petitioner's future earning capacity is indeterminate, the Arbitrator places less weight on this factor.

5) The treating medical records in this case corroborate Petitioner's right shoulder injuries. The Arbitrator places some weight on this factor.

As a result of the injuries sustained, Petitioner is entitled to have and receive from Respondent 175 weeks at a rate of $468.00 per week because she sustained 20% loss of use of her right arm (biceps tendon rupture, mini-biceps tenotomy) and 25% loss of the person as a whole (partial rotator cuff tear with job loss).

Is Petitioner entitled to penalties/attorney's fees under Sections 19(k), 19(l) and/or 16.

In this case, Respondents' refusal to issue wage differential benefits was neither unreasonable nor vexatious as there existed a legitimate and good-faith dispute as to what, if any, wage differential benefits were due. Calculation of benefits was further complicated by the fact that Petitioner's earnings were infrequent and sporadic. Furthermore, as Respondent's contention that Petitioner sustained no loss in earning capacity is supported by its Labor Market Survey, its position cannot be construed as unreasonable or vexatious. Accordingly, Petitioner's request for penalties and attorney's fees is denied.

O) Other Issues: Overpayment of TTD on 13 WC 13550.

With respect to Petitioner's 10/2/13 accident, the parties stipulated to Petitioner's AWW of $777.77, TTD entitlement for 13 & 1/7 weeks, and Respondent's total TTD credit of $9,111.49. Therefore, the Arbitrator's calculations are as follows:

$777.77 X 2/3 = $518.51 (TTD rate)

13.14 weeks X $518.51 = $6,814.70 (TTD due)

$9,111.49 - $6,814.70 = $2,296.79

Accordingly, the Arbitrator finds that Respondent is entitled to a credit for a TTD overpayment in the amount of $2,296.79, which may be applied to the award on permanency.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC031293
Case Name	FLEMING, BRIAN v. KEYSTONE FREIGHT
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0328
Number of Pages of Decision	13
Decision Issued By	Deborah Simpson, Commissioner

Petitioner Attorney	Brenton Schmitz
Respondent Attorney	Mark Vizza

DATE FILED: 6/30/2021

/s/Deborah Simpson, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF LaSALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRIAN FLEMING,

Petitioner,

vs. NO: 19 WC 31293

NATIONAL RETAIL SYSTEMS/
KEYSTONE FREIGHT,

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, casual connection, TTD, and medical expenses both current and prospective, and being advised of the facts and law, changes 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 agrees with the analysis and reasoning of the Arbitrator and affirms the Decision of the Arbitrator. However, the Commission notes a clerical error in the decision, in which the Arbitrator awarded Petitioner "39.9" weeks of TTD. Upon our calculations, the correct TTD period should be 39&6/7 weeks and the Commission changes the Decision of the Arbitrator accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $540.04 per week for a period of 39&6/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $9,625.40 for current medical expenses as specified in the Decision of the Arbitrator under §8(a) of the Act, subject to the applicable medical fee schedule in §8.2.

IT IS FURTHER ORDERED BY THE COMMISSION, that Respondent authorize and pay for prospective surgery recommended by Dr. Giannoulias, in the form of left-shoulder labral repair and paralabral cyst decompression, including reasonable and necessary associated treatment.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $50,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

/s/*Deborah L. Simpson*
Deborah L. Simpson

June 30, 2021

/s/*Steven J. Mathis*
Steven J. Mathis

DLS/dw
O-5/5/21
46

/s/*Deborah J. Baker*
Deborah J. Baker

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0328
NOTICE OF 19(b) ARBITRATOR DECISION

FLEMING, BRIAN
Employee/Petitioner

Case# **19WC031293**

NATIONAL RETAIL SYSTEMS/KEYSTONE FREIGHT
Employer/Respondent

On 8/31/2020, 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 0.12% 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:

2553 McHARGUE & JONES LLC
BRENTON M SCHMITZ
123 W MADISON ST 18TH FL
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA PC
MARK VIZZA
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSalle)

☐ 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)

Brian Fleming
Employee/Petitioner

v.

National Retail Systems/Keystone Freight
Employer/Respondent

Case # **19** WC **31293**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Ottawa, IL**, on **July 31, 2020**. 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, **9/24/19**, 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's average weekly wage was $**810.06**.

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 $**9,721.08** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**9,721.08**.

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

ORDER

1. Petitioner is entitled to prospective medical care, in the form of a left shoulder labral repair and paralabral cyst decompression as recommended by Dr. Giannoulias. Respondent shall authorize and pay for the same.

2. Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of:

   $516.43 to Illinois Orthopedic Network
   $489.24 to Midwest Specialty Pharmacy
   $2,019.73 to ATI Physical Therapy, and
   $6,600.00 to Gray Medical, as provided in Sections 8(a) and 8.2 of the Act.

3. Respondent shall pay Petitioner temporary total disability benefits of $540.04/week for 39.9 weeks, commencing 10/26/2019 through 7/31/2020, as provided in Section 8(b) of the Act. Respondent is entitled to a credit of $9721.08 under Section8(j) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Susan C. Mgatz

Signature of Arbitrator

8-27-2020
Date

ICArbDec19(b)

AUG 31 2020

STATE OF ILLINOIS)
) SS
COUNTY OF LASALLE)

BEFORE THE ILLINOIS WORKERS COMPENSATION COMMISSION
IN THE STATE OF ILLINOIS

BRIAN FLEMING,	)	
	)	
Petitioner,	)	
	)	Number: 19 WC 31293
vs.	)	
	)	
NATIONAL RETAIL SYSTEMS/	)	
KEYSTONE FREIGHT,	)	
	)	
	)	
Respondents.	)	

STATEMENT OF FACTS

This matter proceeded to hearing before the Arbitrator on July 31, 2020 in Ottawa, Illinois (Arb. 1).

Petitioner allegedly sustained a work-related, left arm injury while disconnecting his loaded trailer from his truck on September 24, 2019. He wishes to undergo left shoulder surgery as recommended by his treating orthopedic physician. Respondent disputes accident, causation, medical bills, TTD and prospective medical treatment (Id.).

Petitioner's Testimony

Petitioner, a truck driver, arrived at a Macy's department store loading dock in Grandville, Michigan just after midnight on September 24, 2019 after hauling a loaded freight trailer for 4 hours from Minooka, Illinois (Tx 7-9, 13).

At the loading dock, Petitioner first had to detach his loaded trailer from his truck which he connected to an empty trailer parked in dock and moved to the parking lot. He then re-attached the loaded trailer which he backed into the loading dock. Petitioner got out of his truck and attempted to detach the loaded trailer but could not pull the fifth wheel lever that releases the trailer (Id. 9) Petitioner testified the bottom of the trailer was 3 ½ to 4 feet from the ground. He had to bend over and reach under the trailer where the fifth wheel connects to the tractor and pull a level that releases the jaw that holds the trailer lock to the tractor (Id. 10). He tried pulling with his right arm a couple of times and it would not move (Id.). He tried with his left arm in a different position where he could get a different angle to no avail (Id.). He got back in his cab and tried to adjust the tractor by pulling up and back a little (Id.). He got of his cab and tried again with his left arm and felt a pull in the top of his eft shoulder (Id. 11). He took a minute off, rubbed his left shoulder and then grabbed the lever with his right hand and successfully released the trailer (Id. 12).

Petitioner then finished his work at Macy's, which involved attaching an empty trailer to his truck and filling out his logs, before he drove for approximately a half hour to a truck stop where he stopped for the night (Id). Petitioner testified he was nearly out of legal driving hours and had to make the stop at around 1:30 or 2:00 am (Id.13). Based on this recollection, Petitioner believed the injury to his left shoulder occurred sometime between 12:30am and 1:00am (Id).

Petitioner testified that he felt pain in his left arm that evening at the truck stop and couldn't fall asleep right away (Id). The next morning, he drove back to Minooka, IL, arriving at approximately 4:00 pm (Id). He spoke with Bill Alexopoulos, the terminal manager, and reported the incident (Id. 14). Bill told Petitioner he could see a doctor if his shoulder didn't feel better in a week or two (Id).

Petitioner testified he continued working for another week-and-a-half and noted reduced left arm strength at which time Bill, sent Petitioner for medical care.

Regarding his current condition, Petitioner testified he feels pain in his shoulder down to the elbow and has difficulty and pain with lifting (Tx 17-18). He cannot lift a two-pound jar of peanut butter up into a cabinet. He is able to get his left arm over his head, but it causes pain (Id. at 18). Prior to the accident, Petitioner had no accidents, injuries, or medical treatment involving his left shoulder (Id. at 20).

Petitioner has followed up with Respondent, who has not offered any light duty work (Id.).

He wishes to undergo the surgery being recommended (Id. at 17).

Medical Records

Triage records from Physicians Immediate Care reflect that on October 8, 2019, Petitioner arrived at approximately 10:25 am reporting a history of "pulling a handle to release a trailer, felt pain [in] the Lt shoulder. Occurred 2 weeks ago" (Px1; Rx1). Petitioner's chief complaint was "constant joint pain of the left shoulder since Tue. Sep 10, 2019" (Id.).

A history on the same page noted:

> *The patient reports it was the result of an injury that occurred on 9/10/2019, which was work related, which had a sudden onset. The patient had no similar problems in the past. This is not the result of a motor vehicle accident. Patient denies that any non-work related event or illness possible contributed to or is related to development of symptoms. Pt c/o L shoulder pain and weakness sustained over 2 wks ago at work after repetitive pulling. He reports continuing work even after sustaining injury. He took some ibuprofen to alleviate pain. However, pain has worsened and now he had weakness of L shoulder* (Id.).

On exam, Dr. Kathleen Talamayan noted left lateral and anterior shoulder and bicipital groove tenderness along with positive Speed and O'Brien tests. Petitioner had pain and difficulty raising his left arm past 90 degrees flexion (Id.). Petitioner was discharged at 10:47 am with instructions to ice and take Tylenol and Ibuprofen alternatively. A left shoulder MRI was ordered, and light duty restrictions were imposed (Id.).

Petitioner testified that no light duty work was made available to him by Respondent (Tx15-16).

On October 18, 2019 Petitioner followed up at Physicians Immediate Care reporting no improvement since the last visit.

On exam, positive Speed and O'Brien's along with the inability to raise his left arm above 90 degrees were noted (Px1). Apparently, Petitioner had attempted to have the MRI performed but was unable to tolerate due to anxiety. A sedative was prescribed which Petitioner was instructed to take 30 minutes prior to his MRI (Id.).

On October 21, 2019 Petitioner presented for a left shoulder MRI. The report notes the following:

1. An anterior superior and posterior superior labral tear with extension into the posterior inferior labrum. There is a cluster of paralabral cysts adjacent to the posterior inferior labrum measuring 1.8 x 1.9 x 0.5 cm. and;

2. Feathery edema of the infraspinatus muscle which can be related to muscle strain or denervation edema and:

3. Mild acromioclavicular joint arthritis (Px2).

On October 24, 2019 Petitioner followed up at Physicians Immediate Care (Px1). Dr. Talamayan reviewed the recent left shoulder MRI noting a labral tear with paralabral cysts (Id.). Petitioner was referred to an orthopedic physician and his light duty restrictions were continued (Id.).

On October 28, 2019 Petitioner presented to Dr. Eugene Lipov (Anesthesiology and Pain Management) at the Illinois Orthopedic Network reporting a history of a September 24, 2019 work-related injury after pulling a lever up underneath a trailer causing acute pain, pulling and a pop in his left shoulder (Px2). Petitioner denied any history of prior left shoulder pain (Id.).

On exam, Dr. Lipov noted biceps tenderness, active forward flexion to 140 degrees and the ability to passively elevate to 180 degrees. Full abduction pain with resisted abduction was noted along with negative Hawkins and Neers. Dr. Lipov reviewed the recent MRI noting an anterior, superior and posterior superior labral tear with extension of the posterior and inferior labrum, as well as infraspinatus edema (Id.). Dr. Lipov referred Petitioner to an orthopedic physician, Dr. Giannoulias, recommended physical therapy and prescribed anti-inflammatory medication. Dr. Lipov noted a diagnosis of a labral tear in the anterior aspect of the left shoulder and restricted Petitioner from lifting, pulling, pushing in excess of 20 pounds (Id.).

On November 5, 2019 orthopedic surgeon, Dr. Christos Giannoulias, noted Petitioner presented for initial consult regarding his left shoulder (Px2). Petitioner reported a history of injury to his left shoulder at work when he was pulling on a bar to help pry something out followed by sharp, stabbing left shoulder pain (Id.). Dr. Giannoulias reviewed the MRI noting "some labral tear in the anterior aspect of the shoulder" along with "some cartilage degeneration as well" (Id.). The doctor recommended conservative treatment, light duty work if tolerated, And follow up in one month's time (Id.).

Petitioner began physical therapy at ATI on November 6, 2019 at which time he reported a history of a work-related accident after he "reached under the truck to pull the lever to unhook trailer" when he felt something pull in the left shoulder. Petitioner complained of left shoulder ached down to his left elbow limiting the inability to sleep or lift anything over his head (Px2).

On November 27, 2019 Petitioner presented to the Pain & Spine Institute where he reported a history of a September 24, 2019 work-related accident to his left shoulder after pulling a pin underneath a truck.

On December 3, 2019 Petitioner followed up with Dr. Giannoulias at G&T Orthopedics and Sports Medicine with continued left shoulder complaints (Id.). On exam, the doctor noted weakness of 4/5 in elevation and external rotation and pain with O'Brien's maneuver (Id.). Dr. Giannoulias noted the following:

> *I do feel that he needs surgery. At this point the cyst is compressing the nerve and he is getting weakness from that. We want to do this sooner rather than later that this does not become more long term and he starts developing atrophy in the infraspinatus muscles.*

On January 8, 2020 pursuant to Respondent's Section 12 request, Petitioner presented to Dr. Michael Cohen of DuPage Medical Group Orthopedics (Id. at 20). Petitioner reported a work-related accident to his shoulder after pulling a handle to release a trailer underneath his truck on September 24, 2019 (Rx1). Dr. Cohen reviewed the October 21, 2019 MRI noting a "degenerative-type SLAP tear with multiple paralabral cysts" (Id.). He further noted, "there is not significant glenohumeral effusion, and there is some signal change in the infraspinatus muscle consistent with a muscle strain" (Id.).

Dr. Cohen opined that Petitioner sustained a strain to his left shoulder on September 24, 2019 which correlates "with some signal change on the MRI in the infraspinatus muscle" (Id.). Dr. Cohen opined the "labral changes" on the MRI "are accompanied by paralabral cysts, and no glenohumeral effusion, less than 4 weeks from the date of injury and, therefore appear to be chronic". He asserted the labral changes, and paralabral cysts were both "incidental findings" predating the accident. The doctor recommended an EMG to address possible nerve compression but thought there were no indications for a labral repair based on Petitioner's exam and/or subjective complaints. Additionally, Dr. Cohen noted "a labral repair in a 58-year-old gentleman is unlikely to be successful" (Id.).

On February 11, 2020 Petitioner followed up with Dr. Giannoulias reporting no significant changes in his symptoms despite physical therapy (Px2). On exam, positive O'Brien's was noted, pain with resisted elevation, significant weakness in external rotation with specific testing of the infraspinatus muscle. Dr. Giannoulias noted the "paralabral cyst is directly responsible" for Petitioner's weakness. The doctor further noted, "if this persists, he will have permanent weakness in his shoulder".

Dr. Cohen authored an addendum report dated February 4, 2020 opining that any nerve compression would be anatomic and not related to the work accident (Id. at 27).

CONCLUSIONS OF LAW

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

Petitioner presented at the hearing as a credible witness. His tone of voice, gestures, mannerisms and facial expressions left the Arbitrator with the impression that he was honest and trustworthy. After reviewing the medical records in evidence, the Arbitrator finds his testimony is corroborated by such.

Petitioner testified the accident occurred on September 24, 2019, just after midnight (Tx8). He reported the injury as soon as he returned to Minooka, IL, the same day (Id. 13-14). When first seen at Physicians Immediate Care on October 8, 2019, the triage notes indicate a history consistent with his testimony, noting "Pt was pulling a handle to release the trailer, felt pain the Lt shoulder. Occurred 2 weeks ago" (Px1 at 5; emphasis added). The Arbitrator notes that October 8, 2019 is exactly 14 days following September 24, 2019.

The medical records of Dr. Lipov, Dr. Giannoulias, and Petitioner's physical therapists contain histories of the accident that corroborate Petitioner's testimony as does the report of Respondent's IME.

Respondent presented no witnesses to refute Petitioner's credible testimony.

Based on a preponderance of the credible evidence, the Arbitrator finds Petitioner suffered an accident arising out of and in the course of his employment by Respondent.

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

The Arbitrator finds that Petitioner's current condition of ill-being of a left shoulder partial labral tear with paralabral cysts causing nerve compression is causally related to his September 24, 2019 work accident. The Arbitrator relies on the credible testimony of the Petitioner, the medical records in evidence and the opinions of Dr. Giannoulias which the Arbitrator found more persuasive than the opinions of Respondent's Section 12 examiner, Dr. Michael Cohen.

Petitioner credibly testified he had no history of left shoulder complaints or issues prior to his accident. No evidence contained in the record refutes this testimony. On September 24, 2019 he suffered a pulling injury to his left shoulder, causing the immediate on set of pain, which became worse over the following weeks.

In the first treating record, 14 days following the accident, Dr. Kathleen Talamayan noted left lateral and anterior shoulder and bicipital groove tenderness along with positive Speed and O'Brien tests. Petitioner had pain and difficulty raising his left arm past 90 degrees flexion (Id.).

Less than a month following the accident a left shoulder MRI noted an "anterior superior and posterior superior labral tear with extension into the posterior inferior labrum" and "a cluster of paralabral cysts adjacent to the posterior inferior labrum measuring 1.8 x 1.9 x 0.5 cm" and "feathery edema of the infraspinatus muscle which can be related to muscle strain or denervation edema" along with mild acromioclavicular joint arthritis (Px2).

Dr. Giannoulias opined that Petitioner suffered a partial labral tear, which caused the formation of post-traumatic paralabral cysts which are compressing a nerve in Petitioner's shoulder:

I do feel that he needs surgery. At this point the cyst is compressing the nerve and he is getting weakness from that. We want to do this sooner rather than later that this does not become more long term and he starts developing atrophy in the infraspinatus muscles.

Respondent relies on the Section 12 opinions of Dr. Cohen, who believes that Petitioner suffered only a shoulder strain, and that any other issues are preexisting and degenerative. However, Dr. Cohen does not address Petitioner's condition of good health in his shoulder prior to the accident.

The Arbitrator finds that the preponderance of evidence contained in the record supports a finding that the Petitioner's labral tearing and paralabral cysts were either caused or aggravated by the work accident, such that Petitioner now requires surgical intervention.

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

Having found for Petitioner on the issues of accident and causal connection, and after reviewing the medical records and bills contained in the record, the Arbitrator finds the medical treatment provided thus far was reasonable and necessary. Dr. Cohen did not comment on the reasonableness or necessity of Petitioner's medical treatment. The Arbitrator has reviewed Petitioner's course of treatment in detail, including office visits, diagnostics, physical therapy, prescription medication, and finds all past treatment to be reasonable, necessary, and causally related to the work accident.

Respondent shall pay reasonable and necessary medical servicespursuant to the medical feeschedule, of:

$516.43 to Illinois Orthopedic Network
$489.24 to Midwest Specialty Pharmacy
$2,019.73 to ATI Physical Therapy, and
$6,600.00 to Gray Medical, as provided in Sections 8(a) and 8.2 of the Act.

L. What temporary benefits are in dispute?

The Arbitrator finds that Petitioner is entitled to TTD benefits from October 26, 2019 through July 31, 2020, the date of trial, based on a preponderance of the credible evidence contained in the record. Respondent is credited for $9,721.08 in TTD benefits, covering October 26, 2019 through February 28, 2020. Benefits to be paid at a weekly rate of $540.04.

K. Is Petitioner entitled to any prospective medical care?

Based on a preponderance of the credible evidence contained in the record including the opinions of Dr. Giannoulias, the Arbitrator finds Petitioner in entitled to the left shoulder labral repair and paralabral cyst decompression as recommended by Dr. Giannoulias.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	19WC029159
Case Name	CORSO, JOSEPH v. URSA LOGISTICS
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0329
Number of Pages of Decision	12
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Thomas Rich
Respondent Attorney	Khristopher Dunard

DATE FILED: 6/30/2021

/s/Deborah Baker, Commissioner

Signature

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 Permanent Disability	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOSEPH CORSO,

Petitioner,

vs. NO: 19 WC 29159

URSA LOGISTICS,

Respondent.

DECISION AND OPINION ON REVIEW

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

CONCLUSIONS OF LAW

The Arbitrator concluded Petitioner's right middle finger injury merited an award of loss of use of the hand. The Commission views the evidence differently.

There are two avenues by which a claimant with a finger injury can establish permanent disability as loss of use of the hand: 1) statutorily under §8(e)9, or 2) the evidence establishes the disability to the finger affects the functionality of the hand. Section 8(e)9 provides as follows:

> The loss of 2 or more digits, or one or more phalanges of 2 or more digits, of a hand may be compensated on the basis of partial loss of use of a hand, provided, further, that the loss of 4 digits, or the loss of use of 4 digits, in the same hand shall constitute the complete loss of a hand. *820 ILCS 305/8(e)9.*

In the instant matter, Petitioner suffered an injury to only one joint of one digit: the metacarpophalangeal joint of his right middle finger. As such, his injury does not come under the umbrella of §8(e)9. Therefore, to qualify for permanent disability to the hand, the evidence must establish that the disability to Petitioner's right middle finger affects the functionality of his hand. The Commission finds Petitioner's strength and motion deficits and the difficulties he described are not so burdensome as to equate to a loss of the hand. The Commission finds Petitioner's permanent disability is properly measured as a loss of use of a finger.

Section 8.1b(b)(i) – impairment rating

Neither party submitted an impairment rating. As such, the Commission assigns no weight to this factor and will assess Petitioner's permanent disability based upon the remaining enumerated factors.

Section 8.1b(b)(ii) – occupation of the injured employee

Petitioner resumed his pre-accident job as a truck driver. The Commission observes that while Petitioner returned to work without restrictions, his job requires frequent gripping, squeezing, lifting, pulling, and tugging, and Petitioner experiences increased pain and swelling while performing his job duties. T. 20, 16-17. Petitioner credibly testified his pain occasionally reaches 10/10 when he is working. T. 20. The Commission finds this factor is indicative of increased permanent disability.

Section 8.1b(b)(iii) – age at the time of the injury

Petitioner was 54 years old on the date of his accidental injury. Petitioner is past middle age and as an older person, his ability to adapt to his residual deficits is diminished. The Commission finds this weighs in favor of increased permanent disability.

Section 8.1b(b)(iv) – future earning capacity

Petitioner returned to his pre-accident job with Respondent. As such, there is no evidence Petitioner's work injury adversely affected his future earning capacity as a truck driver. However, his finger injury does prevent Petitioner from playing the drums, and as such, he is no longer booked for paid gigs. The Commission finds the fact that Petitioner's truck driving earnings are unaffected is indicative of decreased permanent disability, while his loss of occasional drumming earnings is indicative of increased permanent disability.

Section 8.1b(b)(v) – evidence of disability corroborated by treating medical records

Petitioner testified he has baseline pain in the finger at 2/10, and his pain increases with the gripping, squeezing, lifting, pulling, and tugging activities he must do on a frequent basis. T. 20. The Commission observes Petitioner's testimony of activity-driven pain is corroborated by the March 18, 2020 Functional Status Report: "Chief complaint remains pain in [right middle finger metacarpophalangeal joint] with resistive or prolonged gripping." Pet.'s Ex. 6. The Functional Status Report also demonstrates decreased middle finger range of motion as well as decreased

finger grip strength on his dominant side. Pet.'s Ex. 6. We note Dr. Naam documented the same deficits: "Total [active range of motion] of right long finger is 251 degrees compared to 260 degrees on the left…five-position grip strength testing [Right/Left]: 1) 29/54, 2) 76/100, 3) 75/98, 4) 78/90, 5) 65/83." Resp.'s Ex. 1, Dep. Ex. 3. The Commission further emphasizes Petitioner's right middle finger metacarpophalangeal joint was still visibly swollen as of the September 11, 2020 hearing. T. 13-14. The Commission finds the medical records corroborate Petitioner's claim of disability as to his right middle finger and weigh in favor of increased permanent disability.

Based on the above, the Commission finds Petitioner sustained 50% loss of use of the right middle finger.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 13, 2020, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $484.30 per week for a period of 19 weeks, as provided in §8(e)3 of the Act, for the reason that the injuries sustained caused 50% loss of use of the right middle finger.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of 10% loss of use of the right hand is vacated.

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 the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $9,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

June 30, 2021

/s/ *Deborah J. Baker*

DJB/mck

O: 6/9/21

/s/ *Stephen Mathis*

43

/s/ *Deborah L. Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

21IWCC0329

CORSO, JOSEPH
Employee/Petitioner

Case# **19WC029159**

URSA LOGISTICS
Employer/Respondent

On 10/13/2020, 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 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0000 WIEDNER & McAULIFFE LTD
JUAN ARIAS
101 S HANLEY RD SUITE 1450
ST LOUIS, MO 63105

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

Joseph Corso
Employee/Petitioner

v.

URSA Logistics
Employer/Respondent

Case # **19** WC **29159**

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 **Frank Soto**, Arbitrator of the Commission, in the city of **Herrin, Illinois**, on **September 11, 2020**. By stipulation, the parties agree:

On the date of accident, **July 2, 2019**, 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 $**807.16**, and the average weekly wage was $**41,972.32**.

At the time of injury, Petitioner was **54** years of age, ***single*** with **0** dependent children.

Necessary medical services and temporary compensation benefits have been **or will be** provided by Respondent.

Respondent shall be given a credit of $**All TTD Paid** for TTD, $**N/A** for TPD, $**N/A** for maintenance, and $**N/A** for other benefits, for a total credit of $**All TTD 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 **$484.30**/week for a further period of **20.50** weeks, as provided in Section **8(e)9** of the Act, because the injuries sustained caused the **10% loss of Petitioner's right hand as a result of serious and permanent injuries sustained to Petitioner's right hand/right long finger.**

Respondent shall pay Petitioner compensation that has accrued from **07/02/2019** through **09/11/2020**, 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

10/1/2020
Date

OCT 13 2020

FINDINGS OF FACT

This matter came before an Arbitrator appointed by the Commission on Petitioner's motion for a hearing on all issues. The only issue in dispute was the nature and extent of Petitioner's injuries. (T. 6) Petitioner is employed as a truck driver for URSA Logistics. (T. 10) The parties stipulated that he sustained accidental injuries on June 25, 2019, when, while attempting to loosen a strap that secured his load to mail carts in the back of his trailer, he had to pull on it harder than usual and when he did, he felt a snapping sensation in his hand along with pain over the middle knuckle on his dominant right hand. (T. 10, 11) Prior to June 25, 2019, Petitioner had carpal tunnel surgery which had been asymptomatic up to the date of the accident. (T. 22, 23)

Immediately following the incident, Petitioner presented to SIH Work Care Medicine Clinic and gave the consistent history of the injury. (PX3, 6/27/19) X-rays were taken which suggested no acute fracture or dislocation, and Petitioner's diagnosis was not yet clear. *Id.* He was instructed to use ice and Ibuprofen, and was referred to Dr. Young, an orthopedic hand specialist. *Id.* Petitioner returned to SIH Work Care Medicine Clinic on July 5, 2019, with worsening symptoms. (PX3, 7/5/19) Petitioner noticed swelling along his knuckle even though he was taking over-the-counter medications. *Id.* He was not working, as there was no light duty available. *Id.* He still had swelling along the dorsal aspect of the MCP joint, and had crepitus with palpation and quite a bit of pain. *Id.* Once again, the recommendation was made for a referral to Dr. Young and it was noted that approval had not yet been not forthcoming. *Id.*

Petitioner returned to SIH Work Care one week later on July 12, 2019, where it was again noted that Petitioner had ongoing symptoms, and again, Petitioner was recommended to see Dr. Young for an evaluation. (PX3, 7/12/19) The physician's assistant, Ms. Lashway, was concerned that Petitioner had a possible partial tear or subluxation. *Id.* Ms. Lashway kept petitioner on light duty. *Id.*

Six days later, and over three and a half weeks after the accident, Petitioner was finally allowed to be evaluated at Dr. Young's office. (PX4, 7/30/19) On July 30, 2019, he saw Dr. Young's nurse practitioner, who took the history of the injury, noted that Petitioner was having ongoing symptoms, and recommended an MRI scan. *Id.* The MRI was performed on August 5, 2019, the impression of which was moderate to severe subchondral cystic change of the third PIP joint. (PX5) The radiologist felt that this could be post-traumatic, however, needed correlation "for rheumatoid arthritis or gouty arthritis." *Id.* A high-grade partial radial collateral tear/inflammatory changes of second MCP joint was also noted. *Id.*

Petitioner returned to see Dr. Young on August 12, 2019, to go over the findings of the MRI. (PX4, 8/12/19) Dr. Young's assessment was that Petitioner sustained an injury to the collateral ligament of the long finger of his right hand. *Id.* Dr. Young performed an injection in his office and instructed Petitioner to follow up with physical therapy, use medication, and continue on light duty. *Id.*

Petitioner was next seen in Dr. Young's office on September 19, 2019, and while his therapy was going well, he had not noticed improvement. (PX4, 9/19/19) Petitioner gave was given Voltaren gel, a Medrol Dosepak, and orders to continue occupational therapy. *Id.*

On September 26, 2019, Respondent had Petitioner examined by Dr. Nash Naam, who authored a report and gave a deposition. (RX1, Dep. Ex. 2) In his report, Dr. Naam noted that Petitioner's MRI showed an incomplete tear of the radial collateral ligament of the metacarpophalangeal joint of the right long finger, and that subsequently, Petitioner had an injection of the metacarpophalangeal joint and was started on a physical therapy program. *Id.* When he saw Dr. Naam, Petitioner still had weakness in his right hand and complaints of pain in the metacarpophalangeal joint of the right long finger. *Id.* Dr. Naam noted that these symptoms awakened Petitioner at night and caused a loss of strength in his hand. *Id.* He also noted that Petitioner was taking Meloxicam. *Id.* Dr. Naam's examination showed a slight degree of swelling over the dorsal aspect of the metacarpophalangeal joint of the right long finger, a slight degree of tenderness along the radial side of the MP joint, pain with radial and ulnar stressing, no triggering, good range of motion, but loss of grip strength. *Id.* Dr. Naam recommended a well-structured therapy program under the supervision of a certified hand therapist. *Id.* He also recommended repeating the injection of the right long finger and obtaining blood test to rule out any inflammatory arthritis problem. *Id.* Dr. Naam believed that Petitioner's symptoms were related to the injury and that his subjective complaints correlated well with his objective findings. *Id.*

Dr. Naam saw Petitioner again on March 3, 2020, and noted that Petitioner had been treated by Dr. Young, "his excellent hand surgeon," who injected the MP joint on the right long finger and prescribed additional physical therapy. (RX1, Dep. Ex. 3) Despite the improvement resulting from treatment, Dr. Naam's examination showed a slight degree of swelling of the dorsal aspect of the metacarpophalangeal joint of the long finger. *Id.* Radial and ulnar stressing did not cause instability and produced no pain with the ligaments being intact. *Id.* Petitioner's grip strength of his dominant right hand was still reduced when compared to his non-dominant left hand. *Id.* Dr. Naam believed that Petitioner could return to work at his normal duties and did not provide an AMA rating. *Id.*

Petitioner return to Dr. Young, continued his medication, therapy, and home exercises and gradually progressed to the point where he was released to work without restriction. (PX4, 11/21/19-3/20/20; PX6)

On July 28, 2020, Dr. Naam testified by way of deposition. (RX1) On direct examination, his testimony was consistent with his report. *Id.* at 5-15. On cross-examination, Dr. Naam testified that both he and Dr. Young did not recommend surgery because the tear of the ligament was not complete, and that the ligament would be strong enough to allow the joint to be stable and allow the other fibers that have been torn to heal. *Id.* at 15, 16. He testified that this might take a while, but hopefully healing is better than surgery. *Id.* at 15, 16.

At Arbitration, Petitioner displayed his hand, and the Court observed an area on Petitioner's MCP joint of the long finger that was raised from a quarter to a half an inch, and the width of which was about a half of an inch. (T. 13, 14) As a result of his injury, Petitioner still experiences symptoms. (T. 14, 15) He has been a professional drummer for 28 years and was not able to play during the healing of his injury and is currently not back to playing yet. (T. 14, 15) He testified that this is because he has a hard time sustaining the impact of hitting the drums with the stick because he still gets a shocking sensation and his grip strength "just isn't there." (T. 15, 16) Prior to his injury, Petitioner earned approximately $200 per show twice a month performing drumming. (T. 16) In addition to his inability to drum, Petitioner testified that he was really hoping that his hand and finger would look and feel better at this point. *Id.* He still has a lot of stiffness, problems with gripping and squeezing, and pain that he described as a "shocking electrical type." (T. 16, 17) His symptoms improved to the point where he was able to return to work, but since he's gone back to work, the swelling has increased. (T. 17)

CONCLUSIONS OF LAW

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 uses the remaining factors to evaluate Petitioner's permanent partial disability.

(ii) **Occupation**: Petitioner continues to serve as a truck driver for Respondent. (T. 10) Petitioner's job duties include a lot of gripping, squeezing, lifting, pulling, and tugging, and Petitioner experiences an increase in pain and swelling while performing his job duties. (T. 17, 19, 20) He testified that his pain level can sometimes reach a 10 on the pain scale if he is performing a difficult task. (T. 20) Petitioner was able to return to work, however, due the hand-intensive job he performs and his corresponding symptoms, Petitioner's condition is likely to affect his ability to perform his job in the future. (T. 10, 17, 19, 20) The Arbitrator places some weight on this factor.

(iii) **Age**: Petitioner was 54 years old at the time of his injury. (AX1) He has diminished healing capacity as a result thereof. The Arbitrator places little weight on this factor.

(iv) **Earning Capacity**: While there is no direct evidence of reduced earning capacity contained in the record; based on the severity of Petitioner's injuries, the requisite treatment and the resulting disability, it is reasonable to conclude that such repercussions will manifest in the

near future, because of Petitioner's lessened ability to play the drums. The Arbitrator places significant weight on this factor.

(v) **Disability**: As a result of his accident, Petitioner sustained an injury to the collateral ligament of the long finger on his dominant right hand. (PX4, 8/12/19) Petitioner was treated conservatively with injection, physical therapy, Voltaren gel, Medrol Dosepak, and over-the-counter medications. (PX3, 6/27/19; PX4, 8/12/19, 11/21/19; PX6) He was released at maximum medical improvement on March 20, 2020. (PX4, 3/20/20) Despite his improvement, Petitioner still experiences pain, which he describes as an electrical shocking pain, along with stiffness, swelling, and loss of grip strength. (T. 15-17; PX4, 3/20/20) He experiences symptoms when gripping, lifting, squeezing, pulling, and tugging, all movements which he must perform while doing his job. (T. 16, 17, 19, 20) Petitioner testified that he experiences pain every day that gets worse any time that he starts to use his hand. (T. 19, 20) Depending on the difficulty of the activity that he is performing, his pain level can go as high as a 10. (T. 20) He manages his symptoms with Ibuprofen and Aleve, which he takes every three to four hours every day in order to decrease his pain while performing his job. (T. 20, 21) Petitioner testified that he hoped that his hand and finger would look and feel better than they do at this point. (T. 16)

Prior to his work injury, Petitioner was a professional drummer for approximately 28 years. (T. 15) Since his injury, he has been unable to continue playing drums because he lacks the grip strength necessary to play, he experiences and shocking sensation, and his hand cannot sustain the impact of hitting the drums with a stick. (T. 15, 16)

Based upon the foregoing evidence and factors, the Arbitrator finds that Petitioner sustained serious and permanent injuries that resulted in the 10% loss of Petitioner's right hand.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	13WC017729
Case Name	SANCHEZ, JESUS v. HENRY PRATT COMPANY
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0330
Number of Pages of Decision	23
Decision Issued By	Deborah Baker, Commissioner

Petitioner Attorney	Frank J. Bertuca
Respondent Attorney	Robert Newman

DATE FILED: 6/30/2021

/s/Deborah Baker, Commissioner

Signature

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 Causation, Permanent Disability	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JESUS SANCHEZ,

Petitioner,

vs. NO: 13 WC 17729

HENRY PRATT COMPANY,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of whether Petitioner sustained repetitive trauma injuries to his left hand and right elbow manifesting on April 4, 2013, whether Petitioner's left hand and right elbow conditions of ill-being remain causally related to his work activities, entitlement to Temporary Total Disability benefits, entitlement to incurred medical expenses, and the nature and extent of Petitioner's permanent disability, and being advised of the facts and law, modifies the Corrected Decision of the Arbitrator as stated below and otherwise affirms and adopts the Corrected Decision of the Arbitrator, which is attached hereto and made a part hereof.

I. Accident/Causal Connection

A. Carpal Tunnel Syndrome

On Review, Respondent argues the negative EMGs conclusively prove Petitioner did not have carpal tunnel syndrome, and this dispositive fact is corroborated by Dr. Vender. The Commission disagrees.

Petitioner worked for Respondent for 18 years; for the last seven years he performed large valve assembly. T. 49. Petitioner and Mr. Darby, Respondent's senior production supervisor, both testified this job involves constant handling and gripping with regular use of vibratory tools as well as fine finger manipulation of nuts and bolts. T. 51-58, 189, 210. This testimony is corroborated by the job description Respondent created. Pet.'s Ex. 2.

The Commission observes Petitioner's treating physicians all diagnosed him with carpal tunnel syndrome, and they concurred the negative EMGs did not rule out that diagnosis. On June 28, 2013, Dr. Fajardo noted his review of the negative EMG but did not alter his prior diagnosis of carpal tunnel syndrome, stating "there is research that states people can have carpal tunnel syndrome with a normal NCV/EMG…will plan for surgery." Pet.'s Ex. 7. On September 12, 2013, Dr. Henderson confirmed an EMG can be normal notwithstanding abnormal pathology and referred Petitioner to Dr. White for carpal tunnel syndrome. Pet.'s Ex. 8. On September 23, 2013, Dr. White observed the lack of findings on EMG indicated the possibility that Petitioner's numbness was not related to carpal tunnel syndrome, but nonetheless offered carpal tunnel release "because clinically he does demonstrate findings consistent with carpal tunnel syndrome." Pet.'s Ex. 8, Resp.'s Ex. 13. Dr. Prinz too opined Petitioner developed carpal tunnel syndrome as a consequence of his work activities, and the doctor similarly rejected the notion that negative EMG findings definitively exclude a carpal tunnel syndrome diagnosis, particularly when the patient has consistent symptoms and clinical findings such as positive Tinel's and Phalen's signs. Pet.'s Ex. 9, p. 39. The Commission further notes that following the carpal tunnel release, Petitioner's numbness and tingling improved. We find the positive surgical outcome evidences Petitioner had carpal tunnel syndrome. While Dr. Vender opined Petitioner did not have carpal tunnel syndrome, the doctor conceded his opinion was predicated on the negative EMGs. Resp.'s Ex. 1, p. 26. Dr. Vender did not perform Tinel's and Phalen's tests because in his opinion those tests are inaccurate, though he could not identify any journal articles substantiating his opinion. Resp.'s Ex. 1, p. 42, 38. Finally, Dr. Vender agreed carpal tunnel syndrome is causally related to forceful activity on a persistent basis, and the doctor acknowledged Petitioner's job description reflects handling and gripping is done on a constant basis. Resp.'s Ex. 1., p. 52-53. Dr. Vender had the opportunity to inquire with Petitioner as to the nature of the gripping yet did not bother to do so. Resp.'s Ex. 1, p. 34. The Commission finds Dr. Vender's opinions are neither credible nor persuasive.

The Commission finds Petitioner proved he sustained repetitive trauma injuries to his left hand manifesting on April 4, 2013. We further find the credible evidence establishes Petitioner's left carpal tunnel syndrome and the permanent restrictions imposed following his treatment thereof are causally related to his repetitive work activities.

B. Right Elbow

Both parties take issue with the Arbitrator's right elbow determination. Petitioner argues his current right elbow condition remains causally related to his work activities, and this is established by Dr. White's imposition of a permanent restriction against repetitive use of the right arm. Respondent in turn highlights Dr. Vender's opinion that Petitioner suffers from a naturally occurring degenerative condition and work activities do not make the underlying disease any worse. The Commission agrees with Petitioner.

Our analysis begins with the treating records. Petitioner's right elbow treatment was primarily with Dr. White. At the August 1, 2013 initial evaluation, Dr. White recorded a history of an onset of elbow pain in the spring; the pain had progressed to become constant and got worse when Petitioner did any lifting more than 10 pounds. Pet.'s Ex. 8. After an examination, Dr. White diagnosed possible degenerative joint disease. Pet.'s Ex. 8. Although indicating he needed to see the Castle Orthopedics records prior to making any further recommendations, Dr. White did document his suspicion:

> I suspect that if he had x-rays and then was told at Castle that there is nothing that could be done, he probably has significant arthritis and quite frankly I would agree that treatment is more symptomatic management of the arthritis rather than curing the problem. He says he has to lift up to 50 pounds or more on a regular basis at work, and if he has arthritis in the elbow that may not be something that we can return him to with any guarantee of success. Pet.'s Ex. 8.

At the August 29 re-evaluation, Dr. White noted the Castle Orthopedics records confirmed the degenerative joint disease diagnosis, and the doctor reiterated his concerns about Petitioner continuing to perform his regular work duties:

> I advised patient and his wife that the problem is arthritis in the elbow and is not much that can be done about that…I offered symptomatic management with cortisone injection. He declined, prior injection really caused problems with his blood sugar. Mostly, he continues to talk about his problems at work. I told him there really is not much we can do about that. He has already been told by his employer that light duty is not available and if he is having elbow problems, he should go get his elbow fixed and come back to work. The problem in his elbow is not something that can be fixed. I offered to write him a note for permanent light duty, but told him his employer does not necessarily need to follow the restrictions, and it is possible that they might terminate him. He wanted a note, and this was provided. Pet.'s Ex. 8.

Dr. White released Petitioner with a permanent modified duty restriction of no lifting over 20 pounds and documented no follow-up was necessary unless Petitioner wished to try a cortisone shot. Pet.'s Ex. 8. Ultimately, Petitioner elected to proceed with the injection, and this was done during his October 11, 2013 carpal tunnel surgery. Pet.'s Ex. 8.

On December 2, 2013, Dr. White observed Petitioner had likely obtained the maximum benefit from the cortisone injection and, beyond scheduling repeat injections as symptoms warranted, there were no viable treatment options. Pet.'s Ex. 8. As to Petitioner's work status, Dr. White documented the following: "Either his employer needs to find him some less repetitive work to do with the right arm, or he needs to return to work regular duty and accept the pain in his elbow, or he needs to find a different employment." Pet.'s Ex. 8. Dr. White updated the permanent restriction to no repetitive use of the right arm. Pet.'s Ex. 8. While the Commission is cognizant that Dr. White did not provide a causal connection opinion, we find it significant that Dr. White repeatedly documented Petitioner's job duties were detrimental to his arthritis.

Our analysis next turns to the conflicting expert opinions of Dr. Prinz and Dr. Vender. Dr. Prinz opined that, based on his review of the medical records, Petitioner's history, and physical examination, Petitioner's elbow arthritis was aggravated by his "work activity which included extensive use of power tools, heavy lifting, heavy pushing, heavy pulling…up to 10 hours a day [five] days a week for 18 years." Pet.'s Ex. 9, Dep. Ex. 2. Dr. Prinz agreed with Dr. White that Petitioner required work restrictions, though he would have clarified the wording to reflect no repetitive use of the right elbow, and Dr. Prinz confirmed that restriction was a consequence of the work-related condition. Pet.'s Ex. 9, Dep. Ex. 3. During his deposition, Dr. Prinz confirmed Petitioner gave a detailed description of the tools he used while working for Respondent. Pet.'s Ex. 9, p. 52. As to his causation opinion, Dr. Prinz explained, "just in terms of osteoarthritis in a joint, it's pretty commonly known among practitioners that repetitive work activity will exacerbate or aggravate an arthritic condition." Pet.'s Ex. 9, p. 63.

Dr. Vender, on the other hand, concluded Petitioner's elbow arthritis was unrelated to his work activities. Dr. Vender indicated arthritis "is an unremarkable and naturally occurring degenerative condition. It would not be related to the performance of work activities. The performance of work activities would not represent an aggravation of a pre-existing arthritis." Resp.'s Ex. 1, Dep. Ex. 2. During his deposition, Dr. Vender testified arthritis is not work-related absent an acute injury: "Elbow arthritis or other arthritis, unless there's a reason for it specifically, is not assumed to be or known to be related to used patterns of the upper extremity." Resp.'s Ex. 1, p. 17. Dr. Vender agreed arthritis symptoms can be worsened by activity but stated activity does not cause further deterioration of the condition. Resp.'s Ex. 1, p. 46, 49-50.

The Commission finds Dr. Prinz's opinions are persuasive. We further note Dr. Prinz's conclusions best align with the treating records. The record evidences an onset of right elbow pain associated with Petitioner's repetitive work activities. Petitioner was diagnosed with arthritis and advised symptom management was the only viable treatment option. Dr. White imposed permanent restrictions which preclude Petitioner's return to his pre-injury position and directed Petitioner to return for cortisone injections as his symptoms warranted. Further, Dr. Vender agreed arthritis symptoms can be worsened by activity, which is in line with Dr. Prinz's opinion that Petitioner's work activities aggravated his right elbow arthritis. The Commission finds Petitioner sustained repetitive trauma injuries to his right elbow manifesting on April 4, 2013, and his condition of ill-being, including the permanent restrictions imposed by Dr. White, remains causally related.

II. Permanent Disability

Our conclusion that both Petitioner's left hand and right elbow conditions of ill-being remain causally related to his April 4, 2013 work injuries necessarily implicates Petitioner's permanent disability. The Commission analyzes the §8.1b factors as follows.

Section 8.1b(b)(i) – impairment rating

Neither party submitted an impairment rating. As such, the Commission assigns no weight to this factor and will assess Petitioner's permanent disability based upon the remaining enumerated factors.

Section 8.1b(b)(ii) – occupation of the injured employee

Petitioner's pre-accident occupation was large valve assembler. Mr. Darby and Mr. Pagella testified this is considered a skilled position at the medium level of physical tolerance. T. 193; Pet.'s Ex. 10, p. 29, 24. Following his work-related injuries, Petitioner was placed under permanent restrictions which both vocational experts agree preclude Petitioner from returning to his pre-accident position. T. 233, 236; Pet.'s Ex. 10, p. 29. The Commission finds Petitioner lost access to his usual and customary employment. This factor weighs heavily in favor of increased permanent disability.

Section 8.1b(b)(iii) – age at the time of the injury

Petitioner was 63 years old on the date of his accidental injury. The Commission notes Petitioner was within three years of his anticipated retirement (T. 93) when his injuries occurred, and therefore the impact on his remaining work-life is diminished. The Commission finds this weighs in favor of decreased permanent disability.

Section 8.1b(b)(iv) – future earning capacity

The vocational experts concur Petitioner's work injuries have compromised his future earning capacity. Mr. Pagella opined Petitioner is no longer employable in the general labor market. Pet.'s Ex. 10, p. 28-29. Mr. Minnich opined Petitioner remains employable but is limited to entry level jobs at the light level, and he testified the wage range for those jobs is $10.00 to $12.00 per hour. T. 252. The Commission finds this weighs in favor of increased permanent disability.

Section 8.1b(b)(v) – evidence of disability corroborated by treating medical records

The treating records reflect Petitioner has permanent restrictions for both upper extremities. Dr. White completed a detailed work capacities form which placed Petitioner in the sedentary category for lifting/carrying with both hands (10 pounds or less frequently), right arm maximum weight of 10 pounds, no above shoulder reaching with right arm, and right hand occasional grasp with five-pound maximum grip strength. Pet.'s Ex. 8. Dr. Prinz concurred with Dr. White and concluded work restrictions are appropriate for each condition. Pet.'s Ex. 9, p. 25. The Commission finds this weighs in favor of increased permanent disability.

Based on the above, the Commission finds Petitioner suffered a loss of career (skilled trade large valve assembly) as a result of his work-related injuries. We further find Petitioner sustained 30% loss of use of the person as a whole.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Corrected Decision of the Arbitrator filed June 17, 2019, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $586.67 per week for a period of 26 weeks, representing June 4, 2013 through December 2, 2013, 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 the sum of $8,455.00 for medical expenses, as provided in §8(a), subject to §8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $528.00 per week for a period of 150 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused 30% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that the awards of 15% loss of use of the left hand and 5% loss of use of the right arm are vacated.

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 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.

June 30, 2021

/s/ *Deborah J. Baker*

DJB/mck

O: 5/5/21

/s/ *Stephen Mathis*

43

/s/ *Deborah L. Simpson*

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0330
NOTICE OF ARBITRATOR DECISION
CORRECTED

SANCHEZ, JESUS Case# **13WC017729**
Employee/Petitioner

HENRY PRATT COMPANY
Employer/Respondent

On 6/17/2019, 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 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:

0293 KATZ FRIEDMAN EAGLE ET AL
FRANK J BERTUCA
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT T NEWMAN
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60606

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

Jesus Sanchez
Employee/Petitioner
v.
Henry Pratt Company
Employer/Respondent

Case # **13** WC **17729**

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 **Geneva**, on **March 16, 2018** and **June 18, 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. **X** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. **X** Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. **X** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. **X** What temporary benefits are in dispute?
☐ TPD ☐ Maintenance **X** TTD
L. **X** What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **April 4, 2013,** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being ***is in part,*** causally related to a work accident.

In the year preceding the injury, Petitioner earned **$45,760.00**; the average weekly wage was **$880.00**.

On the date of accident, Petitioner was **63** years of age, ***married*** with **0** dependent children.

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

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

To date, Respondent has paid $ **0** in TTD and/or for maintenance benefits, and is entitled to a credit for any and all amounts paid.

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

Respondent is entitled to a credit of **$10,159.70** under Section 8(j) of the Act.

ORDER

Medical Benefits

$8,455.00 for medical bills in accordance with the fee schedule, §8 and §8.2 of the Act, with credit to be given for any payments made directly by respondent or pursuant to §8j.

Temporary Total Disability

Respondent shall pay Temporary total disability benefits from **June 4, 2013** through **December 2, 2013**, or **26** at the rate of **$586.67 per week**.

Permanent Disability

Petitioner is entitled to **41.15** weeks, at **$528.00** per week, as petitioner's permanent disability has resulted in **15% of the left hand (28.5 weeks) pursuant to §8 (e) 9 and 5% loss of use of right arm (12.65 weeks) pursuant to §8 (e) 10 of the Act**.

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

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

Christine MOy

Signature of Arbitrator

June 13, 2019

Date

JUN 17 2019

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jesus Sanchez	)	
Petitioner,	)	
vs.	)	**No. 13 WC 17729**
Henry Pratt Company	)	
Respondent.	)	
	)	

ADDENDUM TO CORRECTED ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing in Geneva on March 16, 2018 and concluded on June 18, 2018. The parties agree that on April 4, 2013, petitioner and respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer and that petitioner gave timely notice of the claimed accident. The parties agree petitioner earned $45,760.00 in the year predating the accident and that his average weekly wage, calculated pursuant to §10, was $880.00.

At issue in this hearing is as follows:

1. Whether the petitioner sustained accidental injuries that arose out of and in the course of her employment.
2. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
3. Whether respondent is liable for medical bills.
4. Whether petitioner is entitled to temporary total disability.
5. The nature and extent of petitioner's injury.

STATEMENT OF FACTS

The Petitioner does not speak English; his native language is Spanish. H testified with the assistance of Paula Riordan, a certified interpreter, qualified to translate Spanish to English and English to Spanish. After being duly qualified and accepted by both parties, Ms. Riordan served as an interpreter for the petitioner.

Concepcion Sanchez Testimony

Concepcion Sanchez, has been married to petitioner since 1974. She was employed as a legal assistant for a law firm. Her primary language is Spanish. At times she interpreted for her husband/petitioner on legal issues, doctors and refinancing of their home. She reported petitioner has no problem with Spanish; only English. He speaks Spanish 100% of the time at home to his family members.

Mrs. Sanchez explained and translated documents to petitioner that were in English. She attended doctor appointments and the meeting with vocational counselor, Ed Pagella, to translate for her husband. Mrs. Sanchez assisted petitioner prepare job search logs, identified as Petitioner's Exhibit 3.

Mrs. Sanchez confirmed petitioner worked on the building they own. He did not do plumbing, electrical, or other things; he hired contracts. They had no other employees that worked on petitioner's building.

Mrs. Sanchez confirmed petitioner had retired from respondent.

On cross-examination, Mrs. Sanchez confirmed she and her husband have been in the United States since 1974. Petitioner is a U S citizen. Petitioner speaks Spanish to his children even though they spoke English in School.

Petitioner did not mow lawns or shovel snow at his building. He did some routine maintenance and supervised work that was done on the building. He did not deal with contractors; but he supervised installation of carpeting and collected rent.

As for Petitioner's Exhibit 3, petitioner would jot down information on a scrap of paper; he did not keep the notes. Mrs. Sanchez heard him make calls for jobs in English. The December 12, 2014 entry, the December 18, 2014 of Gusto Packaging entry, and next four entries were written by petitioner.

The letter, identified as Respondent's Exhibit 5 was type by notary, Zoila Aleman; petitioner dictated the letter to her.

Mrs. Sanchez could not recall when the Indian Trail home was transferred to their son.

Mrs. Sanchez confirmed petitioner started his job search after he retired. The date on the job log should have read 2014 and not 2013.

Petitioner, Jesus Sanchez, Testimony

Petitioner was born in Mexico. The highest education he achieved was sixth grade in Mexico. He worked on a line Mexico at a company that made toys.

He came to US in 1973 and became a U S Citizen in 1990. He has a social security number. His primary language in Spanish. He is married to Concepcion Sanchez.

He was hired by defendant in 1995, which is in the business of making water valves and other things. The first year petitioner tested valves. He used Allen wrenches. He was then moved to plain stem department. There he assembled small valves. He used a grinder with a tip. He used a device that would take tires off cars. He used air power tools. He worked in plain stem for eight years. Thereafter, he moved to large valve assembler, where he worked until he retired in 2014. Thus, he worked in large valve assembly for seven out of eighteen years he worked for respondent.

In that department, he used grinders and sanders, which are air power tools. He used both hands. His hands were always hot. He used a pneumatic tool that weighed five to six pounds. The bigger the valve he worked on, the larger the tool he used. He attached the tool to a pneumatic hose. The pneumatic tool was operated by using a trigger.

Between 2012 to 2013, petitioner worked ten hours a day, Monday through Friday, and sometimes six hours on Saturday. His fingers would get tired and hot. He also used another pneumatic tool called a chisel. He operated the chisel by making a fist with both hands. If the leak test failed, he chiseled off the epoxy. The Allen wrench he used was not a pneumatic tool. He occasionally had to lift the valve that weighed 40 pounds without the crane. He had to use a 12" bar if the chisel did not break it up. It weighted at least 12 pounds. Petitioner is right-hand dominant.

His supervisor was Dale Darby. He talked to Darby frequently when he needed parts. Petitioner would speak to him in English and Spanish to his co-workers.

He was diagnosed with diabetes in 1998 or 1999 while working in the plain stem department. He was taking meds and seeing doctor in 1990. He was having problems with his

hands. In 1990, he was evaluated for carpal tunnel syndrome and found to have it in his right but not in the left hand.

In 1995, was examined by a respondent's doctor. He had a pre-employment physical for respondent and had no restrictions. In 2012 he had tingling in his hand that came and went. He was doing very heavy work. The three fingers that tingled where his thumb, index and middle fingers. After the 2012 visit with the doctor, he continued to work at his regular position.

Approximately March 15, 2013, he began having tingling and numbness in left hand and his right elbow also hurt. He reported the problem to his supervisor. On April 9, 2013 he reported having problems in both hands and was sent to Provena Hospital. He was given work restrictions. Petitioner brought a piece of paper, outlining his restrictions, to his supervisor, Dale Darby (PX.1).

Thereafter, petitioner was sent to Dr. Velagapudi at Castle Orthopedics. He also saw Dr. Fajardo in June 2013 for his hands and arms. He was also treated by the doctors at Dreyer Medical Clinic, where he saw Dr. White for hands and arms. Dr. White performed carpal tunnel surgery on the left hand on October 11, 2013. He also received an injection in the right elbow.

He was paid non-occupational disability benefits.

He identified Petitioner's Exhibit 2 as a description of the large valve job he performed for respondent.

Petitioner was provided restrictions by the doctor to return to work in December, 2013. He did not receive an offer of work within his restrictions. Due to the restrictions, petitioner decided to retire on December 1, 2014.

At times his wife translated for him so he had complete understanding. She attended the meeting with Ed Pagella and translated during the meeting. He would speak in Spanish at home.

He began his job search after surgery. Contrary to Petitioner's Exhibit 3, he had not performed a job search, in January, 2013, before he reported incident work he did not look for work.

He agreed that his wife helped prepare the job search log (PX.3). He was offered a position with UPS, which would require him to load his own truck and he couldn't do it.

In 2012 to 2013 he operated a self-propelled lawn mower; it took about twenty to twenty-five minutes weekly. He also did his own snow shoveling.

He did apply for property manager positions, but go no takers.

His left wrist improved. He had numbness in palm and thumb, index and middle finger. He has daily pain in right elbow.

Petitioner did not know how to use a computer. His wife has a tablet. He did not intend to retire until he reached his full retirement age of 66. He will turn 68 on June 11 [2018].

He was examined by Dr. Prinz in Melrose Park in June, 2017 at the request of his attorney.

He would push the large crane back and forth that hung on a crane.

On cross-examination, he confirmed he used an impact air-powered wrench. In the plain stem area, he made smaller valves, which were three to six inches in diameter. The largest valves he worked on where 54 inches in diameter. He used a chisel to remove epoxy and bad seals that were built into the valves. He used the bronze bar only for seating the disc. The Allen wrench measured 24 inches with socket on end.

He agreed he spoke with co-worker, Ted Burger, in English.

His previous employer was all Steel. There he repaired desks. He developed right carpal tunnel syndrome while working for All Steel.

He agreed he completed the job log in English (PX.3). He acknowledged he received disability benefits from respondent. He received retirement benefits as of December 1, 2014.

On June 22, 2015, when he met with vocational counselor Pagella that had no interest in training or looking for a job.

Petitioner drove around looking for jobs. In October to November he applied for property managers position.

He was offered a job by UPS as a package driver. It was not on his job log.

He does his own leaf raking and own plowing.

He denied he told Dr. Palmer on May 14, 2012 that he intended to retire the following year.

He did not recall receiving injection in the elbow on April 27, 2016.

He was able to read and write in English at work.

On redirect, he agreed he had restrictions of no use of right arm, as outlined by Dr. White on December 2, 2013 (PX.8, p.185). He agreed he was provided a different paper outlining these restrictions, which had slightly different restrictions.

He testified that the reason he told Pagella he was not interested in looking for work was that he was discourage by the lack of finding work during his job search.

As for the job with UPS, once he provided the restrictions, UPS said no.

It would take him fifteen to twenty minutes to plow snow. He does not rake leaves any more as he has a machine that sucks them. He also uses a snow blower.

Carl Schnurstein Testimony

Carl Schnurstein, licensed private investigator, testified in behalf of respondent. He and Ryan Lemon, worked together to do surveillance on petitioner and prepared the video of petitioner of October 3, 2014, October 10, 2014 and October 20, 2014. The video, identified as Respondent's Exhibit 8, was played.

Dale Darby Testimony

Dale Darby, senior production supervisor for respondent, testified in behalf of respondent. He has been employed by respondent for almost 40 years. He was petitioner's direct supervisor for four years when petitioner was a large valve assembler. Darby was always able to communicate with petitioner in English. Petitioner had no difficulty completing tasks from work order packets that were written in English. He would fill out tickets as assembler in English.

Darby testified petitioner was a good assembler; he had no problems in following directions. Darby identified Respondent's Exhibits 14 through 19 as documents petitioner signed that were in English.

Darby confirmed that the large valve assemblers where provided with lifting equipment. He confirmed petitioner would need to chisel out the valves sometimes; he would use a bronze bar. He also operated air tools.

On cross-examination, Darby agreed petitioner was a good and trusted employee. He agreed that petitioner performed the tasks identified on Petitioner's Exhibit 2.

Darby did not recall receiving any doctor notes from petitioner as those issues would have been handled by HR in 2013 to 2015.

He could not recall petitioner speaking Spanish to co-worker.

The largest tool petitioner would have to use would be a bronze bar. He would not be allowed to lift greater than 50 pounds. Petitioner built three to four valves a day. He used a small hand held grinder.

Edward Minnich Testimony

Edward Minnich, certified vocational counselor, testified in behalf of respondent. Minnich reviewed the two vocational reports of Edward Pagella, Dr. Vender's report and Dr. White's records. He concluded petitioner was either able to return to his regular position, according to Dr. Vender, or he was capable of working in some capacity as a host, usher, working in retail sales, general sales or security. Minnich did not believe petitioner was doing an appropriate job search and could use direction.

On cross-examination, Minnich agreed that if petitioner was not able to return to his regular job as Dr. Vender had opined, then he would need the assistance of vocational rehabilitation. He also agreed if petitioner could not return to his usual employment then he would have a loss of income.

Provena Mercy Medical Center Spanish Record (PX.1)

Petitioner was reportedly seen at Provena Mercy Medical Center on April 9, 2013 and provided restrictions in Spanish.

Physical Demands of Job (PX.2)

This describes the physical demands of the position of Assembler. The position required the employee to lift, carry, push and pull up to 50 pounds. According to this document, common tasks included handling and gripping tools to assemble product.

Petitioner's Job Search Record (PX.3)

Petitioner recorded his job search efforts from January 6, 2014 to January 15, 2014; February 18, 2014 to February 25, 2014; March 3, 2014 to March 10, 2014; June 30, 2014 to July 3, 2014; December 8, 2014 to December 22, 2014; January 12, 2015 to January 13, 2015; June 30, 2015 to July 9, 2015; and October 20, 2017 to November 3, 2017.

Medical Bills (PX.4)

Petitioner claims the following medical bills:
$7,298.00 Dreyer Medical Clinic
$435.00 Provena Merch Medical Center
$1,311.00 Hinsdale Orthopaedics
$620.00 Castle Orthopedics

Presence Mercy Medical Center (PX.5)

Petitioner was seen on April 9, 2013 due to pain in right elbow and left hand. He reported he did repetitive lifting, twisting and turning. The diagnosis was right distal biceps strain and left upper extremity neuropathy.

He returned on April 16, 2013. The diagnosis was right distal biceps strain or partial tear, left upper extremity neuropathy. He had a positive Tinel and Phalen at the wrist and positive Tinel at the elbow on the left. He was referred to orthopedics for further evaluation.

Castle Orthopaedics Records (PX.6)

Petitioner was seen by Dr. Suresh Velagapudi on May 7, 2013 due to bilateral arm pain and numbness. Petitioner reported pain in right elbow and numbness and tingling in both hands; greater on the left than right. The onset was identified as April 2, 2013. The activities at work

building valves aggravated his symptoms. The Phelan and Tinel signs on the left were positive; negative on the right. The diagnosis was carpal tunnel syndrome. An injection as administered.

Hinsdale Orthopaedics Records (PX.7)

Petitioner was seen by Dr. Marc Fajardo on June 7, 2013 for a second opinion regarding his left hand and right elbow. He was diagnosed with left carpal tunnel and right elbow arthritis. An EMG of the left wrist was ordered.

The June 17, 2013 EMG performed by Dr. Steven Bardfield to the left upper extremity was normal.

On June 28, 2013, Dr. Fajardo discussed additional injections and surgery. The petitioner wished to proceed with surgery.

Dreyer Medical Clinic (PX.8)

On March 5, 2013, petitioner's wife advised petitioner had shooting pain from fingers to elbow. He had previously advised doctor of this, but it was now worse. Petitioner was referred to a neurologist. (36-28)

Petitioner was seen by Dr. Roy Henderson on July 15, 2013 for tingling in his left hand. He reportedly was seen by the workers' compensation doctor until he wouldn't answer questions and was dropped. Dr. Henderson believed the condition was likely carpal tunnel syndrome. He was referred to a neurologist for an EMG. (60-64)

Petitioner called on July 16, 2013 requesting a letter to return to working no lifting greater than 20 pounds (74-77),

Petitioner return to Dr. Henderson on July 26, 2013 due to right elbow pain. Dr. Henderson referred petitioner to surgeon, Dr. Thomas White, and prescribed physical therapy. (78-80)

Petitioner was seen by Dr. Palmer on July 30, 2013 for his diabetes (89)

Petitioner seen by Dr. Thomas White on August 1, 2013. Dr. White diagnosed right elbow pain; possible degenerative joint disease of the right elbow. (94-95)

Petitioner was initially seen for physical therapy to the right elbow on August 5, 2013 (99)

The August 28, 2013 EMG of the left upper extremity was normal (35; 65-66)

On August 29, 2013, Dr. White advised petitioner he had arthritis in the right elbow and could not offer much in the way of treatment other than a cortisone injection (129).

Petitioner was seen by Dr. Henderson on September 12, 2013 due to pain in the right elbow and tingling in left hand. The mechanics of the injury were described as repetitive work. He was referred to Dr. White for possible surgery of the carpal tunnel syndrome. (133-134)

He was seen by Dr. White on September 23, 2013; surgery for carpal tunnel was to be scheduled (137). He was kept off work (304).

He was seen again by Dr. Palmer on October 4, 2013 regarding significant degenerative joint disease of the right elbow, carpal tunnel syndrome, statues post right carpal tunnel repair with good response and diabetes mellitus (145-146).

Petitioner underwent carpal tunnel release on the left and received a cortisone injection to the right elbow by Dr. White on October 11, 2013 (152-153).

He followed up with PA on October 21, 2013 (157)

He was seen by Dr. White on November 4, 2013. He was kept off work and was to return in three weeks (163).

He was seen by Dr. White on December 2, 2013. Dr. White advised petitioner he needed to find less repetitive work or return to work and accept the pain in the elbow (184).

Petitioner returned to Dr. White on May 11, 2015 advising his right elbow was hurting again; his left hand was okay. Petitioner was offered a cortisone injection. (355)

Dr. Paul T. Prinz October 13, 2017 Deposition (PX.9)

Dr. Paul Prinz, board certified orthopedic surgeon, testified in behalf of the petitioner. Dr. Prinz practices in general orthopedics; one-third of his practice is in hand surgery.

On June 10, 2017, at the request of petitioner's attorney, Dr. Prinz performed an independent exam of petitioner and generated a report. In addition to examining the petitioner, Dr. Prinz reviewed the reports of Dr. Velagapudi, Dr. White and Dr. Fajardo.

Dr. Prinz took a history and performed an exam. He concluded petitioner had right elbow arthritis and left carpal tunnel syndrome.

Dr. Prinz believed petitioner's work at respondent's using vibration tools and repetitive work with heavy objects caused, aggravated, or contributed to petitioner's right elbow and left carpal tunnel condition (24).

Dr. Prinz did not believe petitioner had diabetic neuropathy. Despite the two negative EMGs, Dr. Prinz pointed to the fact that the carpal tunnel release brought relief to petitioner as an indication he had carpal tunnel syndrome.

Dr. Prinz agreed osteoarthritis was a condition of aging; however, it is unusual to find it in the elbow joint.

Dr. Edward F. Pagella December 7, 2017 Deposition (PX.10)

Edward Pagella, certified vocational counselor, testified in behalf of petitioner.

After reviewing certain medical records and interviewing petitioner [on June 22, 2015], Pagella determined petitioner would have a difficult time finding alternative employment. Pagella based this opinion on petitioner's physical limitations, limited sixth-grade education and the fact that abundant work for Hispanics (as is petitioner) is in occupations that require repetitive use of hands. (27-28)

Pagella determined petitioner did not have the education or ability to be a property manager despite owning and managing a four-unit building.

Pagella testified that his report dated July 2, 2015 (Dep. Ex. 2) was actually his notes; sent out in error. According to his July 2, 2015 notes/report, petitioner was a candidate for vocational rehabilitation. However, in his July 14, 2015, report he advised petitioner was not a viable candidate for vocational rehabilitation. As to the discrepancy, he testified that he vacillated until he came up with his final opinion as stated in his July 14, 2015 report.

Pagella agreed petitioner's motivation to seek employment was low; he also agreed petitioner did not want to pursue, or was interested in pursuing vocational training.

Petition for Vocational Rehabilitation (PX.11)

Petitioner filed a petition for vocational rehabilitation on January 27, 2015; demanding also that he be allowed to choose his own vocational counselor.

Dr. Michael Vender July 21, 2017 Deposition (RX.1)

Dr. Michael Vender, board certified orthopedic surgeon with a specialty in hand/upper extremity surgery, testified in behalf of respondent.

Dr. Vender first examined petitioner on September 23, 2013 at respondent's request. Dr. Vender did not believe petitioner had carpal tunnel syndrome of the left as he had two negative

EMGs. As petitioner did not have carpal tunnel syndrome, Dr. Vender did not believe petitioner needed a carpal tunnel release. Dr. Vender did not believe petitioner's right elbow osteoarthritis was the result of any work activity; rather, it was the result of natural degenerative changes.

Dr. Vender re-examined petitioner on April 3, 2017. Petitioner reported improvement after the left carpal tunnel release. Again, Dr. Vender stated that he did not believe the carpal tunnel release was necessary as he did not believe petitioner had carpal tunnel syndrome. Other than the scar from the surgery, Dr. Vender did not believe petitioner had any permanent disability of the left hand. Dr. Vender believed petitioner was capable of performing his usual occupation.

Examination of the both wrists were normal. Dr. Vender noted the X-rays showed arthritis in both wrists and both elbows.

Dreyer Medical Clinic Records (RX.2)

The records cover treatment of Petitioner's diabetes from August 25, 2007 to December 18, 2012.

Short Term Disability Payment Record (RX.3)

According to these records, petitioner was paid short term disability from June 1, 2013 December 8, 2013 for a total of $10,404.00.

Long-Term Long Term General Policy Information (RX.4)

The policy calls for 60% for the first $16,667, reduced by deductible income up to a maximum benefit of $10,000 before reduction by deductible income.

Petitioner's November 7, 2014 Letter (RX.5)

Petitioner confirmed in writing that he was retiring as of December 1, 2014. According to the letter, he was basing his decision to retire on the fact that he could not work within the restrictions his doctor had given him.

Surveillance Video (RX.8)

The video shows petitioner driving, walking and dong minor activities around the building.

Response to Petition for Vocational Rehabilitation (RX.10)

Respondent filed a response to petitioner's demand for vocational rehabilitation setting forth the reasons respondent was not liable for vocational rehabilitation.

Edward Minnich Curriculum Vitae (RX.11)

The CV of vocational counselor, Edward Minnich, reflects he is a registered nurse, certified rehabilitation counselor, certified case manager and diplomate, board certified senior disability analyst.

Dreyer Medical Clinic Records (RX. 13)

Petitioner underwent an EMG on July 16, 2013 by Dr. Brian O'Shaughnessy. Dr. White reported on September 23, 2013, that although the EMG was negative, petitioner continued to show signs of carpal tunnel syndrome and he proposed surgery.

Stop the Job 5X5 Analysis Process (RX.14)

An analysis that was in English signed by petitioner on January 9, 2012.

Employee Disciplinary Warning Notice (RX.15)

Petitioner was given a verbal warning in English on July 10, 2012 of absence violations.

Certificate of Achievement (16)

Petitioner was presented with the certificate for successfully completing lean training-lean improvement event in July, 2010.

Respondent's Human Resource Policies Acknowledgement (RX. 17)

Petitioner signed the acknowledgement that was in English acknowledge received notice and a copy of respondent's human resource policy on November 1, 2012.

Respondent's Corporate Policy Acknowledgement (RX.18)

Petitioner signed the acknowledgement that he received respondent's corporate policy 2018 in English.

Petitioner's Probationary Progress Reports (RX.19)

The 15, 30 and 45-day progress reports for petitioner in April and May, 1995 was in English.

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

C. With respect to the issue of whether an accident occurred that arose out of and in the course of Petitioner's employment by respondent, the Arbitrator makes the following conclusions of law:

The testimony of petitioner and Dale Darby, and confirmed in the job description of assembler (PX.2), support a finding that petitioner's job with respondent required him to lift, carry, push and pull up to fifty pounds as well as handle and grip tools to assembly products.

The records of Presence Mercy Medical Center on April 9, 2013 indicate petitioner had complaints of pain in right elbow and left hand after performing repetitive lifting twisting and turning at work. He was later referred to orthopedic surgeon, Dr. Velagapudi. Dr. Velagapudi described petitioner's work activities as those that would aggravate his symptoms in his right elbow and left hand.

Dr. Fajardo, who examined petitioner on June 7, 2013 for what Dr. Fajardo described as status post work injury two months before; with signs of a left carpal tunnel syndrome and right elbow arthritis.

Dr. Henderson of Dreyer Medical Clinic, who saw petitioner on September 12, 2013 due to pain in the right elbow and tingling in left hand, described the mechanics of the injury as repetitive work.

Dr. Prinz, who examined petitioner at his attorney's request, determined petitioner had suffered right elbow arthritis and carpal tunnel syndrome caused by the use of vibration tools and repetitive heavy work.

Dr. Vender did not believe petitioner sustained repetitive carpal tunnel syndrome injury in that he did not believe petitioner had left carpal tunnel syndrome. Dr. Vender also did not find the osteoarthritis of petitioner's right elbow was caused by petitioner's work; rather was degenerative in nature.

The Arbitrator, taking into consideration all of the foregoing evidence, finds petitioner sustained injuries to his left hand and right elbow in a repetitive accident that arose out of and in the course of employment with respondent on April 4, 2013.

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:

The evidence supports a finding that petitioner's left carpal tunnel condition, for which he underwent surgical repair on October 11, 2013, was caused by the repetitive work accident of April 4, 2013. Although petitioner testified he has some numbness in his palm, thumb, index and middle finger, according to Dr. White's record as of December 2, 2013, petitioner had a little scar soreness but overall the hand as to numbness and tingling were improved. He also advised Dr. White on May 11, 2015 that his left hand was doing okay.

The evidence also supports a finding that petitioner's osteoarthritis of the right elbow was not caused by the work activities, but was aggravated by the work activities. The Arbitrator notes petitioner had not worked for respondent after June, 2013 and he was not seen by Dr. White after December 2, 2013 for both the carpal tunnel syndrome and right elbow pain until May 11, 2015. At that time, petitioner had not been working for respondent for almost two years; yet petitioner advised Dr. White that his right elbow was hurting again. Dr. White's diagnosis was degenerative joint disease of right elbow.

Based upon the foregoing, the Arbitrator finds any ongoing problems with petitioner's right elbow was not the result of the work activities, but rather degenerative in nature.

J. With respect to the issue regarding medical bills, the Arbitrator makes the following conclusions of law:

As the Arbitrator determined petitioner had carpal tunnel syndrome on the left, that the carpal tunnel condition and the initial aggravation of petitioner's right elbow degenerative arthritis, was caused by the work accident of April 4, 2013, awards the following bills, to be paid pursuant to the fee schedule, §8 and §8.2 of the Act and subject to credit for payments made directly by respondent or pursuant to §8j:

$435.00 – Provena Mercy Medical Center

$1,311.00 – Hinsdale Orthopaedics

$620.00 – Castle Orthopaedics

$6,089.00*- Dreyer Medical Clinic

*The Arbitrator disallowed the bills totaling $933.00 for the bills from July 27, 2013, November 16, 2013, December 3, 2013 and May 20, 2014 as there were no medical records to support the claim; the $193.00 bill of November 16, 2013 as it was treatment for diabetes; and did not find the May 11, 2015 bill of $83.00 to be related to the April 4, 2013 accident.

K. With respect to the Arbitrator's decision with regard to TTD, the Arbitrator makes the following conclusions of law:

Petitioner claims to be temporarily totally disabled from June 4, 2013 to December 2, 2013. As early as April 9, 2013, it appears from Petitioner's Exhibit 1, that he was released to

return to work with restrictions. On April 16, 2013, petitioner was released to return to work with restrictions. On May 7, 2013, Dr. Velagapudi released petitioner to restricted work of no lifting greater than 20 pounds. Despite the work restrictions, petitioner confirmed he was able to work until June, 2013. Dr. Fajardo reported petitioner was unable to work as of June 28, 2013.

On December 2, 2013, Dr. White released petitioner to return to work as it relates to his carpal tunnel syndrome. Dr. White also, equivocally, released petitioner to return to work without restrictions as it related to the elbow stating: "Either his employer needs to find some less repetitive work to do with the right arm, or he needs to return to work regular duty and accept the pain in his elbow, or he needs to find different employment."

Based upon the foregoing, the Arbitrator finds petitioner proved he was temporarily totally disabled from June 4, 2013 to December 2, 2013, and awards temporary total disability for this period, which is 26 weeks, at the rate of $586.67 per week.

Respondent is allowed credit pursuant to §8j $10,157.70 paid in non-occupational benefits.

L. In support of the Arbitrator's decision with regard to the nature and extent of petitioner's injury, the Arbitrator makes the following conclusions of law:

Despite the two negative EMGs, petitioner had positive Tinel and Phelan signs and was diagnosed by Dr. Velagapudi, Dr. White and Dr. Fajardo with carpal tunnel syndrome. Further indication that petitioner had carpal tunnel syndrome was the fact that he had improvement after the carpal tunnel surgery. As for the claimed right elbow injury, the Arbitrator finds petitioner suffered only an aggravation of osteoarthritis with minimal residuals related to the work injury.

Pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

With regard to subsection (i) of §8.1b (b) the Arbitrator notes that there was no permanent partial disability impairment rating provided. The Arbitrator, therefore, cannot give any weight to this factor.

With regard to (ii) of §8.1b (b) the occupation of the injured employee, the Arbitrator notes petitioner was employed as a large valve assembler that required petitioner to carry, push and pull up to 50 pounds, as well as handle and grip tools to assemble product. Therefore, the Arbitrator gives more weight to this factor.

With regard to (iii) of §8.1b (b) the age of the employee at the time of the injury was 63 years of age. Therefore, the Arbitrator gives little weight to this factor.

With regard to (iv) of §8.1b (b) the employee's future earning capacity, the Arbitrator notes although petitioner claims he is unable to work in his previous occupation, and as a result has a loss of earning capacity, the Arbitrator finds that the inability to return to work, if any, is the result of the unrelated, osteoarthritis of the right elbow and not the carpal tunnel syndrome. The Arbitrator, therefore, gives no weight to this factor.

With regard to (v) of §8.1b (b) evidence of disability corroborated by the treating medical records, the Arbitrator noted Dr. White's records indicated petitioner had a little scar soreness but overall the hand as to numbness and tingling was improved. According to Dr. White's May 11, 2015, petitioner's left hand was doing okay. As for the right elbow, the medical evidence fails to support the claim that the ongoing degenerative arthritis was in any significant way the result of the work accident.

Based on the above factors, and the record taken as a whole, the Arbitrator finds Petitioner sustained permanent partial disability to the extent of 15% loss of use of the left hand under §8 (e) 9 and 5% loss of use of the right arm §8 (e) 10 of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	05WC056531
Case Name	EVANS, PEGGY v. GIBSON ELECTRIC & TECHNOLOGY SOLUTIONS
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0331
Number of Pages of Decision	38
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Stuart Galesburg
Respondent Attorney	Paul Coghlan

DATE FILED: 6/30/2021

/s/ Thomas Tyrrell, Commissioner

Signature

21IWCC0331

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

Peggy A. Evans,

Petitioner,

vs. NO: 05 WC 56531

Gibson Electric & Technology Solutions,

Respondent.

DECISION AND OPINION ON REVIEW

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

After carefully considering the evidence, the Commission affirms the Arbitrator's conclusions regarding all disputed issues in this matter. However, the Commission makes certain minor changes to the Decision. First, the Commission modifies the Arbitration Decision Form so that it accurately reflects the conclusions of the Arbitrator as explained fully in the Arbitrator Decision. After thoroughly examining all the evidence, the Arbitrator concluded that Petitioner failed to meet her burden of proving she sustained any psychological injury or condition due to the July 14, 2004, work accident. The Commission agrees with this conclusion. The Arbitrator wrote in the Findings section of the Decision Form only that Petitioner's current condition of ill-being is causally related to the accident. The Commission modifies this sentence to read as follows:

> Petitioner's current condition of ill-being relating to her lumbar spine, cervical spine, and bilateral hands *is* causally related to the accident. **Petitioner's alleged psychological condition *is not* causally related to the accident.**

The Arbitrator also concluded that Petitioner met her burden of proving she sustained a 40% loss of use of the whole person pursuant to Section 8(d)(2) of the Act as well as a 5% loss of use of each of her hands pursuant to Section 8(e) of the Act. The Commission affirms the award

of permanent partial disability; however, the Commission must correct an error made by the Arbitrator when calculating the value of the award. The Arbitrator calculates the award of 5% loss of use of each hand as a total of 20.5 weeks (10.25 weeks per hand) pursuant to Section 8(e) of the Act. However, the date of accident is July 14, 2004. Thus, the Commission finds that 5% loss of use of each hand calculates to a total of 19 weeks (9.5 weeks per hand). The Commission therefore modifies the relevant portion of the Order section of the Decision Form to read as follows:

> The respondent shall pay the petitioner the sum of $567.87/week for a further period of **19 weeks**, as provided in Section 8(e) of the Act, because the injuries sustained caused 5% loss of use of each hand.

Additionally, while the total award of permanent partial disability is clearly stated in the Order section of the Decision Form, the Arbitrator inadvertently failed to include the award of 5% loss of use of each hand in the final paragraph on page 28 of the Decision. The Commission therefore modifies the final paragraph on page 28 to read as follows:

> Based on all of the above and other factors for which evidence was presented as required by law, and after carefully reviewing the testimony and exhibits offered by both sides, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 40% loss of use of the person as a whole, or 200 weeks of PPD benefits, pursuant to §8(d)(2) of the Act. **The Arbitrator also finds that Petitioner sustained permanent partial disability to the extent of 5% loss of use of each hand, or 19 weeks of PPD benefits, pursuant to §8(e) of the Act.**

Finally, the Commission modifies the relevant portion of the Order of the Arbitrator included on page 29 of the Decision to include the correct calculation of the award of 5% loss of use of each hand. The Commission modifies the final sentence on page 29 to read as follows:

> The Respondent shall pay the petitioner the sum of $567.87/week for a further period of **19** weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused 5% loss of use of each hand.

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on February 21, 2017, is modified as stated herein.

IT IS FURTHER ORDERED that Petitioner's current condition of ill-being regarding her lumbar spine, cervical spine, and bilateral hands is causally related to the July 14, 2004, work accident. Petitioner's alleged psychological condition is not causally related to the work accident.

IT IS FURTHER ORDERED that Respondent shall pay Petitioner permanent partial disability benefits of $567.87/week for 200 weeks, because the injuries sustained caused the 40% loss of the person as a whole, as provided in Section 8(d)2 of the Act. Respondent shall also pay Petitioner permanent partial disability benefits of $567.87/week for 19 weeks, because the injuries sustained caused the 5% loss of each hand, as provided in Section 8(e) of the Act.

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

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

June 30, 2021

o: 5/18/21
TJT/jds
51

/s/ *Thomas J. Tyrrell*
Thomas J. Tyrrell

/s/ *Maria E. Portela*
Maria E. Portela

/s/ *Kathryn A. Doerries*
Kathryn A. Doerries

21IWCC0331

EVANS, PEGGY A
Employee/Petitioner

Case# **05WC056531**

06WC008968

GIBSON ELECTRIC & TECHNOLOGY SOLUTIONS
Employer/Respondent

On 2/21/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.64% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0207 STUART H GALESBURG
ATTORNEY AT LAW
4548 W PRATT AVE
LINCOLNWOOD, IL 60712

2986 PAUL A COGHLAN & ASSOC
15 SPINNING WHEEL RD
SUITE 1000
HINSDALE, IL 60521

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

PEGGY A. EVANS
Employee/Petitioner

v.

GIBSON ELECTRIC & TECHNOLOGY SOLUTIONS
Employer/Respondent

Case # **05** WC **56531**

Consolidated cases: **06 WC 8968**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **July 6, 2015, July 7, 2015, July 23, 2015, August 10, 2015, August 11, 2015 & September 15, 2015.**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **7/14/2004**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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 **$3,049.20**; the average weekly wage was **$1,386.00**.

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

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

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

Respondent shall be given a credit of **$124,734.41** for TTD, **$.00** for TPD, **$.00** for maintenance, and $ for other benefits, for a total credit of **$124,734.41**.

Respondent is entitled to a credit of **$.00** under Section 8(j) of the Act.

ORDER

- The respondent shall pay the petitioner temporary total disability benefits of $ **924.00**/week for **145 & 4/7ths** weeks, from **7/15/2004** through **4/29/2007** , which is the period of temporary total disability for which compensation is payable. Respondent shall receive a credit for compensation paid in the amount of $124,734.41.

- The Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of unpaid medical remaining in the amount of **N/A**, as provided in Sections 8(a) and 8.2 of the Act. The respondent shall be given a credit for other medical benefits that have previously been paid.

- The respondent shall pay the petitioner the sum of **$567.87**/week for a further period of **200** weeks, as provided in Section **8(d)(2)** of the Act, because the injuries sustained caused **40% loss of use of the person as a whole.** .
  The respondent shall pay the petitioner the sum of **$567.87**/week for a further period of **20.5** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **5% loss of use of each hand** .

- The respondent shall pay the petitioner compensation that has accrued from **7/14/2004** through **9/15/2015** , and shall pay the remainder of the award, if any, in weekly payments.

- The respondent shall pay the further sum of $ **N/A** for necessary medical services, as provided in Section 8(a) 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.

Deborah L. Simpson

Arbitrator Deborah L. Simpson

February 16, 2017
Date

FEB 21 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Peggy A. Evans,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 05 WC 56531**
	)	**06 WC 8968** (separate decision issued)
	)	
Gibson Electric Co., et.al.,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on July 14, 2004, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer.

At issue in this hearing is as follows: (1) Did an accident occur that arose out of and in the course of the Petitioner's employment with Respondent; (2) What was the date of the accident; (3) Was timely notice of the accident given to Respondent; (4) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (5) What were the Petitioner's earnings; (6) were the medical services that were provided to Petitioner reasonable and necessary and has the Respondent paid all appropriate charges for all reasonable and necessary medical services; (7) Is Petitioner entitled to TTD and/or maintenance; (8) What is the nature and extent of the injury; (9) Should penalties or fees be imposed upon the Respondent; and (10) Is Respondent due any credit.

Case number 06 WC 8968 was consolidated with this case. The cases were heard simultaneously. There are separate stipulation sheets for each case. There is one transcript of all the testimony and one set of exhibits. There will be a separate decision issued for each case.

STATEMENT OF FACTS

On July 14, 2004 petitioner was 47 years of age and employed as an electrician by Respondent. Petitioner had been working for the Respondent since June 28, 2004. At that time she was paid $34.65 per hour. According to the Petitioner the duties of an electrician include knowing the City of Chicago codes and OSHA standards; carrying a 10 foot ladder by yourself; carrying up to 80 pounds unassisted; being able to put pipes together, do the appropriate bends; putting the pipes together to run the circuits; pull wire, stoop, bend, squat or kneel to work on designated areas as called for; wire houses, install security systems and fire alarms; be able to

use power tools including saws alls; use a transformer to step volts down from 400 to 120; and drive a boom.

On July 14, 2004 the Petitioner began work at 7:00 a.m. Petitioner testified that when she started work she was fine. Petitioner was working at the University of Chicago, Comer Children's Hospital that day. Her foreman was Roger. Petitioner was assigned to read the blueprints for the fire alarm, check the physical layout of the alarm system and make sure it matched the blueprints. This assignment required her to climb ladders to examine the wiring in the ceilings which were twelve to fourteen feet high. Petitioner was using a ten foot ladder to make the inspections. Petitioner stated that she was up and down ladders, removing tiles from the ceiling, matching the fire alarms and their numbers ensuring that they matched the blueprints. She also had to check and make sure that they had the correct pipes in place so that it would be accurate. The blueprint drawings were large and Petitioner testified that she could not take them up on the ladder with her, so she would make a drawing of what she saw, get the numbers, take that down the ladder and compare it to the blueprint. If it matched she climbed back up the ladder and put the tiles back into place.

At some point that afternoon, after she put the ceiling tiles back in place she climbed back down the ladder. There was a ladder placed horizontally on its side behind her. Petitioner said she did not see the ladder and as she was walking backwards she backed into the ladder and fell over it, backwards. When she fell over the ladder she landed on her back and hands, with her buttocks in the space created by the rungs and sides of the ladder. She stated that her back hit the legs of the ladder and she injured her back and also her hands/arms at that time. She stated that her hands and arms were hurting right away because she tried to catch herself and prevent the fall. Petitioner testified that she hurt her head, neck, back, buttocks and fingers when she fell.

According to the Petitioner Roger and the crew came over to see what happened. Roger helped her up and asked if she was hurt. She said she told him that her fingers, shoulders and head hurt.

Jeff Marks, the General foreman came over as well. He advised her that because of the Safety Program / Policy she needed to go to the hospital and be examined by a doctor. After discussing the matter they decided to take her next door to the University of Chicago hospital. The Respondent's attorney indicated that the Respondent was not disputing that Petitioner fell over the ladder.

On July 14, 2004 Ms. Evans presented to University of Chicago Emergency Room. She told the examining physician that she fell backward over a ladder and landed on her back. On the intake form from the University of Chicago Hospital Emergency Department, Ms. Evans indicated that she had a previous injury resulting from an accident that occurred in 1998, however, it is not specified whether or not that was a workers' compensation matter, or what type the accident was. Upon examination, she complained of pain in the right upper arm and the little

finger of the left hand. There was no loss of consciousness. A bruise was noted on the right arm/shoulder. Ms. Evans has full range of motion in the little finger of the left hand. There was no swelling or deformity. X-rays taken of the left fifth finger and the right shoulder were negative for fracture. An x-ray of the right shoulder showed evidence of mild arthritis in the AC joint. She was diagnosed with multiple contusions, prescribed pain medicine, anti-inflammatories, and released from the ER to follow up with Employee Health Systems. Petitioner was given an off-work slip stating that she could return to work on July 19, 2004. (RX 18)

On July 21, 2004 Petitioner presented to May Medical Center complaining of pain in the neck and both shoulders, right thigh, pelvis and rear end. Petitioner was diagnosed with acute traumatic cervical radiculopathy, multiple hematomas of both shoulders, and a contused coccyx. Physical therapy was recommended and apparently undertaken at May Medical Center. Petitioner was taken off work. (PX 43)

Petitioner returned to May Medical Center for physical therapy in July (4 visits total in July) and August (9 visits) of 2004. She continued to complain of pain and tenderness, and said that she was unable to sleep due to the neck pain. (PX 43)

On August 10, 2004, Dr. May issued an off work slip that stated Petitioner was unable to work until August 23, 2004. (PX 43)

On September 3, 2004, Ms. Evans presented to Dr. Bergin for an initial consultation on referral from Dr. May. She complained of low back pain that radiated into her buttocks and neck pain that radiated bilaterally. Petitioner did not report any head pain despite her claim that she hit her head upon falling and complaints of her small finger on the left hand had resolved at this point. Petitioner reported that she had not undergone any x-rays, which is incorrect since x-rays were taken on the date of accident at the ER. Petitioner reported no other health problems at this time. X-rays of the cervical spine revealed disc space narrowing and osteophyte formation at C5-6 and, to a lesser extent, at C4-5 and C6-7. An X-ray of the lumbar spine revealed mild diffuse degenerative changes. X-rays of the sacrum and coccyx were normal. Ms. Evans was diagnosed as having a cervical strain/sprain. An MRI was ordered as well as physical therapy. She was maintained off work. (PX 39, 48)

On September 16, 2004 Petitioner underwent an MRI of the cervical spine revealed moderate to large central herniations at C4-5 and C5-6 that were causing moderate to severe central canal narrowing with posterior displacement of the cord. In addition, there was mild congenital spinal canal stenosis, straightening of the normally lordotic curve, and protrusions and/or herniations of the upper thoracic spine for which an MRI of the thoracic spine was recommended. An MRI of the Lumbar spine performed on the same date revealed a small central bulge at T12-L1, a small left paracentral protrusion at L3-4 and mild bulging at L4-5. (PX 39, 48)

On September 21, 2004 Petitioner presented to Dr. Bergin for follow up. Petitioner reported that since the accident she had begun dropping objects and difficulty maintaining coordination while walking. Dr. Bergin opined that Petitioner was suffering from herniated discs at C5-6 and C6-7 and opined that the herniations were caused by her fall at work. Dr. Bergin also diagnosed Petitioner as having early cervical myleopathy. Dr. Bergin ordered an MRI of the thoracic spine without infusion. Dr. Bergin recommended surgery consisting of an anterior cervical discectomy and fusion at C5-6 and C6-7. Dr. Bergin indicated that if petitioner did not proceed with decompression surgery petitioner may develop a neurological deficit. (PX 39, 48)

On October 26, 2004 Petitioner returned to Dr. Bergin for follow-up. The physical exam was unchanged from the prior visit. Dr. Bergin recommended a decompression and fusion of Ms. Evans's cervical spine. She was to be seen again after the IME. (PX 39, 48)

Petitioner was evaluated at the employer's request by Dr. Rabin on November 22, 2004. In her medical history form for that evaluation, Petitioner indicated that physical therapy made the pain worse. This is included in Dr. Rabin's IME report. Dr. Rabin reviewed the MRIs, though it is not clear whether he reviewed the actual films, and opined that Petitioner had some diffuse disc bulges in the lumbar spine and osteophytic disc complex at C4-5 and C5-6. Ms. Evans had no findings of myleopathy. The neurological exam was normal. Dr. Rabin found a causal relationship based on the fact the Petitioner denied any symptoms prior to the fall. Dr. Rabin recommended that epidural steroid injections be tried before surgical intervention. In addition, he recommended further physical therapy. (PX 35)

On December 9, 2004, Petitioner returned to Dr. Bergin for follow-up. Petitioner's main complaint on this date was neck pain that radiated into her upper extremities. Petitioner did not report and complaints with respect to her low back and buttocks. Per Dr. Rabin's IME opinions Dr. Bergin prescribed a course of epidural steroid injections and additional physical therapy. Petitioner was to remain off work at that time.

On December 23, 2004 Petitioner presented to The Comprehensive Pain Management Group for an initial evaluation and was seen by Dr. Howard Konowitz. Petitioner's pain complaints, particularly around the bilateral orbital pain, were noted to be very vague. The records also noted that petitioner was very vague regarding leg pain in which petitioner replied that "the pain can come anywhere on my legs." Petitioner also reported three occasions of losing bladder control since the accident but stated that she had not sought any medical treatment for it. The nurse noted a high pain score and positive depression score using the Beck's test. The doctor's impression was a herniated disc at C5-6 and C67, with early cervical myelopathy and diffuse bulges at L3-4 and L4-5. The nurse recommended pain medication, an EMG of her bilateral upper extremities by Dr. Piekos, and a cervical epidural steroid injection. It was recommended that petitioner return after the injection for further evaluation. (PX 49)

On January 31, 2005, Petitioner presented to Dr. Piekos at Midwest Neurology Associates for an NCS/EMG study. The NCS revealed bilateral carpal tunnel syndrome. Petitioner did not complete the needle portion of the study on that date due to her subjective complaints of pain. (PX 49)

On February 8, 2005 Petitioner returned to Dr. Bergin. Dr. Bergin noted that she was being evaluated for epidural steroid injections by Dr. Konowitz, but did not receive an injection. Petitioner was kept off work. (PX 48)

On February 11, 2005, Petitioner presented to Dr. Konowitz for re-evaluation. The EMG was reviewed that revealed carpel tunnel syndrome right greater than left. Petitioner was diagnosed as having occipital neuralgia, bilateral carpel tunnel, and cervical disc protrusion. A nerve block was deferred because Ms. Evans had a cold. Petitioner was referred to Dr. Visotsky for assessment of petitioner's carpal tunnel syndrome. (PX 49)

On March 11, 2005 petitioner presented to Dr. May. Petitioner advised that Dr. Bergin wanted to proceed with surgery. Notes indicate that petitioner attempted to undergo an EMG/NCV but was unable to complete the procedure. (PX 43)

A prescription note of March 4, 2005 provides petitioner with a prescription for Xanax. It appears that Dr. Piekos prescribed two tablets for petitioner to take prior to the EMG/NCV study due to petitioner's inability to complete the first test. Office notes for this date indicate that another date was scheduled to finish the testing but petitioner failed to appear. (PX 48)

On March 17, 2005, Petitioner returned to Midwest Neurological Associates to complete the EMG test which had previously ended prematurely due to pain complaints in January. The test showed median neuropathy in both wrists indicative of carpal tunnel syndrome. The test again ended prematurely due to petitioner complaining of too much pain. (PX 49)

On April 6, 2005 petitioner presented to Dr. Gireesan. Dr. Gireesan advised that petitioner would have to either deal with the pain or undergo surgery. Petitioner was continued off of work and advised to follow up in 1 month. (PX 44, 51, 67)

On April 7, 2005 Petitioner returned to Dr. Konowitz for re-evaluation. It was noted that petitioner had previously been scheduled for an occipital nerve root injection in February but that it had been cancelled due to Petitioner having the flu. Dr. Konowitz reviewed an EMG study which showed carpal tunnel syndrome. Dr. Konowitz noted the EMG was negative for cervical radiculopathy, bracioplexopathy, and myopathy. It was also noted that petitioner was referred to Dr. Visotsky regarding her carpal tunnel syndrome but had not contacted the doctor to set up an exam due to insurance reasons. Dr. Konowitz adjusted petitioner's prescriptions and again recommended a consultation visit with Dr. Visotsky. (PX 49)

On April 18, 2005 Ms. Evans presented to Dr. Schmell for evaluation. She was not referred by any of her doctors, but by an "old patient" of Dr. Schmell. She was diagnosed as having bilateral carpel tunnel syndrome, cervical disc herniation with radiculopathy, and lumbar disc derangement. Dr. Schmell wanted to review the EMG/NCV study before planning any course of action. Dr. Schmell took Petitioner off work from April 18, 2005 through June 1, 2005. (PX 54, RX 31)

On April 19, 2005 Pet presented to Dr. Visotsky for evaluation of her carpal tunnel syndrome as a referral from Dr. Konowitz. Petitioner reported pain in her neck, shoulder, and a new complaint of bilateral hand pain with dysesthesias. Dr. Visotsky recommended a carpel tunnel release but indicated a full work up would be needed first due to family history of diabetes and endocrine and thyroid work up. (PX 48)

On May 4, 2005 petitioner returned to Dr. May regarding follow up after her EMG/NCV study for left arm pain and numbness. Petitioner advised that the study attributed her complaints to a C5-6 disc bulge. Petitioner continued to complain of left arm swelling. Dr. May noted that blood work was needed prior to completing any injections. Petitioner returned on May 11, 2005 for the blood tests. It appears that petitioner was scheduled for a follow up to review the test results on May 20, 2005 but the notes on this date are blank. (PX 43)

On May 31, 2005 Petitioner was examined by Dr. Visotsky. Dr. Visotsky did not recommend carpal tunnel surgery because the objective tests did not correlate with Petitioner's subjective complaints. Petitioner presented to the office visit with her daughter, at C7 complete quadriplegic. Dr. Visotsky recommended that she sit down with either Dr. Bergin or Dr. Rabin and discuss the nature of the cervical disc surgery to help alleviate some of her hesitancy. (PX 48)

Petitioner was re-evaluated by Dr. Rabin on June 20, 2005. She was complaining of problems in her bilateral arms. The nerve conduction study showed bilateral carpal tunnel syndrome, however, it is reported that Petitioner did not go for the epidural steroid injections because she said, "I don't want a temporary solution. I want a permanent solution." She complained of posterior occipital pain, pain in the neck and pain radiating down her arm. She reported that she had bilateral hand tingling and, at its worst, she had spasms where her arm would be clutched to her chest and her hand would become deformed like a claw. Dr. Rabin noted that the EMGs only showed bilateral carpel tunnel syndrome and that the carpel tunnel syndrome was not related to Petitioner's symptoms since she was experiencing radicular symptoms. In addition, the EMGs did not show any evidence of radiculopathy. Dr. Rabin opined that Petitioner did not have carpel tunnel syndrome as she did not have a positive Tinel's or Phalen's sign, nor were her symptoms consistent with carpel tunnel syndrome. Dr. Rabin reviewed the MRI scan which showed disc complex at C4-5 and C5-6. Petitioner still had not had any epidural steroid injections as recommended. Dr. Rabin again recommended epidural steroid injections, but Petitioner was refusing those. Dr. Rabin expressed concern over her desire

to return to work. He also expressed concern that she would not improve even with surgery. He reported that due to the findings of her MRI it would not be unreasonable to proceed with an anterior cervical discectomy and fusion. It was noted that petitioner and her daughter were "relatively hostile and poorly cooperative." (PX 35)

On August 9, 2005 Dr. Bergin issued an off work slip keeping Petitioner off work until reevaluation. He also ordered an MRI of the cervical spine without contrast. (PX 48)

On August 17, 2005 Petitioner returned to Dr. May. She complained of pain in the heels of her feet as well as shooting pain down both arms. Dr. May's assessment was a bulging disc. (PX 43)

On August 22, 2005 an MRI of the cervical spine was performed at Holy Cross Hospital. It revealed degenerative changes with sulci at C3-4 and C4-5. At C4-5, there was a large central and paracentral disc herniation causing some mild spinal stenosis. It was associated with large posterior and anterior osteophytes. At C3-4 there were posterior and anterior osteophytes which were associated with a small central disc bulge, but no herniation.

On August 23, 2005, Petitioner returned to Dr. Bergin. It was noted that he had not seen petitioner in about six months, since February 8, 2005. Petitioner reported that she decided not to undergo epidural injections due to the potential risks/side effects. Again petitioner's complaints consisted of neck with corresponding upper extremity pain. No mention of petitioner's lumbar spine was made. Due to age of prior MRI studies the doctor ordered a repeat study. Petitioner was continued off of work. (PX 48)

On September 26, 2005 Petitioner presented to Dr. Bovis for a consultation at Dr. Bergin's request. Petitioner offered a consistent accident history. She reported a spasticity of her left upper arm, worse on the left than right. She reported, apparently for the first time, some occasional bowel and urinary incontinence and irritable bowel syndrome. A neurological examination revealed that Petitioner had hyperreflexia on the left hemi body and an up going toe on the left. The MRI was reviewed that revealed a herniated disc at C4-5 and a large herniated disc with cord compression at C5-6. Dr. Bovis reported that it appeared that she had myelopathy related to C4-5 and C5-6 discs. Dr. Bovis recommended proceeding with an anterior cervical discectomy and fusion at C4-5 and C5-6. (PX 48)

There is a note from Dr. Bergin dated October 11, 2005, in which he reports that the herniated discs are at C4-5 and C5-6 and that these are the levels that would need to be addressed in the two level fusion. Dr. Bergin reported that C6-7 did not need to be addressed.

On October 14, 2005, Petitioner presented to Dr. Bergin for an appointment. Dr. Bergin's notes report that she had a terrible toothache and went to take care of that and rescheduled the appointment.

On October 18, 2005 Petitioner returned to Dr. Bergin. Petitioner reported a desire to have the surgery performed but it was noted that petitioner had already undergone the repeat MRI but did not bring it with her to the exam so that the doctor could review it. Petitioner was advised to follow up in six weeks. (PX 48)

On November 11, 2005 Petitioner retuned to Dr. May for a pre-surgical workup.

On November 29, 2005 she returned to Dr. Bergin. She continued to complain of neck pain radiating into her arms. On this date, Dr. Bergin apparently reviewed the MRI from August 22, 2005 and reported that Petitioner needed an anterior cervical discectomy and fusion at C4-5, C5-6, and "to a lesser extent" C6-7. Dr. Bergin recommended a C4-5 and C5-6 decompression. The surgery was hypothetically scheduled for December 14, 2005 in conjunction with Dr. George Bovis.

Petitioner returned to Dr. May on November 30, 2005 for additional pre-surgical exam.

On December 7, 2005 there is a letter from Mr. Cooper confirming Ms. Evans's request for a second orthopedic evaluation. It was scheduled for January 4, 2006 with Dr. Srdjan Mirkovic of Northwestern. (PX 37)

There is a report from Dr. Bergin dated December 23, 2005 indicating that he received a request from the medical records department at Illinois Bone and Joint Center to amend Petitioner's medical records at her request. It appears Petitioner wanted amendments to the clinical notes dated August 23, 2004, October 18, 2005, and November 29, 2005. These requests had to do with the timing of her surgery and her request for a second opinion. Dr. Bergin reported that when he saw Petitioner on October 18, 2005, he wanted to get the surgery done within the next six weeks. Petitioner needed to get workers' compensation approval and preoperative clearance. Dr. Bergin reported his recollection that Petitioner requested having the surgery done after the first of year so that she had adequate family support. Dr. Bergin reported that when he saw her on November 29, 2005, she was requesting an earlier date for surgery because of what the doctor thought of as pressure by the workers' compensation carrier. The date of December 14, 2005 was settled on, but Petitioner wanted to get another opinion by Dr. Mirkovic. Dr. Bergin reported that Petitioner postponed the operation at that point and that as of the date of this report there was not a date set for surgery. The doctor reported he did not know whether or not Petitioner had a second opinion by Dr. Mirkovic, but that she was to call when she wanted to reschedule surgery. (PX 48)

On January 13, 2006 Petitioner presented to Dr. Gireesan for evaluation. She complained of pain in the neck with radiation into both upper extremities and occasional radiation into the lower extremities. Dr. Gireesan diagnosed her as having intervertebral disc disorder of C4-5 and C5-6 level, aggravated by the work injury and discogenic lower back pain aggravated by the work injury. She was to get an X-ray and MRI of the lumbosacral spine to be reviewed. Petitioner was also to present her MRI studies to Dr. Gireesan for his review. Petitioner was to

remain off work and provided a disability certificate indicating that petitioner was totally incapacitated. (PX 44)

On January 25, 2006, Petitioner presented to Advanced Medical Imaging Center where an MRI of her lumbar spine without contrast was performed. The impression was L5-S1 and L3-L4 disc herniations, multilevel degenerative disc changes, and multilevel facet joint degenerative changes that were reported might contribute to clinical symptoms. At L5-S1, there was a left nueral foraminal contained disc herniation that was restrained medially by the posterior ligament and laterally by disc fibers. There was mild left lateral spinal canal stenosis. At L4-5 there was a disc bulge on a bilateral facet arthropathy. At L3-4 there was a left nueral foraminal contained disc herniation restrained by the disc fibers without stenosis. There was the potential for left L3 radicular symptoms. At L2-3 there was circumferential disc bulging without significant stenosis. At L1-2 there was no significant disc abnormality. (PX 44)

Petitioner underwent an MRI of the thoracic spine on March 14, 2006 at MRI of River North. The MRI showed bulging at various levels but no impingement on the spinal cord. Petitioner also underwent an MRI of the cervical spine. The MRI showed a large herniated disc at C4-5 and C5-6 and moderate bulge/possible herniation at C7-T1. (PX 44)

On March 27, 2006 petitioner presented to Elite Physical Therapy for initial evaluation. Petitioner reported chronic cervical pain with some pain in her mid to low back. She reported episodes of numbness and tingling in her upper extremities that followed no pattern. She also reported some loss of bowel and bladder control and dull leg pain. Petitioner reported that she was diagnosed with bilateral carpel tunnel syndrome and disc herniations at C5-6 and C6-7. She treated at Elite from March 27, 2006 through May 11, 2006 when she discharged herself. (PX 55) Ms. Evans missed physical therapy on April 3, April 17, April 19, and April 26, 2006. Overall petitioner did not progress with therapy. (PX 55)

Petitioner transfered her therapy to Professional Physical Therapy from approximately May 10, 2006 through August 4, 2006 at which time the therapist recommended an additional 3-4 weeks of therapy. Petitioner was ultimately discharged on August 28, 2006 after petitioner failed to return for further treatment. There is a letter included in the records to Dr. Gireesan advising that petitioner was complaining of an electrical shock feeling to her face. Dr. Gireesan later advised petitioner to present to the ER if the shock occurred again. Another note included is a call from petitioner on July 14, 2005 in which petitioner reported that her hand went limp and she felt tingling. The physical therapist advised petitioner to go to the ER. There were no records offered into evidence establishing that the Petitioner sought medical treatment for the shocks, tingling or limpness she complained of. (PX 50)

On March 14, 2006, Petitioner had another MRI examination of her cervical spine and her thoracic spine. The cervical spine MRI showed large herniated discs at C4-5 and C5-6 with

a disc bulge at C7-T1. The thoracic MRI showed bulging discs with no cord compression at any level.

On March 23, 2006 Petitioner presented to Dr. Gireesan. At that time Petitioner was still complaining of pain in the neck area that radiated to the upper extremities as well as some spasms and tingling in the bilateral upper extremities. MRIs were reviewed that were reported to show a herniated disc at C5-6 and C6-7. In addition, the doctor reported that the MRI revealed a bulging disc at L5-S1. This correlates to the MRI reports. The doctor discussed treatment, however surgery was not mentioned. Petitioner was given the choice of steroid injections or physical therapy. Petitioner chose to try physical therapy. This was prescribed at 3 times a week for four weeks. Petitioner was kept off work with a disability certificate and to return in one month. (PX 44)

On March 27, 2006 petitioner presented for physical therapy at Elite Physical Therapy. The therapist noted that petitioner's symptoms were "highly irritable subjectively" and that it was "difficult to assess her pathology secondary to subjective pain with all motions and palpation locations." (PX 55)

An April 27, 2006 physical therapy update indicates that petitioner's main complaint at this time was thoracic pain. Petitioner did continue to note bilateral upper extremity numbness and tingling along with cervical pain. (PX 55)

On May 4, 2006, Petitioner returned to Dr. Gireesan for follow up. She continued to complain of the same type of pain and added that she had difficulty sleeping. It was reported that petitioner was making slow progress in physical therapy. Clinical examination showed no cranial nerve paralysis. Strength was 5/5 in the bilateral upper and lower extremities. Range of motion in the neck revealed some pain with extension and extreme flexion. The doctor reported that the MRI revealed a herniated disc at T4-T5, however the MRI report indicates only a disc bulge. Treatment options were again discussed, though there is no mention of surgery. It was reported that petitioner "wants to pursue the physical therapy treatments." Petitioner was kept off work, and to return in a month for follow up. Petitioner was provided a disability certificate from 5/4/2006 until further notice. (PX 44)

In the summer of 2006 petitioner enrolled in college courses at Kennedy King College consisting of statistics and composition. On or about April 30, 2007 Petitioner signed an agreement to work as a realtor with Schleder Referral Service. It appears that the Petitioner never showed up to work this position, however, the Arbitrator finds that at the very least the Petitioner was capable of returning to work and also able to find work in the competitive labor market without assistance as of this date, and was at MMI absent any reversal of her decision not to proceed with the cervical surgery which had been offered to her. (RX 4, 5, 6)

Petitioner testified at the hearing that she had decided against having surgery to attempt to improve her medical condition. She did not request that surgery be awarded at the time of

trial. During the course of the hearing the Petitioner alleged many roadblocks to her being capable of proceeding with surgery including hypertension and dental issues neither of which are related to the injuries she sustained on July 14, 2005. As such the testimony and evidence offered and admitted regarding those issues are not relevant.

On June 8, 2006 Petitioner was seen again by Dr. Gireesan. The doctor noted that Petitioner had been attending physical therapy and was making steady progress. The doctor wrote that, "she informed that the first physical therapy was not very helpful at all. She does like the present physical therapy outfit." The doctor's examination was essentially normal, although the doctor continued his diagnosis of C4-C5 and C5-C6 herniated discs that were aggravated as a result of a work related injury and a herniated disc at the T4-5 level as the result of a work related injury. The doctor indicated that she was to continue physical therapy three times a week for four weeks and that after she had completed at least three months of physical therapy he would obtain a functional capacity evaluation. She was given a prescription of Lyricia and Amitriptyline. The doctor continued the off work restrictions. It does not appear that Petitioner ever advised Dr. Gireesan that she had a contract to begin selling real estate or was working on getting her real estate license. (PX 44)

On July 6, 2006 the therapists at Professional Physical Therapy wrote a letter to Dr. Gireesan noting some improvement with therapy and recommending that Petitioner continue physical therapy for 3-4 weeks to further decrease pain and continue physical therapy for 3-4 weeks to further decrease pain and increase function. (PX 44, 50)

On the same date, July 6, 2006, Petitioner returned to Dr. Gireesan. Petitioner reported that she was making progress with physical therapy. Petitioner continued to complain of pain in the neck area. Dr. Gireesan suggested that petitioner continue with physical therapy. He reported that once petitioner completed the physical therapy she would start a work hardening program and an FCE to determine her capabilities. Petitioner reported that she got an electric shock sensation a few times and was told that if it happened again she should go to an emergency room to have that evaluated. Petitioner was to continue physical therapy 3-4 times a week for an additional 4 weeks. Petitioner was kept off work. Petitioner was to return in a month for follow up. (PX 44)

Petitioner returned to May Medical Center on July 21, 2006 complaining of "shocks" in her face and sharp pain in the left arm. There is nothing further stated about these shocks but it is noted that petitioner "still does not want surgery." (PX 43)

On August 14, 2006 Petitioner returned to Dr. Gireesan for follow up. Petitioner still had the same complaints, but stated that hot baths and physical therapy were helping. Petitioner reported that the pain returned if she was active. The doctor suggested that Petitioner continue with physical therapy for 4 weeks and then transition into work hardening and ultimately an FCE

to establish Petitioner's capabilities for work. When Dr. Gireesan brought up the potential release to return to work, the Petitioner again began to suggest that she now wanted surgery.

Petitioner began a course of physical therapy at Therapy Providers of America on August 17, 2006. Petitioner was ultimately discharged on October 13, 2006 due to plateauing. (PX 50)

On August 24, 2006 petitioner was evaluated by Dr. Alexander Ghanayem for an IME at the request of the employer. Petitioner provided consistent history of accident and advised that surgery had been recommended, however she had not undergone the procedure. Dr. Ghanayem opined that petitioner suffered an aggravation of her cervical spondylosis and/or disc disease as a result of her fall at work. Dr. Ghanayem agreed that petitioner was a surgical candidate for a two level fusion at C4-5 and C5-6 with discectomy. No surgery was recommended for the thoracic or lumbar spine. Dr. Ghanayem opined that petitioner would be at maximum medical improvement approximately 6 months post-surgery. (PX 45, 46)

On September 14, 2006 Petitioner returned to Dr. Gireesan for follow up. Petitioner complained of the same pain, adding pain in the lower back radiating into the bilateral legs. Clinical examination revealed limited range of motion in the neck area, but was otherwise normal. Petitioner was scheduled to see Dr. Cybulski, a neurosurgeon, and to continue physical therapy 3 times a week for 4 weeks and to remain off work. (PX 44)

There is a physical therapy progress note from Therapy Providers of America dated September 22, 2006 indicating that Petitioner was progressing with physical therapy. Petitioner is quoted as saying, "I feel well when I come to therapy, but at night it acts up again." Petitioner was discharged from therapy on October 13, 2006. The discharge note indicates that petitioner's condition was unchanged. (PX 50)

On October 16, 2006 Petitioner returned to Dr. Gireesan for a follow up. She continued to complain of neck pain and spasms. Petitioner reported that she was seen by Dr. Cybulski, however, Dr. Gireesan did not have his evaluation. Clinical examination revealed a normal gait and 5/5 strength in the bilateral upper and lower extremities. The doctor suggested that Petitioner undergo an FCE and gave her a prescription for that. Petitioner was to return after the FCE was performed. Also Dr. Gireesan provided petitioner with a disability certificate which indicated that petitioner was totally incapacitated. (PX 44)

On October 23, 2006 petitioner presented to Dr. May. Petitioner reported a muscle spasm in her low back. Petitioner noted that she was scheduled for an FCE exam and treating with Dr. Cybulski. (PX 43)

Petitioner presented for said FCE evaluation on November 2, 2006. The FCE placed petitioner at a sedentary to light duty work level. Petitioner's work restrictions would include no lifting more than 10 pounds, no carrying, no pushing/pulling more than 20 pounds and no prolonged sitting for more than 30 minutes. Petitioner was deemed a good candidate for work

hardening. According to the FCE petitioner's educational level was a 3rd year college student. (PX 40)

On November 3, 2006, Petitioner presented to Dr. Cybulski for an evaluation. Petitioner offered a consistent accident history. Despite that fact that on examination Petitioner's strength was noted to be 5/5 on numerous occasions by Dr. Gireesan, Dr. Cybulski reported her strength in the right arm to be 4+/5 with a positive Spurling sign. Dr. Cybulski reported that the MRIs revealed degenerated discs at C4-5 and C5-6. Dr. Cybulski recommended an anterior C4-5 and C5-6 anterior cervical discectomy and fusion to be performed in conjunction with Dr. Gireesan.

On November 27, 2006 Petitioner returned to Dr. Gireesan. Clinical examination, motor examination, and sensory examination were all normal. The doctor reported that based on the recommendations of Drs. Ghanayem and Cybulski, Petitioner advised that she would like to have the two level discectomy performed. Petitioner was advised that the surgery would not address her subjective thoracic or lumbar pain, and that she may need continued physical therapy for to treat that. Petitioner was to have preoperative testing including preoperative dental testing prior to surgery. The doctor noted that Petitioner was having some dental work performed and he wanted a statement from her dentist that she could undergo surgery. The surgery was to be scheduled for some time in January 2007. Petitioner was to remain off work. (PX 44)

On January 29, 2007, Dr. Gireesan examined Petitioner and recommended that she be evaluated for high blood pressure in advance of surgery and recommended she see Dr. Nicholas. Also noted was that petitioner was undergoing dental surgery for tooth decay and infection. (PX 44)

On March 13, 2007, Petitioner met with Dr. Nicholas who indicated that he would begin working with her after she was cleared for surgery by the dentist. Dr. Nicholas indicated that there were no acute internal medicine issues presented to him by Petitioner. (PX 30)

On February 19, 2007 and March 29, 2007, Petitioner returned to Dr. Gireesan who noted that she was still undergoing dental procedures in order to be medically cleared for surgery.

On April 26, 2007, Petitioner was seen by Dr. Gireesan. He indicated that he would obtain a plain radiograph of the cervical spine area. He further indicated that she would need a two level fusion. It was reported that Petitioner had been cleared by the dentist for surgery, but that she was now being followed for high blood pressure. It was recommended that Petitioner see an internist for the high blood pressure. She was kept off work and provided a disability certificate. (PX 44)

On April 30, 2007 Evans signs agreement to sell real estate for Schleder Realty. Petitioner did not, however, actually show up and work the position. (RX 5)

On May 14, 2007, Petitioner returned to Dr. Gireesan. The doctor indicated that he reviewed letters from Petitioner's attorney. The doctor informed Petitioner that if the pain is severe she should decide to undergo surgery. The doctor indicated that options were discussed and suggested that she be seen by Dr. Cybulski to get a pre-operative evaluation. (PX 44)

On May 14, 2007 petitioner underwent x-rays at Northwestern Memorial Hosptial. The x-rays were interpreted as degenerative disk disease at C4-C7; most severe at C5-6 with loss of lordotic curve. (PX 51, 44) On May 15, 2007, she was seen by Dr. Nicholas for preoperative evaluation. She complained of bloating, headache, and high blood pressure. (PX 30)

On May 25, 2007, Petitioner returned to Dr. Nicholas advising him that she did not fill the prescribed medications. She was cleared for surgery with respect to her high blood pressure. She was given samples of Nexium for bloating and instructed to return in a week. (PX 30)

On June 6, 2007, Petitioner returned to Dr. Nicholas for preoperative follow up. She reported that the bloating continued. The doctor reported that she was not medically ready for surgery and recommended that she go to the county clinic for healthcare. The surgery was cancelled by Dr. Nicholas. (PX 30)

On June 12, 2007, Petitioner returned to Dr. Nicholas. Her blood pressure was recorded as 122/74. It was reported that her teeth were okay and that her EKG was okay.

On June 28, 2007, she returned to Dr. Gireesan for follow up. The doctor reported that she was scheduled for surgery, though the surgery had been cancelled. Apparently, Petitioner reported that she was not taking medication and she was not obtaining medical care through the county clinic as recommended by Dr. Nicholas. The doctor reported that she had high blood pressure. Petitioner was kept off work and provided with a disability certificate on this date.

On October 4, 2007 petitioner presented to Dr. Alexander Ghanayem for an IME re-evaluation. At this time petitioner alleged that she wanted to undergo the recommended spinal surgery but that other medical issues were preventing her from getting it done, specifically uncontrolled hypertension and repeated dental infections. Dr. Ghanayem opined that petitioner was still a surgical candidate but if petitioner elected not to proceed then and FCE would be appropriate. (PX 45, 46)

On December 13, 2007 petitioner presented to Dr. Gireesan. The doctor noted that Dr. Ghanayem agreed with the surgical recommendations. Petitioner had begun a regimen of high blood pressure medication in preparation for surgery. Petitioner was advised to discuss the surgery with her family and follow up.

On January 17, 2008, February 21, 2008, April 28, 2008 and June 17, 2008 petitioner followed up with Dr. Gireesan. For multiple reasons no surgery was scheduled. Petitioner's

alleged basis for not undergoing surgery was further dental problems which were repeatedly delayed due to lack of funds according to Petitioner. It also appears that petitioner was not managing her high blood pressure well and was advised to follow up with her family physician at Stroger Hospital. Petitioner was maintained off work by Dr. Gireesan. (PX 44)

On June 17, 2008 petitioner presented to Dr. Gireesan. Petitioner advised as this time that she wanted to try exercise to resolve her problems. Dr. Gireesan did not comment on whether or not he supported the notion that exercise could resolve petitioner's alleged back problems. Dr. Gireesan did note that petitioner's unrelated dental issues and blood pressure would need to be taken care of prior to any surgery. Per a June 17, 2008 letter to Northeastern Illinois University from Dr. Gireesan, the doctor noted that petitioner needed adequate space to stretch out during class and additional time to complete large typing and writing projects. At the same time, petitioner was provided a disability certificate.

On February 2, 2009 petitioner presented to Dr. Gireesan. Petitioner's condition remained the same and the additional diagnosis of carpal tunnel syndrome was added. Dr. Gireesan also provided petitioner with a letter on February 4, 2009 indicating that petitioner would need additional rest room breaks while in school due to carpal tunnel and disc disorder. It appears that this letter was intended for Northeastern Illinois University.

Petitioner continued to follow up with Dr. Gireesan. The surgery was not rescheduled and it appears that petitioner had concluded pretty much all forms of non-surgical treatment. Petitioner was treating her symptoms with prescriptions at this time. Petitioner presented to Dr. Gireesan on May 18, 2009 and July 22, 2009 at which time the doctor requested approval for a C4-5 and C5-6 fusion.

On May 21, 2009 petitioner presented to Dr. Alexander Ghanayem for a third IME evaluation. It was noted that the proposed cervical fusion surgery was authorized by workers compensation insurance but was once again rejected by the petitioner. Dr. Ghanayem placed petitioner at light duty work consisting of no lifting more than 15 pounds and no overhead work. If petitioner continued to refuse surgery, Dr. Ghanayem opined that petitioner was at maximum medical improvement. (PX 45, 46)

On September 14, 2009 the deposition of Dr. Alexander Ghanayem was taken. Dr. Ghanayem testified that petitioner's refusal to have surgery would result in permanent work restrictions that would prevent her from returning to employment as an electrician. (PX 46)

On December 18, 2009 petitioner presented to Vocational Rehabilitation Consultants, specifically David Patsavas, for vocational assessment. Mr. Patsavas noted that petitioner was presently off of work per Dr. Gireesan and that even if petitioner underwent the proposed surgery and underwent extensive vocational training in computers petitioner would qualify only for entry level secretarial work. There would be a significant wage differential due to petitioner earning

over $40.00 per hour as an electrician and entry level secretarial work at $8-10.00 per hour. (PX 2)

On February 22, 2010 petitioner presented to Dr. Gireesan. The doctor noted at this time that the petitioner "is afraid of surgery and is not too keen on going through with it." (Medical Records, 2/22/2010). It appears that at this time that while surgery was approved petitioner had not made a decision as to proceeding yet. Petitioner advised that she had presented for a vocational assessment. Dr. Gireesan provided petitioner with a disability certificate which placed petitioner at totally incapacitated until further notice.

On March 15, 2010 and April 26, 2010 petitioner presented to Dr. Gireesan. Dr. Gireesan noted that the proposed surgery for a two level fusion at C4-5 and C5-6 had been approved, however, petitioner elected to not proceed with the surgery due to petitioner being "afraid of surgery and decided to learn to live with the limitation." Petitioner requested a release to light duty since she had "no income and needs to work."

On approximately May 14, 2010 petitioner began the recommended computer/vocational training at Vocamotive. Petitioner was provided access to the training as well as money for meals, a loaner computer for home use, and mileage reimbursement. On July 26, 2010 petitioner reported that she was not satisfied with the vocational training and needed one-on-one time training. She was informed that one-on-one training was not part of the program. (PX 5, 6) Petitioner failed to appear for her next appointment (reportedly to due to her car being booted). A check with the City of Chicago Citation Administration Division reveals that petitioner's vehicle has never been booted,(RX 1) and at trial Petitioner claimed that she had not made that statement.

On June 19, 2010 petitioner presented to Dr. May for tingling and burning sensations in her hands for three weeks. Petitioner reported that she had begun vocational training. Dr. May noted that petitioner was "still refusing surgery." Dr. May prescribed Tylenol and physical therapy. (PX 43)

Around June or July of 2010 petitioner began mental treatment with a counselor, Mr. Hayes, at Greater Grand Mental Health Center. (PX 57)

Vocamotive records indicate that follow up calls were made to Petitioner for the next several days but there was no answer. The following week petitioner presented to the vocational facility unexpectedly and reported that she did not present for training due to depression symptoms. A new training calendar was created. The following week she presented 4 ½ hours late for her training. The following week petitioner again presented 4 ½ hours late for her appointment and reported that she had not used her loaner computer at all for home training. In September of 2010 it was noted that petitioner was several weeks behind in training due to timeliness and attendance issues. Vocamotive recommended that computer training for Petitioner should be re-evaluated and further visits were cancelled. All vocational services were suspended

by the employer secondary to Petitioner's noncompliance with the demands of the program. ((RX 11)

Petitioner presented to the Sinai Psychiatry and Behavioral Health Center at Mount Sinai Hospital on June 21, 2010. Petitioner reported that she "wanted to be evaluated to support her workers compensation claim." Petitioner was placed at a composite score of 23 on the Locus scale. Petitioner attributed her problems to her pending workers compensation claim. Petitioner reported that she hadn't treated with a psychiatrist in several years however petitioner had just presented to Greater Grand Mental Health Center that same month. Petitioner was scheduled for an examination but according to the records petitioner never returned to this facility. The examiner did note that petitioner was very agitated and angry.

On July 12, 2010 petitioner presented to Dr. Gireesan. This routine visit noted that petitioner was participating in vocational rehabilitation.

On July 28, 2010 petitioner presented to Dr. May. Petitioner complained of neck, hand, back and leg pain which began two weeks prior. Petitioner reported that she is very depressed and had presented to a mental health center the day before. Dr. May diagnosed petitioner with depression, lumbago, carpal tunnel syndrome and herpes. Petitioner was prescribed various medications and advised to follow up in three months.

Petitioner followed up with Dr. May on September 1, 2010. Petitioner voiced the same complaints: low back pain, carpal tunnel syndrome, and neck pain. Dr. May gave petitioner samples for various medications including: Prisitq, Micardis, Avelox, and Librium. Dr. May provided petitioner with general advice with her various complaints such as activities that caused discomfort and the use of wrist splints.

On September 13, 2010 petitioner made an unscheduled visit to Vocamotive. The Hinsdale Police were called secondary to her initial refusal to leave the premises after she was advised she did not have an appointment.

On October 25, 2010 petitioner presented to Dr. Gireesan. Petitioner advised that vocational rehabilitation had stopped no basis for the discontinuation was noted in the records. Dr. Gireesan opined that vocational rehabilitation would benefit petitioner and help "get back in to a productive life." Dr. Gireesan provided petitioner with a prescription for vocational training for light duty. (PX 44)

On November 16, 2010 petitioner presented to Dr. Gireesan. The doctor noted continued pain in her neck and both upper extremities. Petitioner noted that she was continuing to await vocational training despite the fact that she had just filed suit against the vocational facility. She requested a psychiatric referral, which Dr. Gireesan provided to a Dr. Robert Reff. Petitioner never apparently presented to Dr. Reff.

On November 23, 2010 petitioner returned to Dr. May. Petitioner complained of low back pain and persistent headaches. Dr. May administered a B12 injection as well as Micardis, hydrochlorothiazide, and Xanax. Petitioner was advised to follow up in one month.

On January 26, 2011 petitioner presented to Dr. May for medication refill. Dr. May once again gave petitioner an injection of B12. Petitioner was also provided with a referral to Mont Sinai Hospital for psychiatric evaluation of petitioner's depression symptoms. It appears that petitioner instead elected to see Dr. Sylvia Santos.

Petitioner presented to Dr. Gireesan on five occasions during 2011: January 26, March 1, June 6, September 6, and December 20. Petitioner's treatment remained unchanged as well as her medication treatment. In January Petitioner again requested a psychiatric referral, which Dr. Gireesan provided. Dr. Gireesan also provided petitioner a prescription for vocational training in light duty work.

It appears that petitioner sought psychiatric evaluation from Dr. Sylvia Santos February 24, 2011. Petitioner reported angry outbursts, agitation, anxiety, insomnia, headaches, crying spells, fleeting suicidal ideations, nightmares and bad memories about her accident. Dr. Santos diagnosed petitioner with major depressive disorder and prescribed appropriate medications.

Petitioner attended a psychological IME evaluation by Dr. Joseph Beck on May 18, 2011 at the request of her attorney. Dr. Beck concluded that petitioner was suffering from a pain disorder along with other symptoms such as depression, dysphoria and anhedonia. Petitioner was prescribed Cymbalta and Abilify. The doctor also concluded that petitioner's pain disorder was related to her initial work injury. It appears that the Petitioner began treating with Dr. Beck following the IME. (PX 58)

Petitioner followed up with Dr. Beck on June 29, 2011. Dr. Beck further evaluated petitioner's ability to work. The doctor surmised that the petitioner is unable to work due to psychiatric issues. Dr. Beck also recommended that petitioner participate in a partial hospital psychiatric setting in which petitioner could participate in group therapy. The doctor concluded that after such treatment she would be better prepared to return to vocational training. (PX 58)

On February 8, 2012 petitioner presented to her family physician, Dr. May. Petitioner reported continued low back pain, neck pain and left arm pain. Petitioner advised that she was treating with a neurologist and seeing a psychiatrist. Petitioner was prescribed Lyrica, Norco and Abilify.

Petitioner continued to present to Dr. Gireesan for refills of prescriptions. Petitioner presented on February 10, 2012 and April 10, 2012 at which time the injury is indicated with no changes and the same pain/depression medications were prescribed.

On April 18, 2012 petitioner presented to Dr. Henry Lahmeyer, a psychiatrist, for an IME evaluation at the request of Respondent. (RX 26)

Dr. Gireesan, petitioner's treating orthopedic surgeon, testified by way of evidence deposition on August 10, 2012. Dr. Gireesan testified that petitioner was a surgical candidate but that due to fears she had not elected to have the surgery. Dr. Gireesan stated that according to an FCE performed on November 2, 2006 petitioner was capable of returning to work at a sedentary or light duty level. Dr. Gireesan noted that if petitioner had undergone the surgery it was likely that petitioner could work at the medium level work duty or possibly more. Furthermore, Dr. Gireesan supported petitioner's return to work at a real estate agent and indicated that it fit within the present work restrictions. (PX 67)

The deposition of Dr. Joseph Beck, petitioner's IME psychiatric physician turned treating psychiatrist, was taken on September 20, 2012, and again on February 26, 2015. Dr. Beck testified that petitioner suffered from anxiety, depression and disturbed sleep which he felt prevented her from returning to gainful employment. He believed that because of her mental status she was not able to return to the work force.

Dr. Beck met with the Petitioner many times over the course of her treatment. He discussed her physical and mental symptoms with her as well as discussing her experiences with vocational rehabilitation. He determined that the Petitioner need medical treatment for her mental health issues. He was concerned that her medications were not being covered by the workers' compensation insurance. It was during the first deposition of Dr. Beck that issues arose between the Petitioner and the respondent's attorney resulting in the Petitioner being charged criminally and eventually tried for battery against the Respondent's attorney. She was acquitted. Dr. Beck in his subsequent depositions seemed to have issues with the Respondent's attorney. The situation between the Petitioner and the Respondent's attorney has no bearing on this case, however, it does seem to have affected Dr. Becks assessment of the situation and of the Petitioner's mental status. Dr. Beck was of the opinion that Petitioner's injuries were the cause of the Petitioner's mental health issues and therefore opined that it was causally connected. (PX 68B and 68C) Dr. Beck is concerned about the Petitioner's well -being. However, Dr. Beck did concede, that Petitioner was in part responsible for some of these problems due to her own actions. (PX 68 A, B, C)

Dr. Lahmeyer, Respondent's psychological IME physician, testified on March 11, 2015. Dr. Lahmeyer opined that petitioner could work without psychiatric restrictions based on her ability to successfully take college courses and pass the real estate exam. Dr. Lahmeyer also opined that petitioner's depression was in remission and personality disorder was a pre-existing condition. With respect to the pain disorder Dr. Lahmeyer indicated that there may be some medical basis but was largely caused by her resistance to therapy and hope for monetary gain and that the problem would likely not resolve until litigation was over. (RX 26)

Respondent also introduced video surveillance demonstrating the Petitioner driving, shopping, and engaging in the activities of daily life without any noticeable impairment or disability. (RX 32)

Petitioner testified that she has acted as a foster parent subsequent to the accident and also engages in various activities including dancing and swimming.

This matter was tried over several days. The Arbitrator had an opportunity to observe and evaluate the Petitioner during the hearing and also at several depositions that the Arbitrator attended in the presence of both her attorney and the attorney for the Respondent. The Petitioner was pleasant. She was very knowledgeable of her case. She had her own files, which appeared to be organized. She was able to find records and pull documents out at the request of her attorney and actually explained some of the documents to her attorney in a voice loud enough for the rest of the people in the room to hear. Petitioner pulled out transcripts and located specific information in the transcripts for her attorney. The Petitioner often directed her attorney to ask questions of the various witness and gave him documents to question them about on several occasions. The Petitioner appeared to have small temper tantrums when Petitioner's attorney did not do what she wanted him to do. She also reacted with displeasure several times to the Respondent's attorney as he questioned witnesses particularly during the testimony of Mr. Blumenthal.

On several of the days of the trial the Petitioner had a laptop computer with her. During the testimony of the witnesses she appeared to be using a mouse to search for something. During the testimony of Mr. Budas the Petitioner was typing something. She typed non-stop for an hour during his testimony. She did not stop to shake out or rub her hands, she did exhibit any signs of pain or difficulty while typing or of numbness or inability to find her way around the keyboard. Neither attorney questioned her about this when she testified regarding the pain in her hands and the carpal tunnel.

The Petitioner testified on July 23, 2015. Her testimony began shortly after 9:00 a.m. We took a break from 10:25 a.m. until 10:36 a.m. broke for lunch at 12 o'clock noon. The hearing resumed at 12:55 p.m. There was a break from 1:25 p.m. until 1:37 p.m. Testimony continued for the rest of the afternoon. Cross examination started shortly after the afternoon break.

The Petitioner testified about the accident, her medical treatment, the aches and pains that she was feeling etc. She was clear and concise. She did not have any difficulty recalling details she even corrected the attorneys both on direct examination and on cross examination when they made a misstatement in their questions. She did not show any signs of confusion or inability to understand what was being asked.

The Petitioner testified that she cannot climb ladders, cannot carry heavy objects, she cannot type for more than 10 or 15 minutes without her hands becoming either numb or quite

painful from the carpal tunnel. She testified that even though she is in significant pain she is afraid to have the surgery. The pain prevents her from carrying out many of her activities of daily living. She has pain in her head, her neck, her shoulders, her back, her hands and her buttocks. She testified that the medications make her sleepy, cause mood changes, headaches, bloating and diarrhea. These medical issues interfered with her ability to complete the tasks for vocational rehabilitation through Vocamotive. She testified that her work hardening program interfered with the vocational rehabilitation as well.

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987).

Longstanding Illinois law mandates a claimant must show that the injury is due to a cause connected to the employment to establish it arose out of employment. *Elliot v. Industrial Commission*, 153 Ill. App. 3d 238, 242 (1987).

The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 Ill. 2d 214 (1969).

The burden of proving disablement and the right to temporary total disability benefits lies with the Petitioner who must show this entitlement by a preponderance of the evidence. *J.M. Jones Co. v. Industrial Commission,*71 Ill.2d 368, 375 N.E.2d 1306 (1978)

Credibility is the quality of a witness which renders his evidence worthy of belief. The Arbitrator, whose province it is to evaluate witness credibility, evaluates the witness' demeanor and any external inconsistencies with testimony. Where a claimant's testimony is inconsistent with his actual behavior and conduct, the Commission has held that an award cannot stand. *McDonald v. Industrial Commission*, 39 Ill. 2d 396 (1968); *Swift v. Industrial Commission*, 52 Ill. 2d 490 (1972).

An employer's liability for benefits cannot be based on guess, speculation or conjecture. *Illinois Bell Telephone* v. *Industrial Commission*, 265 Ill.App.3d 681, 638 N.E.2d 207 (1994).

"Preponderance of the evidence is evidence which is of greater weight or more convincing than the evidence offered in opposition to it; it is evidence which as a whole shows that the fact to be proved is more probable than not." *Central Rug & Carpet v. Industrial Commission*, 838 N.E.2d 39 (1st Dist. 2005).

ANAYLSIS

It is well established that a claimant carries the burden of proof with respect to each element of his claim by the preponderance of credible evidence. *Parro v. Indus. Comm'n*, 260 Ill.App.3d 551, 554-55 (1st Dist. 1993). The claimant may present witnesses to prove his case. It is the function of the Arbitrator to determine the credibility of those witnesses, draw reasonable inferences based on thc tcstimony, and determine the weight to be assigned the testimony. *Parro*, 260 Ill.App.3d at 554. The Arbitrator need not find for a claimant merely because there is some testimony that standing alone would justify a favorable outcome. *Burrgess v. Industrial Comm'n*, 169 Ill.App.3d 670, 676 (1st Dist. 1988). Rather, the Arbitrator should consider both direct and circumstantial evidence and draw reasonable inferences there from, even if it is contrary to the testimony. (*Id.*) It is the Commission's function to evaluate the evidence and resolve the conflicts that arise. *Beattie v. Industrial Comm'n*, 276 Ill.App.3d 446, 449 (1995).

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 incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Arbitrator finds that the Petitioner met her burden of establishing with sufficient credible evidence that she sustained a work injury on June 14, 2004 as alleged which arose out of and in the course of her employment with Respondent. The Petitioner testified with clarity to falling over the ladder, described what parts of her body struck what areas and that she went for medical treatment right away per the safety program in place. The Respondent's attorney during the Petitioner's direct examination conceded that they were not challenging the Petitioner's claim to have fallen over the ladder.

In support of the Arbitrator's decision with regard to what the date of accident was, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Petitioner established through the testimony and the contemporary medical records that the accident occurred on July 14, 2004.

In support of the Arbitrator's decision with regard to whether Petitioner gave timely notice of the accident to the Respondent, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Petitioner explained to her supervisor Roger and the crew who came to her rescue and to find out what happened immediately after she fell what happened. Jeff Marks the General Foreman also came over and inquired what happened immediately after she fell then directed her to go to the emergency room and get examined by a doctor per the safety program in place, which Petitioner did. The Arbitrator finds that the Petitioner did provide proper notice of the accident to her employer within the time limits provided in the Act.

In support of the Arbitrator's decision with regard to whether Petitioner's current condition of ill being is causally connected to this injury, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

In light of the testimony, the medical records, reports, depositions, and other evidence, the Arbitrator finds Petitioner has established that her condition of ill-being related to her back, her hands and her cervical spine are related to the accidental injury herein. It is certainly plausible that after this accident the Petitioner did sustain a re-injury or possible intervening injury when she was involved in a scuffle with security guards at Stroger Hospital on or about November 2, 2004, however the evidence submitted by Respondent revealed that there was only one visit made to Mercy Hospital in relation to that event and the Arbitrator cannot find that the injuries as result of the scuffle were sufficient to break the causal connection between her injuries as result of the fall in July of 2004 and the injuries she may have sustained as result of the scuffle in November of 2004. Despite the less than credible initial denials made by the Petitioner as to this event, and her self-serving testimony that she refused to tell her physicians about the events on said date because they "never asked" there is nonetheless insufficient evidence to establish that Petitioner's condition of ill-being after 11/2/2004 was related to that specific event.

On the other hand, the fact that the Petitioner was physically capable of engaging is such a substantial physical altercation so closely after the initial injury is probative of the seriousness of this injury, and evidence that the Petitioner was exaggerating the extent of her alleged injury(s) to the physicians involved in this matter since she was much more physically capable than she was reporting. The same is true for the complaints with respect to the carpal tunnel. Petitioner testified that she was unable to complete some of the Voc Rehab assignments because she could only type on the computer for a few minutes before she experienced pain, numbness and tingling in her hands. Yet she sat in the hearing room typing on a laptop for more than an hour during the testimony of Mr. Budas without any signs of being in pain, experiencing numbness or tingling. She did not stop and take breaks she just kept on typing in the presence of her attorney, the Respondent's attorney and the Arbitrator.

The Arbitrator further finds that Petitioner's purported mental condition, such as it is, is not causally related to the work accident herein. The Arbitrator finds that the purported psychological treatment and related claimed psychological incapacity to work was a response to the Petitioner being requested to actively attend rehabilitation services at *Vocamotive* as opposed to sequalae from the work injury. The fact that the insurance company and the agencies she was working with would not do what she wanted thereby causing her frustration and anguish does not causally connect her mental condition to the fall on July 14, 2004. The Arbitrator further finds that the claimant failed to meet her burden of proof in demonstrating that the nature of the alleged disabling psychological condition under a "physical-mental" theory established a causal connection between the physical trauma and the resulting psychological condition. It is well settled that it is not sufficient to merely establish a subjective psychological reaction to some nonphysical incident. *See Baggett v. Industrial Comm'n, 201 Ill. 2d 187, 195 (2002); Northwest Suburban Special Education Organization v. Industrial Comm'n, 312 Ill. App. 3d 783, 789 (2000) (quoting Skidis v. Industrial Comm'n, 309 Ill. App. 3d 720, 724 (1999)).*

Here, the claimant presented insufficient evidence to establish that her alleged disabling mental condition, if any, was caused by the June 2004 work injury (i.e., flowing from the physical trauma to her body). To the extent that there was a mental ailment, the evidence suggested that it was triggered not by the injury, but rather secondary to the various obstacles Petitioner perceived within the workers' compensation system in obtaining benefits. The records and testimony established that the Petitioner, in the absence of any determination by the Commission, had convinced herself she was entitled to various ongoing benefits and as a result concluded she was being wronged by Respondent every time her demands for immediate payment(s) of same was challenged. The Arbitrator further notes that the purported mental condition in question, after being quiescent for many years following the work injury, coincidentally arose many years after the accident, specifically in 2010 at the same time claimant was first asked to begin attending daily vocational placement activities at Vocamotive.

Based upon the foregoing, and other evidence, the Arbitrator finds that the Petitioner failed to meet her burden of proof to that her claimed psychological condition is related to the subject work injury. Therefore, any and all benefits requested for the mental health treatment are accordingly denied.

In support of the Arbitrator's decision with regard to what were the Petitioner's earnings, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The parties agree that this was not regular full time employment but sporadic assignments of varying length from the union hall based upon the availability of the Petitioner and the needs

of Respondent for laborers. There is no issue(s) as to overtime since the Petitioner never worked more than 8 hours or Saturday wages since all days worked were between Monday and Friday, approximately 3 days per week for about 3 weeks. The Arbitrator, in reliance upon the wage records submitted by the parties and applying the applicable case law as well as employing methodology which is fair to both sides given the short duration of employment herein, elects to simply multiply the Petitioner's hourly rate of $34.65 times 40 hours, or an average weekly wage of $1,386.00 as calculated pursuant to §10 of the Act since that amount reflects the earnings assuming full performance of her duties without overtime hours and given that the work herein varied in response to the needs of the employer. *See, e.g., Sylvester v. Industrial Comm'n, 197 Ill.2d 225, 230-31, 756 N.E.2d 822, 826 (2001).*

In support of the Arbitrator's decision with regard to whether the medical services that were provided to Petitioner were reasonable and necessary and has the Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The only medical which was in dispute at the time of the trial were the bills from Dr. Beck, who originally was Petitioner's IME physician/psychiatrist, and later began treating Petitioner. Based upon the finding in causal relationship all treatment with Dr. Beck is denied for the reasons stated therein.

Moreover, the Arbitrator finds that Dr. Beck, since he was chosen by claimant's attorney and not within a referral from any other doctor, exceeds the claimant's 2 choices of physicians. At a very minimum, and discounting all emergency room treatment as not constituting a choice due to the emergency nature of the treatment, there clearly was a first choice to treat with Dr. May. The evidence at trial established that when the Petitioner presented to Dr. Schmell she was not referred by any of her existing doctors, but rather by an "old patient" of Dr. Schmell. Therefore, even if the Arbitrator finds every other doctor seen by the Petitioner within the chain of referral of either Dr. May or Dr. Schmell, Dr. Beck nonetheless represents a third choice of physician which exceeds the number of doctors Petitioner is allowed to elect.

The Arbitrator also agrees with Dr. Lahmeyer and finds that the claimed psychological condition was not necessary to cure from any effects of the industrial accident in question. As the Arbitrator finds that the treatment is not causally related to the work accident herein it was not necessary, and also exceeds the choice of allowable physicians it is accordingly denied. Based

upon the foregoing, and other evidence, the claimed medical / psychological treatment, and all related prescriptions, etc., is hereby denied.

In support of the Arbitrator's decision with regard to whether Petitioner is entitled to TTD/Maintenence, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Arbitrator finds that at the very most, the Petitioner was temporarily and totally disabled from 7/15/2004 through the date she agreed to work as a realtor with *Schleder Realty* on April 30, 2007. (RX5). Claimant's doctor, Dr. Gireesan, specifically testified that the Petitioner could work as a realtor following the accident. *(Dr. Gireesan's dep. at p. 74).* The Arbitrator notes that the Petitioner was properly licensed to sell realty on said date and was capable of finding this and other employment following the work accident in the competitive labor market without professional assistance. The Arbitrator further finds that the claimant was at MMI as of the 11/2/2006 FCE and had clearly passed up multiple opportunities to proceed with surgery by that point and therefore had clearly reached a permanent state by that point in time absent a reversal of her decision relative to surgery, which never happened.

The claimant's request for maintenance or vocational rehabilitation benefits is denied. In order to be entitled to such benefits, the claimant must prove that she suffered a reduction in her earning capacity as a result of the work injury, and that rehabilitation will increase her earning potential. *Roper Contracting v. Industrial Comm'n, 349 Ill. App. 3d 500, 506 (2004).* The Petitioner's claim for maintenance after 4/30/2007 is denied since (a) the claimant demonstrated she was capable of returning to work within the competitive labor market without assistance and without a reduction in her earning capacity as a realtor (although she kept that information to herself), and (b) the brief period of time she was asked to attend vocational re-training she was non-cooperative. The Arbitrator finds that the claimant failed not only to attend as required, she also failed to cooperate by failing to fully advise Vocamotive as to the full extent of her activities such as her role as a foster parent, her prior real estate employment contracts, her prior ability to find work unassisted, and refusing to attend her scheduled appointments and providing false explanations (such as her car being "booted") for her non-attendance, and also advising Vocamotive that she had limited computer skills which is contradicted by her college transcripts revealing that she had successfully completed college level computer instruction.

At the depositions and over the many days of trial in this case the Petitioner demonstrated that she can think clearly, has organizational skills, can readily assist her attorney, has the ability to find the documents needed quickly and make suggestions of what to inquire about. She was able to sit through a whole day of questioning, direct examination and cross examination, she

remained focused, could recall details, did not appear to get confused or tired. She corrected the lawyers when they misstated facts repeatedly.

It is undisputed that Petitioner successfully found various jobs after her injury. The Arbitrator finds that the Petitioner has sufficient skills to obtain employment without further training, education, or formal expert job search assistance. Therefore the Arbitrator finds that the Petitioner is entitled to TTD from 7/15/2004 through 4/29/2007, a period of 145 & 4/7ths weeks and all claims for maintenance are denied. Respondent shall receive a credit for all TTD and/or maintenance paid.

In support of the Arbitrator's decision with regard to what is the nature and extent of the injury, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Arbitrator finds that Petitioner met her burden of proof in establishing permanent partial disability related to the subject accidental injury. Petitioner testified that she continues to suffer pain in the back and the medical evidence established that there are permanent limitations related to the subject injury. Petitioner is not able to return to her job as an electrician at least as far as the requirements of the jobs the Respondent has to offer are concerned.

The Arbitrator further finds that the Petitioner is not entitled to a wage differential award. Section 8(d)(1) of the Act provides that wage differential benefits are payable where a claimant is "partially incapacitated from pursuing his usual and customary line of employment" and in such instance is entitled to an amount "equal to 66-2/3% of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or is able to earn in some suitable employment or business after the accident." *820 ILCS 305/8(d)(1).*

First, the Arbitrator does not find that the claimant was entirely honest with her doctors, in that she appears to have exaggerated some of her symptoms as evidenced by her ability to attack and struggle with the police officer.

The Petitioner has not met her burden of proof in establishing that she made a good faith effort to return to her highest level of employment but nonetheless sustained a loss of earnings. The evidence demonstrated, to the contrary, that the claimant was capable of more than testimony suggested, for example she was able to serve as a foster parent after the work accident, and found work as a realtor but then failed to show up and begin working pursuant to the contract she had signed. Petitioner did not cooperate with the Vocational Rehabilitation programs that she was involved in. She did not provide accurate information upon which to

assess her needs, like failing to advise the assessor of her computer skills, getting put in beginning computer classes and then not showing up for the classes and giving at least one proven false explanation for her failure to appear for class in a timely manner, such as when she denied that she advised Vocamotive that her car was "booted," when the evidence established that it wasn't. She was given not one but two chances at vocational rehabilitation.

Even if one assumes that the claimant has restrictions which affect her ability to work unrestricted duties as an electrician, Petitioner failed to meet her burden of proof in establishing that working as an electrician was her usual and customary occupation on the date of the injury. The records from the claimant's union demonstrate that she resigned from full time regular work as an electrician in 1995, nine years before this accident. Between 1996 and 2004, the year of this occupational injury, Petitioner averaged less than 15 hours per year working as an electrician. In fact, during the 2 years immediately preceding the year of the subject accident (2002 and 2003) the claimant worked no hours whatsoever as an electrician. This hardly satisfies the definition of usual and customary employment. The statute only allows for a loss of earnings in instances where the claimant is unable to return to their *usual and customary* employment, not necessarily the job they working at the time of the injury.

The Arbitrator finds that there was simply insufficient consecutive years and hours worked as an electrician to find that occupation was Petitioner's usual and customary employment and notes that the hours she actually worked as an electrician fall far short of regular or part time employment; but instead falls within the definition casual employment. The plain and unambiguous language of the statute therefore is not satisfied and benefits pursuant to §8(d)(1) are accordingly denied.

The credible evidence demonstrated that the Petitioner is well capable of earning income in other occupations as of the date of trial. Insufficient evidence to prove what she could earn let alone that it would be less than as an electrician was offered by the Petitioner. An employer's liability for benefits cannot be based on guess, speculation or conjecture. *Illinois Bell Telephone* v. *Industrial Commission*, 265 Ill.App.3d 681, 638 N.E.2d 207 (1994).

The Respondent's realtor witness testified that there is work available in the competitive labor market as a realtor and that the Petitioner's earnings as a realtor could well exceed the earnings of an electrician. Interestingly, at the time of the accident the Petitioner had just completed re-training herself to begin working as a realtor. She passed her State of Illinois licensure testing on May 14, 2004, about 8 weeks before the accident.

Based on all of the above and other factors for which evidence was presented as required by law, and after carefully reviewing the testimony and exhibits offered by both sides, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 40% loss of use of the person as a whole, or 200 weeks of PPD benefits, pursuant to §8(d)(2) of the Act.

In support of the Arbitrator's decision with regard to whether penalties should be imposed upon the Respondent, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Arbitrator finds that the Respondent in addition to factual disputes relied upon IME opinions and findings of MMI by the treating doctor when benefits were terminated. In addition, the evidence demonstrates that the Petitioner was able to find work unassisted in the competitive labor market and two attempts to help her with Vocational Rehabilitation failed because of her lack of cooperation . There were both objective and good faith bases for non-payment of all disputed compensation and/or psychiatric care or prescriptions. Based upon the foregoing, and other evidence, all claims for penalties and attorneys' fees are denied.

In support of the Arbitrator's decision with regard to whether respondent is entitled to any credit, the Arbitrator makes the following conclusions of law:

The Respondent is entitled to credit for all TTD, maintenance and medical services that were previously paid for.

ORDER OF THE ARBITRATOR

The Respondent shall pay the petitioner temporary total disability benefits of $ 924.00/week for 145 & 4/7ths weeks, from 7/15/2004 through 4/29/2007 , which is the period of temporary total disability for which compensation is payable. Respondent shall receive a credit for compensation paid in the amount of $124,734.41.

The Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of unpaid medical remaining in the amount of N/A, as provided in Sections 8(a) and 8.2 of the Act. The respondent shall be given a credit for other medical benefits that have previously been paid.

The Respondent shall pay the petitioner the sum of $567.87/week for a further period of 200 weeks, as provided in Section 8(d)(2) of the Act, because the injuries sustained caused 40% loss of use of the person as a whole. .

The Respondent shall pay the petitioner the sum of $567.87/week for a further period of 20.5 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused 5% loss of use of each hand .

The Respondent shall pay the petitioner compensation that has accrued from **7/14/2004** through **9/15/2015**, and shall pay the remainder of the award, if any, in weekly payments.

Signature of Arbitrator

February 16, 2017
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	06WC008968
Case Name	EVANS, PEGGY v. GIBSON ELECTRIC & TECHNOLOGY SOLUTIONS
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0332
Number of Pages of Decision	9
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Stuart Galesburg
Respondent Attorney	Paul Coghlan

DATE FILED: 6/30/2021

/s/ Thomas Tyrrell, Commissioner

Signature

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

Peggy A. Evans,

Petitioner,

vs. NO: 06 WC 8968

Gibson Electric & Technology Solutions,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 21, 2017, is hereby affirmed and adopted.

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

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

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

June 30, 2021

o: 5/18/21
TJT/jds
51

/s/ *Thomas J. Tyrrell*
Thomas J. Tyrrell

/s/ *Maria E. Portela*
Maria E. Portela

/s/ *Kathryn A. Doerries*
Kathryn A. Doerries

21IWCC0332

EVANS, PEGGY A
Employee/Petitioner

Case# **06WC008968**
05WC056531

GIBSON ELECTRIC & TECHNOLOGY SOLUTIONS
Employer/Respondent

On 2/21/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.64% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0207 STUART H GALESBURG
ATTORNEY AT LAW
4548 W PRATT AVE
LINCOLNWOOD, IL 60712

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

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

PEGGY A. EVANS
Employee/Petitioner

v.

GIBSON ELECTRIC & TECHNOLOGY SOLUTIONS
Employer/Respondent

Case # **06** WC **8968**

Consolidated cases: **05 WC 56531**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **July 6, 2015, July 7, 2015, July 23, 2015, August 10, 2015, August 11, 2015 & September 15, 2015.**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **7/14/2004**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident *N/A* given to Respondent.

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

In the year preceding the injury, Petitioner earned **$3,049.20**; the average weekly wage was **$1,386.00**.

On the date of accident, Petitioner was **47** 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 **$N/A** for TTD, **$.00** for TPD, **$.00** for maintenance, and $ for other benefits, for a total credit of **$N/A**.

Respondent is entitled to a credit of **$.00** under Section 8(j) of the Act.

ORDER

- Application dismissed as duplicative filing. All issues are adjudicated in companion claim 05 WC 56531.

See attached findings of fact and conclusions of law. See also findings in companion claim no. 05 WC 56531.

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

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

Deborah L. Simpson

Arbitrator Deborah L. Simpson

May 15, 2016
Date

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Peggy A. Evans,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 06 WC 8968**
	)	**05 WC 56531** (separate
	)	decision issued)
Gibson Electric Co., et.al.,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on July 14, 2004, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. The Petitioner stipulated that no notice of the accident was given to the employer.

At issue in this hearing is as follows: (1) Did an accident occur that arose out of and in the course of the Petitioner's employment with Respondent; (2) What was the date of the accident; (3) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (4) What were the Petitioner's earnings; (5) were the medical services that were provided to Petitioner reasonable and necessary and has the Respondent paid all appropriate charges for all reasonable and necessary medical services; (6) Is Petitioner entitled to TTD and/or maintenance; (7) What is the nature and extent of the injury; (8) Should penalties or fees be imposed upon the Respondent; and (9) Is Respondent due any credit.

Case number 06 WC 8968 was consolidated with this case. The cases were heard simultaneously. There are separate stipulation sheets for each case. There is one transcript of all the testimony and one set of exhibits. There will be a separate decision issued for each case.

STATEMEMT OF FACTS

The Petitioner has filed two separate Applications for Adjustment of claim for the very same date of accident, namely July 14, 2004. Moreover, the Application filed in this matter (case no 06 WC 8968) states "fell backward on ladder & ground" which is clearly a reference to the primary accident Petitioner testified to. The Application further states that the nature of the injury is carpal tunnel syndrome.

The Petitioner claimed identical periods of lost time in relation to this case as in the primary case, no 05 WC 56531. The Petitioner testified to only one accident that occurred on that date and testified that as result of the fall she had pain in her hands and arms immediately. It therefore appears that this filing is essentially a claim that the initial injury also resulted in traumatic carpal tunnel. Such issues may be adjudicated in the case without the need to file a further Application since they all relate back to the same accident. Therefore, that claimed medical condition along with all other issues regarding the 7/14/2004 injury is adjudicated in the companion claim.

CONCLUSIONS OF LAW

The Arbitrator finds that this filing is an unnecessary duplicative Application concerning the same alleged accident. The Arbitrator further notes that the Petitioner stipulated that no notice of this claimed accident was given, which would ostensibly be a bar to receiving compensation, however since this filing is determined to be duplicative and is hereby dismissed, all issues herein are rendered moot.

Application dismissed as duplicative. *See Arbitrator's findings in companion case no. 05 WC 56531.*

Deborah L. Simpson

Signature of Arbitrator

May 15, 2016
Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	15WC004594
Case Name	ROEWART, MICHAEL v. MANEVEL CONSTRUCTION CO.
Consolidated Cases	
Proceeding Type	Petition for Review
Decision Type	Commission Decision
Commission Decision Number	21IWCC0322
Number of Pages of Decision	19
Decision Issued By	Marc Parker, Commissioner

Petitioner Attorney	Jeffrey Alter
Respondent Attorney	Jason Stellmach

DATE FILED: 6/28/2021

/s/Marc Parker, Commissioner

Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Roewert,

Petitioner,

vs. NO: 15 WC 4594

Manevel Construction, Co.,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 19, 2019, 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 $17,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

June 28, 2021

/s/ *Marc Parker*
Marc Parker

MP:yl
o 6/17/21
68

/s/ *Barbara N. Flores*
Barbara N. Flores

/s/ *Christopher A. Harris*
Christopher A. Harris

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0322
NOTICE OF 19(b) ARBITRATOR DECISION

ROEWART, MICHAEL Case# **15WC004594**

Employee/Petitioner

MANEVEL CONSTRUCTION

Employer/Respondent

On 8/19/2019, 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:

0009 ANESI OZMON RODIN NOVAK KOHEN
JEFFREY M ALTER
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

0560 WIEDNER & McAULIFFE LTD
JASON STELLMACH
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Michael Roewert
Employee/Petitioner

v.

Maneval Construction
Employer/Respondent

Case # **15** WC **04594**

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 **Paul Seal**, Arbitrator of the Commission, in the city of **Waukegan** on **5/21/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **10/20/14**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**75,694.32**; the average weekly wage was $**1,455.66**.

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

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

Respondent shall be given a credit of $**61,692.26** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**61,692.26**.

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

ORDER

The Arbitrator finds that Petitioner sustained accidental injuries to the right upper extremity and cervical spine on 10/20/14, for which he reached maximum medical improvement by 12/17/15.

Respondent shall pay Petitioner total temporary disability benefits of $970.44/week for 63-1/7 weeks for the period of 10/21/14 through 1/6/16. Respondent receives a credit for benefits paid in the amount of $61,692.26.

The Arbitrator finds that respondent has paid all appropriate medical charges, and has no further obligation in this regard, as petitioner reached maximum medical improvement on 12/17/15.

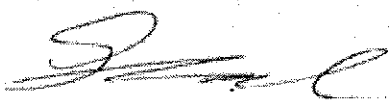
Respondent shall pay Petitioner the sum of $735.37/week for a further period of 25 weeks, as provided in Section 8(d) (2) of the Act, because the injuries sustained caused permanent partial disability to the extent of 5% loss of use of the person as a whole.

Petitioner's request for additional medical treatment is denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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



Signature of Arbitrator

August 17, 2019
Date

AUG 19 2019

STATEMENT OF FACTS

Mr. Michael Roewert (hereinafter referred to as "petitioner") is a 52 year old former skilled laborer for Maneval Construction (hereinafter referred to as "respondent"). On October 20, 2014, petitioner was digging a hole with a four-foot spade when she saw a spark and his next recollection was laying on his back. Petitioner testified that he felt immediate chest and right arm pain. Petitioner was transferred by ambulance to Vista Medical Center, then to Advocate Condell Medical Center. Petitioner testified that he noticed cervical pain upon arrival to Advocate Condell Medical Center.

According to the Advocate Condell Medical Center intake form, petitioner claimed to have been thrown three to four feet backwards, and complained of bilateral elbow pain and chest pressure. Petitioner reported that he had possibly lost consciousness, but did not know for sure. A chest X-ray showed no acute cardiopulmonary disease. Diagnosed with an electric injury, petitioner was admitted overnight for observation.

The following day, on October 21, 2014, petitioner was discharged from the hospital post-electrical injury. Petitioner was told he could return to his regular activity level, with no restrictions, and that he should follow up with Dr. Mitchell Grobman if his symptoms persisted. Petitioner was given a prescription for Percocet and Gabapentin.

Thereafter, petitioner sought treatment at Aurora Healthcare, The Center for Neurology and Sleep Disorders, and Aurora Memorial Hospital of Burlington.

On January 14, 2015, petitioner underwent an MRI of the cervical spine, which showed a diffuse mild to moderate degenerative spondylosis, levels of central canal stenosis, and multilevel bilateral neural foraminal stenosis, greatest at the C6-7 level. That same day, petitioner also underwent an MRI of the right shoulder, which showed subtle fraying and tendinosis involving the bursal surface fibers of the supraspinatus and infraspinatus tendons, with mild acromioclavicular joint degenerative changes, and no significant tears.

On January 23, 2015, petitioner was evaluated by Dr. Dagam. Petitioner reported low back and left lower extremity pain. Petitioner reported that, approximately eight years earlier, he had been carrying a 175-pound water pump and fell, causing the pump to land on his spine. Petitioner reported that he had experienced back pain ever since that incident. Dr. Dagam discussed the possibility of a transforaminal lumbar interbody fusion at L4-5 and L5-S1. Dr. Dagam noted that petitioner would need to quit smoking in order to undergo the proposed procedure.

On May 4, 2015, petitioner was examined by Dr. Tsoulfas at Access Medical Center. Petitioner underwent diagnostic cervical medial branch blocks of the right C3, C4, and C5 medial branch nerves. It was noted that petitioner had been exhibiting symptoms consistent with facet-mediated cervicalgia and cervicogenic headache.

During a visit on June 19, 2015, Dr. Dagam recommended an anterior cervical discectomy and fusion at C6-C7.

On June 20, 2015, petitioner was examined by Dr. Kohli at Aurora Healthcare. Petitioner reported right shoulder and elbow pain secondary to a work injury on October 20, 2014. X-rays of the right shoulder performed on June 20, 2015 showed no acute fracture or dislocation. Dr. Kohli diagnosed right shoulder and elbow pain. It was recommended that petitioner continue to move and use the shoulder as much as possible. Dr. Kohli found no structural problems and concluded petitioner did not require orthopedic intervention at that time.

Petitioner was admitted to Aurora Memorial Hospital of Burlington on July 28, 2015 for right-sided pain with apparent vigorous shaking of the right arm and leg. An MRI of the brain showed no evidence of an acute cerebrovascular pathology. Petitioner underwent a neurology consultation. It was felt that the described incident was likely pain-related as opposed to a syncopal event. Diagnosed with right arm pain, chronic neuropathic pain, and a history of electrocution resulting in chronic pain, petitioner was discharged and was to follow up with his pain clinic.

On August 12, 2015, petitioner was re-evaluated by Dr. Dagam. Petitioner reported that, two weeks earlier, he had been walking across the stress when he felt as it his right elbow "blew up." Petitioner described the pain as unbearable. He reported that the only modality which provided relief was wrapping the right arm in gauze. Dr. Dagam diagnosed intractable right upper extremity pain, and referred petitioner to West Allis Memorial Hospital for further workup and pain control.

On September 9, 2015, petitioner attended an independent medical examination with Dr. Richard Noren of Pain Care Consultants. It was noted that, on October 20, 2014, petitioner had been using a spade when he struck a power line and was electrocuted. Petitioner reported pain throughout the right upper extremity, primarily in his right elbow into his hand and fingertips. Petitioner also reported occasional migraines which lasted up to 10 minutes. Petitioner reported that the right elbow felt as if it was on fire, which was constant, and never improved. Petitioner advised that he functioned with his left upper extremity only due to pain associated with movement, with the only exception being when writing for which he still used his right hand. Petitioner reported that his ability to stand was limited due to dizziness, and he limited walking to one to two blocks. It was further noted that petitioner had discontinued driving due to dizziness and episodes of loss of consciousness associated with difficulty breathing.

On physical examination, petitioner was observed to use his left arm only to remove his shirt at the time of the physical exam. Petitioner refused to remove a wrap on his right elbow. Petitioner intermittently held his right hand throughout the history portion of the evaluation. Petitioner's right arm was noted to be shaking throughout the exam. Upon completion of his examination, Dr. Noren did not find any physical exam findings of symptom magnification; however, he noted that petitioner's examination was not consistent both subjectively and objectively with the reportings of his multiple treating physicians. Dr. Noren noted that petitioner completed a quick dash wherein he scored 100/100, which may be representative of some symptom magnification of his pain syndrome. Dr. Noren diagnosed complex regional pain syndrome, which he attributed to the described October 2014 incident. In terms of additional medical treatment, Dr. Noren felt petitioner would benefit from an evaluation with a neurologist with expertise in treating electrical injuries. Dr. Noren felt petitioner had not yet reached maximum medical improvement, and was incapable of returning to work based upon the September 9, 2015 history and examination.

Surveillance efforts were undertaken by Matt Morgan of PhotoFax, Inc. on September 11, 2015. The surveillance report which Mr. Morgan had prepared as well as the surveillance video were entered into evidence as Respondent's Exhibits 1 and 2, respectively. On September 11, 2015, petitioner is seen both driving and riding as a passenger in a vehicle. At 2:43 p.m., petitioner is seen loading and tying lumber into the bed of a truck in a Home Depot parking lot. At 2:46 p.m., petitioner is seen pulling on a rope used to secure the lumber in the back of the truck.

Petitioner is later seen unloading the lumber from the back of the truck upon arrival at a residence. At 3:42 p.m., petitioner begins unloading the lumber from the back of the truck. At 3:49 p.m., petitioner is seen carrying a large mirror into the house. At 4:54 p.m., petitioner is seen lifting and carrying a bed frame overhead into the home. At 5:00 p.m., petitioner is seen moving additional lumber into the house. At 5:08 p.m., petitioner carries a box spring into the home.

Petitioner testified that he had constructed the bed frame seen on the surveillance which consisted of using a drill gun to secure screws into the frame. Petitioner testified that he held the drill gun in his right hand. Petitioner estimated that he installed eight screws into the bed frame. He testified that he may have performed the drilling by himself with no assistance.

Dr. Noren prepared a supplemental report dated October 14, 2015. Dr. Noren memorialized petitioner's history provided during the September 9, 2015 evaluation, which included limited standing due to dizziness, walking limited to one to two blocks, and discontinued driving. Dr. Noren also noted petitioner's Quick-Score of 100, where he reported 5/5 severity in all 11 items. Dr. Noren summarized the surveillance from September 11, 2015, which he noted included petitioner using his right hand to lock a car door, hold a cart, and using both hands to tie down the wood in the back of the truck. Dr. Noren noted that petitioner used his right hand without any hesitancy of movement or apparent pain behaviors. Petitioner is also seen using his right hand to drive the vehicle. Dr. Noren further notes that petitioner is seen unloading the truck, and removing rope using both hands. Dr. Noren concluded that petitioner's reported impairment to him on September 9, 2015 was inconsistent with petitioner's actions seen on the September 11, 2015 surveillance video. Dr. Noren noted that the surveillance was consistent with both symptom magnification and malingering. Dr. Noren did not recommend any additional medical treatment and noted obvious malingering.

On October 19, 2015, petitioner was examined by Dr. Melissa Macias. Petitioner reported neck stiffness and right arm pain, which he stated began one year earlier when he struck an electrical cable while digging for a construction company. Petitioner reported significant limitations in daily activities due to his inability to use the right hand very often, and reported that he had been noticing worsening gait issues as of late. Dr. Macias felt petitioner was a good candidate for a dorsal column stimulator pending surgical treatment of his current spinal cord issues. With respect to surgery, Dr. Macias recommended an anterior cervical discectomy and fusion at C5-C7.

On December 17, 2015, petitioner attended an independent medical examination with Dr. Steven Mather of DuPage Medical Group Orthopedics Bone, Joint & Spine Center. Petitioner reported that, on October 20, 2014, he had been digging a hole with a shovel when he struck an electrical line. Petitioner reported that since the date of the incident his "right arm has been on

fire." Petitioner reported that he could not tolerate anything touching his right arm, which he constantly kept bandaged with an Ace bandage. Petitioner reported to Dr. Mather that he had no significant use of his right arm since the October 2014 incident. Petitioner reported that he took eight Percocet tablets per day. In terms of activity, petitioner reported that he could not use his right upper arm for anything, and certainly could not perform any light construction.

Petitioner's right arm was shaking upon Dr. Mather entering the examination room. Within approximately 20 seconds, the shaking stopped and did not occur for the duration of the examination, which lasted approximately 40 minutes. Petitioner did not allow Dr. Mather to touch the right elbow or the right upper extremity due to pain. Dr. Mather diagnosed an electrical injury, and psychogenic pain/functional overlay. He noted that petitioner exhibited multiple positive Waddell findings and multiple inconsistencies on examination. Dr. Mather found no causal relationship between petitioner's cervical complaints and the described October 2014 incident. Dr. Mather noted that petitioner did not report any neck complaints for two months following the incident. With respect to the examination findings, Dr. Mather documented extreme tenderness of the entire right upper extremity, a negative Spurling maneuver, and no signs of reflex sympathetic dystrophy. Dr. Mather noted that the only swelling was when petitioner had the right upper extremity tightly wrapped with a tight elastic sleeve and Ace bandage. Once these were removed, the swelling and redness of the right upper extremity went away within approximately 30 seconds. Dr. Mather also noted that petitioner's neurosurgeon, Dr. Dagam, performed upper extremity reflex testing on multiple occasions, yet petitioner would not allow Dr. Mather to even touch the skin of his right upper extremity due to complaints of exquisite tenderness. Dr. Mather recommended no additional medical treatment.

Dr. Mather authored a supplemental report dated December 19, 2015. Dr. Mather summarized the September 11, 2015 surveillance, which he noted showed petitioner using his right arm without difficulty. Petitioner was seen strapping lumber and heavy building materials into the back of his truck and, in doing so, using both upper extremities. Petitioner was also seen carrying multiple 2 x 4s, approximately eight feet long, by himself. Petitioner was seen carrying a large mirror with another person, as well as a bed frame and large box spring mattress by himself. Dr. Mather concluded that petitioner was malingering, as he was shown easily able to use his right upper extremity and tolerate pressure on the elbow without ill effects. Dr. Mather further noted that there were no signs of protective behaviors relative to the cervical spine, to indicate a cervical problem. Dr. Mather maintained his prior finding that petitioner could work without restriction.

The parties deposed Dr. Mather on June 22, 2017. Dr. Mather explained that he did not find petitioner's complaints at the time of his original examination to be causally related to the described October 2014 incident. (p.13). The factors he considered in reaching this determination were petitioner's normal physical examination, positive Waddell findings, and non-organic pain findings. (p.14). Dr. Mather described the surveillance video which he had reviewed and summarized in his addendum report, which showed petitioner carrying 2X4 pieces of lumber, carrying a mirror approximately three by five feet tall, carrying a bed frame, and carrying a mattress or box spring with his right upper extremity clamped against his torso. (p.17). Dr. Mather further explained that petitioner was shown resting his right elbow on his right thigh, despite the fact that petitioner would not allow Dr. Mather to touch his right elbow in any way during his examination. (p.17). Dr. Mather concluded based upon the surveillance and petitioner's complaints during his examination that petitioner was malingering. (p.17-18).

When asked during cross-examination whether Dr. Mather had reviewed the surveillance footage himself, Dr. Mather responded that he clearly remembered the footage. (p.21). Dr. Mather described the surveillance as "an all-timer." (p.21)

In early 2016, petitioner relocated to Hawaii. On March 28, 2016, petitioner presented to The Hilo Medical Center complaining of neck pain. It was noted that petitioner had recently fallen down at home, but that his pain predated this recent fall.

Petitioner was re-evaluated at The Hilo Medical Center on July 15, 2017. Petitioner complained of daily seizures, migraines, and chronic right elbow pain. Per an accompanying family member, petitioner had fallen multiple times that day with associated memory loss. Petitioner was described as a poor historian. According to a nurse note, petitioner had been snorting his narcotic pain pills. Petitioner was also noted to use marijuana, and consume an average of two beers per day. Petitioner was found to have an elevated ETOH level. The examining physician, Dr. Casey Herrforth, concluded that petitioner's symptoms were likely due to alcohol intoxication.

In 2018, petitioner relocated to Wisconsin, where he initiated medical treatment with several providers including Aurora Memorial Hospital of Burlington, Advanced Pain Management, Aurora Health Center, Aurora Health Care, Burlington Hospital, Aurora Neurology, Paddock Lake Clinic, and Aurora Medical Group.

On September 13, 2018, petitioner participated in a functional capacity evaluation at AthletiCo. Petitioner was deemed capable of performing at least sedentary work. The main limiting factor was pain which was easily exacerbated with activity.

On December 18, 2018, petitioner was examined by Dr. Klemens of Aurora Medical Group. It was noted that in October 2014, petitioner struck an electrical line with a shovel, and was electrocuted through his right arm. Since June 2015, petitioner reported to have been experiencing episodes of altered awareness. Petitioner reported their occurrence on a daily basis. It was noted that an MRI of the brain in 2015 was essentially normal. Petitioner was noted to have issues with anxiety and depression, and consumed alcohol on a daily basis. Petitioner was also noted to use marijuana on a nightly basis, as it helped him sleep. An EEG yielded normal findings. Dr. Klemens concluded that the incidents described by petitioner of altered awareness may be non-epileptic spells or related to alcohol abuse. Dr. Klemens recommended that petitioner eliminate alcohol intake.

At trial, petitioner testified that he consumes on average three to five beers per day, a minimum of four days per week. Petitioner also testified to daily use of non-prescription marijuana. Petitioner also admitted to having used cocaine "once or twice." Petitioner acknowledged snorting a half pill of Vicodin each morning, including the morning of trial.

Petitioner testified that at least one of his treating physicians has suggested that his seizures are due to his consumption of alcohol as opposed to the October 2014 event. Petitioner could not recall which physician(s) had made that suggestion. Petitioner testified that some physicians have recommended that he refrain from driving while using pain medication, which he does not always do.

Petitioner acknowledged that he has sought medical treatment for the low back since October 20, 2014, but that said condition and treatment is unrelated to the October 20, 2014 incident.

During direct examination, petitioner testified that he notices complete pain when performing daily activities with the right upper extremity. Petitioner testified that he was unable to shop for longer than five minutes. Petitioner testified that he is unable to work, as he is unable to lift heavy objects.

Petitioner testified that he has not worked, nor has he looked for work, since October 20, 2014. In explanation as to why he had not looked for work, petitioner cited the fact that he is unable to lift heavy objects.

Petitioner testified that only one physician since the October 20, 2014 incident has physically touched his right elbow.

CONCLUSIONS OF LAW

In support of the Arbitrator's decision with respect to (F) causal connection, the Arbitrator finds as follows:

The parties stipulated that an accident occurred that arose out of and in the course of petitioner's employment on October 20, 2014. As a result of said incident, the Arbitrator finds that the petitioner injured his cervical spine and right upper extremity. The Arbitrator further finds that the petitioner reached maximum medical improvement as it relates to both the cervical spine and the right upper extremity by December 17, 2015, which is the date on which Dr. Mather first placed petitioner at maximum medical improvement.

The Arbitrator finds the September 2015 surveillance compelling and persuasive. One month prior to the surveillance, on August 12, 2015, the petitioner reported to Dr. Dagam that his right arm pain was unbearable, and that his right arm and legs shook constantly due to pain. When examined by Dr. Noren two days prior to the surveillance, the petitioner reported that he performed all functions with his left arm with the exception of writing, was capable of only limited standing, could walk a distance of only one to two blocks, and had discontinued driving.

When seen by Dr. Macias on October 19th, the petitioner reported significant limitations in daily activities due to his inability to use the right hand very often. When examined by Dr. Mather on December 17, 2015, the petitioner reported that he could not use his right upper arm for anything. Petitioner reported to Dr. Mather that he could not carry anything with his right arm and could not have anything touch his right arm.

Petitioner's actions as shown on the surveillance are clearly inconsistent with petitioner's assertions to Dr. Dagam, Dr. Noren, Dr. Macias and Dr. Mather.

The Arbitrator notes that the surveillance from September 11, 2015, shows the petitioner loading and tying lumber into the bed of a truck. In doing so, the petitioner uses both his upper extremities with no visible signs of impairment or pain. Petitioner is seen yanking on the rope used to secure the lumber. Petitioner is later seen unloading the truck, again using both arms without any signs of impairment or pain. Petitioner carries what appears to be a large mirror into the house, lifts a bed frame over his head, and lifts and carries a box spring into the house.

Petitioner also testified that he constructed the bed frame seen in the video, and in doing so, operated a hand drill using his right hand. Petitioner testified to inserting approximately eight screws into the bed frame using the hand drill.

The Arbitrator notes that, upon viewing the surveillance video, both Dr. Noren and Dr. Mather concluded that the petitioner's reported impairment was inconsistent with his actual ability, and further, the petitioner's actions were consistent with symptom magnification and malingering. The Arbitrator agrees. While the surveillance does not show a tremendous amount of activity by the petitioner, it does demonstrate the petitioner significantly more active than what he indicates to the doctors.

In addition, the Arbitrator observed the petitioner at hearing and finds his behaviors also to be exaggerated compared with the surveillance and his medical records. In short, the petitioner is not a credible witness.

Based on the aforementioned, the Arbitrator finds that the petitioner reached maximum medical improvement relative to the cervical spine and right upper extremity by December 17, 2015, and that any treatment after December 17, 2015, is unrelated to the described work accident.

In support of the Arbitrator's decision with respect to (J) medical bills, the Arbitrator finds as follows:

The Arbitrator finds that the petitioner reached maximum medical improvement in relation to his work-related injuries by December 17, 2015.

With respect to any medical treatment administered after December 17, 2015, the Arbitrator finds that said treatment was unrelated to the October 20, 2014, incident. Accordingly, the respondent is not responsible for any medical bills incurred after December 17, 2015.

In support of the Arbitrator's decision with respect to (K) prospective medical care, the Arbitrator finds as follows:

The Arbitrator finds that the petitioner reached maximum medical improvement by December 17, 2015. With respect to any medical treatment administered after December 17, 2015, the Arbitrator finds that said treatment was unrelated to the October 20, 2014, incident.

Accordingly, the Arbitrator denies petitioner's claim for prospective medical care.

In support of the Arbitrator's decision with respect to (L) temporary compensation, the Arbitrator finds as follows:

With respect to the petitioner's entitlement to TTD benefits, the Arbitrator finds the conclusions of Dr. Noren and Dr. Mather persuasive. Upon viewing the surveillance video, both Dr. Noren and Dr. Mather concluded that the petitioner was capable of functioning without restrictions. The Arbitrator notes that weekly TTD benefits were paid by the respondent from October 21, 2014, through January 6, 2016, which the Arbitrator finds appropriate.

Accordingly, in light of all of the evidence of record, the Arbitrator denies the petitioner's claim for TTD benefits beyond January 6, 2016.

In support of the Arbitrator's decision with respect to (O) nature and extent, the Arbitrator finds as follows:

As the Arbitrator finds the petitioner to have reached maximum medical improvement by December 15, 2015, the Arbitrator is in position to render a finding relative to permanent partial disability. The Arbitrator finds as follows with respect to the five factors under Section 8.1(b):

1. Reported level of impairment

   The Arbitrator notes that no AMA impairment rating was submitted by either party. The Arbitrator affords this factor no weight.

2. Occupation of injured employee

   At the time of the October 20, 2014, incident, the petitioner was working as a skilled laborer. The Arbitrator adopts the findings of Dr. Noren and Dr. Mather that petitioner is capable of functioning without restrictions. The Arbitrator gives this factor greater weight.

3. Age of employee at the time of the injury

   Petitioner was 47 years old at the time of the October 20, 2014 incident. The Arbitrator gives this factor less weight.

4. Employee's future earning capacity

   No evidence was submitted at trial by either party as to the petitioner's earning capacity. The Arbitrator finds that the petitioner is capable of working without restrictions. The Arbitrator affords this factor some weight.

5. Evidence of disability corroborated by the treating medical records

   Given the inconsistencies between the petitioner's subjective reports of pain and functionality, his behaviors at hearing, and the petitioner's actions as depicted on the September 11, 2015, surveillance; it is difficult to determine the petitioner's level of disability, if any. The cervical MRI showed a diffuse mild to moderate degenerative spondylosis of the cervical spine, with levels of central canal stenosis and multilevel bilateral neural foraminal stenosis. An MRI of the right shoulder showed subtle fraying and tendinosis involving the bursal surface fibers of the supraspinatus and infraspinatus tendons, with no significant tears. The Arbitrator gives this factor some weight.

After considering all of the aforementioned five factors, the Arbitrator finds that the petitioner is entitled to permanent partial disability to the extent of 5% loss of use of the person as a whole under Section 8(d) (2) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	18WC026823
Case Name	COLE, LORI v. NOKOMIS REHAB & HEALTHCARE
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b)
Decision Type	Commission Decision
Commission Decision Number	21IWCC0333
Number of Pages of Decision	19
Decision Issued By	Thomas Tyrrell, Commissioner

Petitioner Attorney	Matthew Brewer
Respondent Attorney	William LaMarca

DATE FILED: 6/30/2021

/s/ Thomas Tyrrell, Commissioner

Signature

21IWCC0333

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lori Cole,

Petitioner,

vs. NO: 18 WC 26823

Nokomis Rehab & Healthcare,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causal connection, medical treatment and expenses, prospective medical treatment, and temporary total disability ("TTD"), and being advised of the facts and law, modifies the Decision of the Arbitrator. The Commission reverses the award of certain medical expenses. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Findings of Facts

In the interest of efficiency, the Commission primarily relies on the detailed recitation of facts provided in the Decision of the Arbitrator. Petitioner worked for Respondent as a housekeeping and laundry supervisor for several years before the date of accident. On June 29, 2018, Petitioner helped prepare rooms in anticipation of residents moving from the south end of the facility to the north end. As part of the preparation, Petitioner lifted and moved several heavy items including furniture and deep cleaned each room. By that night she noticed her shoulders and upper back started hurting. Within a few days her neck was stiff, and she began to experience numbness in her left digits. Petitioner initially thought her complaints would resolve without medical treatment; however, her symptoms continued to worsen.

Petitioner first sought treatment with Cindy Rich, a nurse practitioner, on July 31, 2018. On August 30, 2018, Nurse Rich examined Petitioner and prescribed medication including Norco (hydrocodone). She also referred Petitioner to a neurosurgeon. Petitioner returned to the clinic on September 26, 2018, for medication management. She reported running out of Norco and taking

up to five pills a day. Nurse Rich provided a refill of Petitioner's Norco prescription. Over the next several months, Petitioner continued to regularly follow up with Nurse Rich at the clinic for medication management.

Dr. Dayoub, a neurosurgeon, examined Petitioner on October 10, 2018. Petitioner complained of neck pain as well as tingling in the left arm for the past three months. Petitioner complained of worsening left arm numbness as well as occasional episodes of weakness in the left arm and hand. Dr. Dayoub interpreted the August 2018 MRI as showing a large herniated disc with spinal cord and nerve root compression at C5-C6. The doctor discussed conservative treatment including physical therapy, but ultimately recommended cervical fusion surgery due to the lack of improvement in Petitioner's complaints. On October 11, 2018, Petitioner returned to Nurse Rich for a follow up regarding her medication. She again reported taking five Norco 5mg/325mg pills each day and requested a refill. Petitioner reported no worsening in her symptoms. Nurse Rich provided a refill of the Norco prescription to cover Petitioner until her surgery. On November 7, 2018, Petitioner told Nurse Rich that she ran out of Norco two weeks earlier. Nurse Rich provided a refill of the Norco prescription. On November 19, 2018, Petitioner returned to the clinic and reported she ran out of Norco two days earlier. She reported taking up to six pills a day. Petitioner reported experiencing a brief increase in her symptoms after a recent shift at work. Nurse Rich provided another refill of Petitioner's Norco prescription.

Petitioner then returned to the clinic on December 10, 2018, and reported she ran out of Norco on December 6, 2018. She reported taking approximately six Norco tablets a day. Nurse Rich once again provided a refill of the prescription. On December 20, 2018, Petitioner returned to the clinic and requested a refill of her Norco prescription. She told the nurse that she was not yet out of pills but needed her refill early so she could fill the prescription while the clinic was closed for the Christmas holiday. Nurse Rich provided the refill. On January 16, 2019, Petitioner returned to the clinic for medication management. She reported taking her last Norco on January 2, 2019, and requested a refill. She told the nurse that she was taking up to five pills each day. The nurse refilled the prescription.

On January 31, 2019, Petitioner returned to Nurse Rich for medication management. She reported taking four to five Norco pills each day as well as her prescribed Ibuprofen 400 mg twice daily. She reported most recently taking a Norco pill that morning. Petitioner complained of occasional numbness and tingling in the left arm from the shoulder to her fingers that worsened when she rotated her head. Nurse Rich once again refilled Petitioner's Norco prescription. The nurse then added the following to the office visit note:

> "Rx given to her today and then I had to speak to the pharmacist regarding the issues surrounding the pain meds that she needs now until her surgery is scheduled. The pharmacist was concerned about the regular filling of the 90 pills every 15 days now without further information about rationale why. She was informed about the need due to the injury which caused the cervical spondylosis now and compression on the spinal cord to cause the pain and tingling down the left arm now."

(PX 1).

Petitioner last visited Nurse Rich on February 14, 2019. She reported she was still waiting on a date for her workers' compensation arbitration hearing so she could then proceed with the recommended cervical fusion surgery. Petitioner told the nurse that she was taking her Norco daily—most recently at noon that day. Nurse Rich once again refilled Petitioner's Norco prescription, but she also ordered a routine drug screening. The results of the drug test revealed there was no trace of Norco in Petitioner's system; however, Percocet (oxycodone) and THC (marijuana) were present. No medical professional prescribed Percocet or medical marijuana for Petitioner. Petitioner testified that shortly before her final visit with Nurse Rich, she stopped taking her Norco. Instead, she began giving her Norco to her husband who had recently undergone knee surgery. Petitioner testified that her husband had a prescription for Percocet; however, that medication made him sick. Petitioner testified that she began giving her Norco to her husband and instead took her husband's Percocet. After receiving the results of the drug screen, Nurse Rich told Petitioner that she could no longer prescribe pain medications for Petitioner. Petitioner sought no further treatment from Nurse Rich.

Petitioner testified that she has sought no additional treatment since her February 14, 2019, visit with Nurse Rich. Both Petitioner and Nurse Rich testified that the purpose of Petitioner's office visits from September 2018 until February 2019 was for Petitioner to obtain refills of her prescriptions. She testified that she currently takes Ibuprofen daily to manage her pain. Petitioner testified that her neck pain currently rates 5/10 and complained that her left finger and thumb were tingling a little.

Conclusions of Law

Petitioner bears the burden of proving each element of her case by a preponderance of the evidence. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). After carefully considering the totality of the evidence, the Commission affirms the Arbitrator's conclusions that Petitioner met her burden of proving that she sustained an injury to her cervical spine on June 29, 2018, due to an accident arising out of and in the course of her employment and that Petitioner gave Respondent timely notice of the injury. The Commission also affirms the Arbitrator's conclusion that Petitioner's current condition of ill-being is causally related to the June 29, 2018, work incident. Additionally, the Commission affirms the Arbitrator's award of prospective medical treatment in the form of the cervical fusion surgery recommended by Dr. Dayoub. However, the Commission modifies the Arbitrator's award of medical expenses.

A claimant is entitled to recover reasonable medical expenses that are causally related to the work accident. Pursuant to Section 8(a) of the Act, compensable expenses are those that are "…reasonably required to cure or relieve from the effects of the accidental injury…" It is axiomatic that Petitioner bears the burden of proving any medical treatment and associated expenses are reasonable and necessary. After considering the credible evidence, the Commission finds Petitioner failed to prove her medical expenses incurred on or after December 10, 2018, are reasonable and necessary.

It is undisputed that during her treatment, Petitioner chose to stop taking her prescribed Norco. Yet she continued to regularly visit Nurse Rich in order to receive refills of her prescription. Petitioner certainly has the right to decide she no longer wants to take or use any prescription she

received. However, Petitioner chose to stop taking Norco so that she could instead illicitly give her medication to her husband. In return, she began using the Percocet she testified was prescribed to her husband following his knee surgery. The results of the February 14, 2019, drug test showed that not only was Petitioner improperly taking Percocet, but she was also using marijuana to self-medicate. Most importantly, the drug test revealed that Petitioner had no traces of Norco in her system. The Commission does not believe Respondent should bear the costs of Petitioner's illicit scheme to continuously obtain refills of her Norco prescriptions so she could provide her husband with the narcotic.

Petitioner did not testify as to the date she ceased taking Norco. Instead, she vaguely testified that she started sharing her prescription with her husband shortly before February 14, 2019. While she did not provide the date of her husband's alleged knee surgery, she testified that his surgery occurred shortly before her final appointment with Nurse Rich. At one point she indicated his knee surgery occurred sometime in February 2019. Thus, according to Petitioner's testimony she had only shared her Norco with her husband for no more than two weeks before February 14, 2019. The Commission finds Petitioner's uncorroborated testimony regarding this issue to be disingenuous. Due to Petitioner's wholly improper and deceitful behavior regarding her Norco prescription, the Commission cannot simply rely on her testimony that she only stopped taking (and started sharing) her Norco just a week or two before the February 14, 2019, drug test. Instead, the Commission must rely on the medical records to determine when Petitioner began abusing her Norco prescription.

After thoroughly examining the medical records, the Commission believes there is ample evidence that Petitioner began abusing her Norco prescription by December 10, 2018. As Norco is a controlled substance, patients are only able to obtain a prescription for a supply lasting 15 days. Accordingly, each of Nurse Rich's refills provided a 15-day supply of the drug to Petitioner. The medical records reveal that Nurse Rich ordered a refill of Petitioner's prescription on November 7, 2018. Petitioner then returned to the clinic on November 19, 2018, and reported running out of her Norco two days earlier. However, Petitioner's most recent prescription refill should have provided sufficient medication through November 22, 2018. Nevertheless, Petitioner obtained yet another refill during the November 19, 2018, office visit. Petitioner then returned to Nurse Rich on December 10, 2018, and claimed she ran out of Norco on December 6, 2018. After Nurse Rich provided a refill of the prescription, Petitioner returned on December 20, 2018, for yet another refill. Petitioner told Nurse Rich she needed her refill early due to the clinic's closure over the Christmas holiday. That refill should have provided medication through January 9, 2019. Instead, Petitioner told Nurse Rich on January 16, 2019, that she ran out of Norco on January 2, 2019. Petitioner obtained another prescription refill on January 31, 2019. By that date, Petitioner's pharmacist was concerned about the amount of Norco Petitioner had obtained. Finally, on February 14, 2019, Nurse Rich provided Petitioner with a final refill of the Norco prescription and ordered a drug test. The medical records show that by December 10, 2018, Petitioner was already engaging in drug-seeking behavior regarding the Norco prescription.

The Commission declines to find Respondent liable for medical expenses resulting from Petitioner's abuse of her Norco prescription. Both Nurse Rich and Petitioner testified that the sole reason for Petitioner's routine office visits was to manage Petitioner's medication. However, the credible evidence shows that Petitioner at best was misusing her Norco prescription for no less

than a few months before February 14, 2019. As a result of Petitioner's clear abuse of her Norco prescription, the Commission finds only medical expenses related to treatment Petitioner received before December 10, 2018, are reasonable, necessary, and causally related to the June 29, 2018, work injury. This includes any prescriptions for Norco Petitioner received on or after December 10, 2018. Therefore, the Commission modifies the Decision of the Arbitrator and awards reasonable and necessary medical expenses incurred by Petitioner only through December 9, 2018.

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on April 2, 2020, is modified as stated herein.

IT IS FURTHER ORDERED that Respondent shall pay reasonable and necessary medical expenses incurred by Petitioner through December 9, 2018, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $7,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

June 30, 2021

o: 5/4/21
TJT/jds
51

/s/ *Thomas J. Tyrrell*
Thomas J. Tyrrell

/s/ *Maria E. Portela*
Maria E. Portela

/s/ *Kathryn A. Doerries*
Kathryn A. Doerries

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

21IWCC0333

COLE, LORI
Employee/Petitioner

Case# **18WC026823**

NOKOMIS REHAB & HEALTHCARE
Employer/Respondent

On 4/2/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0352 LaMARCA LAW OFFICE PC
WILLIAM LaMARCA
1118 S 6TH ST
SPRINGFIELD, IL 62703

5354 STEPHEN P KELLY ATTY AT LAW
MATT BREWER
2710 N KNOXVILLE AVE
PEORIA, IL 61603

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Lori Cole
Employee/Petitioner

v.

Nokomis Rehab & Healthcare
Employer/Respondent

Case # **18** WC **26823**

Consolidated cases: **None**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **February 26, 2020**. 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, **June 29, 2018**, 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 $24,627.97; the average weekly wage was $473.61 .

On the date of accident, Petitioner was **46** 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 $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**0.00**.

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

ORDER

Respondent shall approve and pay for prospective medical care as being recommending by Dr. Dayoub.

Respondent shall pay reasonable and necessary medical services, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Carl Lee
Signature of Arbitrator

3/30/20
Date

ICArbDec19(b)

APR 2 - 2020

Lori Cole v. Nokomis Rehab & Healthcare
18 WC 26823

STATEMENT OF FACTS

Petitioner testified regarding her pending claim and her employment with Respondent, Nokomis Rehab and Healthcare. Petitioner testified she is currently employed by Respondent and had been so employed for eleven and one half years. Her job title was Housekeeping and Laundry Supervisor. Petitioner was asked to provide the Arbitrator with a general job description and whether there had been any change in her job duties since her accident of June 29, 2018. Petitioner testified she was unable to do as much now due to her injury. In particular, she testified she is unable to do any heavy lifting or mopping as a result of her cervical condition.

Petitioner was asked to describe her activities on her date of accident. Petitioner testified that they were, "clearing off the north end" to make room for new residents in anticipation of another facility closing. The process involved deep cleaning the rooms, setting the rooms up, moving the residents and their belongings, storing unused furniture and other cleaning and moving activities. Petitioner confirmed there were some time constraints. Petitioner testified she was performing lifting activities throughout her shift and even at the end of the shift she testified she was still cleaning walls and light fixtures. "By the end of the day I was just spent." Petitioner confirmed that it was her belief that the rigorous activity that she performed on Friday, June 29, 2018 caused the problems she is now having with her neck and arm. She confirmed her cervical condition was not the result of a single lift, but the, "whole day was a heavy day, busy day."

Petitioner testified she was not having any problems when she arrived at work on June 29, 2018. As the day progressed and by the end of her shift, Petitioner testified she noticed pain developing in her shoulders and the top of her back.

Petitioner was asked what she was noticing about herself the following day. She testified the symptoms that developed the previous day across the top of her shoulders became more centralized in her neck. Petitioner testified in addition to the neck pain, she began noticing numbness in her fingers and thumb in her left hand.

Petitioner confirmed that the first time she went for medical care was July 31, 2018. She testified that prior to seeking medical care she was trying certain home remedies and not working as hard or working through it. Petitioner testified despite all of her efforts, her condition worsened. "Because everything I was trying myself wasn't working."

Petitioner testified she saw Cindy Rich, NP in her doctor's office on July 31, 2018. At that time Ms. Rich recommended a shot and gave her a prescription for prednisone and muscle relaxers. Ms. Rich also took Petitioner off work the following three days.

Petitioner was asked if she had made a formal claim or filled out an accident report prior to seeing Ms. Rich. She stated she had not. Petitioner stated she may have mentioned she was having pain and neck problems to a couple of co-workers.

Petitioner was asked if she gave anyone at work the note she received from Ms. Rich. Petitioner testified she gave the note to Jessica Ashcraft, who was the administrator at that time. Petitioner testified that she told Jessica that if her condition did not improve she was going to have to make an appointment for an MRI. When her condition did not improve she scheduled the MRI. Regarding mentioning anything to Jessica or anyone in a supervisory position about her accident, Petitioner stated,

> When I went to the doctor on the 31st, I called the doctor that morning, made the appointment for that afternoon, so I went and told Jessica, I've got an appointment this afternoon so I need to leave at this time. And I told her why, that I think I hurt myself when we were moving all that furniture down there and I want to see if I can get - -

The Arbitrator at this point wished to verify the date of this conversation, which Petitioner stated was July 31, 2018.

Petitioner testified she eventually filled out an accident report. She remembers that she had her MRI on the 13th of August and advised Jessica that if there was evidence of damage, "that I was going to want to file workman's comp. If there wasn't no damage, then, you know, if it's just muscle related then I will just go back to work."

Petitioner testified that subsequent to undergoing the MRI and when Jessica returned to work on the 22nd of August she had another conversation with Jessica requesting at that time that she fill out paperwork, "because the MRI showed the damage." Petitioner's was shown Petitioner's Exhibit 7. She confirmed that this was the paperwork that Ms. Ashcraft filled out and Petitioner signed after reviewing the information Jessica had put in the form. Petitioner confirmed that the date of August 22, 2018 contained in the report was not the first occasion she had spoken to Jessica about her accident. August 22nd was the day Jessica returned back from being gone from work. She had given Jessica a copy of the note from Cindy Rich on August 6, 2018 when she returned to work. Petitioner verified that she continues to work. She also confirmed Ms. Rich had placed restrictions on her work activities of no lifting greater than ten pounds. Petitioner verified Respondent has been able to accommodate her restrictions.

Regarding her pre-accident condition, Petitioner's attention was directed to Petitioner's Exhibit 6, an emergency room report dated October 4, 2016. Petitioner testified after mowing, she developed pain in her upper back. She testified she was diagnosed with trapezius muscle strain. After taking medication she got better. She had no restrictions and did not have ongoing problems.

Petitioner was asked about her last appointment with Ms. Rich in February, 2019. Petitioner confirmed that no other treatment, other than surgery was recommended at that time. Petitioner was also asked about the medication, Norco that Ms. Rich had prescribed for her pain. Petitioner acknowledged that she had been taking her husband's pain medication because it made him very sick so she gave him the Norco that Ms. Rich had prescribed. Petitioner confirmed that her husband had undergone surgery in February, 2019.

Petitioner testified the current recommendation for treatment is surgery and that it is her desire to pursue that course of treatment.

With respect to her present condition, Petitioner testified she is having pain at a level of severity of 5. She further testified she is experiencing numbness and tingling in her left thumb and index finger. She continues taking ibuprofen for pain control.

Petitioner confirmed she had never filed a workers' comp claim in the past.

With respect to average weekly wage, Petitioner was asked about her employer's policy on overtime, and whether there is a requirement that an employee comply with a request to work overtime or is it the employee's choice. Petitioner testified that when there is a "state survey" being conducted in the building overtime is mandatory. Overtime is also required in the event another employee she supervises cannot work.

On cross-examination Petitioner was asked about her conversation with her supervisor on July 31st. She confirmed that when she spoke with Jessica at that time she went to her office after making the appointment with the doctor for the same day telling her she had to leave because she wanted to go to the doctor, "because I thought I maybe pulled a muscle in my neck that day we moved all that furniture down there, and I wanted to see about getting a higher dose of ibuprofen or maybe some muscle relaxers." Petitioner was also asked on cross-examination about any conversation after July 31st. Petitioner stated, when she came back to work on August 6th, she gave Jessica the doctor's note. She did not give her the doctor's note on July 31st and she did not tell Jessica about the MRI on July 31st because it had not been scheduled.

Petitioner was asked if there was a state survey in the year prior to her accident. Petitioner testified they do state surveys every year and that there is an annual state survey usually in October or November during each year.

On cross-examination Petitioner stated she did not fill out an accident report when she was first injured, "I didn't think it was an accident. It wasn't an accident until after I had the MRI done." Petitioner clarified her answer by stating if she just had a pulled muscle then it would heal and there would be no reason for her to file a claim. Unfortunately her symptoms did not improve and so she decided to fill out an accident report after the MRI performed showed a problem requiring further treatment.

On cross-examination Petitioner was shown Respondent's Exhibit 2 which was also Petitioner's Exhibit 7, the actual accident report. Petitioner was asked to explain an apparent discrepancy between the date in the accident report when she reported the accident to be August 22, 2018 and her testimony that she advised her supervisor of her accident on July 31, 2018. Petitioner stated that August 22, 2018 is when her supervisor returned to work after being on a leave of some sort. Petitioner again reiterated that she did not refer to the July 31st conversation when she first advised her supervisor of her accident because at that time she wasn't sure it was going to be a workers' comp claim. "Not until after August 13th when I had the MRI done." Petitioner was also asked on cross-examination about certain personal time off requests. These requests were for unrelated events Petitioner was requesting time off to do but had nothing to do with her accident or injuries.

On cross-examination Petitioner was again asked about the drug screen that was ordered by Ms. Rich in February, 2019 and the results of the drug screening. Petitioner stated as she had testified on direct examination that she had given her husband the Norco that Ms. Rich had prescribed and that she was using the Oxycontin or Percocet that her husband had been prescribed after knee surgery because he had an adverse reaction to the Oxycontin and was in pain.

On redirect Petitioner again referred to her conversation with Jessica on July 31, 2018. Petitioner also clarified that regarding the reference to possibly having slept wrong causing her neck pain, that she was referring to the night of her accident and not before her accident.

Petitioner called Missy Marley to testify. Ms. Marley testified that she had worked for Respondent up until July 31, 2018 as a Dietary Manager and had been so employed for eight years. Ms. Marley's attention was directed to June 31, 2018 (sic) asking if she recalled at that time having a conversation with Petitioner. Ms. Marley stated that Petitioner had come out on lunch and told Ms. Marley she thought she had hurt herself from moving things in the south hall at work. She believed Petitioner had told her she had hurt her neck. Ms. Marley testified that the only relationship she has with Petitioner is working together at the facility and has no outside relationship with Petitioner. She further confirmed she was present at the hearing pursuant to a subpoena she had received.

On cross-examination Ms. Marley confirmed that the conversation she had with Petitioner was on a Monday in June. Petitioner's counsel inadvertently referred to the date as June 31st. The correct date is June 30, 2018.

Respondent called Jessica Ashcraft to testify. Ms. Ashcraft identified herself as a former employee of Respondent. Her position was Administrator. She had been in that position for approximately one year as of June, 2018. Ms. Ashcraft confirmed that in June, 2018 she was Petitioner's direct supervisor. Ms. Ashcraft acknowledged that she recalled having a conversation with Petitioner regarding her accident. Ms. Ashcraft stated to that to the best of her recollection, the first time she had a conversation with Petitioner regarding a work accident was August 24th. Ms. Ashcraft was handed Petitioner's Exhibit 7, the Report of Injury. Ms. Ashcraft's attention was directed to the date on the accident report of August 22, 2018. Ms. Ashcraft stated that prior to August 22nd Petitioner had not reported a work accident to her. Ms. Ashcraft recalled having received a work note from Petitioner's physician on July 31, 2018 but she could not recall if she spoke with Petitioner on that date.

On cross-examination Ms. Ashcraft was asked if she recalled whether she received the note dated July 31st from Cowden Medical Clinic from Petitioner or from the facility. Ms. Ashcraft could not recall. Ms. Ashcraft was also asked if she recalled having a conversation with Petitioner at the time she received the note. Ms. Ashcraft stated she didn't know. If it was the same day she did remember Petitioner saying that her arm hurt. Ms. Ashcraft stated it was possible that conversation occurred prior to August 22nd. Once Ms. Ashcraft was made aware that Petitioner believed the physical problems she was having was related to her work activities she contacted Shannon Peyton. At that point both Ms. Ashcraft and Ms. Peyton began the investigation process. Regarding the investigation, Ms. Ashcraft acknowledged that it was a somewhat extensive investigation. Ms. Ashcraft was asked if there was anything about the investigation that was not completed. Ms. Ashcraft stated not to her knowledge. Ms. Ashcraft further acknowledged that although she was not sure she spoke with Petitioner on July 31st, she did recall having other conversations where Petitioner advised her that her shoulder/arm had hurt.

Ms. Ashcraft was asked what reaction Petitioner had when she advised her that she wanted to turn the accident in as a workers' compensation claim. Ms. Ashcraft acknowledged that Petitioner became very tearful and stated, "I don't want to lose my job, I thought it would go away."

Petitioner introduced eight exhibits. Petitioner's Exhibit 1 is office notes from Cindy Rich, NP from July 31, 2018 through February 14, 2019. Petitioner's Exhibit 2 is an x-ray dated July 31, 2018 and an MRI dated August 13, 2018. Petitioner's Exhibit 3 is an office note from Dr. Hayan Dayoub dated October 10, 2018. Petitioner's Exhibit 4 is a narrative report dated April 2, 2019 from Cindy Rich, NP. Petitioner's Exhibit 5 is the deposition of Cindy Rich, NP dated June 12, 2019. Petitioner's Exhibit 6 are pre-accident emergency records dated October 4, 2016. Petitioner's Exhibit 7 is a Report of Injury and related accident forms and Petitioner's Exhibit 8 are a collection of medical bills and medical bill summary.

In her narrative report dated April 2, 2018 Ms. Rich stated the first time she saw Petitioner for cervical spine pain was on July 31, 2018 that had developed after an incident that occurred on June 29, 2018 at Petitioner's employment for Respondent. It was Ms. Rich's opinion based upon her understanding of events that occurred on June 29, 2018 within a reasonable degree of medical certainty that Petitioner's cervical spine injury and pain was due to the activity Petitioner was performing on June 29, 2018 in the course of her employment for Respondent. Petitioner's Exhibit 4 also includes a letter dated March 27, 2019 from Petitioner's attorney requesting the narrative report.

In her deposition dated June 12, 2019 marked as Petitioner's Exhibit 5, Ms. Rich testified as to her training and qualifications as a nurse practitioner and her relationship with Dr. Opilka. Ms. Rich confirmed that in her practice she has treated patients with orthopedic injuries. To the best of her recollection she did not recall Petitioner ever complaining to her prior to July 31, 2018 of any cervical or upper extremity problems. Ms. Rich confirmed that on July 31, 2018 Petitioner complained of neck pain and that she had injured her neck while

moving furniture. The onset of her symptoms was approximately three weeks ago. A physical exam revealed pain with movement of the neck and a decreased range of motion. Treatment involved a steroid shot and a dose pack of prednisone as well as ordering an x-ray.

Ms. Rich testified that on August 6th there was a phone call from Petitioner at which time she asked Ms. Rich's office to fax the x-ray to her work to discuss it with her boss. She also asked at that time if the MRI could be ordered as her condition was not improving. Ms. Rich stated that she had given Petitioner an excuse from work on the 1st, 2nd and 3rd of August and to return to work on August 6th with no restrictions.

Ms. Rich confirmed that on August 31st she saw Petitioner at which time she received additional details about the activities she was engaged in on June 29, 2018. At that time Ms. Rich referred Petitioner to a neurosurgeon for evaluation. She also gave Petitioner a note for work with restrictions. Regarding the MRI, Ms. Rich stated that the radiology report revealed a disc osteophyte complex at the C5-6 level and left sided disc herniation impinging on the left C6 nerve root. There was also a disc osteophyte complex at the C6-7 level causing mild to moderate left foraminal stenosis. Ms. Rich stated that Petitioner's complaints and her examination results were consistent with the MRI findings.

Ms. Rich testified that on October 11th Petitioner was still complaining of neck pain. She was now taking five pain pills a day with ibuprofen in between and had had a recent appointment with Dr. Dayoub. It was Ms. Rich's understanding that Dr. Dayoub was recommending a C5-6 fusion surgery. Ms. Rich testified she continued prescribing Norco to control Petitioner's pain and maintained the same work restrictions.

Ms. Rich stated that an appointment on February 14, 2019 Petitioner was still complaining of neck pain. On this occasion Ms. Rich ordered a drug screen that she typically orders once a year for patients that are on pain medication. She confirmed that the Norco that she had prescribed did not show up in the drug screen but that Oxycodone and THC showed up. Ms. Rich testified that at that point she had advised Petitioner she could not prescribe any more pain medication.

Ms. Rich reiterated her opinion that within a reasonable degree of medical certainty Ms. Cole's cervical spine injury was due to the incident that occurred on June 29, 2018 in the course of her employment for Respondent. Ms. Rich stated it was not necessary for her to know the weight of the furniture and other items she was moving in order to render an opinion. Ms. Rich further testified as to the mechanism of injury and how repetitive lifting can cause or contribute to the development of a herniated disc.

On cross-examination Ms. Rich confirmed her physical exam of Petitioner revealed objective findings along with subjective complaints of numbness, tingling and pain with flexion and extension. Ms. Rich also confirmed on cross-examination that it was her understanding that Petitioner's injury was the result of, "accumulative affect" from working all day on her date of accident.

On cross-examination Ms. Rich confirmed that her opinion regarding causation would not change if it was shown Petitioner had not sought medical care prior to seeing her on July 31, 2018. Ms. Rich was also asked about the drug testing performed on February 14, 2019 and the results of that testing. On redirect Ms. Rich confirmed that based on what Petitioner told her at the August 30th visit, it was her understanding that Petitioner's neck pain first began after she, "had been working, moving furniture all day and wiping walls."

Petitioner's Exhibit 6 is a pre-accident emergency room report dated October 4, 2016. At that time Petitioner advised the medical provider she had developed pain in her left trapezius and left posterior shoulder approximately seven days ago with an onset after using a push mower to mow an acre of land of tall grass with many "mole holes." The exam at that time revealed some muscle spasm in the left trapezius muscle, painless

range of motion, no vertebral tenderness, moderate soft tissue tenderness. The neurological exam was normal. The clinical impression was muscle strain of the left trapezius at the left shoulder.

Petitioner's Exhibit 7 are copies of the Report of Injury dated September 6, 2018 referring to a date of accident of June 29, 2018.

Petitioner's Exhibit 8 is a collection of medical bills and medical bill summary.

Respondent introduced fifteen exhibits. Respondent's Exhibit 1 is a copy of the Form 45: Report of Injury or Illness completed by Shannon Peyton on September 10, 2018. Respondent's Exhibit 2 is an Employee Incident Checklist referring to the date of injury of June 29, 2018, a Report of Accident, Supervisor's Incident Report and other blank forms. Respondent's Exhibit 3 is an Absence Request for various periods of time signed by Petitioner.

Respondent's Exhibit 4 is the Evidence Deposition of Dr. Jesse Butler dated July 26, 2019. Dr. Butler identified himself and provided a brief summary of his medical training and qualifications. Dr. Butler testified that 25% of his practice is made up of performing independent medical examinations or record review.

Dr. Butler was asked about a report he prepared dated November 20, 2018 and medical records he reviewed prior to preparing the report. Dr. Butler summarized his physical exam and findings including loss of range of motion and radiation of pain down the left arm. Dr. Butler referred to the MRI, that he said revealed a large herniated disc causing substantial compression of the C6 nerve root. Dr. Butler was under the impression Petitioner performed full duty work after her injury. However, Petitioner testified she self restricted her activities to avoid anything that increased her pain symptoms. Petitioner also testified to taking over the counter pain medication prior to seeing Ms. Rich on July 31, 2018. Dr. Butler stated it was difficult to say whether the disc herniation was present prior to June 29, 2018. Dr. Butler's diagnosis was C5-6 disc herniation with radiculopathy at C6. Dr. Butler agreed with the recommendation of Dr. Dayoub that Petitioner needed to undergo an anterior cervical discectomy and fusion at C5-6. Dr. Butler testified that it was difficult for him to provide an opinion within a reasonable degree of medical certainty as to whether the activities Petitioner described as moving furniture on June 29, 2018 may have caused or aggravated or accelerated the condition of Petitioner's neck. Dr. Butler did state that he found the history contained in the records he was provided to be consistent throughout.

On cross-examination Dr. Butler admitted that he relied in part on a cover letter Respondent provided in reaching certain conclusions regarding the first date Petitioner advised Respondent she had injured herself on June 29, 2018. Dr. Butler stated that in his experience, lifting objects can cause or lead to the development of a herniated cervical disc. He also stated that the symptoms Petitioner described to Ms. Rich were consistent with the MRI findings showing a herniated cervical disc. Dr. Butler was asked that assuming Petitioner did not have the symptoms she developed subsequent to her accident on June 29th and that on that date she did in fact lift furniture and other objects and then woke up with increasing symptoms trying to figure out what caused the problem, "Is it more likely than not that the lifting activity may have caused or contributed to the development of a herniated disc and the need for surgery." Dr. Butler stated that, "That's probably an accurate statement."

Respondent's Exhibit 8 are copies of Petitioner's payroll check stubs for the period 07/01/2017 through 06/30/2018.

Respondent introduced the evidence depositions of five employees who worked for Respondent: Melissa Wright, Dennis Lewey, Tammy Bourke, Patsy Warnisher and Dawn Goldsmith. Each of the employees were asked about their general job duties and their knowledge of Petitioner's accident. Ms. Wright testified she was

not aware of Petitioner's accident. She also testified she was not working with Petitioner directly on the date of accident. Dennis Lewey also testified he was not aware of Petitioner's accident although he recalled Petitioner being off work for some medical problem with her shoulder and offered to help her if she needed any help. He could not recall whether he worked with Petitioner on the date of accident. Tammy Bourke testified she was not aware of Petitioner's work accident and she also did not know Petitioner was working with restrictions after her accident. Patsy Warnisher testified she could not recall whether she worked on June 29, 2018. She knew Petitioner had sought medical treatment. She was aware that there had been activity involving moving furniture in June, 2018. Ms. Warnisher did not know Petitioner had restrictions on her work activities. Dawn Goldsmith testified that she had filled out an investigation report. She did not recall whether she worked on June 29, 2018. None of the witnesses had supervisory authority with respect to Petitioner.

FINDINGS AND CONCLUSIONS

Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent? Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner's undisputed testimony was that on June 29, 2018 she was performing lifting and moving and cleaning activities under circumstances when there was some urgency to complete the task and make the room available for new residents. Petitioner testified that at the end of the day she noticed symptoms in her neck and upper back. She subsequently began developing increasing symptoms into her left arm. Hoping her symptoms would go away, she chose not to seek medical care immediately or report the accident to her supervisor. It is clear from Ms. Ashcraft's testimony that Petitioner was genuinely concerned about her job security and even became tearful when she discussed the accident with Ms. Ashcraft. Her description of how she was injured in the Ms. Rich's medical records is consistent with her testimony at arbitration.

Regarding causation, Ms. Rich believed that absent evidence contrary to her understanding of how Petitioner was injured, she believed Petitioner's work activities of lifting and cleaning on June 29, 2018 caused or contributed to the development of the herniated disc in her cervical spine.

On cross-examination, Respondent's IME doctor, Dr. Butler testified that he agreed that repetitive lifting and moving of furniture can contribute to the development of a herniated disc.

After reviewing the testimony of Petitioner and Respondent's witness at arbitration and all exhibits presented at arbitration, the Arbitrator concludes Petitioner sustained accidental injuries that arose out of and in the course of her employment for Respondent on June 29, 2018. The Arbitrator further concludes that Petitioner's injuries to her cervical spine as outlined in the medical records were caused or aggravated by Petitioner's work activities on June 29, 2018.

Was timely notice of the accident given to Respondent?

Based on all of the testimony from both Petitioner and Respondent's representative, Petitioner gave Respondent notice of her accident of June 29, 2018 as early as July 31, 2018 and as late as August 22, 2018. Petitioner testified that she had a conversation with her supervisor on July 31, 2018 at which time she advised her supervisor she may have injured herself, "that day we moved all that furniture down there." Petitioner's supervisor, Jessica Ashcraft testified that she recalled having a conversation with Petitioner at that time and that Petitioner told her she was having problems with her neck and arm but that Petitioner did not tell her the problem was related to a work injury. The Arbitrator finds the testimony of Petitioner in this regard to be more credible.

On cross-examination Ms. Ashcraft testified that a complete investigation was conducted concerning Petitioner's alleged accident. Therefore, any delay or defect in notice to Respondent had absolutely no effect on Respondent's ability to conduct a full investigation. In addition to conducting a very extensive interviewing and investigation process which co-workers were questioned about what they knew about Petitioner's accident, Respondent had Petitioner examined by Dr. Butler on November 20, 2018. Respondent offered no evidence that any delay or defect in notifying Respondent in any way prejudiced Respondent's ability to investigate Petitioner's claim of injury.

The courts and Commission have consistently held that a claim is only barred if no notice whatsoever has been given. In Silica Sand Transport Inc. v. Industrial Commission, 197 Ill. App. 3d 640, 651, 143 Ill. Dec. 799, 554 N.E. 2d 734, 742 (1990) the court held, "If some notice has been given, but he notice is defective or inaccurate, then the employer must show that he has been unduly prejudiced." id

What were Petitioner's earnings?

Respondent's Exhibit 8 are copies of Petitioner's payroll check stubs for the period 07/01/2017 through 06/30/2018. Her total earnings during the 52 week period prior to the accident as referenced on page 8 of the exhibit is $24,627.97. This calculation includes overtime, paid time off, regular earnings and regular second shift pay. The total hours of overtime during this period is 11.68 hours. In that regard, Petitioner testified there are times during the year when she is required to work overtime for a state survey and in her capacity as a supervisor when a scheduled employee failed to report to work.

The Arbitrator concludes in the year preceding the injury, Petitioner earned $24,627.97 and her average weekly wage is $473.61.

Were the medical services that were provided to Petitioner reasonable and necessary?

Petitioner marked and introduced Petitioner's Exhibit 8, which contains a group of medical bills and a summary of medical expenses. The summary reflects the total amount of bill and balances due.

The Arbitrator has reviewed the medical exhibits introduced by Petitioner and the medical bills contained in Petitioner's Exhibit 8. The medical expenses appear to be reasonable and necessary and related to Petitioner's accident of June 26, 2018. Having ruled that Petitioner sustained an accidental injury that arose out of and in the course of her employment for Respondent and that Petitioner's current condition is causally related to her accident, the Arbitrator finds that Respondent is responsible for the payment of any and all unpaid related medical expenses incurred by Petitioner for the treatment of her cervical condition.

Is Petitioner entitled to any prospective medical care?

Petitioner testified Dr. Dayoub had recommended surgery to treat the condition of her cervical spine. Dr. Dayoub's office note dated October 10, 2018 was marked and introduced as Petitioner's Exhibit 3. The Arbitrator notes that the Dr. Dayoub stated, "Given that her problems of (sic) not improved on current conservative management, I recommend surgery. (C5-6 ACDF)" The Arbitrator notes that Dr. Butler who examined Petitioner at the request of Respondent also believed Petitioner would benefit from cervical surgery. Given the above findings and in light of a concensus that Petitioner would benefit from surgery, the Arbitrator concludes the recommended surgical procedure is reasonable and related to Petitioner's accident and therefore the responsibility of Respondent to pay. Respondent is ordered to approve the recommended treatment.

ILLINOIS WORKERS' COMPENSATION COMMISSION

DECISION SIGNATURE PAGE

Case Number	17WC013292
Case Name	GLYNN, ANTHONY v. UTILITY TRANSPORT SERVICE INC
Consolidated Cases	
Proceeding Type	Petition for Review under 19(b) & 8a
Decision Type	Commission Decision
Commission Decision Number	21IWCC0334
Number of Pages of Decision	24
Decision Issued By	Kathryn Doerries, Commissioner

Petitioner Attorney	Charles Haskins, Jr.
Respondent Attorney	Timothy O'Gorman

DATE FILED: 6/30/2021

/s/Kathryn Doerries, Commissioner
Signature

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
X reverse as to denial of prospective med.	☐ PTD/Fatal denied
☒ Modify to award prospective medical	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANTHONY GLYNN,

Petitioner,

vs. NO: 17 WC 13292

UTILITY TRANSPORT SERVICE,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b)/8(a) having been filed by Petitioner herein, and notice given to all parties, the Commission, after considering the issues of causal connection, temporary total disability, medical expenses, and prospective medical 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 a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

Petitioner, a 50-year-old employee of Respondent, described his job as a roll-off truck driver. Petitioner agreed he was working for Respondent on 4/17/17. Prior to that time, Petitioner had not sustained any injuries to his low back, nor had he received any type of treatment for any back condition. Before that date, he was under no work restrictions or limitations relative to his low back. Petitioner was born in Ireland. He came to the USA in 1996. Prior to coming he had obtained a high school education in Ireland. He had worked in the glue industry in Dublin, Ireland,

which entailed loading hoppers with chemicals and monitoring the heat and distillation process. He lifted items weighing in the range from 25 kilos to lifting a 55-gallon drum off the ground. (T.15-17)

When he came to the America in 1996, because his company was expanding to the U.S., Petitioner became a permanent resident. He initially came to the Chicago area and the company was located in the Frankfort, Illinois area. Petitioner became a member of the Laborers' Union in 1998 performing various labor work which included lifting, bending and stooping. Petitioner then worked for a company called Brackenbox where he drove a roll-off truck. Petitioner next went to work for Respondent, which was affiliated with Brackenbox, but Respondent was the entity that employed all union drivers. The job of roll-off driver dealt with construction debris, sand and dirt.

On the date of accident, April 17, 2017, Petitioner was operating a truck and lifting a roll-off dumpster in the air with a hook from his truck. Petitioner testified that the front wheels of his truck came off of the ground due to the weight of the box. Petitioner testified the box fell and the truck slammed to the ground. After that happened, Petitioner was in a lot of pain and agony in his lower back. (T.20)

Petitioner was transported by ambulance to Swedish Covenant Hospital where he remained in-patient from 4/17/17 to 4/22/17. Petitioner was diagnosed with a compression fracture of L2. Petitioner came under the care of Dr. Laich who performed stabilization surgery consisting of L1-L3 posterior reconstruction including utilization of posterior screws and rod (PX 4). Petitioner agreed he was off work at that time. After discharge, Petitioner followed up with Dr. Laich on 5/25/17 and 7/27/17. Dr. Laich recommended physical therapy and aquatic therapy. Petitioner testified he did not have the therapy at that time as the insurance had denied it. Petitioner was continued off work and under care of Dr. Laich whom he saw again November 2017. (T.20-22)

Petitioner agreed he was seen by Dr. Michael Kornblatt at the request of Respondent. Dr. Kornblatt had indicated (per reports) that therapy was appropriate and Petitioner started therapy at ATI, including water therapy. Petitioner had to drive periodically for the water therapy to Bourbonnais, Illinois, from his home in Midlothian. Petitioner was also receiving land based therapy at that time and continued this course of treatment. Dr. Kornblatt indicated Petitioner could return to work under light duty restrictions. At that time, Dr. Laich indicated that Petitioner should be off of work. (T.22-24)

Respondent offered Petitioner a light duty position and he returned to light duty work around 12/5/17. Petitioner's job duties at this time included sweeping the floors in the shop at the truck shop yard, mopping the offices, emptying garbage, and picking up and delivering parts for trucks. When he delivered truck parts, he testified, he drove a distance between 3 and 70-80 miles. (T.24-25)

Petitioner testified that during that time, he had to take a lot of breaks and he was feeling pain in his lower back. He was in physical therapy at that time and they were recommending that

he progress to work hardening. Petitioner believed it was Dr. Kornblatt who recommended the work hardening. Petitioner began work hardening at ATI on 2/18/18 where he was pulling weights on a cable towards his body. He pushed weights out with his arms, while laying on a mat and bringing his body upwards with a ball under his knees. He also lifted weights while laying on a bench and utilized a treadmill. Petitioner testified the longer he was doing it the worse he felt, the more pain he was in and the less energy he had. (T.25-27) Petitioner attended part of the day on 2/19/18. Petitioner testified on the 2nd day of work hardening, he recalled lying on the bench after lifting some weights, 10-20 pounds in each arm. He then tried to get off the bench but was unable to do so. He stated he had to roll off the bench to "sort of fall on the floor." He advised the therapist at ATI he was not going to be able to do it. Petitioner stated the therapist advised him to call his doctor. (T.27-28)

Petitioner saw Dr. Laich on 2/23/18 who provided an off work note and Petitioner brought it to Respondent. Petitioner continued receiving regular therapy rather than work hardening at ATI. Petitioner was ultimately discharged from therapy during the middle of March 2018. Petitioner was returned to restricted work on 3/19/18. Petitioner underwent a CT scan at the request of Dr. Laich which revealed the comminuted fracture at L2 and it was noted that the fusion L1 to L3 with the rods and pedicle screws with hardware intact. Dr. Laich reviewed the results of the CT scan and recommended Petitioner consider an L2 corpectomy and reconstruction given Petitioner's ongoing pain complaints. (T.28-31)

Petitioner continued to work light duty for Respondent during that time period. Petitioner testified that in July 2018 he was relocated to Respondent's site at 700 East 138th Street in Chicago. Petitioner stated dump trucks arrived daily with loads of dirt and he was initially supposed to check the loads with a PID tester which tests for contamination. He then had to write a ticket for the trucks indicating their location, material, order number, and date. Petitioner testified that job was easier than the job at the other yard he had worked at for Respondent. Petitioner testified he brought a rocking chair from home with a cushion to sit in. Petitioner stated he was now required to inspect every truck which required him to climb on every truck and inspect every load. (T.31-33)

Petitioner testified he had viewed the surveillance videos of him performing various activities around his home, driving and traveling. Petitioner testified he was out of the country for about 10 days in Ireland, and he had stopped in Iceland. He testified he informed Respondent of that trip. Petitioner further testified that from what he viewed on the surveillance videos, he did not perform any activity that he would not have performed while on light duty. (T.33-34)

On cross examination, Petitioner agreed he had returned to light duty on 12/5/17. He participated in work hardening on 2/17/18, but did not return to work on 2/20/18. Petitioner returned to work 4 weeks later on 3/18/18. Petitioner agreed the job duties he was asked to perform on 3/18/18 were similar to the job duties he had been performing prior to work conditioning. Petitioner was currently working. (T.34-36)

Medical Records

The medical records of Swedish Covenant Hospital dated 4/17/17 noted Petitioner's complaints of low back pain at 10/10 for several hours. The history of accident states, "Patient was inside the cabin of a dump truck, the dump truck was lifted off the ground to (sic) heavy weight in the rear, and the front end slammed down. The patient was lifted off of his seat and sustained the injury to his low back." (PX 4) An x-ray of the lumbar spine revealed a compression fracture L2 vertebrae. The operative report noted the fracture and an L1-3 reconstruction posterior with pedicle screws was performed by Dr. Laich. (PX 4)

On 4/18/17, Petitioner had a neurology consult with Dr. Laich. Dr. Laich noted the same history of accident and noted that the MRI showed an acute fracture at L2, moderate loss of disc space and stenosis. Dr. Laich diagnosed the traumatic compression fracture as well as muscular strain/sprain. (PX 4)

The Swedish Covenant discharge summary of 4/22/17 noted the same diagnosis and MRI findings. The record further noted a CT scan showed several fracture lines at L2 with the largest at transverse plane AP. (PX 4)

Petitioner continued to treat with Dr. Laich who noted on 5/25/17 Petitioner reported low back pain with activity, increased pain with long standing and bending. Petitioner was prescribed Chantix. (PX 6) A follow-up visit on 7/27/17 noted Petitioner reported ongoing low back pain and right leg pain. Dr. Laich noted symptoms improving but pain with sitting, walking and increased pain with sustained activities during the day. Dr. Laich further noted negative Waddell's signs. Physical therapy was prescribed. The follow up visit on 11/24/17 noted ongoing low back pain, increased with activity. Workers' Compensation was then approving therapy. Dr. Laich noted that Petitioner was deconditioned. Petitioner was kept off work and physical therapy and aqua therapy were prescribed. Dr. Laich was then considering a CT myelogram due to Petitioner's lack of progress. (PX 6)

Petitioner returned to Dr. Laich on 1/5/18 where it was noted Petitioner has been performing light duty since 12/1/17 secondary to an IME (Dr. Kornblatt). Dr. Laich noted ongoing low back pain and right leg pain, aggravated by activity. Dr. Laich disagreed with Dr. Kornblatt's plan for physical therapy to be followed by an FCE. Dr. Laich noted Petitioner had returned to smoking with his return to work. Dr. Laich again noted negative Waddell's signs and he prescribed physical therapy and aquatic therapy, and to remain on light duty. (PX 6)

Dr. Laich saw Petitioner for follow-up on 2/16/18 and noted Petitioner was tolerating light duty if working upright, with no twisting or lifting. Dr. Laich further noted that Petitioner did not feel he had a desirable lifestyle with his ongoing pain symptoms. Therapy was continued and Dr. Laich ordered Petitioner off work through work hardening and an FCE. (PX 6) Petitioner underwent a second CT scan at Swedish Covenant on 2/28/18 which revealed the comminuted

fracture at L2 and identified the fusion at L1-L3 with rods and pedicle screws with intact hardware and normal alignment. (PX 5)

Petitioner returned to Dr. Laich on 3/16/18 and again reported his current life was unacceptable and desire for activity under his current circumstances was not possible. Petitioner at that time was considering the previously recommended L2 corpectomy and reconstruction, but Petitioner needed to work to survive financially. Petitioner's chief complaint was low back pain, right and left leg pain. Dr. Laich allowed Petitioner to return to light duty work, 20 pound lifting restriction with no driving; restrictions set per work hardening. Dr. Laich was still considering surgery. (PX 6)

Petitioner returned for follow-up on 4/26/18 where Dr. Laich noted Petitioner's ongoing low back pain with right radiculopathy. Petitioner was returned to work and considering the recommended surgery. Dr. Laich noted Petitioner had a recent IME and he disagreed with the IME opinion that Petitioner would not benefit from the recommended surgery. The diagnosis of Dr. Laich then was degenerative disc disease, closed unstable burst fracture L2 with delayed healing, post fusion, low back pain. Dr. Laich took Petitioner off work. (PX 6)

Medical records of ATI where Petitioner received therapy between 11/14/17 and 3/19/18 noted Petitioner's signs and symptoms were consistent with the diagnosis, low back pain with radiating pain right lower extremity. They noted Petitioner's deficits with stairs, bending, lifting, and they noted Petitioner's job required heavy to very heavy demand. Petitioner's status as of 1/2/18 was noted as sedentary. (PX 8)

Respondent presented surveillance video admitted as RX 7. Petitioner is viewed on 8/15/17 walking by garbage cans, walking to the house, and later retrieving empty garbage cans and bringing them up the driveway. The surveillance video dated 8/26/17 showed Petitioner briefly in a van. The video clip from 9/20/17 showed Petitioner driving, and later walking by the house. The video clip from 9/22/17 showed Petitioner picking up garbage with a grabber and pulling garbage cans up the driveway. Petitioner is also seen kneeling and bending over on to hands and knees cleaning under a riding mower for 5-10 minutes. Petitioner is then shown driving a mower cutting grass for approximately 15 minutes; some bouncing on the mower can be seen. Petitioner is seen picking up grass/debris from the sidewalk with the grabber and then walking away with the bucket.

A video clip from 6/24/18 showed Petitioner walking with buckets in the yard, doing some yard work, moving up and down, and trimming bushes. Some kneeling and bending is also noted. The video clip from 6/28/18 shows Petitioner driving to the airport and sitting in a van. After about 9:00 p.m., Petitioner is seen pulling bags and standing in line for bag check-in and, later, standing outside, then returning back to the line. (RX 7). Petitioner viewed the surveillance video and indicated that there was nothing depicted in the videos that he had not done while performing light duty for Respondent. (T.34)

Deposition Testimony of Dr. Edward Goldberg

Dr. Goldberg, board certified orthopedic surgeon with a concentration in spinal conditions, is licensed in Illinois and practices at Midwest Orthopedics at Rush. He examined Petitioner at Petitioner's counsel's request on 8/31/18. Dr. Goldberg reviewed Petitioner's medical records and the film of the recent CT scan. (PX 7, T.3-5)

Dr. Goldberg noted that Petitioner reported being 52 years old and was working for Respondent at the time of the accident. Petitioner had injured his lumbar spine on 4/17/17 when he was attempting to load a dumpster and the front of the truck went into the air and then slammed to the ground. He noted Petitioner had sustained an L2 fracture from the accident. Petitioner underwent a posterior procedure by Dr. Laich. Petitioner reported he started therapy about 3 month's post-operative, and had returned to light duty work in December 2017. Dr. Goldberg noted Petitioner continued to have low back pain and was off medications. Petitioner denied any radicular pain, paresthesia, motor deficits, or bowel/bladder dysfunction. (PX 7, T.5-6)

Dr. Goldberg noted Petitioner had seen Dr. Laich who was recommending a corpectomy/vertebrectomy L2. He noted Dr. Kornblatt, Respondent's IME physician, disagreed with that recommendation. (PX 7, T.6-7)

Dr. Goldberg reviewed Petitioner's medical records including the operative report. Surgery was reported as without complications. Dr. Goldberg noted the 5/25/17 CT scan showed instrumentation was well positioned. Dr. Goldberg noted that Dr. Laich indicated on 7/27/17 Petitioner denied significant problems. Dr. Goldberg stated there was no bone graft placement noted in the 4/19/17 operative report for arthrodesis per radiographic criteria. Petitioner was examined again by Dr. Kornblatt on 11/6/17 who noted the work injury and diagnosed the lumbar fracture and 6 months post-surgery, ORIF L1-L3. Dr. Goldberg noted Dr. Kornblatt felt the treatment had been reasonable and necessary and that Petitioner could return to light duty work with 20 pound occasional lifting and 10 pound frequent lifting. Dr. Kornblatt did not feel Petitioner was at MMI at that time. (PX 7, T.7-8)

Dr. Goldberg noted Petitioner saw Dr. Laich on 11/23/17 and discussed the x-ray results which showed artifact around a screw. Further physical therapy was planned at that time. Dr. Goldberg noted on 1/5/18, Dr. Laich again released Petitioner to light duty and noted Petitioner's ongoing low back pain and Dr. Laich recommended further therapy. Dr. Goldberg noted that on 2/16/18 Dr. Laich again recommended further therapy, but not work conditioning. Dr. Goldberg noted Petitioner underwent a CT scan on 2/28/18 which re-demonstrated an unhealed L2 vertebrae body fracture; the instrumentation was well positioned, however, there was no bony fusion evidencing healing. (PX 7, T.8)

Dr. Goldberg noted on 3/16/18 Dr. Laich discussed the possibility of a corpectomy and reconstruction due to the fact the fracture had not healed. Dr. Goldberg noted on 4/19/18, Dr. Kornblatt felt that Petitioner was at MMI and Dr. Kornblatt did not feel the proposed surgery would provide any significant relief. Dr. Goldberg noted on 4/26/18, Dr. Laich found Petitioner

symptomatic and again recommended surgery. On 6/17/18, Dr. Kornblatt again evaluated Petitioner and he felt Petitioner was at MMI. (PX 7, T.8-9)

Dr. Goldberg examined Petitioner and noted the well healed incisions from surgery and negative Waddell's signs. Dr. Goldberg reviewed the CT scan and stated the L2 fracture site was not healed; there was still a gap between the front and back of the bones. Dr. Goldberg stated the appropriate treatment given Petitioner's ongoing symptoms was either consider surgery or live with the pain. Dr. Goldberg further testified that if Petitioner was considering surgery, "[t]he issue here is it's too late to get the fracture to heal, you're out of the golden period." When asked what the "golden period" was, he responded, "If you're going for just the internal fixation, it's a week. As this point, what you're talking about is resecting the fractured bone which---isn't going to heal and doing a reconstruction from L1 to L3, that may involve, most commonly, a cage with bone graft. In other words, you're removing the bad vertebral body and replacing it with a cage and you ultimately would be fusing L1 to L2/3." (PX 7, T.9-11)

Dr. Goldberg reviewed Dr. Kornblatt's IME report dated 9/17/18. Dr. Goldberg did not view the surveillance video that Dr. Kornblatt referred to in the report. Dr. Goldberg testified activities like weeding, sitting in a car for an hour, potentially taking an airplane trip, did not change his opinion. He did not agree with Dr. Kornblatt's opinion that the corpectomy surgery would not increase Petitioner's functional capacities. Dr. Goldberg stated that the fracture was not healed so that was why Petitioner had residual pain. Dr. Goldberg stated that there is motion at the fracture site and that results in Petitioner's ongoing pain. Dr. Goldberg believed that the surgery would improve the pain and potentially improve Petitioner's functional capacities. Dr. Goldberg, however, did not know to what degree of improvement. Dr. Goldberg testified that the delay in starting therapy did not impact Petitioner's condition as immobilization promotes healing of the fracture. (PX 7, T.11-13)

Deposition Testimony of Dr. Kornblatt

Dr. Kornblatt identified his IME report of 11/6/17 (Dep X 2) regarding Petitioner. He had reviewed Petitioner's medical records as summarized in his report as well as the surveillance video of 8/15/17. He obtained a history from Petitioner and noted Petitioner was 51 years old and worked for Respondent for 5 years. Dr. Kornblatt testified that on 4/17/17 Petitioner sustained an L2 compression fracture when a heavy load was placed on his truck that lifted the truck's front end and violently dropped it to the ground. (RX 1, T.4-7)

Dr. Kornblatt stated Petitioner was transported to Swedish Covenant Hospital and diagnosed with a fracture, underwent surgery 2 days after admission and was discharged 2 days later. While at home, Petitioner underwent sessions of occupational therapy and was scheduled for post-operative physical therapy but that was not done as it had not been approved. Petitioner's activity level at home consisted of walking about three quarters to two miles per day, and he performed light housework. Petitioner had reported significant relief with the surgical treatment. (RX 1, T.7)

Dr. Kornblatt examined Petitioner who reported moderate central low back pain with sitting greater than 1 hour, and with bending, twisting or lifting. Petitioner reported tingling in the right thigh and at times in the leg when driving greater than 1 hour. Petitioner had reported no radicular leg pain. He examined Petitioner and noted no apparent distress. He noted the well-healed lumbar scars from surgery. The spine was not tender and his gait was intact. There was some limitation in the range of motion of the lumbosacral spine. Straight leg raising was with tight hamstrings, at 80 degrees without pain. Muscle strength and neurologic exam was normal. Dr. Kornblatt observed no signs of symptom magnification. Dr. Kornblatt's diagnosis was 6 months post-operative ORIF L2 compression fracture, fusion L1-3. (RX 1, T.7-9)

Dr. Kornblatt stated Petitioner sustained a work injury that resulted in an L2 compression fracture necessitating surgery and treatment. The treatment had been reasonable and necessary to treat the symptoms. At that time, he felt Petitioner should remain on light duty restrictions and, in the future, he may be able to reduce the restrictions. At that time, he felt Petitioner had not yet reached MMI. (RX 1, T.9-11)

Dr. Kornblatt identified his IME report of 4/9/18 (Dep X 3). He had reviewed additional medical records for the report and obtained additional history from Petitioner. Petitioner reported that he had returned to light duty work in December 2017. Dr. Kornblatt noted Petitioner had tried participating in work conditioning but it had increased his pain. Petitioner had been off of work for about a month when he saw Petitioner at that time. Petitioner complained of moderate to severe throbbing back pain, mid to low back region. Petitioner had increased left low back pain with sitting and at times to the right side. Dr. Kornblatt again examined Petitioner noting the physical findings were the same as his previous findings. He reviewed the 2/28/18 CT scan that showed the internal fixation with pedicle screws and rods L1-3 intact, no obvious loosening. He felt the alignment was well maintained. He noted the compression fracture involving the L2 vertebral body. Dr. Kornblatt noted degenerative changes at L1-3 and he felt there was progressive healing at the fracture site. Dr. Kornblatt testified there was no evidence of spinal canal compromise at any motion level. The cortices were excellent posteriorly and anteriorly; nothing was impinging the canal. (RX 1, T.11-14)

Dr. Kornblatt stated his diagnosis was 1 year post-surgery fusion L1-3, L2 compression fracture. He stated the treatment had been reasonable and necessary and causally related to the accident. Dr. Kornblatt felt the time that Dr. Laich restricted Petitioner to light duty had been reasonable. Dr. Kornblatt testified that to really determine Petitioner's functional level, an FCE should be performed. He felt Petitioner reached MMI and no further treatment would improve Petitioner's ability to function. He stated the fracture was clinically healed at that time. However, Dr. Kornblatt wanted to review x-rays. (RX 1, T.14-16)

Dr. Kornblatt identified his IME addendum report of 6/7/18 (RX 1, Dep. Exhibit 4). He had reviewed the x-rays noting they were AP and lateral and lateral flexion-extension x-rays from 1/5/18. He noted the pedicle screw and rod fixation was noted L1-3, there was no internal fixation at the fractured L2 segment. Dr. Kornblatt noted no changes from the prior x-rays he had reviewed.

He saw no evidence of loosening and testified the fixation was solid. He again felt it was 1 year post-operative and Petitioner was at MMI. (RX 1, T.16-18)

Dr. Kornblatt identified his 9/17/18 addendum IME report (Dep. X 5). He reviewed additional medical records and surveillance video. At that time, he felt Petitioner could at least work light to medium level work and he felt Petitioner should have an FCE. As to the surgical suggestion by Dr. Goldberg, Dr. Kornblatt did not believe an L2 corpectomy was an appropriate procedure for Petitioner. Dr. Kornblatt did not think the procedure would alleviate the type of symptoms Petitioner reported and it was not going to allow Petitioner to be more active or lead a more active life style. He did not think the procedure would make Petitioner more functional or diminish the work restrictions. Dr. Kornblatt stated it was possible the surgical procedure could make it worse noting it is a big surgery. He understood from the records that Petitioner did not want to undergo further surgery. (RX 1, T. 18-22)

On cross examination, Dr. Kornblatt testified that he certainly would not, in this case, advise the procedure to be performed. He was not saying a corpectomy for a non-union fracture is inappropriate, he testified. If a patient is asymptomatic you would not do it even if diagnostics showed it never healed and there might be some progression of a deformity. Dr. Kornblatt testified that there are patients with a fracture at the L2 level that has healed or almost completely healed, there is no progression of deformity, and they have pain, so "somebody might want to do a corpectomy on them and an interspinous fusion." Dr. Kornblatt testified it depends on the clinical situation. When asked if there was a non-union in this case, Dr. Kornblatt testified, "[c]linically there is no non-union. But radiographically, that fracture can heal over a period of two years." He stated you need a period of time and need to compare x-rays. He stated theoretically a nonunion of a fracture may be a competent cause of mechanical back pain. However, in his opinion, the proposed corpectomy surgery was not necessary. (RX 1, T.24-27)

The Commission notes Dr. Kornblatt reviewed additional medical records and reviewed surveillance video for his 9/17/18 addendum report. At that time he felt Petitioner could at least work light to medium duty level work and he felt Petitioner should have an FCE. As to the surgical suggestion by Dr. Goldberg, Dr. Kornblatt did not believe an L2 corpectomy was an appropriate procedure for Petitioner. He did not think the procedure would alleviate the type of symptoms Petitioner reported and it was not going to allow Petitioner to be more active or be beneficial for Petitioner. At deposition, Dr. Kornblatt admitted that an L2 corpectomy and fusion is appropriate for a non-union fracture at the L2 level (RX 1, T.24-27) He further testified that patients with healed or almost healed fractures who have pain may need a corpectomy. (RX 1, T.25) In Dr. Kornblatt's 4/9/18 report (RX 1, Dep. Exhibit 3), Dr. Kornblatt noted that he had reviewed the CT scan of 2/28/18 and he opined it appeared to reveal progressive healing at the fracture site. On cross examination, Dr. Kornblatt admitted that *progressive* healing indicates something that was not complete. He further admitted that a non-union was a competent cause of mechanical low back pain (RX 1, T.26)

The Commission notes Dr. Goldberg examined Petitioner and noted negative Waddell's signs. He too reviewed the CT scan and stated the fracture was not healed; there was still a gap between the front and back of the bones. Dr. Goldberg stated that with the ongoing symptoms there were 2 options; live with the condition or consider surgery, as the fracture will not heal at that point. Dr. Goldberg indicated most likely it would involve a cage and ultimate fusion at L2-3. (PX 7, T.9-11) At deposition, Dr. Goldberg was shown a recent report prepared by Dr. Kornblatt from 9/17/18. He did not view the surveillance video that Dr. Kornblatt referenced in the report. Dr. Goldberg stated activities such as weeding, sitting in a car, potentially going on an airplane trip did not change his opinions. He did not agree with Dr. Kornblatt's opinion that surgery would not increase Petitioner's functional capacities. Dr. Goldberg stated that the fracture was not healed and that was causing residual pain. Dr. Goldberg stated there was motion at the fracture site and that results in pain. Dr. Goldberg believed that the surgery would improve the pain complaints and potentially improve functional capacities. Dr. Goldberg did not, however, know to what degree as Petitioner would still need to go through rehabilitation. (PX 7, T.11-13)

The surveillance video admitted into evidence (RX 7) shows Petitioner performing a number of yard chores, walking around and driving. The video shows Petitioner bending over and on his hands and knees, reaching and doing yard work for some periods of time. The Commission notes the video depicts Petitioner performing relatively light activities, albeit with some bending and reaching, however, nothing significant was observed as beyond the stated light duty restrictions.

Dr. Laich indicated the proposed surgery was an attempt to relieve Petitioner's ongoing pain and symptoms. There is a difference of medical opinion if the compression fracture is healed but it was acknowledged by Dr. Kornblatt a non-healed compression fracture can be a source of pain. (RX 1, T.24-27) Dr. Goldberg indicated it was a decision for Petitioner as to whether or not to pursue surgery. If Petitioner could not live with the pain, Dr. Goldberg thought the proposed would help Petitioner's ongoing pain and symptoms. (PX 7, T.11-13)

The ATI discharge summary of 3/19/18 documented Petitioner's low back pain with radiation to the right leg, and low back pain with all movements. (PX 8)

Dr. Laich's 4/26/18 follow up record noted Petitioner's ongoing low back pain with right radiculopathy. He noted Petitioner was returned to work and considering the recommended surgery of an L2 corpectomy and reconstruction. Dr. Laich noted Petitioner had a recent IME and he disagreed with the opinion of Dr. Kornblatt that Petitioner would not benefit from the recommended surgery. The diagnosis of Dr. Laich at that time was degenerative disc disease, closed unstable burst fracture L2 with delayed healing; post fusion, low back pain and he took Petitioner off work. (PX 6)

The Commission finds that the evidence and testimony in this record shows the prospective surgery, the L2 corpectomy and reconstruction, recommended by Drs. Laich and Goldberg is reasonable and necessary to cure or relieve the effects of the work-related injury. The evidence in

this record clearly documents Petitioner's testimony of complaints with activity. Specifically, the medical case management final report of 6/29/18 noted, "…lower back pain 2-3/10 with minimal activity and 6-8/10 with increased moderate activity, he has pain with any movement." (PX 9, Progress Report 13)

The Commission finds the opinions of Drs. Laich and Goldberg are persuasive and fully supported by the evidence. The Commission adopts the opinion of Dr. Goldberg that as seen on the most recent CT scan, there is still a gap between the front and the back of the bones and in this case it is too late to get the fracture to heal. Petitioner is out of the *golden period*, as Dr. Goldberg stated (PX 7, T. 10-11). Although Dr. Kornblatt indicated that clinically the healing was complete, he acknowledged that radiographically, the fracture can heal over a period of two years. Thus, the healing was not complete radiographically. Dr. Kornblatt admitted performing a corpectomy and fusion for a non-union fracture was not inappropriate. (RX 1, T.24-27) The Commission finds Dr. Kornblatt's testimony, in essence, supports the need for surgery for Petitioner's ongoing condition of ill-being from a non-healed fracture. The evidence clearly shows the proposed surgery is reasonable and necessary to alleviate Petitioner's ongoing pain and potentially improve his quality of life and increase his functional capabilities.

The Commission, herein, reverses as to denial of prospective medical care of the L2 corpectomy and reconstruction and, herein, awards the same. All else is affirmed.

The Commission, herein, affirms the finding as to causal connection, and specifically affirms the denial the ATI medical bill in the amount of $3,701.44, and denial of temporary total disability benefits after February 20, 2018.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the reasonable and necessary and causally related prospective medical procedure/surgery recommended by Drs. Laich and Goldberg pursuant to the fee schedule, as provided in §8(a) and §8.2 of the Act. The Commission specifically affirms the denial of the ATI bill.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $842.74 per week for a period of 33-4/7 weeks (4/18/17-12/4/17 and 2/17/18-2/20/18), that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $40,000.00. 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.

June 30, 2021

/s/*Kathryn A. Doerries*
Kathryn A. Doerries

o-5/4/21
KAD/jsf

/s/*Maria E. Portela*
Maria E. Portela

/s/*Thomas J. Tyrrell*
Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION 21IWCC0334
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

GLYNN, ANTHONY Case# **17WC013292**
Employee/Petitioner

UTILITY TRANSPORT SERVICE INC
Employer/Respondent

On 3/27/2020, 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 0.80% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0147 CULLEN HASKINS NICHOLSON ET AL
CHARLES G HASKINS JR
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

2965 KEEFE CAMPBELL BIERY & ASSOC
TIMOTHY J O'GORMAN
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

ANTHONY GLYNN
Employee/Petitioner

v.

UTILITY TRANSPORT SERVICE, INC.
Employer/Respondent

Case # **17** WC **13292**

Consolidated cases: **n/a**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **APRIL 30, 2019 and JUNE 20, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **APRIL 17, 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 $**65,733.72**; the average weekly wage was $**1,264.11**.

On the date of accident, Petitioner was **50** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of $**28,171.59** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**4,480.20** for other benefits, for a total credit of $**32,651.79**.

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

ORDER

As detailed in the attached memorandum discussing the *Findings of Fact and Conclusions of Law:*

- The Arbitrator denies Petitioner's claim for outstanding medical bill balance from ATI Physical Therapy. (AX 1); and,

- The Arbitrator denies Petitioner' claim for prospective medical care under Section 8(a) as recommended by Dr. Laich and Dr. Goldberg.; and,

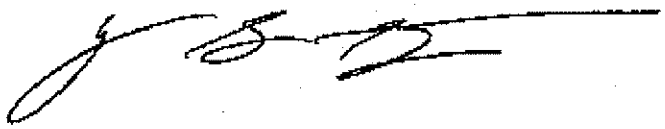
- The Arbitrator finds the Respondent shall pay Petitioner temporary total disability benefits of **$842.74**/week for **33 4/7 weeks**, covering the periods from April 18, 2017 through December 4, 2017 and February 17, 2018 through February 20, 2018, as provided in Section 8(b) of the Act. Additionally, Respondent shall be given a credit for **$28,171.59** for previously paid TTD benefits.; and,

- The Arbitrator finds the Respondent shall pay Petitioner a minimum statutory fracture benefit of **$758.47**/week for **6 weeks** due to a fracture of L2 vertebrae, as provided in Section 8(d)2 of the Act. Respondent shall be given a credit for **$4,428.20** for previously paid statutory fracture benefits.; and,

- Furthermore, in no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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



Signature of Arbitrator

MARCH 25, 2020
Date

MAR 27 2020

ANTHONY GLYNN v. UTILITY TRANSPORT SERVICE, INC.

17 WC 13292

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried on Petitioner's Section 19(b)/8(a) Petition before Arbitrator Steffenson, first on April 30, 2019 and, subsequently, after re-opening proofs, on June 20, 2020. (Arbitrator's Exhibit 1, Petitioner's Exhibit 1, and Transcript (June 20, 2020)). The issues in dispute were causal connection, medical bills, Temporary Total Disability (TTD) benefits, and prospective medical care. The parties agreed to receipt of this Arbitration Decision via e-mail and requested a written decision, including findings of fact and conclusions of law, pursuant to Section 19(b) of the Act. (Arbitrator's Exhibit (*hereinafter*, AX) 1).

FINDINGS OF FACT

Petitioner testified on April 17, 2017, he was an employee of Respondent, Utility Service Transport, Inc. (Transcript (*hereinafter*, TX) at 15). Petitioner stated prior to that date, he had never sustained any injuries to his low back. (TX at 15). Petitioner testified prior to April 17, 2017 he had never received treatment or been placed on any work restrictions as a result of any low back condition. (TX at 16). Petitioner testified he originally was born in Ireland and immigrated to the United States after his company expanded in the United States. (TX at 16-17). Petitioner testified he joined the laborer's union in 1998. (TX at 18). Petitioner testified he worked for Brackenbox driving a roll-off truck. (TX at 18-19). Petitioner testified he then went to work for an affiliate of Brackenbox named Utility Transport Service, Inc. (TX at 19). Petitioner explained a roll-off box transports construction debris, sand and dirt. (TX at 19). Petitioner stated a hook is used to lift the box and place it on the back of a truck. (*Id.*). Petitioner testified on April 17, 2017 he was in a truck when it was lifted off the ground and slammed back onto the ground. (TX at 20). Petitioner testified he was taken by ambulance to Swedish Covenant Hospital. (TX at 21).

Petitioner came under the care of Dr. Daniel Laich who performed a L1-L3 posterior reconstruction of Petitioner's lower spine as Petitioner's L2 vertebrae was fractured. (Petitioner's Exhibit (*hereinafter*, (PX) 6). Petitioner continued in therapy and treatment with Dr. Laich thereafter. (PX 6). Petitioner was also seen by Dr. Michael Kornblatt pursuant to

Section 12 of the Illinois Workers' Compensation Act. (Respondent's Exhibit 1). At the time Dr. Kornblatt examined Petitioner on November 6, 2017, Dr. Kornblatt opined he could return to work with restrictions of no lifting above 20lbs occasionally and no lifting above 10lbs frequently. (Respondent's Exhibit (hereinafter, RX) 1). On November 30, 2017, Petitioner was offered a position within those restrictions outlined by Dr. Kornblatt and Petitioner returned to work on December 5, 2017. (RX 2 and TX at 24). Petitioner explained his accommodated duties included sweeping floors, emptying garbage, delivering parts for trucks up to 70 or 80 miles away. (TX at 25). Petitioner testified he took a lot of breaks due to the pain. (TX at 25).

Petitioner testified he was prescribed work hardening and began work hardening therapy on February 18, 2018. (TX at 26). Petitioner explained he participated in work hardening on February 18, 2018 and February 19, 2018. (TX at 26). Petitioner testified the work hardening therapy included pulling exercises, pushing exercises, laying on a mat and lifting his body upwards with a ball, laying on a bench while lifting weights with his arms and being on a treatment for a period of time. (TX at 27). Petitioner testified the work hardening increased his symptoms. (TX at 27). Petitioner testified he self-terminated work hardening therapy on February 19, 2018. (TX at 28). Petitioner testified he did not return to work until March 19, 2018. (TX at 29). Petitioner testified the work duties he performed after March 19, 2018 were the same as the work duties he performed previously before February 19, 2018. (TX at 35). Petitioner testified he underwent a CAT scan on February 28, 2018. (TX at 30). Petitioner testified after the CAT scan was complete, he received a surgical recommendation from Dr. Laich. (TX at 30). Petitioner testified he wishes to proceed with surgery in the hopes it would relieve his symptoms. (TX at 31). Petitioner also testified he had been recommended to quit smoking. (TX at 36). He stated he had been prescribed Chantix to assist with smoking cessation. (TX at 36). However, he admitted he continues to smoke despite being counseled to quit. (TX at 37). Petitioner also reported he can perform his job duties with accommodations. (TX at 37).

Petitioner was examined at Petitioner's counsel's request in accordance with Section 12 by Dr. Edward Goldberg, whose deposition testimony was taken. (PX 7). Dr. Goldberg testified to Petitioner's medical history contained in the records. (PX 7). Dr. Goldberg testified Petitioner's physical examination revealed two incisions at approximately the L2 level of the spine, Thoracolumbar flexion with pain at 60 degrees of flexion and 20 degrees of extension. (*Id.*). Dr. Goldberg testified Petitioner did not exhibit radicular symptoms, exhibit no deformity and demonstrated normal motor and strength function. (*Id.*). Dr. Goldberg testified at the time he saw Petitioner he believed Petitioner would be a candidate for an L2 corpectomy as Petitioner's L2 fracture had not healed. Dr. Goldberg testified if Petitioner could live with the pain, he would not recommend the surgery and recommended an FCE would be appropriate and for Petitioner to continue living with residual symptoms, if capable. (*Id.*). Dr. Goldberg was presented with surveillance video of Petitioner and testified the demonstrated activities in the

video did indicate an ability to live with the pain symptoms. (*Id.*).

Dr. Michael Kornblatt was also deposed subsequent to his Section 12 examination. (RX 1). Dr. Kornblatt testified as of November 6, 2017 he believed Petitioner could work within restrictions of no lifting over twenty pounds occasionally. (RX 1). Dr. Kornblatt testified on November 6, 2017 he did not believe Petitioner to be at MMI and to continue in his treatment plan. Dr. Kornblatt reported Petitioner's physical examination was largely normal. (*Id.*). Dr. Kornblatt testified he believed Petitioner's treatment to date as of November 6, 2017 was reasonable and necessary. (*Id.*). Dr. Kornblatt also stated he examined Petitioner again on April 9, 2018. (*Id.*). Dr. Kornblatt noted Petitioner had gone back to work within accommodated duty restrictions and was working at the time he examined Petitioner. (*Id.*).

Dr. Kornblatt reported he reviewed Petitioner's CT scan dated February 28, 2018 and observed the images to reveal the alignment of the spine was well maintained, a compression type fracture was evidence at L2, the cortices were noted to be excellent posteriorly and anteriorly and there was progressive healing at the fracture site. (RX 1). Dr. Kornblatt observed there was no evidence of spinal canal compromise and no impingement on the spinal nerve roots. (RX 1). Dr. Kornblatt opined Petitioner could continue working within the restrictions he was working in at the time. (*Id.*). Dr. Kornblatt did not believe there was any further treatment that would improve Petitioner's ability to function and that from a clinical standpoint. Petitioner's fracture had healed. (*Id.*). Dr. Kornblatt confirmed he reviewed Petitioner's x-rays on June 7, 2018 and noted Petitioner's pedical screws and rod demonstrated solid internal fixation. (*Id.*). Dr. Kornblatt stated he believed Petitioner was at maximum medical improvement and the images demonstrated in the x-ray did not change his opinion. (*Id.*). Dr. Kornblatt also reviewed surveillance video on September 18, 2018 depicting Petitioner working on his lawn, going on a flight to Iceland and seemingly weeding a garden. (*Id.*). Dr. Kornblatt testified he believed Petitioner would work in a light to medium physical demand level and disagreed with Dr. Goldberg's recommendation that Petitioner undergo a corpectomy. (*Id.*). Dr. Kornblatt explained he did not believe the prescribed procedure would alleviate the symptoms or allow Petitioner to be more active. (*Id.*). Dr. Kornblatt opined a surgery such as a corpectomy had a chance of increasing Petitioner's pain symptoms rather than relieving them. (*Id.*).

Respondent submitted two Utilization Review (UR) reports into evidence dated August 8, 2017 and August 23, 2017. The UR reports dispute the reasonableness and necessity of a requested 36 sessions of physical therapy and 24 sessions of lumbar aquatic therapy. (RX 3). The August 23, 2017 UR Report, authored by board certified neurologic surgeon Dr. Jason Garber, explains Petitioner's lack of symptom relief as a basis to opine Petitioner's treatment is not reasonable and necessary. Dr. Garber noted his conversation with Dr. Laich's nurse practitioner who was unable to explain any overt reason why the therapy recommended would

be appropriate. (RX 3). Dr. Garber notes Petitioner's records do not demonstrate any extenuating circumstances why Petitioner's treatment plan may deviate from the ODG Guidelines and as such, Petitioner's requested physical therapy and aqua therapy is not reasonable and necessary.

Surveillance video was reviewed which demonstrated Petitioner cutting and trimming rose bushes with large hedge trimmers, picking up debris and placing it in a trash bin, working on all four hands and knees removing weeds, picking up suitcases, back packs and grocery bags. Petitioner is observed bending, lifting and working on his knees in the garden without any seeming difficulty. (RX 7).

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

Issue F: *Causal connection*

It is the burden of every Petitioner before the Workers' Compensation Commission to establish with evidence every disputed issue litigated at trial, including the issues establishing Respondent's liability for benefits. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207 at 214 (1969), *Edward Don v Industrial Commission,* 344 Ill.App.3d 643 (2003). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a causal connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v. Industrial Commission,* 198 Ill.App. 3d 43 (1989).

After careful review of the evidence and trial testimony, the Arbitrator finds Petitioner's current condition of ill-being is related to the alleged incident on April 17, 2017. Petitioner testified credibly as to the circumstances surrounding the accident and his treatment plan moving forward. The Arbitrator notes Petitioner's complaints have been consistent throughout the pendency of his claim and Petitioner's doctors agree on his functional capabilities.

However, they disagree regarding his prospective treatment plan that will be discussed below. As such, Petitioner's current condition as he appears at trial on April 30, 2019 is causally related to his alleged incident on April 17, 2017.

Issue J: *Medical bills*

Under Workers' Compensation Act, employer may only be ordered to pay for treatment which is reasonably required to cure or relieve from the effects of accidental injury. *Levkovitz v. Industrial Com'n*, 256 Ill.App.3d 1075 (1993). The Arbitrator finds Petitioner's disputed treatment of 36 physical therapy visits and 24 lumbar aquatic therapy visits were not reasonable and necessary. Petitioner testified he participated in the physical therapy and lumbar aquatic therapy. (TX at 29). However, Petitioner's symptoms and/or functional capabilities do not appear to have found relief. Dr. Garber's report notes multiple attempts to elicit details which would allow for a deviation from the ODG Guidelines. However, Dr. Laich's office appears unable to rationalize the treatment recommended. Furthermore, Dr. Garber's opinions appear to have been proven true due to Petitioner's continued complaints of pain. As such, Petitioner's request for the outstanding balance of ATI Physical Therapy bills in the amount of $3,701.44 is denied.

Issue K: *Prospective medical*

It is the Workers' Compensation Commission's function to resolve disputed questions of fact, including those of causal connection, to draw permissible inferences, and to decide which of conflicting medical views is to be accepted. *Peabody Coal Co. v. Industrial Com'n*, 213 Ill.App.3d 64 (1991). A workers' compensation claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of a claimant's injury. *City of Chicago v. Illinois Workers Compensation Com'n*, 409 Ill.App.3d 258 (2011).

The Arbitrator denies Petitioner's request for prospective treatment based on the opinions of Dr. Michael Kornblatt and Petitioner's observed appearance while on video surveillance. The Arbitrator notes Dr. Goldberg, a board-certified spine surgeon, provided opinions that are equivocal at best. Dr. Goldberg testified that if Petitioner was unable to live with the symptoms of his low back condition, it would be appropriate to elect for corpectomy

surgery. Dr. Goldberg admitted on cross examination that Petitioner's observed appearance on surveillance did demonstrate Petitioner's ability to live with the symptoms of his condition. Dr. Kornblatt's opinions are supported by the surveillance evidence that Petitioner can live with his symptoms and that a surgery as serious and invasive as a corpectomy would not be appropriate. Dr. Kornblatt found upon physical examination of Petitioner no deformity of his spine which would suggest such a surgery is indicated. Additionally, Petitioner's diagnostic testing does not reveal "loosening of the internal fixation above and below the fracture site" that also would warrant surgical intervention as recommended by Petitioner's physicians. (RX 1 at 40).

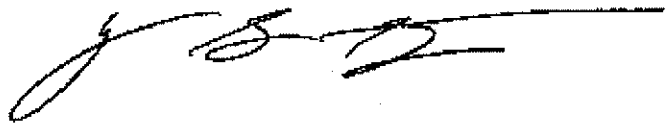
Furthermore, the video surveillance revealing Petitioner's gardening and other activities severely undermines Petitioner's credibility before the Arbitrator. (RX 7). Especially troubling are extended scenes of Petitioner weeding on his hands and knees and tending to his riding lawnmower in awkward positions on a cement sidewalk. (RX 7). Petitioner's activity level in the surveillance video does not gybe with his sworn testimony that, while performing his job duties, he rests between his truck inspections on a cushioned "rocking chair" he brought from home. (TX at 32).

Accordingly, Petitioner's request for prospective medical care as suggested by Dr. Laich and Dr. Goldberg is denied.

Issue L: *TTD*

The Arbitrator awards Petitioner's TTD for all periods stipulated to and denies Petitioner's request for TTD after February 20, 2018. Petitioner testified he was performing accommodated work prior to his work hardening therapy on February 17, 2018. Petitioner attended two days of work hardening before self-terminating on February 19, 2018. Petitioner did not return to work until March 19, 2018. Petitioner testified the accommodated duty activities after March 19, 2018 were the same as those accommodated duty activities prior to February 17, 2018. (TX at 35). The Arbitrator finds Petitioner would have been capable of working in an accommodated duty position, as he had been for several months, and denies Petitioner's request for TTD after February 20, 2018.

Lastly, 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.



Signature of Arbitrator

MARCH 25, 2020
Date