STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHARLES KALBFELL,

Petitioner,

vs. No. 03 WC 38839

PREMIER AIR CENTER, INC.,

Respondent.

ORDER

This matter comes before the Commission on Respondent's Motion to Compel Section 12 Examination and Petitioner's Motion to Quash Respondent's Motion to Compel and his Motion for Penalties Pursuant to Sections 19(k)/19(l) and Attorney Fees Pursuant to Section 16. A hearing was held on February 6, 2017 in Collinsville before Commissioner White. The parties were represented by counsel and a record was taken.

The matter was initially arbitrated in April of 2004 under Sections 8(a)/19(b) of the Act. The Arbitrator found Petitioner sustained a compensable accident and awarded medical treatment. The Decision of the Arbitrator was affirmed and adopted by the Commission, confirmed by the Circuit Court, and affirmed by the Appellate Court. The matter was remanded to the Arbitrator who awarded Petitioner loss of 55% of the left leg. Thereafter, the parties arrived at a settlement, which was approved by the Commission on July 16, 2008. In the contract, Petitioner received a total of $52,275.35, representing $41,817.60 for the underlying loss of 55% of the left leg and $10,457.75 as a compromise settlement for outstanding medical expenses. Petitioner's prospective medical treatment was left open.

The parties have indicated that prior to the arbitration, Respondent's Section 12 medical examiner, Dr. Lehman, examined Petitioner and found that any prospective treatment, other than possible future knee replacement, was not appropriate. Respondent indicated that in order to further opine on the matter, Dr. Lehman asked for a re-examination, which Respondent now wants to compel Petitioner to attend. It argues that the contract only requires it to pay for reasonable and necessary prospective treatment and the Section 12 examination is necessary to determine what prospective treatment is appropriate.

Petitioner responds that Respondent's Motion to Compel is not ripe because he was not seeking any medical treatment at the current time. He argues that Respondent is simply attempting to harass Petitioner to settle the entire case and close out his rights to prospective medical. Petitioner's lawyer also presented a ledger of the time he has spent in defending Respondent current motion. In it he alleges he spent 21.5 hours and a fee rate of $250.00 an hour. He seeks total attorney fees in the amount of $5,375.00.

The Commission agrees with Petitioner that Respondent's current motion is not appropriate because Petitioner has no request for medical treatment pending. If at some time in the future he does seek treatment, Respondent may attempt to proceed with another examination under Section 12 to determine the appropriateness of the treatment sought. However, there is no controversy currently pending. We do not ascribe to Petitioner's assertion that Respondent motion is motivated simply to harass Petitioner. Nevertheless, Respondent's motion is improper and unnecessarily required Petitioner's lawyer to expend time to defend the motion. We do not believe Petitioner or his lawyer should be required to bear the cost of defending a moot motion. The Commission finds the fees requested by Petitioner's lawyer reasonable. Therefore, we award Petitioner attorney fees in the amount of $5,375.00. However, Respondent has neither denied nor delayed any payments of benefits either current or outstanding. Therefore, no penalties under Sections 19(k) and 19(l) are appropriate.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Motion to Compel Section 12 Examination is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay $5,375.00 for attorney fees pursuant to Section 16 of the Act.

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

DATED: MAR 1 - 2017

Ruth W. White

Charles J. DeVriendt

Michael J. Brennan

RWW/dw
R-2/6/17
46

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Patrick Malone,

Petitioner,

vs.

No. 04 WC 14471

Central Leasing Management, Inc.,

17IWCC0139

Respondent.

DECISION AND OPINION ON REVIEW UNDER SECTION 8(a)/
ORDER ON PETITION FOR PENALTIES AND ATTORNEY FEES

A petition for review under section 8(a) and a contemporaneous petition for penalties and attorney fees having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, prospective medical care, temporary disability, penalties and attorney fees, and being advised of the facts and law, grants in part the 8(a) petition and denies the penalties and fees petition for the reasons set forth below.

On July 16, 2008, the Arbitrator filed a decision in connection with the work accident Petitioner sustained on February 6, 2004. The Arbitrator found the accident necessitated a complex spinal decompression surgery at L4-L5 and nerve root decompression at L5-S1. The Arbitrator awarded temporary total disability benefits through August 30, 2006, as well as medical expenses and permanent disability benefits representing 25 percent disability to the person as a whole. The Arbitrator's decision became final after Respondent dismissed its petition for review on September 26, 2008.

On January 13, 2015, Petitioner filed a petition for temporary disability benefits and prospective medical care pursuant to section 8(a) of the Workers' Compensation Act (the Act). Contemporaneously, Petitioner filed a petition for penalties under sections 19(k) and 19(l) and attorney fees under section 16 of the Act. Subsequently, on December 31, 2015, Petitioner's counsel filed a motion to withdraw, which the Commission granted on February 24, 2016.

On September 21, November 16 and December 14, 2016, Commissioner Stephen Mathis held a hearing on the merits of Petitioner's petitions. After the hearing, the parties submitted their respective written arguments.

The following evidence was adduced at the hearing. Petitioner testified that he was a bricklayer. He did not work much in 2009 and received unemployment benefits. Likewise, he did not work during half of 2011 and received unemployment benefits. During 2010, Petitioner underwent three epidural steroid injections because he was in severe pain. During 2012, he underwent three injections, and during 2013 he underwent three more injections. Respondent's workers' compensation carrier paid for his medical care until 2014. Petitioner indicated he worked intermittently on "light duty," meaning lighter construction work.

Petitioner further testified that on September 9, 2014, he woke up with severe pain in the left leg. He saw Dr. Richard Lim, who obtained imaging studies. During 2015 and the first half of 2016, Petitioner continued to suffer from severe pain. At the time of the hearing, the pain was not as severe. Petitioner stopped working on September 9, 2014. However, he was working at the time of the hearing, doing concrete work. Petitioner felt he needed physical therapy.

The medical records and section 12 reports in evidence show that in April of 2004, Dr. Lim performed a complex decompression at L4-L5 and a microdiscectomy, foraminotomy and nerve root decompression at L5-S1. In April and May of 2006, Petitioner underwent epidural steroid injections at left L4 and L5. On August 30, 2006, Dr. Lim released Petitioner to return to work without restrictions. At the time, Petitioner was relatively asymptomatic. Dr. Lim advised Petitioner that "he does have degenerative discs, mostly at the L4-5 but also to a lesser degree at L5-S1, that will most likely continue to degenerate over the years, but we will treat him as necessary."

On June 9, 2010, Petitioner returned, complaining of significant back pain with symptoms in the left buttock, hip and leg. X-rays showed a "nearly complete collapse of his L4-5 disc space." Regarding causation, Dr. Lim stated: "[H]is L4-5 disc pathology is a direct continuation of his prior injury which he sustained at the 4-5 level." An MRI performed June 14, 2010, was interpreted by the radiologist as showing "[l]umbar spondylosis, multilevel disc protrusion, and spinal, lateral recess and neural foraminal stenosis ***. There are findings consistent with previous surgery at L4/5 ***. Chronic compression deformity of L4 and to a greater extent L5 vertebral bodies." On June 18, 2010, Dr. Lim reviewed the MRI, noting: "It is the same disc that is causing him the problem, L4-5 and L5-S1 similar to what he had when he had his injury and surgery as a work comp injury several years ago. This is clearly related." Dr. Lim recommended epidural steroid injections. Petitioner underwent a series of three epidural steroid injections at left S1 during June through August of 2010, reporting significant improvement.

On May 1, 2012, Petitioner returned, complaining of recurrent radicular type symptoms, identical to the symptoms he had in the past. Straight leg raise test was positive on the left. Dr. Lim opined the symptoms were "a direct continuation of his lumbar disk pathology" and recommended epidural steroid injections. Petitioner underwent a series of three epidural steroid

injections at left S1 during May through July of 2012, again reporting significant improvement.

On July 26, 2013, Petitioner returned, complaining of recurrent left-sided symptoms "exactly the same as what he had last year." X-rays showed no apparent worsening compared to a year earlier. Dr. Lim ordered an MRI. The MRI, performed August 14, 2013, showed: lumbar spondylosis; "[m]oderate to marked neural foraminal stenosis from L4-S1 with suspected compression on the left L4 nerve root at L4/L5 and bilateral exiting L5 nerve roots at L5-S1;" congenital and acquired canal stenosis; and endplate degenerative changes. After reviewing the MRI, Dr. Lim recommended additional epidural steroid injections, which Petitioner underwent at left S1 in September and October of 2013.

On August 27, 2014, Petitioner returned, complaining of intermittent back pain and inflammation. X-rays showed disc space collapse at L4-L5 and L5-S1, without evidence of lytic lesions or instability. Dr. Lim recommended against epidural steroid injections because Petitioner had no radicular symptoms. Instead, Dr. Lim recommended home exercises. On October 1, 2014, Petitioner returned, complaining he was "miserable. Anytime he stands and walks any distance, he is getting the pain that shoots down into his left lower extremity." Dr. Lim opined the symptoms were "clearly radicular," ordered an MRI, and took Petitioner off work. The MRI, performed October 11, 2014 and compared to an MRI from March of 2006, was interpreted by the radiologist as showing: new or worsened left-sided disc pathology at L2-L3 and L3-L4; unchanged findings at L4-L5; and somewhat worsened right-sided disc pathology at L5-S1. On October 21, 2014, Dr. Lim reviewed the MRI, noting "significant disc changes, a disc collapse and modic changes, L3-4, L4-5, L5-S1. There is a lot paracentral disc protrusion but nothing severe." Dr. Lim recommended home exercises and weight reduction, rather than surgery, and kept Petitioner off work. In the work status note, Dr. Lim stated Petitioner "needs to begin PT." On November 4, 2014, Petitioner followed up, complaining of severe back pain with radiation down the left leg and requesting another epidural steroid injection. Dr. Lim was concerned about additional injections because of risk of osteopenia resulting in fracture. Nevertheless, he ordered another injection and kept Petitioner off work.

On March 30, 2015, Dr. Kern Singh, an orthopedic surgeon, examined Petitioner at Respondent's request. Petitioner complained of low back pain radiating to the left leg, rating the pain an 8/10. On physical examination, Dr. Singh found 5/5 positive Waddell signs. Dr. Singh reviewed medical records from Dr. Lim and requested Petitioner's imaging studies in order to formulate a causation opinion. In an addendum report dated July 29, 2015, Dr. Singh diagnosed preexisting degenerative lumbar spondylosis from L3 to S1 unrelated to the work accident on February 6, 2004.

Petitioner did not return to Dr. Lim for approximately a year. During that time, Dr. Lim issued a number of summary reports on Petitioner's behalf. In a report dated November 18, 2014, Dr. Lim stated Petitioner was under his care for continued lumbar radiculopathy. Regarding causation, Dr. Lim stated: "I feel this current flare up of pain is directly related to his original injury from 2004 and is ongoing and not the result of any new back injury." On December 15, 2014, Dr. Lim stated Petitioner was under his care and "unable to work due to ongoing symptomatic Severe Lumbar Radiculopathy. Patient is restricted to very limited walking, standing, or sitting." On January 6, April 6 and July 21, 2015, Dr. Lim stated Petitioner

17IWCC0139

was under his care and "unable to go to court due to the ongoing symptomatic Severe Lumbar Radiculopathy. Patient is restricted to very limited walking, standing, or sitting." On July 24, 2015, Dr. Lim stated Petitioner was under his care for a lumbar spine condition and not released to return to work.

On October 30, 2015, Petitioner returned, reporting intermittent, mild pain. Straight leg raise test was negative for radiculopathy, but positive for back pain. X-rays showed disc space narrowing at L4-L5 and L5-S1. Petitioner wanted to hold off having surgery. Dr. Lim recommended pain management at a pain clinic. On January 8, 2016, Dr. Lim issued a summary report stating Petitioner was off work until further notice. On February 2, 2016, Dr. Lim stated Petitioner "had a X-Ray done 10/30/2015 and a MRI done 10/11/2014. There has been no new injury since 2004."

On March 9, 2016, Petitioner followed up, complaining of ongoing left leg pain and requesting physical therapy. Petitioner stated the pain had improved somewhat since the last visit. Physical examination was notable for mild left calf atrophy. Straight leg raise test was negative. Dr. Lim agreed that Petitioner needed physical therapy. On April 13, 2016, Petitioner followed up, complaining of severe pain and functional limitations. X-rays showed marked disc space collapse at L4-L5 and L5-S1 with foraminal stenosis. Dr. Lim discussed surgery and ordered a repeat MRI.

On November 23, 2016, Dr. Singh issued an addendum report after reviewing additional medical records and imaging studies. Dr. Singh opined Petitioner did not require any treatment, based on a normal neurological examination without evidence of instability. Further, Dr. Singh opined Petitioner could return to work full duty.

Petitioner seeks payment of medical bills since September of 2014, prospective medical care recommended by Dr. Lim, and wage loss (temporary disability) benefits. Petitioner also seeks compensation/damages that are not within the purview of the Act.

Having carefully considered all the evidence, the Commission finds that Petitioner's symptoms resulting from pathology at the L4-L5 and L5-S1 levels continue to be causally connected to the work accident on February 6, 2004. To the extent Dr. Singh opined otherwise, his opinion is contrary to the law of the case. Because Petitioner offered no medical bills into evidence, the Commission is unable to award past medical expenses at this time. Turning to prospective medical care, the Commission finds the opinions of Dr. Lim more persuasive and awards diagnostic studies and treatment prescribed by Dr. Lim to treat the symptoms and pathology at the L4-L5 and L5-S1 levels.

Regarding wage loss/temporary disability benefits, the Commission is bound by the decision of the appellate court in Curtis v. Workers' Compensation Comm'n, 2013 IL App (1st) 120976WC, holding that a petition for additional temporary disability benefits must be filed within 30 months of the issuance of the decision awarding compensation. This time limit is jurisdictional. The Commission must deny Petitioner's request for wage loss/temporary disability benefits because Petitioner's petition was filed more than 30 months after the Arbitrator's decision issued on July 16, 2008.

17IWCC0139

Lastly, the Commission finds that no penalties or attorney fees are warranted, as Respondent reasonably relied on the opinions of Dr. Singh.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's request for wage loss/temporary disability benefits is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for payment of past medical expenses is denied without prejudice.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay for diagnostic studies and treatment prescribed by Dr. Lim to treat the symptoms and pathology at the L4-L5 and L5-S1 levels, pursuant to §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's petition for penalties and attorney fees 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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 3 - 2017
d-02/23/2017
SM/sk
44

Stephen J. Mathis

Stephen Mathis

Mario Basurto

David L. Gore

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

Aynie Gizaw,
Petitioner,
vs.

NO: 04WC 014564

Illinois Department of Public Aid.
Respondent,

17IWCC0182

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 February 22, 2016, 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.

DATED: MAR 2 8 2017
MJB/bm
o-3/7/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GIZAW, AYNIE
Employee/Petitioner

Case# **04WC014564**

ILLINOIS DEPARTMENT OF PUBLIC AID
Employer/Respondent

17IWCC0182

On 2/22/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0598 LUSAK & COBB
JOHN E LUSAK
221 N LASALLE ST SUITE 1700
CHICAGO, IL 60601

5273 ASSISTANT ATTORNEY GENERAL
MEGAN MURPHY
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

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

FEB 22 2018

Ronald A. Rascia, Acting Secretary
Illinois Workers' Compensation Commission

A Gizaw v IDPA, 04 WC 014564

17IWCC0182

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

Aynie Gizaw
Employee/Petitioner

v.

Illinois Department of Public Aid
Employer/Respondent

Case # 04 WC 014564

An *Application for Adjustment 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 **September 1, 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 _____

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FINDINGS

On May 14, 2003, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned $32,138.52; the average weekly wage was $626.99.

On the date of accident, Petitioner was 51 years of age, *single*, with 0 dependant 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 $0.00.

ORDER

Claim for compensation denied, Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent on May 14, 2003 and failed to prove a causal connection between any such accidental injuries and her current condition of ill-being regarding her right upper extremity.

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

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

Signature of Arbitrator

February 22, 2016
Date

ICArbDec p. 2

FEB 22 2016

17IWCC0182

FINDINGS OF FACT

Petitioner pursued this action under the Workers' Compensation Act and sought relief from the Respondent-employer Illinois Department of Public Aid (IDPA). On September 1, 2015, the Parties appeared at a hearing before Arbitrator Jeffrey Huebsch. Jack Lusak of Lusak and Cobb appeared on behalf of Petitioner. Assistant Attorney General Megan Murphy of the Illinois Attorney General's office appeared on behalf of Respondent. The issues in dispute were: Whether Petitioner sustained accidental injuries which arose out of and in the course of her employment by Respondent on May 14, 2003; whether there is a causal connection between the said injury and Petitioner's current condition of ill-being; and what is the nature and extent of the injuries. Medical bills and lost time benefits were not in dispute.

On May 14, 2003, Petitioner was working for the IDPA, Department of Child support. Her job was to work the front desk, greeting, screening, logging, making copies, pulling clients' folders and running referrals to family support specialists. She was coming out of reception, and she had to pull open a heavy door, using her full strength. She testified that the door was not stuck, it was just heavy. She felt like her right wrist snapped, and her right hand swelled and was red and hot. She also testified that she felt shoulder pain. However, according to the Notices of Injury dated May 16, 2003 and July 22, 2003, she did not report shoulder pain. (ResEx. 1) The accident occurred at about 12:25 pm. Petitioner notified a supervisor, Karen Lewis, about the incident. Another supervisor, Jerena Williams, let Petitioner go home early on May 14th.

Petitioner went to her primary care physician, Dr. Roy, the next day. She was off work for about a week or a week and a half, and then she returned to work. Her last day worked was June 6, 2003. Petitioner then went on short term disability, long term disability and SSDI. Long term disability started in 2005. Petitioner was not paid TTD benefits.

Petitioner had medical treatment by Dr. Roy, who referred her to Dr. Patel at Weiss Memorial Hospital. She also had treatment with Dr. Daniel Mass at University of Chicago and with Dr. Craig Westin on a referral by her lawyer.

Petitioner was seen by Dr. James P. Elmes, M.D. (orthopedic surgeon) at the request of the State Employee Retirement System of Illinois and also Mary I. Nunchuck, D.O. (who provided a psychiatric evaluation). Petitioner's disability appears to be related to her psychiatric condition, as Dr. Nunchuck diagnosed: Major depression, single episode with psychotic features, severe. Petitioner appeared delusional and her prognosis was extremely poor. (PetEx. 1)

Petitioner received psychological treatment from James N. Watzke, Ph.D. He supported Petitioner's disability for: PTSD, Depressive Disorder and Pain Disorder; Compulsive personality with submissive features; Carpal tunnel, headaches, body pain, shakiness: economic and job problems (Petitioner had been assaulted by co-employees in the past and perceived that fellow employees were talking about her and making fun of her). (PetEx. 2)

Petitioner testified that she has been diagnosed with psoriatic arthritis. It causes painful joints, stiffness, crooked joints, and the weather affects her. She testified that her psoriatic arthritis is unrelated to her work injury. She has also developed lung cancer. Petitioner testified that because of these unrelated issues, she is unable to have surgery for her work injuries.

Petitioner testified that her hand and shoulder hurts. She feels numbness and tingling from her shoulder to her fingers. She feels it in her thumb, ring, and little finger. Her thumb and wrist hurt, she feels weakness, and it sometimes wakes her up at night. It hurts to raise her hand above shoulder level.

Petitioner is right handed. Petitioner was not questioned regarding any prior right hand/wrist or right shoulder treatment. She was not questioned regarding any subsequent injuries.

The medical records show that Petitioner first sought treatment with Dr. Shirley Roy, her primary care physician, on May 15, 2003. Dr. Roy's records are handwritten and difficult to read. It appears that Petitioner complained of right wrist and shoulder pain, in addition to other unrelated problems. Dr. Roy recommended x-rays of the right shoulder, forearm, and wrist, all of which were negative. On June 6, 2003, just three weeks after her injury, Petitioner requested that Dr. Roy place her on a medical leave of absence from work because of

stress and depression. Petitioner continued to see Dr. Roy approximately weekly through September 2003. She then saw Dr. Roy approximately monthly, although it is unclear what treatment she received for the work injury, if any. Petitioner completed physical therapy from July through October 2003. Dr. Roy sent Petitioner to Dr. Patel. (ResEx. 3)

Dr. Roy's records do appear to support that Petitioner had right wrist and right shoulder problems prior to May 14, 2003. Right wrist x-ray in 2002 (no Fx). The chart from May 15, 2003 documents that some of Petitioner's upper extremity complaints on that day were "present in a lesser degree prior." (ResEx. 3)

When Petitioner was first seen by Dr. Patel, he thought that she had carpal tunnel syndrome and rotator cuff tendinitis. Carpal tunnel was ruled out by diagnostics. On October 17, 2003, Petitioner saw Dr. Patel. He opined that Petitioner was reporting overall improvement with less paresthesias and numbness in the median nerve distribution in the right hand and less pain in the shoulder that radiates down the arm. Her shoulder demonstrated nearly full range of motion with minimal pain. Her EMG and nerve conduction studies were within normal limits, and the reason for her numbness and paresthesias remained unexplained. The shoulder complaints were likely due to myofascial pain. As of the October 17, 2003 visit, Dr. Patel determined there was no need for orthopedic intervention and recommended that she see a rehab specialist. (ResEx. 3)

Petitioner began treating with Dr. Mass on December 16, 2003. Dr. Mass noted that Petitioner had been taking Celebrex and had physical and occupational therapy for tingling in the hands and pain in the shoulder, and this has been persistent since May with slow resolution of the tingling in hands more recently, but the shoulder is still bothersome. He gave Petitioner a steroid injection in her shoulder. (ResEx. 4)

On December 30, 2003, Petitioner had the psychological evaluation with Dr. Nunchuck, D.O. and an orthopedic exam by Dr. Elmes. The history to Dr. Elmes was of a sudden onset of pain in the right shoulder, arm and wrist while turning a doorknob at work on 5/14/2003. The clinical impression was: non-specific right shoulder pain; right rotator cuff tendinitis; right carpal tunnel syndrome; non-specific right elbow pain; non-

specific neck pain; non-specific low back pain; and depressive disorder by history. Petitioner was not able to do her regular job. Causation was not addressed. (PetEx. 1)

Petitioner continued to treat with only Dr. Roy on a monthly basis throughout 2004. (Rx. 3). Her treatment with Dr. Roy appears to have been mainly for psychological purposes, as well as back pain. (ResEx. 3)

Petitioner returned to Dr. Mass on November 22, 2004, nearly a year after her first visit with him. He recommended that Petitioner get an EMG and MRI of her right wrist and right shoulder. After reviewing her MRIs and EMG, he noted that she had a rotator cuff tear and TFCC tear, and he recommended an arthroscopic rotator cuff repair, then 3-4 months later, arthroscopic triangular fibrocartilage debridement or repair with possible ulnar shortening. Petitioner indicated that she would think about it and get back to him. Petitioner then waited to follow up with Dr. Mass until April 5, 2005. He noted that she is still not emotionally ready for a surgical procedure, so he recommended trying acupuncture and mild weight lifting exercises. She then returned to Dr. Mass just two weeks later with multiple complaints. Dr. Mass noted that he basically told her that he could not spend time just discussing her psychological problems. At that point, Petitioner completely stopped treating for the rest of 2005, all of 2006, and most of 2007. (ResEx. 4)

Petitioner then participated in a Section 12 examination with Dr. Visotsky on April 20, 2007. Dr. Visotsky found that Petitioner was at maximum medical improvement. (ResEx. 2)

Petitioner then returned to Dr. Mass on October 22, 2007. At that time, Dr. Mass noted that it was his impression that Petitioner has a questionable impingement syndrome and does have a positive history of MRI in the past that showed evidence of triangular fibrocartilage complex, as well as a rotator cuff tear, but it is questionable whether her pain is really coming from these problems, as it is diffuse and she is now talking about numbness and tingling. Dr. Mass noted that it is his opinion that Petitioner has significant physiological and emotional overlying condition, as well as fibromyalgia, which may be strongly contributing to her condition. He referred her to the University of Chicago Neurology Clinic. (ResEx. 4)

On November 12, 2007, Petitioner saw Dr. Walsh at the Neurology Clinic, and it was noted that Petitioner had an inconsistent sensory exam with a limitation of motor exam secondary to pain. On December 10, 2007, Dr. Walsh noted that the imaging studies were inconsistent with any particular underlying etiology. She had no abnormalities on the neurological exam. He noted that she had pain syndrome not otherwise specified, but it may be consistent with her previous diagnosis of fibromyalgia. He recommended only physical and occupational therapy. At that point, Petitioner stopped treating again. (ResEx. 4)

Petitioner next returned to Dr. Mass on November 23, 2010, when he opined that she had degenerative changes of the shoulder and wrist. He opined that she had a degenerative tear of the triangular fibrocartilage. He recommended wrist surgery, but in May 2011, he decided to hold off on surgery as Petitioner had recently been hospitalized with a systemic disease. Petitioner never returned to Dr. Mass. (ResEx. 4)

After that time, Petitioner began treating at Stroger Hospital for a diagnosis of psoriasis and psoriatic arthritis with arthropathy, which affected her right upper extremity, among other things. She was also diagnosed with lung cancer. (ResEx. 5)

In September 2012, Petitioner saw Dr. Westin regarding her shoulder, on a referral by her attorney. He believed that she had a partial rotator cuff tear based on her reports of pain with subsequent weakness since 2003. It appears that Dr. Westin did not review any of her past imaging studies. He recommended physical therapy and a cortisone injection. Petitioner did not follow up with his recommendations. He stated that he did not think her shoulder pain had anything to do with her psoriatic arthritis. Petitioner next visited Dr. Westin on April 12, 2013. He had not reviewed her imaging studies of the right upper extremity. He stated that he believed further treatment of the shoulder and hand may be necessary, but said it should be deferred until Petitioner had things better defined about the lung cancer. This was Petitioner's last date of treatment regarding her right upper extremity.

Petitioner saw Dr. Visotsky for a Section 12 exam on April 20, 2007. He opined that her current diagnosis was rotator cuff partial thickness tear of the supraspinatus with impingement syndrome. Petitioner had mild symptoms of wrist tenosynovitis. There were no indications of carpal tunnel syndrome. Cervical degenerative arthritic changes have no relationship to the injury. He opined that he was unclear of the exact etiology of the injury. Dr. Visotsky did not see causation with respect to her shoulder, hand, or neck injuries with relationship to simply opening a door or being struck by a door. After reviewing Dr. Mass's notes, he could not find a clear etiology of the source of her pain or whether it is traumatic in origin or due to underlying metabolic disease. He opined that with respect to Petitioner's treatment based on time and duration of the injury and the fact that the patient has now returned to work, the patient has reached maximum medical improvement with conservative treatment and care. (ResEx. 2)

Petitioner has not returned to work since June 6, 2003.

CONCLUSIONS OF LAW

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

In support of the Arbitrator's decision relative to Issue (C), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent and Issue (F), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds:

The Arbitrator finds that Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent. Petitioner testified that she was opening a heavy door, when she felt a "snapping" in her right wrist. The door was not defective, it was heavy. The medical records do not support that an acute injury was sustained and that any such injury was related to Petitioner's employment. The medical records do support that Petitioner had severe psychological problems and was likely delusional and psychotic at the time of the alleged accident. Perhaps Petitioner's wrist did snap when she opened the heavy door. Whether this can be said to have resulted in an injury is not persuasively established by the medical records. Petitioner's testimony that the door was heavy does not persuade the Arbitrator that her injury arose out of her employment.

Clearly the incident occurred in the course of Petitioner's employment. She was performing a task associated with her job duties as a receptionist, on Respondent's premises, at a time that she was working.

The arising out of element has not been established. There must be a risk incidental to the employment (i.e.: a nexus between the work activities and the injury) in order for an injury to arise out of the employment. Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193 (2003) Here the proofs are that Petitioner felt a snap or snapping in her right wrist when she opened a heavy door. The door was not defective. There was no testimony establishing an increased risk of injury related to Petitioner's employment.

Petitioner then receives a great deal of treatment (with various gaps in treatment) regarding her right shoulder and right wrist, without a clear diagnosis or causality opinion being rendered (albeit, there were diagnosis of wrist sprain, CTS, TFCC tear, RTC tear, RTC tedinitis, shoulder strain, myofascial pain, etc.) This is for a patient with psychotic and delusional conditions. Dr. Roy's records persuade the Arbitrator that petitioner had prior problems with her right wrist and right shoulder. The Record does not establish that Petitioner had or has a condition of ill-being regarding her right wrist or right shoulder which is related to the door incident, such that it can be said that Petitioner sustained an accidental injury related to her work.

For the above reasons, along with the persuasive opinion of Dr. Visotsky, the Arbitrator finds that Petitioner has failed to prove a causal connection between the alleged work accident of May 14, 2003 and her current condition of ill-being regarding her right shoulder and right hand/wrist.

Accordingly, the claim for compensation is denied.

In support of the Arbitrator's decision relative to Issue (L), What is the nature and extent of the injuries, the Arbitrator finds:

As the Arbitrator has found that Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent and has failed to prove a causal connection between her current condition of ill-being regarding her right shoulder and right wrist and any alleged injuries, the Arbitartor needs not decide this issue.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Frank McDowell,

Petitioner,

17IWCC0123

vs.

NO: 05 WC 34616

Argosy Gaming Company,

Respondent.

DECISION AND OPINION ON §19(h) PETITION

Timely Petition for Review under §19(h) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering all of the issues and being advised of the facts and law, denies Petitioner's §19(h) Petition for the reasons set forth below.

On November 16, 2005, the Arbitrator issued a Decision awarding Petitioner permanent partial disability benefits representing 35% of the left leg pursuant to §8(e). Section 19(h) of the Act provides that if an injured employee's disability has material changed within 30 months after the decision, or a settlement contract that provides for installment payments, either party may request a review by the Commission. Petitioner filed a §19(h) Petition on May 8, 2008, within the 30 month review window. Petitioner did not complete the Notice of Motion for the Petition, indicating it would bring its Petition on a date and time "TBD" before Commissioner "TBD." Petitioner did not take any further action to have its Petition set for hearing before the Commission.

Almost eight years later, on March 28, 2016, Petitioner filed another §19(h) Petition and brought it for hearing before the Commission on June 20, 2016. Petitioner sought additional temporary total disability benefits and permanent partial disability benefits commencing with his 2014 total knee replacement, and an award of penalties and fees. After considering all of the evidence, we deny the Petition for Review under §19(h).

In *Eschbaugh v. Industrial Comm'n, 286 Ill. App.3d 963 (1996)*, the Appellate Court determined that the 30 month period for review of compensation is jurisdictional. A court is divested of review jurisdiction where a claimant seeks review after the 30 month period. In

Cassens Transp. Co. v. Industrial Comm'n, 218 Ill.2d 519 (2006) it was the employer who was denied relief under §19(h) when it sought to terminate the PPD award to the employee 10 years later. The Supreme Court found that the Commission had no jurisdiction to hear the case. In the case at hand, Petitioner argues that by filing its May 8, 2008 §19(h) Petition within 30 months, the window for review remains open. Petitioner took no further action to seek review under §19(h) for an additional period of approximately eight years until March 28, 2016. We find no persuasive support for Petitioner's argument and find that it is contrary to the case law previously cited.

Furthermore, the Commission shall only consider whether the employee's disability has materially changed within 30 months after the Decision. Petitioner was still working full duty for Respondent for the 30 months following the November 11, 2005 Decision and the medical records show that his physical condition had not materially changed. At arbitration on October 15, 2005, Petitioner complained of ongoing weakness, swelling and instability in his left knee. The medical records corroborate that Petitioner continued to experience symptoms in his left knee and treated conservatively with pain medication and injections. Petitioner's treating physician, Dr. McMullin, anticipated that Petitioner would need a left total knee replacement in the future for his advanced osteoarthritis. Petitioner continued working his regular job for Respondent for approximately five years after arbitration. He went on to work for two other employers before he stopped working entirely in 2012. When Dr. McMullin and Petitioner decided to forego further conservative treatment, Petitioner underwent a left total knee replacement on June 9, 2014. The surgery, and all of Petitioner's medical treatment for the left knee, was authorized and paid for by Respondent. We note that Respondent's liability for medical expenses under §8(a) is not in dispute.

After considering all of the evidence, we find that Petitioner filed insufficient pleadings and failed to act within a reasonable time to bring its Petition before the Commission while it retained jurisdiction to modify the award for up to 30 months as per the requirements of §19(h). Furthermore, no evidence shows that Petitioner incurred a material change to his disability during the 30 month period following the Arbitrator's Decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's petition under §19(h) is hereby denied.

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

DATED: MAR 1 - 2017
RWW/plv
o-1/18/17
46

Ruth W. White

Joshua D. Luskin

Charles J. DeVriendt

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

Lajuana Dukes,
Petitioner,
vs.

NO: 06 WC 14432
08 WC 00260

Howe Center,
Respondent,

17IWCC0125

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, causal connection, medical care, permanent partial disability, credit and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 11, 2016, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that 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: MAR 2 - 2017
o022317
DLG/mw
045

David L. Gore

Stephen Mathis

Mario Basurto

IMCCOTS

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DUKES, LAJUANA
Employee/Petitioner

Case# **06WC014432**

08WC000260

HOWE CENTER
Employer/Respondent

17IWCC0125

On 5/11/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1747 SEIDMAN MARGULIS & FAIRMAN LLP
STEVEN J SEIDMAN
20 S CLARK ST SUITE 700
CHICAGO, IL 60603

5782 ASSISTANT ATTORNEY GENERAL
KELLY KAMSTRA
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CHICAGO, IL 60601

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
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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

MAY 11 2016

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

LIMCOTT

ILWCC

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

LAJUANA DUKES
Employee/Petitioner

Case #06 WC 14432
#08 WC 00260

V.

HOWE CENTER
Employer/Respondent

17IWCC0125

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on March 30, 2016. After reviewing all of the issues, the stipulations of the parties and the evidence, it is hereby found and ordered as follows:

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

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

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

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

N. ☒ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On January 31, 2006, the respondent was operating under and subject to the provisions of the Act. The date is the subject matter of claim #06 WC 14432.

- On September 7, 2007, the respondent was operating under and subject to the provisions of the Act. The date is the subject matter of claim #08 WC 00260.

- On those dates, an employee-employer relationship existed between the petitioner and respondent.

- On those dates, the petitioner sustained injuries that arose out of and in the course of employment.

- Timely notice of the accidents was given to the respondent.

- In the year preceding the injury on January 31, 2006, the petitioner earned $42,965.13; the average weekly wage was $826.25.

- At the time of injuries, the petitioner was 47 and 48 years of age, respectively, single with no children under 18.

- The petitioner agreed that the respondent paid for all the reasonable and necessary medical services provided the petitioner and all temporary total disability benefits for claim #06 WC 14432.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $550.83/week for 33 weeks from July 15, 2009, through March 2, 2010, which is the period of temporary total disability for which compensation is payable. The respondent is entitled to a set-off of $87,307.10 in temporary total disability benefits previously paid to the petitioner. The petitioner's request for temporary total disability benefits after March 2, 2010, is denied.

- The respondent shall pay the petitioner the sum of $495.75/week for a further period of 125 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 25% loss of use of the person as a whole.

- The respondent shall pay the petitioner compensation that has accrued from January 31, 2006, through March 30, 2016, and shall pay the remainder of the award, if any, in weekly payments.

- The medical care rendered the petitioner for her cervical spine through September 13, 2007, and for her lumbar spine through July 12, 2010, was reasonable and necessary and is awarded. The medical care rendered the petitioner for her lumbar spine after July 12, 2010, was not reasonable or necessary and is denied. The respondent shall pay the medical bills in accordance with the Act, the medical fee schedule or any prior adjustments or negotiated rate. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

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

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

Robert E. Williams

Signature of Arbitrator

May 10, 2016

Date

MAY 11 2016

FINDINGS OF FACTS:

On January 31, 2006, the petitioner, a mental health technician, received care at Ingalls Hospital for back pain and left buttock pain down to her calf and reported falling after being pushed. X-rays of her lumbar spine and right elbow were negative. The incident is the subject matter of claim # 06 WC 14432. On February 1st, the petitioner saw Dr. Imlach at Midwest Physician Center and reported back pain with radiation down the front and back of her left leg. Dr. Imlach's diagnosis was a back sprain, for which he prescribed mediation and work restrictions. On February 6th, the petitioner complained mostly of lower back pain and left-sided pain but reported no radicular complaints. On February 24th, the petitioner reported back pain at night to her primary care physician, Dr. Anjum Hameeduddin at Ingalls Family Care Center. The petitioner reported no progress to Dr. Imlach on March 2nd. Dr. Imlach noted a slightly improved range of motion. An MRI on March 10th revealed mild diffuse disc bulges at L3-4 and L4-5 and bilateral lateral recess narrowing at L4-5. On March 16th, Dr. Imlach noted continuing complaints of some discomfort in her lower back and opined that the MRI showed no evidence of a herniation, spinal canal stenosis or an acute traumatic process. The petitioner was discharged and released to full-duty work.

Dr. Hameeduddin saw the petitioner on March 20th and noted complaints of right hip and upper and lower back pain with radiation to legs and feet. On March 21st, the petitioner saw Dr. Panuska at Provena St. Mary's Hospital and reported August 2004, March 2005 and January 2006 back injuries. She complained of depression and bilateral leg pain with radiation on the left to her foot and on the right from her knee to her ankle. Dr. Panuska noted lower back tenderness but no spasms. An EMG study on April 4th

provided electrodiagnostic evidence of a mild left S1 chronic radiculopathy but no evidence of sensorimotor polyneuropathy.

Dr. Howard Robinson at the Chicago Institute of Neurosurgery saw the petitioner on April 12, 2006, for low back and left leg pain and noted that he last saw her on June 30, 2005, for a left-sided L4-5 extruded disc fragment. The petitioner reported a significant relief with an injection but the return of her pain shortly thereafter and continuous low back and left leg pain since then. The petitioner received a left L5 transforaminal epidural injection on April 24, 2006. A lumbosacral myelogram/CT scan on May 18th disclosed multilevel degenerative disc disease, a broad-based circumferential disc bulge at L4-5 causing mild central spinal stenosis and left greater than right neural foraminal stenosis. The petitioner received additional left L5 transforaminal epidural injections on June 2nd and June 30th. On August 8th, the petitioner reported excellent improvement of her pain over the prior few weeks, continued low back and left leg pain and feeling able to return to work. Dr. Robinson released the petitioner to work without significant restrictions. On September 12th, Dr. Robinson noted minimal discomfort and that she was working without difficulties or restrictions. Dr. Robinson opined that the petitioner was at maximum medical improvement. On May 22, 2007, the petitioner reported a flare-up of her low back pain and left leg pain to Dr. Robinson. She described the pain as a burning sensation and reported tingling in her left foot. On June 7th, the petitioner received a left-sided L5 transforaminal injection. A medical note indicated no relief with the injection.

On September 7, 2007, the petitioner was struck in the eye by a door and fell. The incident is the subject matter of claim # 08 WC 260. She received care at St. James

Hospital where it was noted that she had a laceration of her left eyebrow. A head CT scan ruled out intracranial hemorrhage. On September 8th, she saw Dr. Imlach at Midwest Physician Center and reported injuring her neck, lower back and left eye. The doctor noted a limited cervical range of motion with side bend and forward flexion and some perispinal tenderness. His diagnosis was a facial laceration and neck and back sprain. He gave the petitioner work restrictions. The petitioner returned to work shortly thereafter. On September 13, 2007, the petitioner reported daily headaches and lower back pain to Dr. Imlach. The petitioner's examination was normal and it was noted that she smiled throughout the exam. She was discharged without restrictions.

Dr. Hameeduddin saw the petitioner periodically for check-ups and her lumbar condition and other medical problems and on September 27, 2007, noted complaints of neck tenderness, left rotator cuff pain and mid back tenderness. On December 10th, the petitioner reported to Dr. Robinson low back pain and left calf pain and burning. On December 14th, the petitioner saw Dr. Robinson and complained of an increase in her low back pain radiating down her left leg. The petitioner was given sedentary restrictions.

On January 17, 2008, the petitioner reported continued low back and left leg pain but requested a full-work release due to financial problems. A lumbar MRI on February 3rd showed moderately advanced spondylosis in the mid and lower lumbar spine, a broad-based disc prolapse/herniation at L4-5 with moderate to severe central spinal stenosis with a degree of progression of the protrusion since the MRI on March 21, 2005. Dr. Robinson opined on March 17, 2008, that the MRI showed a larger herniation. On April 3rd, the petitioner received a left-sided L5 transforaminal injection, which did not provide any significant relief. She received a caudal epidural steroid injection on June 2nd. The

petitioner reported significant improvement for a few days but a gradual return of her pain. Dr. Robinson increased the petitioner's restrictions to light-duty work only. The petitioner sought emergency care for back pain at Ingalls on September 30, 2008. The petitioner received a second caudal epidural steroid injection on October 9, 2008, but reported no improvement on October 23rd. She was released to work without restrictions.

The petitioner sought emergency care for back pain at Ingalls on June 8, 2009. A diagnostic study on July 2, 2009, revealed mild median sensory neuropathy but no cervical radiculopathy. A lumbar MRI on July 9, 2009, revealed a moderate broad-based disc herniation at L4-5 with mass effect on the ventral margin of the thecal sac, bilateral neural foraminal narrowing and mild posterior central canal narrowing. Dr. Luken performed a left L4-5 interlaminar laminotomy, partial facetectomy, foraminotomy and discectomy at Ingalls Memorial Hospital on July 15, 2009. Dr. Luken noted little improvement at follow-ups. She sought emergency care at Ingalls for gradual back pain that started the prior day on September 30th. On December 21st, the petitioner reported relief of the agonizing shooting radicular pains in her left leg, but complained of a burning sensation in her left foreleg and numbness in her great toe. Dr. Luken noted a negative straight leg raise on the right and positive buttock and posterior thigh pain on the left. The petitioner also had give-away weakness of her left foot on dorsiflexion but symmetrical patellar and Achilles deep tendon reflexes. Dr. Luken prescribed assistive devices and started work conditioning on January 15, 2010.

A lumbar MRI on January 22, 2010, revealed mild lumbosacral degenerative disease. The petitioner returned to Dr. Robinson on February 9th and reported back and bilateral lower extremity pain increased by work hardening. Dr. Luken noted on February

12th that the petitioner reported the exertions during her recent work conditioning significantly injured her, that essentially undid the spectacular benefits of her surgery and left her with incapacitating, burning pain from her back into her legs. She stated that her TENS unit provided significant and ongoing pain relief. The doctor noted a negative straight leg raising bilaterally and excellent strength of foot dorsiflexion, bilaterally. Dr. Luken opined that he did not feel further surgical intervention would be beneficial. Dr. Luken suggested an FCE to gauge any secondary gain issues. Dr. Robinson opined March 2nd that the MRI showed a mild bulging L4-5 disc and recommended sedentary restrictions. On April 20th, Dr. Robinson noted that he gave the petitioner a left L5 transforaminal epidural steroid injection and continued the sedentary-work restrictions. An inconsistent FCE on May 20th was at the sedentary physical-demand level. On May 25th, Dr. Robinson gave permanent restrictions of sedentary work. The petitioner saw Dr. Luken on June 4th and reported low back and bilateral leg pain that she again ascribed to work conditioning efforts. Pursuant to the petitioner's request, Dr. Luken opined that the petitioner was at MMI. On July 12th, Dr. Luken found no clear change in the petitioner's neurologic findings and re-documented a permanent 10-pound lifting restriction.

On October 12, 2010, Dr. Hameeduddin noted complaints of back pain and depression. She reported that she had been off work since August 30, 2010, and wanted psychiatric care. The petitioner began treatment with Dr. Joseph Beck on December 8th and followed up on January 10, 2011, at which time he noted that she was having disorganization of her thoughts, breakthrough pain and problems with her emotional state related to her ongoing issues with the insurance company. The petitioner sought emergency care for back spasms for a week at Ingalls Tinley Parks on March 5, 2011.

The petitioner reported back pain for four years and feeling worse. The doctor noted that she denied any neck pain and had a full range of motion. A psychological evaluation by Patricia Merriman at Rush Pain Center on March 14th noted moderate, provisional, major depressive disorder, single episode. The petitioner continued psychiatric care with Dr. Beck through March 2, 2016, for recurrent, moderate major depression and received periodic psychological counseling with Patricia Merriman through March 21, 2016. The petitioner saw Dr. Holly Carobene at Comprehensive Pain Care on July 21, 2011, who gave her a lumbar epidural injection on August 2, 2011, and a left L5 nerve root block on October 11, 2011.

At the request of the respondent, on September 19, 2012, the petitioner was evaluated by Dr. Babak Lami. The doctor noted that there were no cervical complaints and opined that the petitioner's subjective symptoms were out of proportion to the physical findings, that no further treatment was needed and that she had reached maximum medical improvement regarding the September 7, 2007, accident.

The petitioner began chiropractic care for her low back at Tinley Park Chiropractic on March 15, 2013, and followed up approximately weekly through August 27, 2014. The petitioner followed up frequently with Dr. Hameeduddin for back pain and many other medical issues through August 16, 2013, at which time, cervical tenderness was noted. Dr. Hameeduddin noted that the petitioner was wearing a back brace and cervical collar on September 26th. On December 5th, the petitioner told Dr. Hameeduddin that she had no back pain when she went to Jamaica on November 10, 2013, but her back pain returned. She reported a new neck pain with radiation to her left arm to Dr. Hameeduddin on August 19, 2014, and continued back pain on January 12, 2016.

On July 8, 2013, Dr. Hartman evaluated the petitioner at the request of the respondent. Dr. Hartman's diagnosis was malingering and narcissistic personality disorder. Susan Entenberg's vocational rehabilitation evaluation of the petitioner on November 7, 2013, was that she was not an appropriate candidate for vocational rehabilitation. On November 19, 2013, Patricia Merriman opined by deposition that the discontinuation of the petitioner's benefits contributed to her mental distress significantly, that she did not believe petitioner had a narcissistic personality disorder or was malingering. On December 12, 2013, Dr. Hartman opined by deposition that the petitioner's psychological issues were not plausible or credible, that she felt an entitlement to disability benefits and that she was not willing or motivated to return to any employment. On March 17, 2014, Amy Portz with Creative Case Management opined by deposition that the petitioner's transferable skills were in the light-duty occupations – security officer, fast-food worker, retail sales and hair stylist, that she had the ability to learn additional skills and that her earning capacity was between $19,000 to $30,000. Ms. Entenberg opined by deposition on March 26, 2014, that the petitioner was not able to return to work as a mental health technician, that she was not a good candidate for vocational rehabilitation and that there was no stable labor market available to her.

The petitioner had a previous lumbar injury in August 2004 and received conservative care at Ingalls Memorial Hospital for a lumbar strain at L4-5. On March 14, 2005, the petitioner received emergency care at Ingalls Memorial Hospital for left low back pain with radiation down the back of her left leg to her foot after jumping and twisting on a trampoline. The diagnosis was sciatica. A lumbar MRI on March 21, 2005, revealed posterior disc bulging and extrusion of disk material to the left of the midline at

L4-5 with the fragment on the left of the midline and extending upward over the posterior aspect of the body of L4, probably impinging the L4-5 nerve root on the left side. An EMG on April 19, 2005, revealed evidence of mild acute/subacute lower lumbar root level involvement with needle EMG abnormalities confined to the lumbosacral paraspinal muscles. The petitioner saw Dr. Robinson on May 6, 2005, and reported a gradual onset of low back that began in March 2005 and complained of a deep aching pain with burning and electric shock going all the way down her left leg into her left foot. The petitioner received a left L5 transforaminal epidural injection on May 12, 2005. The petitioner reported 20% improvement to Dr. Robinson on May 27, 2005, and a repeat left L5 transforaminal epidural injection was given on June 16, 2005.

FINDING REGARDING THE AMOUNT OF WAGES:

There is no evidence of the petitioner's wages in the year preceding the injury on September 7, 2007.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner for her cervical spine through September 13, 2007, and for her lumbar spine through July 12, 2010, was reasonable and necessary and is awarded. The medical care rendered the petitioner for her lumbar spine after July 12, 2010, was not reasonable or necessary and is denied. The respondent shall pay the medical bills incurred after February 1, 2006, in accordance with the Act and the medical fee schedule. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act, and any adjustments, and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that her current condition of ill-being with her lumbar spine through July 12, 2010, is partially causally related to the work injuries.

The petitioner failed to prove that her current condition of ill-being with her lumbar spine after July 12, 2010, cervical spine and rotator cuff is partially causally related to the work injuries. The petitioner returned to work shortly after Dr. Imlach released her with work restrictions on September 8, 2007. On September 13, 2007, Dr. Imlach discharged the petitioner without restrictions. The petitioner was given sedentary restrictions by Dr. Robinson on December 14, 2007, after complaining of an increase in her low back pain and radiating down her left leg. Then, on January 17, 2008, the petitioner requested a full-work release from Dr. Robinson due to financial problems. The petitioner reported a gradual return of her pain and Dr. Robinson increased her restrictions to light-duty work only. On October 23, 2008, the petitioner was again released to work without restrictions.

After her left L4-5 laminotomy surgery on July 15, 2009, the petitioner reported relief of the agonizing shooting radicular pains in her left leg. Dr. Luken noted on February 12, 2010, a negative straight leg raising bilaterally and excellent strength of foot dorsiflexion, bilaterally, opined that he did not feel further surgical intervention would be beneficial and suggested an FCE to gauge any secondary gain issues. The petitioner returned to work on March 3, 2010. The petitioner's efforts were inconsistent during an FCE on May 20, 2010. On May 25, 2010, Dr. Robinson gave permanent restrictions of sedentary work. Pursuant to the petitioner's request, Dr. Luken opined June 4, 2010, that

the petitioner was at MMI. On July 12, 2010, Dr. Luken found no clear change in the petitioner's neurologic findings and re-documented a permanent 10-pound lifting restriction. The petitioner's lumbar complaints have been inconsistent, irregular and bizarre. In light of her pre-existing lumbar condition and her waxing and waning lumbar symptoms, the evidence is insufficient to establish an adequate relationship with her work injuries after July 12, 2010.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

The petitioner was off work due to her work injuries from July 15, 2009, through March 2, 2010. The respondent shall pay the petitioner temporary total disability benefits of $550.83/week for 33 weeks, from July 15, 2009, through March 2, 2010, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner. The petitioner's request for temporary total disability benefits after March 2, 2010, is denied.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The petitioner failed to prove that she is obviously incapable of employment or that she cannot perform any services except those which are so limited in quantity, dependability or quality that there is no reasonably stable labor market for them. The petitioner can perform some form of employment without seriously endangering her health or life. The petitioner feels that she is unable to work and did not look for any employment. She did not conduct a genuine, legitimate and diligent search for employment. The opinions of Dr. Beck, Susan Entenberg and Patricia Merriman are not consistent with the evidence, unrealistic and speculative. Their opinions are not given any probative weight.

The petitioner complains of the inability to squat, bend or kneel. She has increased symptoms with prolonged sitting, standing or walking. She has a throbbing irritation under her breast due to her clothes and is depressed.

The respondent shall pay the petitioner the sum of $495.75/week for a further period of 125 weeks as provided in Section 8(d)2 of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 25% loss of use of the person as a whole.

FINDING REGARDING THE BENEFITS AND MEDICAL PAID BY THE RESPONDENT:

The respondent paid $87,307.10 in temporary total disability benefits after July 15, 2009.

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 WILL)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Margaret Webb,

Petitioner,

vs. NO. 07WC 36523

Harrah's Illinois Corp.,

17IWCC0129

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, prospective medical care, notice, wage differential, penalties and fees, 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 25, 2016 is hereby affirmed and adopted.

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

17IWCC0129

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

DATED: MAR 3 - 2017
SJM/sj
o-2/23/2017
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WEBB, MARGARET
Employee/Petitioner

Case# **07WC036523**

HARRAH'S ILLINOIS CORP
Employer/Respondent

17IWCC0129

On 4/25/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.35% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
MARK WEISSBURG
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

1139 NOBLE & ASSOCIATES
MICHAEL E MAHAY
1979 N MILL ST
NAPERVILLE, IL 60563

17IWCC0129

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Margaret Webb
Employee/Petitioner

v.

Harrah's Illinois Corp.
Employer/Respondent

Case # **07** WC **36523**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni**, Arbitrator of the Commission, in the city of **New Lenox**, on **April 8, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **July 9, 2007**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was*** 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 **$9,188.94**; the average weekly wage was **$510.50**.

On the date of accident, Petitioner was **47** years of age, ***single*** with **4** dependent children.

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

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

Respondent shall be given a credit of **$1,609.21** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$1,609.21**.

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

ORDER

Denial of benefits

PETITIONER HAS NOT PROVEN BY A PREPONDERANCE OF THE EVIDENCE THAT AN ACCIDENT AROSE OUT OF AND IN THE COURSE OF HER EMPLOYMENT WITH RESPONDENT. THEREFORE, NO BENEFITS ARE AWARDED PURSUANT TO 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.

Robert E Abrams — April 20.2016

Signature of Arbitrator — Date

APR 25 2016

Issues

The disputed issues in this matter are: [C] Accident; [E] Notice; [F] Causal Connection; [J] Medical Expenses; [K] Temporary Total Disability; [L] Nature and Extent of the injuries and [M] Penalties. (Arb. Ex 1)

Findings of Fact

At arbitration, petitioner amended her Application for Adjustment of Claim to reflect an accident date of July 9, 2007 to allegedly comport with the medical records. Petitioner then testified that on that date, she incurred an injury to her chest and low back during a specific incident when she was bending over with plates weighing 5 to 10 pounds in her hand. Next she testified she notified her supervisor, "Terry" and went home. Neither party produced "Terry" to testify. Later that same day, petitioner began a course of medical treatment at Silver Cross Hospital.

[C.] Did an Accident Occur that Arose Out of and in the Course of Petitioner's Employment with Respondent?

The Arbitrator notes the histories contained in the Silver Cross Hospital Emergency Room records (Px-4) do not corroborate petitioner's testimony with regard to the mechanism of injury claimed. First, the Silver Cross Emergency Room Nurses Note of July 9, 2007 indicates petitioner's presenting complaint is, "Patient states: non-radiating chest pain with shortness of breath onset one hour PTA while at work waitressing. Care prior to arrival: None. Method of arrival: In a wheelchair." (Px-4) This history does not document any complaints to petitioner's lower back and does not corroborate petitioner's testimony regarding her mechanism of injury. She does not mention any history of bending and carrying plates.

Second, the Arbitrator notes a review of the Physician Documentation record of July 9, 2007 shows petitioner gave a history of, "chest pain that is located primarily in the substernal area. The chest pain is described as sharp. The pain radiates to the onset: the symptom/episode began/occurred this morning..." (Px-4) This doctor makes a diagnosis of "chest pain with a plan for admission and observation." (Px-4) There are complaints of back pain noted in this report. (Px-4) The arbitrator finds that this note contains no history of a work related incident occurring on July 9, 2007.

Third, the July 9, 2007 History and Physical Examination note contained in the emergency room records documents petitioner's chief complaint as, "Chest Pain". (Px-4) It then gives a history of "Patient reported substernal chest pain mild to moderate without any radiation. No shortness of breath or diaphoresis. This occurred in the morning yesterday and she was at work waitressing". (Px-4) Again, the arbitrator notes there is no history of petitioner bending while holding plates as she mentioned in her testimony. There is no mention of any specific incident occurring that would corroborate her testimony. This same document notes that a review of

her symptoms revealed that there was no history of focal similar symptoms or musculoskeletal symptoms and the pain lasted a few minutes. (Px-4)

This note also gives a diagnosis as 1.) Atypical chest pain. Likely musculoskeletal; 2.) Anemia Mild; and 3.) Patient complains of back pain for about three days. She reports that she was at work, she was lifting heavy plates and she felt pain in the left side of her lower back. (Px-4) The doctor then, inexplicably, ordered an x-ray of the cervical spine. (Px-4) The arbitrator notes that this history does not corroborate petitioner's testimony with regard to the mechanism of injury. Petitioner did not testify to lifting heavy plates three days before her emergency room visit and, in fact, amended the Application for Adjustment of claim to reflect an accident date of July 9, 2007. Further, petitioner never testified to any cervical problems related to the alleged incident of July 9, 2007.

Fourth, the emergency room records contain a Report of Consultation from Ramalingappa Mukunda, MD. (Px-4) This report provides the following history: "This is a 47 year old female who was working at Harrah's yesterday when she developed retrosternal and chest pressure at approximately 11:00 am. She was sitting at work when this occurred. The day before when she was at work she lifted heavy plates and experienced significant back pain and it was difficult for her to sleep...." (Px-4) The doctor's impression was that she presented with atypical chest discomfort while at work but was currently pain free. He then noted it may be musculoskeletal in nature and further noted she did have any back pain yesterday. He then ordered a stress test. (Px-4)

Again, the Arbitrator notes the Report of Consultation does not corroborate petitioner's testimony. This note indicates petitioner's chest pain began while she was sitting at work.

The Arbitrator finds petitioner was initially examined at Silver Cross Hospital due to chest complaints that occurred while she was sitting at work on July 9, 2007 without any evidence of an inciting work related event. Further, the Arbitrator finds petitioner's back complaints are not related to the alleged events of July 9, 2007 as none of the initial emergency room records corroborate petitioner's testimony. In fact, the emergency room records support a finding that the petitioner's back complaints predate the alleged accident date of July 9, 2007.

The Arbitrator gives greater weight to the histories contained in the initial emergency room records than to that of the petitioner's testimony and finds that petitioner's condition of ill-being at the time of the arbitration hearing did not arise out of and in the course of her employment with respondent, Harrah's Illinois Corp. Therefore, no benefits are awarded under the Illinois Workers' Compensation Act. All other issues are moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KELLY JOINER,

Petitioner,

17IWCC0164

vs.

NO: 07 WC 41419

CITY OF CHICAGO,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by both the Respondent and Petitioner 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.

Petitioner sustained a work-related accident on July 30, 2007 working for Respondent as a cement laborer after lifting a heavy object with a co-worker. Both accident and causation were stipulated at the time of arbitration. Petitioner testified she experienced severe pain in her right lower back and right hip. Later that day, Petitioner presented to the Emergency Department at Little Company of Mary Hospital for lower back pain and stiffness. She denied any previous injuries. Lumbar x-rays were normal, considering Petitioner's age (39). Lumbar back strain was diagnosed, an intermuscular injection was administered, Vicodin and Flexeril were prescribed, and Petitioner was taken off work the next day. The next day Petitioner presented to MercyWorks where Dr. Haskins diagnosed low back strain with sciatica, prescribed medications and a home exercise program, and took Petitioner off work until reevaluation.

On September 7, 2007, Petitioner presented to Dr. Wehner reporting back pain since her work accident on July 30. Dr. Wehner reviewed the MRI which she deemed as "basically normal." Thereafter, she diagnosed lumbar strain with some element of sacroiliitis. She prescribed Ultram and physical therapy and released her to light duty.

Two weeks later Petitioner returned to Dr. Wehner and reported she was worse. She reported she was off work because her restrictions could not be accommodated. Dr. Wehner indicated that Petitioner's complaints seemed out of proportion to her soft tissue injury, clinical examination, and MRI findings. She recommended work hardening. Petitioner continued to treat with physical therapy, medication, and injections. However, it appears that she did not have work hardening.

On April 1, 2008, Petitioner had a Functional Capacity Evaluation ("FCE"). She was found to have given consistent effort and was able to work at a light-medium physical demand level. A query was made whether she could attend two weeks of work hardening. Improvement to the physical demand level required to perform her previous position was considered unlikely because of the heavy demand level of that job. On April 4, 2008 Petitioner presented to Dr. Diadula at MercyWorks who noted that Petitioner reported 6/10 pain and had an FCE on 4/1/08. He prescribed Norco as needed and a home exercise program. He declared Petitioner at maximum medical improvement and discharged her from treatment. He outlined various restrictions apparently based on the FCE. Respondent did not accommodate Petitioner's restrictions and she remained off work collecting temporary total disability benefits.

Respondent sent Petitioner to Dr. Graf for a medical examination pursuant to Section 12 of the Act on September 7, 2012. At that time, she reported 10/10 pain, which was never below 4-5/10. Petitioner indicated she was "to go for hip surgery" and that at 16 "she had dislocated her right hip and was in traction for eight days." Dr. Graf's physical exam appears to have been normal. Dr. Graf could not substantiate any sacroiliac joint pathology and noted her lumbar MRI was normal except for arthritis. He thought her pain was emanating from her groin. He also indicated that she had been placed at maximum medical improvement at various times during her treatment. His diagnosis was right groin pain and unsubstantiated back pain with radiculopathy. He did not recommend any additional treatment. He could not determine her ability to return to work because he had to review the FCE.

Petitioner returned to Dr. Graf for another Section 12 medical examination on August 20, 2013. Petitioner indicated that nothing really had changed since the first examination. She was told she needed "a trial type new surgery" on her hip but that was not approved. She was also told she would eventually need hip replacement. She still reported groin, hip, and low back pain. The groin pain was rated as 9/10 and the other pain was rated as 3-4/10. Dr. Graf again opined that he did not believe Petitioner's symptoms were related to her lumbar spine, but rather her hip. He would not comment on any recommendation for hip surgery, because he saw no reference to such a recommendation in the record. He again opined that Petitioner did not need any treatment for her lumbar spine and could return to work with no restrictions.

Nothing changed regarding Petitioner's status and she continued to receive temporary total disability benefits until March 4, 2014, when Respondent returned her to work at full duty in her previous job as cement laborer. She performed that job until she allegedly suffered another work-related injury on April 16, 2014. That alleged injury was the subject of a separate workers' compensation claim. The 2014 claim was consolidated with the instant claim at arbitration. However, that claim was the subject of separate Arbitration and Commission decisions.

After the alleged 2014 accident/injury, Respondent sent Petitioner for another Section 12 examination with Dr. Butler. He reviewed a recent MRI from May 28, 2014 indicating it was "normal. There are no disc herniations or stenosis. No annular tears or bulging noted." Dr. Butler diagnosed lumbar strain with chronic nonobjective pain disorder. He indicated that she suffered a minor strain in the 2014 work injury, but the current MRI was normal, "so there does not appear to be any relationship between the prior injury from 2007 other than the prolonged deconditioning that would have occurred with her being out of the work place for nearly 7 years before returning back to work as a concrete grader." Current medical treatment was neither reasonable nor necessary. She had no specific radicular pain or compressive pathology. She needed no additional testing or treatment. The normal time for resolution of a lumbar strain was three months; Petitioner had exceeded that period. She could return to work without restrictions.

In the instant claim, the Arbitrator awarded Petitioner 40 weeks of permanent partial disability benefits representing the loss of 8% of the person-as-a-whole. She found that Petitioner suffered a lumbar strain, which initially resulted in restrictions that Respondent did not accommodate and Petitioner stayed off work. "After several years, the need for these restrictions eventually" resolved and she was returned to full duty per the opinion of Dr. Graf. The Arbitrator also noted the "lack of treatment in the years between the FCE and her return to work."

The Commission notes that Petitioner did not specifically testify as to her condition between her first and second work injury. She did not specifically testify about her ability or inability to work during that time period. She was never diagnosed with anything other than a lumbar strain or sciatica. Her MRIs were described as normal. In addition, both one of her treating doctors, Dr. Wehner, and Dr. Butler, a Section 12 medical examiner, specifically found Petitioner exhibited symptom magnification, and another Section 12 medical examiner, Dr. Graf, referred to her back pain as "unsubstantiated."

As noted by the Arbitrator, Petitioner received only conservative treatment and there is no indication that she received medical treatment at all between the time of her FCE in 2008 and her return to work in March of 2014. However, the lack of treatment the result of her treating doctor, Dr. Diadula, declaring her at maximum medical improvement and releasing her from treatment as of April 4, 2008. Furthermore, there is no indication in the record before us that Petitioner actually sought additional treatment in the interim and she clearly never proceeded under Section 8(a) to require Respondent to authorize additional treatment.

The fact that Petitioner was off work for several years does not in itself establish the seriousness of her injury. Petitioner's ability to return to work in her previous heavy job demand level job indicates she did not lose earning potential from her 2007 injury and suggests that the injury did not result in serious permanent impairment. In looking at the entire record before, us the Commission concludes that on July 30, 2007 Petitioner suffered a work accident resulting in a lumbar strain and the loss of 4% of the person-as-a-whole. Accordingly, the Commission modifies the Decision of the Arbitrator.

17IWCC0164

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $636.15 per week for a period of 20 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of use of 4% 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.

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

DATED: MAR 2 1 2017

Kevin W. Lamborn

Charles J. DeVriendt

Joshua D. Luskin

KWL/dw
O-3/8/17
42

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0164

JOINER, KELLY
Employee/Petitioner

Case# 07WC041419

14WC014685

CITY OF CHICAGO
Employer/Respondent

On 3/30/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0704 MARTAY LAW OFFICE
WILLIAM H MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
DANIEL WELLNER
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

17IWCC0164

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
NATURE AND EXTENT ONLY

Kelly Joiner
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **07** WC **41419**

Consolidated cases: **14 WC 14685**

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 **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **2/19/16**. By stipulation, the parties agree:

On the date of accident, **7/30/07**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**70,317**, and the average weekly wage was $**1352.50**.

At the time of injury, Petitioner was **39** years of age, ***single*** with **3** dependent children.

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

Respondent shall be given a credit of $**304,594.21** for TTD and maintenance, and $ for other benefits, for a total credit of $**304,594.21**.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $636.15/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 has a credit for $304,594.21 paid to date for temporary total disability and maintenance.

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.

FINDINGS OF FACT

Petitioner was hired by Respondent in 2000, as an administrative assistant. She was subsequently transferred to a laborer's position, which she worked without incident for five years. Her job duties included digging, cutting tree branches, framing, and raking and grading wet cement. She testified that she heard a snap and felt severe pain in her low back and right hip on July 30, 2007, while helping a co-worker push a bucket, which had been dropped by a bobcat. Petitioner immediately went to the emergency room at Little Company of Mary Hospital, where she was diagnosed as having a lumbar back strain. Petitioner was told to report to the City of Chicago doctor the next day and not to return to work. Tr. pp. 14-18; PX2.

On July 31, 2007, Petitioner began treatment at MercyWorks on Ashland, in Chicago, Illinois. X-rays were taken that were negative for any fracture or dislocation of her lower back. Dr. Theresa Haskins opined that the Petitioner was suffering from a low back strain with sciatica. Petitioner was provided with therapy and medication. She was placed on a light duty status and presented to Dr. Julie Wehner, who also prescribed additional therapy and medications. PX3 & 4.

On August 6, 2007, Petitioner presented to Oak Lawn MR and Imaging Center for an MRI of the lumbar and thoracic spine. Dr. Baronofsky opined that the MRI of the thoracic spine was normal. Dr. Baronofsky opined that the MRI of the lumbar spine revealed mild lumbar facet arthrosis but no disc protrusion.
In 2008, Petitioner also treated with Dr. Amine, who prescribed therapy, medications and injections into the lower back. Plaintiff continued treatment at MercyWorks and was place on light duty status.

On April 1, 2008, Petitioner had a functional capacity evaluation ("FCE"), which determined that she was functioning at the light-medium work level. Petitioner could lift a maximum of 35 pounds from knee to above the shoulder occasionally; and 42 pounds from the floor to mid-thigh level,

occasionally. Petitioner could occasionally carry a maximum of 32 pounds and occasionally pull up to 30 pounds. Petitioner was to alternate sitting and standing every 15-20 minutes; and could walk a maximum distance of .56 miles at a time. PX3, 5 & 6.

Petitioner was released to return to work within these restrictions and placed at maximum medical improvement ("MMI") by the doctors at MercyWorks. Respondent did not provide restricted work and eventually requested that Petitioner completed job search logs every week, over the next four to five years. She was still an employee of Respondent and would have lost her position if she had not handed in the job logs. Tr. p.19.

On April 7, 2009, June 9, 2010 and on April 22, 2011, the Petitioner presented to MercyWorks for pension board visits. Dr. Diadula attended with the Petitioner and on all three visits opined that she was suffering from low back and right SI joint pain. On each date, Dr. Diadula noted that the Petitioner was at MMI and was discharged however, the restrictions in the Petitioner's FCE report dated April 1, 2008, still applied. An April 19, 2012, a work status report showed low back and right SI joint pain and that Petitioner was released to return to work with specific lifting, carrying, pushing and pulling restrictions. PX3.

On September 7, 2012, Respondent obtained an independent medical examination ("IME") with Dr. Graf with an addendum dated August 20, 2013. Dr. Graf opined that the Petitioner's alleged permanent restrictions were related to an underlying hip issue as opposed to the Petitioner's lumbar spine. With respect to the Petitioner's lumbar spine, Dr. Graf noted that the Petitioner did not require any additional treatment. Dr. Graf opined that the petitioner's correct diagnosis was right groin pain with unsubstantiated occasional leg radiculopathy. With respect to the Petitioner's lumbar spine, Dr. Graf noted the Petitioner should have no work restrictions. Respondent requested that Petitioner return to full duty employment as a cement mixer/labor, which she did on March 4, 2014.

CONCLUSIONS OF LAW

The sole issue in dispute is the nature and extent of Petitioner's injury. No testimony was elicited from Petitioner with regards to her physical condition or ability to perform her job duties following her return to work and prior to the second injury. Therefore, the Arbitrator must assess permanency from the medical records. The Arbitrator finds that Petitioner has a lumbar strain as a result of the work accident, with some element of radiculopathy per the treating medical records. She received conservative treatment, including joint injections. Initially, this caused Petitioner to have restrictions preventing her return to work in a full duty capacity and as Respondent could not accommodate her restrictions she stayed off work. After several years, the need for these restrictions eventually full duty resolved, as Petitioner demonstrated that she was able to return to work in a full duty capacity, on March 4, 2014. Her full duty position was a heavy labor position as a cement mixer. This return to work was based upon the opinion of Dr. Graf who found no work restrictions. However, the Arbitrator notes the lack of treatment in the years between the FCE and her return to work. In addition, Dr. Graf found no need for treatment. Therefore, the Arbitrator finds that Petitioner is

entitled to permanent partial disability benefits under Section 8(d)(2) of the Act, at 8% loss of use of a person as a whole.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lester Stevens,
Petitioner,

17IWCC0122

vs.

NO: 08 WC 29060

Freeman United Coal Mining Company,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of benefit rates, occupational disease, 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 December 4, 2015, is hereby affirmed and adopted.

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

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

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

DATED: MAR 1 - 2017
o1/31/17
RWW/rm
046

Ruth W. White

Joshua D. Luskin

17IWCC0122

DISSENT

I must respectfully dissent from the majority's decision that the Petitioner failed to prove that his current condition of ill-being is causally connected to his occupational exposure resultant from 31 years of working in a coal mine.

I would have assigned greater weight to the opinion of Dr. Paul, a physician treating Petitioner since 1982, as well as the opinion of Dr. Cohen, another physician who examined Petitioner, as well as the b-reads of Dr. Smith, Dr. Alexander, and Dr. Sood. I would assign little to no weight to the opinions of Respondent's experts as none of them examined and/or met with Petitioner. Additionally, Dr. Wiot has been discredited as a credible expert before the Commission, Dr. Tuteur is not a b-reader, and has, in fact, taken the b-reader test and failed. I further would assign little weight to Dr. Rosenberg as he did not examine Petitioner and the NIOSH b-readers as their last read was several months before Petitioner stopped working for Respondent.

Petitioner worked as a coal miner for more than 31 years and spent all but his last 6 months underground. (T. 10) Petitioner first started noticing problems 2-3 years after he first started working in the mine. (T. 25) He noticed he would have breathing difficulties when he would exert himself and over time, his breathing problems worsened. (T. 28) He has radiographic evidence of coal workers' pneumoconiosis according to Dr. Cohen, Dr. Alexander, and Dr. Smith, all certified B readers. Dr. Paul diagnosed Petitioner's CWP within one year of the last date Petitioner worked for Respondent. It is well-accepted that CWP can progress after exposure ends. It is also acknowledged that a person who has CWP should not resume coal mining. It is these factors that constitute Petitioner's disablement.

Petitioner proved his asthma, sinusitis and bronchitis were caused as a direct result of his exposure to coal dust during the 31 years he spent working for Respondent underground in the mine. Petitioner's treating physicians and experts were more credible than those of Respondent. For the reasons stated above, I would have found Petitioner's claim compensable and would have awarded benefits under Section 8(d)2.

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0122

STEVENS, LESTER
Employee/Petitioner

Case# **08WC029060**

FREEMAN UNITED COAL MINING COMPANY
Employer/Respondent

On 12/4/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

17IWCC0122

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

LESTER STEVENS
Employee/Petitioner

v.

FREEMAN UNITED COAL MINING COMPANY
Employer/Respondent

Case # **08 WC 29060**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina S. Hemenway**, Arbitrator of the Commission, in the city of **Springfield**, on **September 29 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. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [x] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] 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. [x] Other **Sections 1(d)-(f) of the Occupational Diseases Act**

FINDINGS

On **August 28, 2007**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

The Arbitrator makes no Findings as to the remaining issues in dispute.

ORDER

Petitioner failed to prove that he suffers from coal workers' pneumoconiosis, chronic obstructive pulmonary disease, emphysema, bronchitis or asthma that arose out of or in the course of the exposures of his coal mine employment, and that his current condition of ill-being is causally related to his employment. All benefits are denied. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

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

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

Signature of Arbitrator

November 30, 2015
Date

DEC 4 - 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

LESTER STEVENS
Employee/Petitioner

v. Case #08 WC 029060

FREEMAN UNITED COAL MINING COMPANY
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

At the time of his work accident, Petitioner was 53 years of age and employed by Respondent as a coal miner in the Crown II mine. He was so employed for 31 years, all of which was spent working underground with the exception of the last 6 months, when he was a repairman in the prep plant. During his employment with Respondent, Petitioner testified he was regularly exposed to coal dust, silica dust, roof bolting glue fumes, diesel fumes, and smoke from coal fires. Prior to working for Respondent, Petitioner graduated from Hillsboro High School.

Petitioner began working for Respondent in December 1976 and worked for Respondent his entire career. He started out as a laborer where he built stoppings, plastered stoppings, and delivered supplies. He was also a shuttle car operator. The shuttle car takes the coal from the face of the mine where they drill it to the belts so it can leave the mine. He testified he was in the area where the actual drilling and cutting out of the coal occurred, and that it was a pretty dusty area. Petitioner also worked as a roof bolter. In that job he was at the face putting roof bolts in the top behind the miner cutting the coal and used tubes of glue to set the roof bolts. He testified this job exposed him to glue fumes as well as rock dust. In 1979 Petitioner bid into a repairman's job, and remained in that classification for the remainder of his career with Respondent. As a repairman, he worked on any underground machinery that broke down, including electrical, plumbing, hydraulics and welding. He testified he was exposed to rock dust, diesel fumes, and black diesel smoke which "sometimes you couldn't hardly see it was so bad".

Petitioner last worked in a coal mine on August 28, 2007, in the classification of repairman. He testified he was exposed to coal mine dust on that day. The mine closed after that day. Petitioner testified he had considered ending his coal mining career before the mine closed because of his breathing problems and health. He testified he had options to go to other coal mines, including Respondent's Crown III mine or the new Mine at Hillsboro, but chose not to because of the aforementioned breathing problems and health concerns.

After leaving the mine Petitioner worked at Schutt Manufacturing where they make football helmets and other kinds of sporting equipment. He was a maintenance person and worked on their equipment. He worked there for approximately one and half years. He worked 40 hours per week and made $10.00 per hour. He next worked at Pittsburg Pipe, through a

temporary agency, for approximately 3 months. He ran a forklift and did maintenance. He worked 40 hours per week and earned a little over $8.00 per hour. Petitioner next worked for Hope School as a maintenance person for approximately 3 months. He earned $10 per hour. Petitioner next worked for Midway Truck Parts for approximately one and half years. He delivered truck parts and worked 40 hours per work. He earned $10 per hour. At the time of arbitration Petitioner was working at Altorfer Caterpillar Incorporated, which is a Caterpillar dealer. His classification is tool crib attendant but he also does a lot of maintenance and delivers parts. He works 40 hours per week. He started the job earning a little over $11 per hour but at the time of arbitration was earning $21 per hour.

Petitioner testified that he first noticed breathing problems after 2 or 3 years of working in the mine. He testified that the coal dust and rock dust caused him problems when he was exerting himself, and particularly when he was dragging things down the belt line. Petitioner testified that from the first time he noticed breathing problems until the time he left the mine, the problems got worse. He further testified that from the time he left the mine until the date of arbitration the problems have stayed the same. Petitioner testified he can walk on level ground at a normal pace for 100-200 feet before becoming short of breath and can climb one flight of stairs before having to stop and rest. He has a Combivent inhaler that he carries with him and which he had at arbitration.

Petitioner testified his hobbies include camping and motorcycle riding. He is no longer able to hunt due to the walking involved. His wife does most of the lawn mowing with a push mower because he is unable to push the mower up a hill. He cannot rake leaves.

Petitioner testified that he is currently being treated by Dr. Paul, whom he has seen off and on since 1982. The frequency of his visits with Dr. Paul depends on how he is feeling. He may see him several times in 2-3 weeks or may see him only once or twice every six months. Petitioner testified he quit smoking in 1990 after having smoked 15-18 years. He smoked up to half a pack a day. Petitioner takes medications for diabetes, sinuses, and cholesterol.

Dr. Robert Cohen examined Petitioner on March 2, 2009, upon referral by the Department of Labor for a Black Lung Evaluation. PX1, Deposition Exhibit No. 2. He testified by way of evidence deposition on October 29, 2009. PX1. Dr. Cohen is a senior attending physician at Stroger Hospital of Cook County and is the Medical Director of the hospital's pulmonary physiology and rehabilitation section. He is also the Medical Director of the Black Lung Clinic of Stroger Hospital and the National Coalition of the Black Lung and Respiratory Disease Clinic. Dr. Cohen has been a B-reader since 1998.

Dr. Cohen interpreted the grade 1 x-ray of September 20, 2008, as positive for pneumoconiosis, profusion 1/0 with Q/Q shaped opacities in all lung zones. PX1, Deposition Exhibit 2. Based upon his reading of the x-ray, Dr. Cohen testified that Petitioner has coal workers' pneumoconiosis, which he opined was due to his 31 years of coal mine dust exposure. He testified that Petitioner should not have further exposure to coal mine dust and that further exposure could develop a worsening scarring process in the lung leading to gas exchange impairment and pulmonary function impairment. PX1.

Dr. Cohen testified that for a person to have pneumoconiosis they must have a tissue reaction to the coal dust that is trapped in their lungs. The tissue reaction takes the form of fibrosis, the laying down of fibroblasts and collagen and elastin, leading to scar tissue. The scar tissue then pulls apart the adjacent lung, which leads to focal emphysema. The emphysema causes an obstructive impairment. The scarring and emphysema of coal workers' pneumoconiosis cannot perform the function of normal healthy lung tissue. Dr. Cohen testified that by definition if a person has coal workers' pneumoconiosis they have lost normal functioning lung tissue and have some impairment of the lung. He testified that coal workers' pneumoconiosis is a respiratory disease that is permanent and has no cure. PX1.

Dr. Cohen testified Petitioner has a clinical diagnosis of chronic cough, which he based upon Petitioner's report of a chronic nonproductive cough. He testified that Petitioner related the cough was nonproductive and therefore does not meet the criteria for chronic bronchitis. He testified that Petitioner's cough was related to his 31 years of coal mine dust exposure. He noted the chronic cough seemed to be stable in that it had not appeared to be progressing in the recent past. PX1.

Dr. Cohen took a patient history from Petitioner, which revealed his main complaint was that of dyspnea on exertion. Petitioner related that over the last 15 years prior to the exam he could initially walk five miles a day and climb six flights of stairs before the onset of symptoms. At the time of the exam Petitioner related he could walk less than a mile and climb two flights of stairs before the onset of symptoms. Petitioner reported to Dr. Cohen that he had not been able to go hunting for the last eight years. Based on all the data available to him, Dr. Cohen testified that Petitioner has clinically significant pulmonary impairment. His cough and his dyspnea exertion were significant. Dr. Cohen attributed this clinically significant pulmonary impairment to Petitioner's 31 years of coal mine dust exposure and to his eight pack years of smoking, with the coal mine dust exposure being more significant. PX1.

Dr. Cohen testified he did not review treatment records for Petitioner. He testified it can be helpful to review treatment records when reviewing a case with the presence and clinical significance of an occupational disease. He testified that exertional shortness of breath can be due to many causes, including causes unrelated to pulmonary disease. Dr. Cohen testified that Petitioner was taking medications at the time of the examination, including Pseudovent for sinus and chest congestion, Guaifenesin for cough and Pseudoephedrine for congestion. PX1.

Dr. Cohen testified that his understanding was that Petitioner left his employment in the coal mine due to closure of the mine. Petitioner did not tell Dr. Cohen that he left work due to breathing problems, problems with his cough, or on the advice of a physician. He did not tell Dr. Cohen that he was unable to perform his last job in the mine. PX1.

Dr. Cohen testified that Petitioner does not have any lung function impairment that was out of the range of normal. He testified the main impairment he found was the x-ray abnormalities. He testified examination of Petitioner's chest was normal. PX1.

Dr. Cohen testified the most common opacity seen in coal workers' pneumoconiosis is the round opacity. The most common finding for opacities related to coal mine dust exposure involves the upper lung zones, with a right side predominance. PX1.

Dr. Cohen testified he performed pulmonary function testing, to include spirometry, lung volumes, blood gases both at rest and with exercise, a diffusing capacity, and a cardiopulmonary exercise test. He testified the results were normal. He did not have knowledge of Petitioner's pulmonary function at any point in time other than October 14, 2008, the date of the exam. Dr. Cohen testified that the results of the testing did not provide him with a cause for Petitioner's complaint of shortness of breath. He testified that from a pulmonary standpoint Petitioner was capable of heavy manual labor. PX1.

Dr. Glennon Paul is the medical director of St. John's Respiratory Therapy and Clinical Assistant Professor of Medicine at SIU Medical School. Dr. Paul is the senior physician at the Central Illinois Allergy & Respiratory Clinic, a practice which takes care of patients with respiratory diseases, critical care, allergic diseases, and some internal medicine problems. Dr. Paul is not a B-reader. He reads approximately 5000 chest x-rays a year and interprets about the same number of pulmonary function tests. In his practice he has had occasion to treat coal miners for coal mine induced lung disease and has frequently examined coal miners at the request of coal companies. Dr. Paul testified by way of evidence deposition on March 27, 2012. PX2.

Dr. Paul testified that he provided care and treatment to Petitioner beginning in the early 1970's, and which care continued through the time of his deposition. Over the course of his care and treatment of Petitioner, Dr. Paul performed pulmonary function tests, took blood gases, conducted physical examinations, took patient histories, took chest x-rays, and admitted Petitioner into the hospital. Dr. Paul testified that Petitioner used to get wheezing, coughing and shortness of breath quite frequently. Every time he got an upper respiratory tract infection he would go into asthmatic bronchitis and sometimes it required acute treatment with IV aminophylline and nebulizer treatments. Petitioner's symptoms would wax and wane over time. He testified that Petitioner reported he would get short of breath walking about four flights of stairs or one mile, and that when he got an exacerbation of his lung disease he could not walk at all. Petitioner smoked half a pack of cigarettes a day for about 20 years and quit smoking in 1990. Dr. Paul testified Petitioner's smoking history was a mild exposure which was mildly significant. He testified that part of Petitioner's treatment is a burst of Prednisone, Albuterol, and Theo-Dur. PX2.

Dr. Paul examined Petitioner on August 21, 2008. PX2, Deposition Exhibit 2. Upon his physical examination of Petitioner's chest, Dr. Paul noted one plus wheezing. He testified that Petitioner's pulmonary function studies were normal and this was a day when Petitioner was not having any trouble. His measurable pulmonary function would be something that could vary from time to time. Dr. Paul testified that Petitioner's methacholine test was negative, and that the negative methacholine challenge meant that Petitioner was not having any asthma at that time. He testified that during the course of his treatment he would describe the reactivity that he found usually to be in the bronchitic range. PX2.

Dr. Paul testified that based on his treatment of Petitioner it was his opinion that Petitioner had asthmatic bronchitis, as well as chronic bronchitis. He testified that his coal mine exposure was 100% the cause of Petitioner's reactive airways disease. Dr. Paul testified that in his opinion Petitioner has coal workers' pneumoconiosis. He testified that x-rays in his records that do not mention pneumoconiosis does not mean that Petitioner does not have it. He testified that the radiologists were not looking for it. They were looking for acute changes on the x-ray. Dr. Paul testified that his records contain references to sinusitis and that sinusitis sometimes occurs when people have upper respiratory tract infections such as bronchitis or asthma or asthmatic bronchitis. He testified that Petitioner's exposures as a coal miner were aggravating factors in the sinusitis. Dr. Paul testified that in light of his diagnoses of coal workers' pneumoconiosis, bronchitis, asthmatic bronchitis, and asthma, Petitioner could not have any further exposure to the environment of a coal mine without endangering his health. He testified that on a good day Petitioner would have the capacity to do heavy manual labor and that on a bad day he would not have the ability to leave his house. PX2.

Dr. Paul testified that in order to have pneumoconiosis one must have not only coal mine dust deposited in his lungs but also a tissue reaction to it, which is called scarring or fibrosis. The scarring of cannot perform the function of normal healthy lung tissue. By definition, if one has coal workers' pneumoconiosis he has some impairment in the function of the lung at the site of scarring, whether it can be measured by spirometry or not. Dr. Paul testified that it is possible to have injury or disease in the lung despite having normal pulmonary function test results. He testified that it is possible to have coal workers' pneumoconiosis that's radiographically significant and have normal pulmonary function testing, normal blood gases, normal physical examination of the chest, and no shortness of breath. PX2.

Dr. Paul testified he had developed a physician/patient relationship with Petitioner prior to his examination of August 21, 2008. The most pronounced medical problem for which he was treating him was migraine headaches. On the date of the examination Petitioner did not have wheezing, coughing, or shortness of breath. His spirometry was normal, as was his total lung capacity and diffusion capacity. There was no evidence of an obstruction or a restriction. PX2.

Dr. Henry Smith, board certified radiologist and B-reader, interpreted grade 1 chest x-ray dated December 3, 1999, as positive for pneumoconiosis, profusion 1/0 with P/S opacities in the middle and lower lung zones. He made identical interpretations of grade 1 chest x-rays dated December 31, 2002, and February 10, 2004. Dr. Smith interpreted grade 1 chest x-ray of December 16, 2004, as positive for pneumoconiosis, profusion 1/0 with S/P opacities in the middle and lower lung zones. He interpreted grade 2 chest x-ray of 2007 (month and date not listed) as positive for pneumoconiosis, profusion 1/1 with P/P opacities in all lung zones. He interpreted grade 1 chest x-ray of March 24, 2008, as positive for pneumoconiosis, profusion 1/1 with S/P opacities in the middle and lower lung zones. He also interpreted grade 2 chest x-ray of September 20, 2008, as positive for pneumoconiosis, profusion 1/1 with P/S opacities in all lung zones. PX3.

Dr. Michael Alexander, board certified radiologist and B-reader, interpreted grade 2 chest x-ray of October 30, 2007 as positive for pneumoconiosis, profusion 1/1 with P/P opacities in all

lung zones. He made an identical interpretation of grade 2 chest x-ray dated March 24, 2008. PX4.

Dr. Robert Cohen interpreted grade 1 chest x-ray dated December 13, 1999, as positive for pneumoconiosis, profusion 1/0 with Q/Q opacities in all lung zones. He made identical interpretations of grade 1 chest x-rays dated December 31, 2002, February 4, 2004, and December 16, 2004. He interpreted grade 3 chest x-ray from 2007 (month and date not listed) as positive for pneumoconiosis, profusion 1/1 with P/Q opacities in all lung zones. PX5. Dr. Cohen interpreted grade 1 chest x-ray dated September 20, 2008, as positive for pneumoconiosis, profusion 1/0 with Q/Q opacities in all lung zones. RX7.

Dr. Akshay Sood, B-reader, interpreted grade 3 chest x-ray from 2007 (month and date not listed) as positive for pneumoconiosis, profusion 1/0 with S/T opacities in left lower lung zone. PX6.

Records of NIOSH were admitted into evidence. Chest x-ray of June 20, 1979, was interpreted by B-reader Gordonson as being negative and by A-reader Rademacher as positive for pneumoconiosis, profusion 1/1 with P/P opacities in the right lower lung zone. Chest x-ray of September 1993 was interpreted by B-reader Shipley as negative for pneumoconiosis, profusion 0/1 with Q/Q opacities in all lung zones. The same x-ray was interpreted by B-reader Williams as completely negative. Chest x-ray of March 31, 1998, was interpreted by B-reader Williams and B-reader Wheeler as negative. Chest x-ray of May 7, 2007, was interpreted by B-reader Siden and B-reader Penker as negative for pneumoconiosis. RX4.

At request of counsel for Respondent, Dr. Jerome F. Wiot reviewed chest x-rays of Petitioner and testified by way of evidence deposition on July 9, 2009. Dr. Wiot was past President of the American Board of Radiology and served as an examiner for the Board. He was also past President of the American College of Radiology and, as a member of the Task Force on Pneumoconiosis, he helped develop the weekend symposium which eventually became the modern day B-reader program. Dr. Wiot sat on the faculty at the outset of the B-reader program. Dr. Wiot has been a B-reader since the program's inception and has been board certified in radiology since 1959. RX1.

Dr. Wiot reviewed Petitioner's chest x-rays dated December 3, 1999, December 31, 2002, February 10, 2004, December 16, 2004, March 24, 2008, and September 20, 2008. He classified all of the films as quality 1 with the exception of the 1999 film, which he found to be quality 2 because it was slightly overexposed. His interpretation of the films was that there was no evidence of coal workers' pneumoconiosis. Dr. Wiot testified that the film dated September 20, 2008, showed that Petitioner had a deposition of subpleural fat on both lateral chest walls, which is a normal variant and not in any way related to coal dust exposure. He also noted a small calcified granuloma along the right lung base which was not of any clinical significance. RX1.

Dr. Wiot testified that in reviewing a chest x-ray for coal workers' pneumoconiosis the B-reader looks at the profusion, or the degree of involvement. The B-reader also looks at the opacity type, whether rounded or irregular. He testified that in coal workers' pneumoconiosis

the vast majority of the nodules will be Qs and Ts. The primary opacity is predominantly rounded and the secondary opacity is predominantly irregular. The B-reader also looks at which lung zones are involved. He testified that coal workers' pneumoconiosis invariably begins in the upper lung zone and moves into the mid and lower lung zones as it progresses. Dr. Wiot testified that the scarring and emphysema of coal workers' pneumoconiosis is permanent and has no normal function. By definition, if a person has the disease there would be impairment in the function of their lungs at the site of the scar tissue, even though that impairment may not be able to be measured by pulmonary function testing. Dr. Wiot testified that coal workers' pneumoconiosis is permanent, has no cure, and the only treatment for the disease is to remove the affected individual from further coal dust exposure. Most coal workers' pneumoconiosis will not progress after the exposure ceases. RX1.

Dr. David Rosenberg conducted a review of medical records and films regarding Petitioner at the request of Respondent's counsel. He testified by way of evidence deposition on September 14, 2009. Following graduation from medical, Dr. Rosenberg completed a Fellowship at the National Institutes of Health. He is board certified in internal medicine, pulmonary disease, and occupational medicine. He has been a B-reader since 2000. Dr. Rosenberg is a member of the American Thoracic Society, the American College of Chest Physicians, and the American College of Occupational and Environmental Medicine. He presently has patients he treats for coal workers' pneumoconiosis. RX2.

Dr. Rosenberg interpreted Petitioner's chest x-rays taken December 3, 1999, December 31, 2002, February 10, 2004, December 16, 2004, and March 24, 2008. He testified that all of the x-rays were of diagnostic quality and that none showed the presence of coal workers' pneumoconiosis. He testified that Petitioner's pulmonary function tests were normal, without obstruction or restriction, associated with a normal diffusing capacity and preserved oxygenation in association with exercise. Dr. Rosenberg indicated that Petitioner had a flare-up of asthma in 2003. This diagnosis was based on his clinical findings, his various symptoms, his examination, and his pulmonary function tests, which showed a 21 percent improvement in air flow after the administration of bronchodilators. At a later point in time additional pulmonary function tests were performed and Petitioner did not have a significant response to bronchodilators or the bronchodilators were not administered. Dr. Rosenberg testified that this isolated occasion when Petitioner had a positive reaction to bronchodilators is, by definition, asthma. He testified that asthma is intermittent air flow obstruction that is reversible. The fact that Petitioner has asthma does not mean he should not be working in an underground coal mine. On a transient basis coal dust could exacerbate that and it should respond with appropriate treatment. RX2.

Dr. Rosenberg testified that his review of Petitioner's records and films revealed that Petitioner does not have micronodularity, 0/0, related to past coal dust exposure. His total lung capacity was normal and he does not have restriction. His diffusing capacity was normal which indicates the alveolar capillary bed within his lungs is intact. He does not have evidence of even the most minimal degree of coal workers' pneumoconiosis. Dr. Rosenberg testified that it would be unlikely that any cough Petitioner has at the present time would be related to his past coal mine dust exposure which ceased in 2007. Most likely the cough Petitioner described is related to his chronic sinus disease as well as his past history of asthma, for which he has been treated. Both chronic sinus disease and asthma are common etiologies for a nonproductive cough. He

agreed with Dr. Cohen that Petitioner does not have chronic bronchitis. Dr. Rosenberg opined that Petitioner does not have coal workers' pneumoconiosis or any associated impairment and/or disability related to his past coal mine dust exposure. RX2.

Dr. Rosenberg testified that long term coal mine employment and inhalation of coal mine dust can result in chronic cough but it would be unlikely that two years after exposure had ceased the chronic cough would be related to the coal mine. The irritant effect of coal dust would dissipate within months of a miner leaving the coal mine. Dr. Rosenberg testified that there are exposures in the underground coal mine that could aggravate Petitioner's asthma, but that would be on a temporary basis. RX2.

Dr. Rosenberg testified that he reviewed the reports of Drs. Wiot, Cohen, and Smith, all of whom are B-readers. His review noted none of them diagnosed airtrapping as part of their evaluation of the films, nor did they diagnose emphysema or COPD. Dr. Smith's finding of S/P opacities in the mid and lower lung zones would not be expected in relationship to coal dust exposure. RX2.

Dr. Peter Tuteur reviewed medical records and chest x-rays regarding the Petitioner at the request of Respondent's counsel and he testified by way of deposition on July 14, 2015. He completed a pulmonary fellowship at the University of Pennsylvania and then spent two years in the United States Air Force as a pulmonary consultant. He then joined the faculty at Washington University School of Medicine, Department of Internal Medicine, Pulmonary Critical Care Division. Dr. Tuteur is board certified in internal medicine and pulmonary diseases. He was the director of the pulmonary function lab at Washington University School of Medicine for in excess of thirty years. When he relinquished his directorship the lab was doing about thirteen thousand studies a year. He was doing pulmonary function studies, spirometry, lung volumes, arterial blood gas analysis, rest and exercise arterial blood gas analysis, cardiopulmonary exercise study, methacholine challenge, impedance oscillometry, conductance resistance, and studies of muscle strength. Dr. Tuteur is well versed in the requirements of the American Thoracic Society for all that testing. RX3.

Dr. Tuteur reviewed medical records regarding Petitioner at the request of Respondent's counsel. He reviewed records from Dr. Paul and colleagues from January 20, 2003, through August 25, 2008. He reviewed graphic and numerical data associated with a pulmonary function study dated August 21, 2008. He also reviewed chest x-rays dated December 3, 1999, December 31, 2002, February 10, 2004, December 16, 2004, and March 24, 2008. RX3.

Dr. Tuteur testified that Petitioner had worked 31 years in the coal mine, with all but the last six months being underground. He testified that Petitioner was exposed to sufficient amounts of coal mine dust to produce coal workers' pneumoconiosis in a susceptible host. He also smoked cigarettes at the rate of one-half pack per day for about twenty years, ending in 1990. This put him at some increased risk for the development of health problems associated with tobacco smoke, including chronic obstructive pulmonary disease, chronic bronchitis/emphysema, arteriosclerotic heart disease and/or lung cancer. RX3.

Dr. Tuteur testified that Petitioner reportedly had no specific allergies, but did have chronic sinusitis with acute exacerbations documented as early as 1992. No documentation of lower respiratory infections was found in the database. Petitioner only experienced productive cough and wheezing with upper respiratory infections. He testified this was presumably from drainage during episodes of acute superimposed on chronic sinusitis. Petitioner's chronic medications included Albuterol and theophylline preparations with systemic corticosteroids used during acute exacerbations of upper respiratory infections. RX3.

Dr. Tuteur testified that pulmonary exams were normal with the exception of one occasion when wheezing was heard. Pulmonary function studies reviewed were associated with normal spirometry, normal residual volume, and normal total lung capacity. The maximum voluntary ventilation maneuver was associated with a value inappropriately low for the measured FEV-1 and was not associated with available graphic data. As such, he testified that the value must be considered invalid as an assessment of maximum function. RX3.

Dr. Tuteur testified that chest x-ray reports were reviewed from six different readers concerning six different examinations between 1994 and 2008. Only one report indicated the presence of changes compatible with coal workers' pneumoconiosis. He personally reviewed five of the films from 1999 to 2008 and found them all to be quite similar. Striking was the obese physiognomy and the associated subpleural fat. Calcification typical of old healed infectious granulomatous disease was also noted. There was no evidence of active disease and no convincing evidence to suggest the presence of simple coal workers' pneumoconiosis. RX3.

Dr. Tuteur testified that Petitioner has no evidence of the presence of coal workers' pneumoconiosis or any other coal mine dust-induced disease and no evidence to support a diagnosis of any primary pulmonary condition. Petitioner does have chronic sinusitis associated with recurrent exacerbations. When drainage occurs, productive cough and wheezing develop, which resolve without objectively demonstrated air flow obstruction on pulmonary function testing as late as August 21, 2008. This condition is not related to, aggravated by, or caused by inhalation of coal mine dust or development of coal workers' pneumoconiosis. Petitioner does not have chronic daily productive cough and thus does not meet the criteria for chronic bronchitis. He does not have persistent irreversible abnormalities on physical examinations of the chest that would be consistent with coal workers' pneumoconiosis. Pulmonary function studies and chest x-rays are normal and free of changes compatible with coal workers' pneumoconiosis. He does not have chronic cough or air flow obstruction and thus does not have the clinical picture of chronic obstructive pulmonary disease. RX3.

Dr. Tuteur testified that Petitioner has not suffered any permanent functional impairment as a consequence of his coal mine exposure. He agreed with Dr. Cohen that Petitioner is capable of heavy manual labor from a pulmonary standpoint. He reviewed the methacholine challenge testing done by Dr. Paul and agreed with Dr. Paul that it was a negative test, indicating the absence of bronchial reactivity. RX3.

Dr. Tuteur testified that for a person to have coal workers' pneumoconiosis there must be a tissue reaction to the coal mine dust deposited in the lungs. Part of the tissue reaction is scarring or fibrosis, which is permanent. The scar tissue cannot perform the function of normal

healthy lung tissue; however, a lung which is scarred may perform normally. He testified that it is an infrequent occurrence that a person who leaves the mine with a normal chest x-ray to develop an abnormal one. It is possible that a person can have radiographically significant coal workers' pneumoconiosis and still have normal pulmonary function testing, normal chest examination, and no symptoms or complaints. Dr. Tuteur testified that shortness of breath can be due to heart problems as well as the perception of breathlessness due to musculoskeletal disease. RX3.

Dr. Tuteur testified that Petitioner's exercise tolerance was the ability to walk one block and climb four flights of stairs, which was appropriate for his age. There was no evidence of significant exercise intolerance. He testified that if Petitioner had an aggravation of the sinusitis while he was at the mine, it would be temporary. He did not see any evidence of permanent impairment for Petitioner from an aggravation of his sinusitis in the coal mine. RX3.

Medical records from SIU Physicians and Surgeons were admitted into evidence. On March 17, 1997, Petitioner was seen for chronic sinusitis which had most recently begun in November 1996. It was noted he had had 3 prior sinus surgeries. Diagnoses were chronic sinusitis and septal deviation to the right. An operative report of March 26, 1997, noted Petitioner underwent revision of septoplasty. RX6.

Medical records from Orthopedic Center of Illinois were admitted into evidence. On February 17, 2004, Petitioner underwent left shoulder surgery for complete rotator cuff tear and partial thickness tear of the long head of the biceps tendon. On March 15, 2005, Petitioner underwent left shoulder surgery for massive rotator cuff tear, failed previous repair. On September 6, 2005, Petitioner underwent surgery for right arm distal biceps tendon rupture. On April 10, 2006, Petitioner was examined by Dr. Leo Ludwig for one year follow up of left shoulder repeat rotator cuff repair, at which time he was given permanent work restrictions. He could lift 5 pounds overhead with both arms, lift 10-15 pounds from waist to chest, and lift 50 pounds from floor to waist. He could use a 4-pound hammer with limited use of a large sledgehammer. He could shovel as long as was shoveling down low and was not required to pick the material up to chest level or above. He could use a pry bar down low. RX5.

Medical records from Central Illinois Allergy and Respiratory Services were admitted into evidence. On December 31, 2002, Petitioner underwent a chest x-ray. There were no parenchymal, pleural or diaphragmatic lesions noted. Mild air trapping was seen consistent with mild COPD changes and clinical diagnosis of asthma. Petitioner was seen on January 23, 2003, and complained of congestion and drainage. It was noted his asthma had flared up, and he had increasing shortness of breath, some cough and wheezing as well as chest tightness. He was not on any inhalers. The impression was influenza, sinusitis and asthma exacerbation. On examination the respiratory system revealed normal inspiratory and expiratory effort. He had no wheezes or rales. On June 22, 2004, and October 14, 2004, it was charted that Petitioner's respiratory system was normal. On December 16, 2004, Petitioner underwent a chest x-ray. The reason for same was cough. The lungs showed mild chronic obstructive pulmonary disease changes with calcified post-granulomas residual. On October 12, 2006, it was charted that Petitioner's respiratory system was abnormal. This was related to sinusitis. On June 20, 2008, it was charted that Petitioner's respiratory system was normal. PX7.

CONCLUSIONS OF LAW

In regard to disputed issues of disease and causal connection, to recover compensation under the Workers' Occupational Diseases Act, a claimant must prove that he suffers from an occupational disease and that a causal connection exists between the disease and his employment. An occupational exposure need not be the sole or principal causative factor, as long as it was a causative factor in the condition of ill being. *Bernardoni v. Indus. Comm'n*, 362 Ill. App. 3d 582, 596 (2005).

In this case, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he suffers from coal workers' pneumoconiosis. In so concluding the Arbitrator relies, in part, upon the findings of NIOSH that Petitioner's x-ray of May 7, 2007, three months prior to the mine closure, did not reveal any evidence of coal workers' pneumoconiosis. The Arbitrator further notes that, although more temporally remote, all of the NIOSH B-readers found that Petitioner's x-rays of June 20, 1979, September 28, 1993, and March 31, 1998, were negative for coal workers' pneumoconiosis. RX4.

The Arbitrator relies on the opinions of the NIOSH physicians, as NIOSH is the governmental agency responsible for administering the health surveillance program for the benefit of coal miners, NIOSH is not a party to this action, and the x-rays were taken and reviewed for reasons independent of litigation. As such, the Arbitrator places greater weight on the reading and conclusion of the NIOSH B-readers, and in particular the B-readers who reviewed the x-rays dated May 7, 2007, than the physicians and/or B-readers hired by either party of this claim. The Arbitrator recognizes that Petitioner's alleged condition of coal workers' pneumoconiosis may have developed in the time period subsequent to his final NIOSH x-ray of May 7, 2007. Nonetheless, the Arbitrator finds the reverberation of opinions amongst B-readers Drs. Wiot, Rosenberg, and Tuteur compelling in conjunction with the significant number of negative x-ray interpretations performed at the behest of NIOSH, discussed above, and the Arbitrator notes that the totality of the evidence demonstrates that a significant majority of B-readers concur that Petitioner does not have coal workers' pneumoconiosis. Therefore, the Arbitrator also finds the x-ray interpretations of Drs. Wiot, Rosenberg, and Tuteur to be more persuasive than the interpretations of Drs. Cohen, Smith, Alexander, and Sood. The Arbitrator recognizes that in the past the Illinois Workers' Compensation Commission has found Dr. Wiot's opinions not to be persuasive. It has been noted that Dr. Wiot, while qualified, "could not remember examining a set of x-rays for petitioners' or plaintiffs' attorneys. The overwhelming majority of his work is for insurance companies, respondents and employers." *Lefler v. Freeman Coal Col*, 08 IWCC 1097 (September 25, 2008). See also *Cross v. Liberty Coal Co.*, 08 IWCC 1260 (Nov. 5, 2008). In the instant case, the Arbitrator does not find Dr. Wiot's opinion, on its own, to be dispositive. Rather, the Arbitrator finds his opinion in conjunction with the opinions of Drs. Rosenberg and Tuteur and the NIOSH B-readers to be persuasive.

The Arbitrator does not find the chest x-ray interpretations of Dr. Cohen persuasive, in that he interpreted x-rays from 2007 as positive for pneumoconiosis, with profusion 1/1 with P/Q opacities in all lung zones, and yet subsequently interpreted x-rays from September 20, 2008, as positive for pneumoconiosis, profusion 1/0 with Q/Q opacities in all lung zones. Dr. Cohen's

interpretations would demonstrate that Petitioner's condition regressed from a profusion 1/1 in 2007 to a profusion 1/0 on September 20, 2008. This is inconsistent with the permanent nature of the scarring and opacities of coal workers' pneumoconiosis, as testified to by all experts for both Petitioner and Respondent.

The Arbitrator also does not find the chest x-ray interpretations of Dr. Smith persuasive. Dr. Smith interpreted chest x-ray of 2007 as positive for pneumoconiosis, profusion 1/1 with P/P opacities in all lung zones. He next interpreted chest x-rays of March 24, 2008, as positive for pneumoconiosis, profusion 1/1 with S/P opacities; however he found opacities in only the middle and lower lung zones. He then interpreted chest x-rays of September 20, 2008, as positive for pneumoconiosis, profusion 1/1 with P/S opacities, and again found opacities in all lung zones. His interpretations would demonstrate that Petitioner's opacities found in the upper lung zone in 2007 resolved or otherwise were not present on March 24, 2008, and then reappeared on September 20, 2008. This is inconsistent with the permanent nature of the scarring and opacities of pneumoconiosis, as testified to by all experts for both Petitioner and Respondent.

Dr. Sood interpreted only one x-ray from 2007 and found it to be positive for pneumoconiosis, profusion 1/0 in only the left lower zone. This is inconsistent with all of the other B-readers, including Petitioner's experts, and the Arbitrator assigns it no weight.

The Arbitrator further notes that while Dr. Paul opined that Petitioner has coal workers' pneumoconiosis, the Arbitrator is not persuaded by his opinion, in that he could not testify as to the date of the x-ray he reviewed in making his diagnosis and he did not assign it a profusion rate. Dr. Paul is not a B-reader nor a board certified pulmonologist. Although Dr. Paul had treated Petitioner since 1982, he did not diagnose him with coal workers' pneumoconiosis until one year after the Crown II mine closed and approximately two months after Petitioner had filed his Application for Adjustment of Claim. PX2. Therefore, the Arbitrator does not place weight on Dr. Paul's opinion.

Based on the foregoing and the totality of the evidence, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that he suffers from coal workers' pneumoconiosis.

The Arbitrator further finds that Petitioner failed to prove by a preponderance of the evidence that he has chronic obstructive pulmonary disease, emphysema or bronchitis causally related to the exposures of his coal mine employment. All of the doctors noted that Petitioner's pulmonary function tests were normal. Dr. Paul diagnosed Petitioner with sinusitis and found his exposures as a coal miner would be aggravating factors. Dr. Cohen diagnosed Petitioner with chronic cough, which he related to Petitioner's 31 years of coal mine dust exposure; however, he did not review any treatment records regarding Petitioner. PX1. Drs. Rosenberg and Tuteur reviewed Petitioner's medical records and noted that Petitioner's chronic cough is related to his chronic sinus disease and not his years of coal mine dust exposure. RX2, RX3. Dr. Tuteur noted that Petitioner had chronic and recurrent sinusitis, which leads to upper respiratory infections. This is accompanied by cough, productive cough, and wheezing, all of which resolve as the sinusitis is treated, and which resolve without any objectively demonstrated airflow obstruction. While Petitioner's chronic sinusitis is a medically significant condition, the cause of his

condition is multiple meatal obstructions which do not allow the sinuses to drain properly, and not his exposure to coal mine dust. Dr. Tuteur noted that while inhalation of coal mine dust may transiently aggravate Petitioner's sinusitis, it would be temporary and there is no evidence of permanent impairment as a result of such aggravation. RX3. The Arbitrator finds the opinions of Drs. Rosenberg and Tuteur to be persuasive and finds that Petitioner's cough is related to his chronic sinusitis, neither of which were caused by his exposure to coal mine dust. The Arbitrator finds that any aggravation caused by such exposure was intermittent and temporary in nature, and did not result in permanent aggravation or disablement. See *Fitts v. Industrial Comm'n*, 172 Ill. 303, 310 (1996)(Employment exposure that only temporarily aggravates a claimant's ailment lacks the causal connection necessary to support a permanent disability award).

Dr. Paul diagnosed Petitioner with chronic bronchitis, asthmatic bronchitis, and asthma. He related all of these conditions to Petitioner's coal mine dust exposures. Drs. Cohen, Rosenberg and Tuteur all agree that Petitioner does not have chronic bronchitis, in that he did not have a chronic daily productive cough and thus did not meet the criteria for chronic bronchitis. PX1, RX2, RX3. The Arbitrator is persuaded by these opinions and finds that Petitioner did not prove by a preponderance of the evidence that he has chronic bronchitis.

With regard to asthma, the Arbitrator finds Dr. Paul's records to be contradictory with regard to whether Petitioner does in fact have asthma. Dr. Paul's handwritten notes are illegible and cannot be deciphered, and thus cannot be given weight. Typewritten entries in Dr. Paul's records at times include asthma or asthmatic bronchitis as a listed problem, and other times do not. For example, the note of June 9, 2008, includes "history of asthmatic bronchitis", but the notes of January 3, 2009, and December 24, 2010, do not include asthma in the long list of problems for Petitioner. Medical records proximal to the time of Petitioner's stated date of accident of August 28, 2007, show a lack of complaints which necessitated treatment for asthma. PX7. In reviewing Petitioner's medical records, including those of Dr. Paul, Dr. Rosenberg noted that Petitioner had an isolated incident in 2003 in which he had a positive reaction to bronchodilators which, by definition, is asthma. However, he also noted that subsequent pulmonary function tests were done without significant response to bronchodilators or none were administered. He testified that on a transient basis, coal dust could exacerbate asthma, but it should respond when treated appropriately. RX2. Dr. Tuteur reviewed Petitioner's medical records, including those of Dr. Paul. He specifically reviewed the methacholine challenge testing performed by Dr. Paul in 2008, five years after the isolated incident in 2003, as well as the concurrent pulmonary function studies done. The pulmonary function studies revealed no air flow obstruction, no hyperinflation and no air trapping, and the methacholine challenge test was negative. Based on this negative methacholine challenge test, he eliminated asthma from a differential diagnosis. RX3. The Arbitrator finds compelling the negative methacholine challenge test, as well as Dr. Tuteur's opinion as to the significance of that result, and further finds that Petitioner failed to prove by a preponderance of the evidence that he has asthma.

Based on Dr. Cohen's testing, Dr. Rosenberg was able to rule out Petitioner's complaint of shortness of breath as being related to pulmonary disease. His blood gases showed he had a normal blood gas response to exercise, which excluded any kind of ventilation/perfusion mismatch, oxygenation abnormalities or gas exchange abnormalities. When coupled with Petitioner's normal ventilator function on spirometry and normal diffusing capacity, Petitioner

has normal lung function. RX2. Dr. Tuteur found Petitioner did not have any coal mine dust-induced pulmonary process of sufficient severity and profusion to produce clinical symptoms. He found no physical examination abnormalities and no measurable impairment of pulmonary function or radiographic change. He further found no convincing evidence of the presence of any primary pulmonary processes. RX3.

Based upon the foregoing and the record in its entirety, the Arbitrator concludes that Petitioner failed to prove the he suffers from coal workers' pneumoconiosis, chronic obstructive pulmonary disease, emphysema, bronchitis or asthma that arose out of or in the course of the exposures of his coal mine employment, and that his current condition of ill-being is causally related to his employment. All benefits are denied. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

17IWCC0184

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 Causal connection	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GREGORY LANE,

Petitioner,

vs.

NO: 08 WC 31736

CATERPILLAR, INC.,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, and nature and extent, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below but attaches the Decision of the Arbitrator, which is made a part hereof, for the statement of facts with the modifications noted below.

The Commission finds that the causation opinion of Respondent's first Section 12 physician, Dr. Craig Williams, is more persuasive than that of its second Section 12 physician, Dr. Joseph Monaco. We also find that Dr. Williams' finding of a causal relationship between Petitioner's work activities and bilateral elbow conditions is supported by Petitioner's testimony and the medical records.

When he examined Petitioner on January 25, 2012, Dr. Williams noted that Petitioner had worked for Respondent for many years in a variety of tasks, primarily assembly "with use of different types of tools pneumatic and otherwise." Dr. Williams stated that Petitioner told him that his current position was "not all that forceful or stressful and currently his left medial elbow pain and right elbow pain are really not that severe currently." Dr. Williams discussed Petitioner's treatment history since April 5, 2007 and, based on his examination, stated his impression that Petitioner has a history of chronic, intermittent, and variably symptomatic epicondylitis of both elbows. He noted a well-documented history of right lateral epicondylitis dating back to at least April 5, 2007 and wrote, "It would seem by his history, description and intermittent presentation for symptoms on the right elbow that this has been intermittently

bothersome depending upon his work activities and perhaps other factors over that time but I do believe given what the variety that he has done as he describes that there is a causal connection between his right lateral epicondylitis and the work at Caterpillar both up to April 5, 2007 and currently subsequent to that." Dr. Williams also diagnosed left elbow lateral epicondylitis and slight medial epicondylitis and stated, "With regard to his left elbow and a causal connection, likewise I believe there is a causal connection given the nature and character of his work activities at Caterpillar. Given only the recent diagnosis I would have to say that this is likely due to work at Caterpillar subsequent to April 5, 2007." Dr. Williams found that Petitioner was not at maximum medical improvement and recommended additional conservative treatment instead of immediate surgery. He recommended 30-pound lifting restrictions and concluded his report by stating:

> Given the nature and character of work that he has performed at Caterpillar over time and over the years I do believe that the conditions in the right elbow are causally related to the performance of his work duties at Caterpillar. Therefore, I think the need for further medical care is based upon this as well. Regarding the left elbow I do believe the conditions in his left elbow are causally related to the performance of his work duties at Caterpillar and therefore believe that the need for medical care is likewise.
>
> Finally, I believe that the work restrictions that I have outlined are causally related to the performance of his work duties at Caterpillar due to the above conditions, which I believe are related to his work duties.

(Px2).

We initially note that Respondent stipulated that Petitioner sustained accidental injuries on April 4, 2007. This stipulation is consistent with the opinion of Dr. Williams. However, Respondent subsequently asked Dr. Joseph Monaco to perform a records review only and, according to Dr. Monaco's September 8, 2014 report, he was specifically asked by Respondent to *not* discuss Petitioner's treatment to date nor any future recommendations for treatment. Dr. Monaco also explicitly limited his opinions to Petitioner's "most recent complaints." He wrote:

> Pursuant to your request, this report will address the question of whether or not Mr. Lane's most recent complaints of lateral epicondylitis are causally related in any way to the performance of his work duties. Based on your request, I will not be discussing treatment to date and future recommendations for treatment.

(Rx4 at 13).

Although Dr. Monaco acknowledged Petitioner's belief, based on the medical records, that his right elbow problems dated back to April 2007 and were related to the use of air guns, Dr. Monaco wrote, "The job description I reviewed did not contain the risk factors that would be consistent with the development of lateral epicondylitis." Dr. Monaco wrote, "There is an Employee Incident Report dated April 5, 2007, indicating that Mr. Lane was complaining of pain in the right elbow that started the previous day, April 4, 2007, and did not get any better. He indicated this had been a problem for some time and usually he would let it go. He indicated that he was doing some repetitive use of air guns. On the form, Mr. Lane indicates that the body

parts affected were as follows: right and left elbow."

Dr. Monaco reported that he reviewed a statement of the "Essential Job Functions & Requirements of Product Group: Lower Powertrain, Section: 8767, Job Title: Assembly" and that this was dated November 11, 2011. The Commission notes that this job description is not in evidence; only Dr. Monaco's description of it is. The first question is whether the "Section 8767" job description relied upon by Dr. Monaco was actually Petitioner's job since 2006 and at the time of his alleged date of accident. The Arbitrator found that "there is no evidence in the record to suggest a distinction between that position from an 'Incident Dept/Shift 8941' noted on Petitioner's Incident Reports" and that Petitioner did not testify that it was inaccurate. We do not agree with the assumption that both jobs were the same. Petitioner's claim is based, in part, on his repetitive use of air guns, which both the employee incident report and Petitioner's medical records reflect. However, the job description that Dr. Monaco described does not appear to mention air guns at all. We find that this is most likely explained by the evidence showing that sometime in late 2011, Petitioner was transferred to a different job which was less strenuous and that he performed this job until he retired on June 30, 2012. This is supported by Dr. Greatting's May 14, 2012, record indicating that Petitioner's "more recent job he feels is probably the easiest job he has done at Caterpillar for a long period of time. He works a job where he puts bolts into a machine and then has to push some buttons or controls for the machine. He states his elbows are bothering him minimally at this time."

The Commission finds that, since Dr. Monaco based his opinion entirely on a review of the records, he was unable to determine whether the job description he reviewed was actually representative of Petitioner's job duties at that time of his initial work accident in 2007 and thereafter. In contrast, Dr. Williams' report indicates that he discussed Petitioner's job duties with him. We find that, between Respondent's two examining physicians, Dr. Williams was in the best position to opine on causation even without a written job description. In addition, although Respondent argues that Dr. Greatting never offered an opinion regarding causation, his records as a whole do support such a finding. On March 4, 2009, Dr. Greatting wrote that Petitioner "has some chronic bilateral epicondylitis. Things are not quite as busy at work now so it is not bothering him quite as much. He has also experienced some intermittent discomfort and he describes some numbness over the dorsum of his hand. He works doing assembly at Caterpillar. On October 13, 2011, Dr. Greatting wrote:

> He has bilateral lateral epicondylitis. This has been chronic and present for a long period of time. He has had injections, which have helped, but his pain will recur. He has been employed at Caterpillar for a long period of time. He did assembly work for a long time. The most recent assembly work he did required the use of torque guns. This would significantly aggravate his symptoms. He then ran a forklift for a period of time and now is running a machine. The repetitive activities he does do aggravate his symptoms.

It was at this time that Dr. Greatting recommended bilateral surgeries. The Commission finds that Dr. Greatting's records support a finding that Petitioner's elbow conditions were caused by and/or aggravated by his employment.

We also note that Petitioner gave the following testimony regarding his initial visit to Respondent's medical clinic:

> Q: At that time, what was – what did you notice about your elbows?

Q: Well, I had a stinging pain in my right elbow and my right elbow was worse than the left one. I had a pain that kind of shot up and down and sometimes it would continue on down the arm.
Q: Did you describe to Caterpillar Medical what was causing you the pain?
A: Yeah, I told them about it, yes.
Q: What did you describe?
A: The pain from the elbow here on down.
Q: What did you describe was causing elbow pain?
A: We talked about the job and the torque guns and normal air guns, triggers and stuff like that.

(T.27-28).

The handwritten note by Respondent's medical clinic physician on April 5, 2007, indicates an occupational history of "bldg brakes, repetitive 'stuff' did this" and an assessment of "(R) elbow epicondilitis [sic]" along with the notation "occ" with a handwritten box around it. (Px4). The Commission finds that the most likely explanation for this notation is that Respondent's physician, who initially provided treatment, believed that Petitioner's condition was related to his occupation.

Although Petitioner's treatment had been focused on the right elbow, the records do indicate that he was also having complaints in the left elbow. The initial incident report, on April 5, 2007, indicates that the body parts affected were the right and left elbows. Dr. Greatting's March 5, 2008 record reflects "Lateral epicondylitis of the Left Elbow; Right." On March 4, 2009, Dr. Greatting wrote that Petitioner "has some chronic bilateral epicondylitis." And, on October 13, 2011, he wrote, "He has bilateral lateral epicondylitis. This has been chronic and present for a long period of time."

As to the question of whether Petitioner's elbow conditions remained causally related to his employment after he retired in June 2012, we note that there were periods of time while he was working for Respondent when his complaints waned including after cortisone injections, when work was slow, and when he was put on less strenuous jobs. Dr. Greatting had recommended bilateral elbow surgeries on October 13, 2011, and noted that assembly work requiring the use of torque guns and repetitive activities significantly aggravated Petitioner's symptoms. Petitioner testified that he was working a different, less labor intensive job for the last six to eight months prior to his retirement, which is consistent with Dr. Greatting's note from May 14, 2012, indicating that Petitioner's "more recent job he feels is probably the easiest job he has done at Caterpillar for a long period of time" and that "his elbows are bothering minimally at this time." Petitioner told him that he was planning to retire in a couple of months and he was not sure that he wanted the surgery. Dr. Greatting recommended observation unless his symptoms worsened.

Petitioner testified that his elbows were doing well at the time of his May 14, 2012 visit with Dr. Greatting but "I still had pain." (T.43). He testified that he "was hoping that they would get, maybe get better when I got off the assembly, got away from assembly and using them a lot on the power guns and such." (T.44). Petitioner did not have any other employment after retiring from Respondent but testified that he did some refinishing of woodwork around his house using a paint brush and paint stripper. (T.45). He did not have any accidents or injuries to his elbows after he retired and did not take up any major projects at his house. (T.71). On cross-examination, Petitioner stated that he also did some gardening, housecleaning, put in a couple of

new windows, and did some cosmetic drywall mudding. (T.64-65).

Petitioner testified that, after he retired, he noticed that his elbows had not gotten any better, were still causing him pain, and he wanted to schedule the surgery. (T.46-47). Dr. Greatting's records contain a letter, dated November 30, 2012, to Petitioner requesting that he call the office to schedule it. Respondent had a utilization review performed by Dr. James Anderson on January 2, 2013, which "non-certified" the surgeries.

On January 17, 2013, Dr. Greatting noted that Petitioner's bilateral elbow pain had persisted since he retired and that he "will have pain in both arms when he does heavier activities." Dr. Greatting once again recommended surgery.

Petitioner testified that he moved to Kentucky in February 2013 and, after he retired, he did not have insurance until January 2015. (T.48-49). He followed up with Dr. Greatting after he obtained insurance. (T.50). The March 12, 2015 record of Dr. Greatting indicates that since the workers' compensation insurance carrier was still denying his surgery, Petitioner was thinking about having it done under his own health insurance. Dr. Greatting noted that Petitioner's condition was "chronic and bothering him a long period of time" and he again recommended bilateral surgeries. The right elbow surgery was performed on April 29, 2015, and the left was performed on June 10, 2015.

Petitioner testified that he hasn't had any problems since his surgeries. He no longer has any pain in his elbows even when he holds his arm in certain positions, which bothered him previously. He does physical therapy exercises at home. (T.51-52).

The Commission finds that Petitioner has met his burden of proof that his bilateral epicondylitis was causally related to his employment activities at Respondent, dating back to 2006 and thereafter. We find the opinion of Dr. Williams to be most consistent with the testimony and records including those of Dr. Greatting. We find that Dr. Monaco's opinion is not persuasive because he relied on a job description that may have been Petitioner's job in November 2011 but was not representative of Petitioner's job duties since 2006. We also find that Petitioner's elbow conditions remained causally related after his retirement from Respondent and that the activities he performed around his house do not break the chain of causation.

On the issue of whether the bilateral surgeries were reasonable and necessary, we note the opinion of Dr. Anderson who performed the utilization review on January 12, 2013. Dr. Anderson testified via deposition on March 10, 2014, that he did not believe that surgery was indicated as of the May 14, 2012 visit with Dr. Greatting because Petitioner's symptoms were very minimal and because Petitioner had responded to conservative treatment in the past. (Rx2 at 11). On cross-examination, Dr. Anderson testified that Petitioner was first diagnosed with right lateral epicondylitis in June 2007 and that he had undergone all of the recommended conservative modalities. (Id. at 19-20). He acknowledged that the main reason he didn't certify the surgery was because Petitioner was doing well as of May 2012 but that his opinion might change if Petitioner's pain became moderate to severe after that. (Id. at 20-21). He testified that he was not rendering any opinion as to whether Petitioner currently needed surgery. (Id. at 23). On redirect examination, he opined that if Petitioner's symptoms worsened he would institute additional conservative therapy before doing surgery. (Id. at 24).

We note that the opinion of Dr. Anderson is consistent with Dr. Greatting's May 2012 note indicating that surgery was not being recommended at that time. However, regarding Petitioner's condition after the date of Dr. Anderson's utilization review, we find that Dr. Greatting was in the best position to determine the medical reasonableness and necessity of Petitioner's surgeries. He was Petitioner's treating physician since 2007. He was aware of the

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chronic and intermittent nature of Petitioner's symptoms and how he responded to conservative treatment. We find that Petitioner's bilateral elbow surgeries were reasonable, necessary, and causally related to his employment with Respondent.

Based on the above, we award the outstanding medical bills of $18,576.74 pursuant to the fee schedule in §8.2 of the Act. We note that Petitioner has undergone successful bilateral surgeries for epicondylitis and he no longer has pain in his elbows. He does some physical therapy exercises at home. We find that Petitioner is entitled to permanent partial disability awards for 10% loss of use of the right arm (25.3 weeks) and 10% loss of use of the left arm (25.3 weeks) for a total of 50.6 weeks under §8(e) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $546.07 per week for a period of 50.6 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 10% of the right arm and 10% of the left arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $18,576.74 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 $46,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 28 2017

Charles J DeVriendt

Joshua D. Luskin

SE/
O: 1/31/17
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SPECIAL CONCURRING OPINION

This case was scheduled for Oral Arguments on January 31, 2017, before a three-member panel of the Commission including members Charles DeVriendt, Joshua Luskin, and Ruth White, at which time Oral Arguments were either heard, waived or denied. Subsequent to Oral Arguments and prior to the departure of Ruth White on March 3, 2017, a majority of the panel members had reached agreement as to the results set forth in this decision and opinion, as evidenced by the internal Decision worksheet initialed by the entire three member panel, but no formal written decision was signed and issued prior to Commissioner White's departure.

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Although I was not a member of the panel in question at the time Oral Arguments were heard, waived or denied, and I did not participate in the agreement reached by the majority in this case, I have reviewed the Decision worksheet showing how Commissioner White voted in this case, as well as the provisions of the Supreme Court in Zeigler v. Industrial Commission, 51 Ill.2d 137, 281 N.E.2d 342 (1972), which authorizes signature of a Decision by a member of the Commission who did not participate in the Decision. Accordingly, I am signing this Decision in order that it may issue.

L Elizabeth Coppoletti

L. Elizabeth Coppoletti

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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LANE, GREGORY
Employee/Petitioner

Case# **08WC031736**

08WC031735
08WC031737

CATERPILLAR INC
Employer/Respondent

17IWCC0184

On 12/7/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0293 KATZ FRIEDMAN EAGLE ET AL
KEITH SPARKS
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

2994 CATERPILLAR INC
MARK FLANNERY
100 N E ADAMS ST
PEORIA, IL 61629-4340

17IWCC0184

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

GREGORY LANE
Employee/Petitioner

Case # **08 WC 31736**

v.

Consolidated cases: **08 WC 31735**
08 WC 31737

CATERPILLAR, INC.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the **Honorable Molly Dearing**, Arbitrator of the Commission, in the city of **Springfield**, on **September 25, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 4, 2007**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being in his right and left elbows ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$47,326.40**; the average weekly wage was **$910.12**.

On the date of accident, Petitioner was **53** 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 Section 8(j) of the Act.

ORDER

Because Petitioner failed to prove by a preponderance of the credible evidence that his left and right upper extremity conditions are causally related to his work accident of April 4, 2007, all benefits are denied.

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

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

Arbitrator Molly Dearing

November 24, 2015
Date

DEC 7 - 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

GREGORY LANE
Employee/Petitioner

v.

Case # 08 WC 31736

CATERPILLAR, INC.
Employer/Respondent

Consolidated Cases: 08 WC 31735, 08 WC 31737

MEMORANDUM OF DECISION OF ARBITRATOR

This matter was consolidated with 08 WC 31735 and 08 WC 31737, which involve Petitioner's low back and right thumb, respectively, and the three matters were tried jointly. However, the Arbitrator's Opinion and Order in this case addresses Petitioner's bilateral elbows only.

FINDINGS OF FACT

At the time of his accident, Petitioner was fifty-three years of age (Arb. X 1) and employed by Respondent as an assembler in the tandem build-up area. Petitioner began working for Respondent on May 15, 1978 as a mill operator before becoming an assembler in 2006, where he worked until he retired on June 30, 2012.

Petitioner testified that as an assembler, he utilized various air and torque guns. His primary job duty was to assemble brake pods and mount them, along with a component called a final drive, to the tandem portion of the equipment, which he described varied in size from three to six feet tall. Occasionally, Petitioner would be required to perform additional duties, such as attaching brake lines, attaching steel covers to gasket holes, or mounting the sprocket or lid to the brake pod.

Petitioner testified that upon receiving a tandem, he first built a brake pod, which then he mounted to the tandem. The brake pods are assembled with bolts tightened utilizing a torque gun. In order to mount the brake pods to the tandem, each pod must be bolted on. Petitioner testified that the smaller tandems required approximately thirty bolts per brake pod and the larger tandems required approximately forty bolts per brake pod. Petitioner testified that "the big ones they take more bolts and they are more involved and the chain on a big one has to be loaded with a hoist because you can't really manhandle them." Petitioner explained that he would start the bolts by hand, "run them on up" with an air gun, and then finish tightening the bolts with a torque wrench. Petitioner would then mount the final drive, which necessitates as many, if not more, bolts as the brake pod, with a torque gun. Petitioner testified that each bolt had to be torqued on both sides. He was also required to connect various chains and input pins in order to secure all the parts into place. Petitioner testified that in the course of his job duties, he utilized air guns, torque wrenches, crowbars, pry bars, hoists, and clamps to tighten various chains on the tandem. He stated that the air and torque guns caused vibration when they were in use. Petitioner testified that the larger torque guns weighed approximately twenty pounds and the air guns weighed only a few pounds. He stated that mounting brake pods and final drives constituted a significant portion of his workday,

and he testified that he assembled three to four sets of tandems per day with two brake pods on each set that required the bolts to be torqued on two sides.

On April 5, 2007, Petitioner presented to Respondent's medical department with complaints of right elbow discomfort. He reported having pain for six months and that the night prior, he experienced an increase in pain and was unable to sleep as a result. Petitioner described his pain as a "'hot needle' in it". He reported that he builds brakes, which he noted to be repetitive work. Petitioner was assessed with right elbow epicondylitis and he was instructed to return to the clinic after being evaluated by an orthopedic physician. PX 4, RX 1. Petitioner testified that at that time, he was experiencing "a stinging pain in my right elbow and my right elbow was worse than the left one. I had pain that kind of shot up and down and sometimes it would continue on down the arm." He stated that, while seeking treatment at Respondent's medical facility, he explained that the use of torque and air guns caused his elbow pain.

On June 7, 2007, Petitioner presented to Dr. Mark Greatting at Springfield Clinic with reports of right elbow pain with elbow extension or lifting activities. Dr. Greatting noted that Petitioner believes his work activities aggravate his symptoms. A physical examination revealed tenderness over the right lateral epicondyle, good motion of his elbow, and pain with resisted wrist extension. Dr. Greatting diagnosed Petitioner with chronic right lateral epicondylitis and administered a corticosteroid injection into his right lateral epicondyle. PX 1.

Petitioner returned to Dr. Greatting on August 8, 2007. Dr. Greatting noted that the injection Petitioner underwent on his previous visit "essentially resolved his pain" and he found minimal tenderness over Petitioner's lateral epicondyle upon examination with full range of motion, good strength, and no pain with resisting wrist extension. Dr. Greatting assessed Petitioner with resolved right lateral epicondylitis and instructed to use the arm as tolerated. PX 1.

On December 12, 2007, Petitioner presented to Dr. Greatting with continued complaints of "a little pain" on the lateral aspect of his elbow and most of his pain on the anterior medial aspect of his elbow and proximal forearm. Dr. Greatting noted no evidence of lateral epicondylitis and he instead believed Petitioner may have inflammation in his flexor pronator area. Dr. Greatting instructed Petitioner to continue to wear elbow straps, which Petitioner testified he had purchased and provided him some relief, and he prescribed Petitioner medication. PX 1.

On March 5, 2008, Petitioner returned to Dr. Greatting with continued right elbow pain. "His symptoms are somewhat diffuse but he localizes them primarily laterally. The last time I saw him he had some medial elbow pain which appeared to be related to his flexor pronator origin, he thinks the meloxicam helped that." A physical examination revealed full motion of his elbow, maximal tenderness in the lateral epicondylar region, mild tenderness in his posterior lateral elbow area and along the radial tunnel, and some pain in the lateral epicondylar area with resisted wrist extension. Dr. Greatting assessed Petitioner with primarily right lateral epicondylitis and he administered a second corticosteroid injection into his right elbow. PX 1.

Petitioner testified that following his second injection, he noticed some improvement in his right elbow. On May 7, 2008, Dr. Greatting noted Petitioner's improvement following his injection. PX 1.

On March 4, 2009, Petitioner presented to Dr. Greatting for his right arm. Petitioner reported that "[t]hings are not quite as busy at work now so it is not bothering him quite as much." Upon examination, Petitioner displayed some tenderness over the lateral epicondyle, full motion of his right elbow and forearm, pain with resisted wrist extension, and some mild tenderness along the extensor tendons over the dorsum of his hand to the long, ring, and small fingers. Dr. Greatting assessed Petitioner with mild right lateral epicondylitis "[f]or now". Dr. Greatting indicated that he would observe and follow Petitioner's condition and he instructed Petitioner to utilize over-the-counter nonsteroidal medication as needed. PX 1. Petitioner testified that during this visit, he and Dr. Greatting discussed Petitioner's use of torque guns in relation to his elbow pain.

Petitioner returned to Dr. Greatting on October 7, 2009 with right elbow pain on the lateral side. Petitioner reported that his diffuse elbow pain "is not really very bothersome to him at this point. When it does bother him more he will take over-the-counter ibuprofen for two or three days and it will help significantly. He also has a lateral Count'R-Force brace which he will wear on an ass-needed basis and it also will help." On physical examination, Petitioner exhibited no significant abnormalities, full motion of his elbow, forearm, wrist and hand, mild tenderness over the right lateral epicondyle, and no real significant increased pain with resisted wrist extension. Dr. Greatting indicated that Petitioner appeared to be doing very well and instructed him to return as needed. PX 1.

From October 7, 2009 through 2011, Petitioner testified that he continued to work in assembly, but he "might have went to another area" within the assembly department. He stated that in 2010, he moved to a position in which he assembled wheels using "those guns."

On October 13, 2011, Petitioner presented to Dr. Greatting. Dr. Greatting noted that Petitioner has chronic bilateral epicondylitis and he also noted that Petitioner's previous assembly work required the use of torque guns. Dr. Greatting stated that Petitioner thereafter "ran a forklift for a period of time and now is running a machine. The repetitive activities he does do aggravate his symptoms." A physical examination revealed good motion of his elbows, forearms, wrists and hands, pain with full elbow extension, significant tenderness over both lateral epicondyles and pain with resisted wrist extension bilaterally. Dr. Greatting diagnosed Petitioner with chronic bilateral epicondylitis and due to his recurrence of pain despite conservative treatment, Dr. Greatting recommended surgical intervention. PX 1. Petitioner testified that at this time, he had "moved over to a circle draw bar area" of the assembly department in which he mounts "the circle" to an A frame using a hoist to "line the teeth up with the gear where it's square and then there is these, I guess you call it brake shoes that – they are large pieces of cast iron, maybe a foot; the bigger the grader the bigger the shoes, and we put three bolts in them, run them down slightly and they are torqued from an overhead torque motor."

Respondent obtained a utilization review for the proposed surgical treatment to Petitioner's bilateral elbows and a report was authored by Dr. William Abraham, a board-certified orthopedic surgeon, on November 22, 2011. Dr. Abraham opined that Petitioner's proposed surgical procedures were not medically necessary or appropriate due to Petitioner's lack of conservative treatment. He stated that "other than two injections noted above for the right elbow, he has no injections for the left elbow. Additionally, there has been no documentation of an aggressive conservative management program for the patient's elbows including therapy, ice, stretching or strengthening as indicated above. Additionally, symptomatology on the left elbow has not been

reported except as of 10/13/2011. There has been no documentation of any conservative treatment to the left elbow." RX 5.

On January 25, 2012, Petitioner underwent an examination with Dr. Craig Williams at the request of Respondent pursuant to Section 12 of the Act. Dr. Williams took a work history from Petitioner regarding his employment with Respondent. Petitioner reported that he had worked for Respondent in a variety of tasks, primarily assembly, and that his tasks have varied from time to time with use of different types of tools, pneumatic and otherwise. Petitioner further reported that his current position "is not all that forceful or stressful and currently his left medial elbow pain and right elbow pain are really not that severe currently." Upon examination, Dr. Williams noted full range of motion of the elbows, tenderness at the lateral epicondyle bilaterally, tenderness over the right medial epicondyle, equivocal tenderness of the left medial epicondyle, positive Tinel's sign over the ulnar nerve of the right elbow and negative on the left, and pain with resisted wrist extensions bilaterally. Dr. Williams opined that Petitioner had left elbow lateral epicondylitis with a mild degree of medial epicondylitis, as well as right lateral epicondylitis and possible slight right medial epicondylitis. Dr. Williams further opined that Petitioner's primary diagnosis was right biceps tendinitis. Dr. Williams noted that Petitioner had a well-documented history of right lateral epicondylitis dating back to April 5, 2007, but "[t]here is no documented epicondylitis in the left elbow other than from the October 13, 2011 note." Dr. Williams opined that Petitioner's bilateral epicondylitis is causally related to his work for Respondent "both up to April 5, 2007 and current subsequent to that." He stated that "I can only presume given his right distal biceps tendinitis being only diagnosed currently that this is again likely related to his work activities given the nature of his activities and the duration of his activities and that this certainly has occurred related to activities since April 5, 2007." He further opined that Petitioner was not at maximum medical improvement and required additional medical care. Dr. Williams recommended Petitioner undergo an MRI for his right elbow to distinguish between the diagnoses of lateral epicondylitis and distal biceps tendinopathy, and some additional conservative treatment prior to considering any surgical intervention. He also recommended instating conservative treatment for Petitioner's left elbow "as no history of conservative treatment is documented and noted other than perhaps self treatment including icing, forearm bracing and anti-inflammatories." Dr. Williams stated that he did not believe immediate surgery was indicated for any of Petitioner's epicondylitis conditions "and in fact indicate to the patient that surgical intervention for epicondylitis should be very cautiously and carefully considered as surgical outcomes can vary greatly." He recommended restrictions of no lifting greater than thirty pounds and avoiding any forearm torque with the right arm until further delineation of his condition of his biceps tendon. PX 2.

On May 14, 2012, Petitioner returned to Dr. Greatting with complaints of bilateral elbow pain and mild right shoulder pain. Petitioner reported moving to a different position in assembly "where he puts bolts into a machine and then has to push some buttons or controls for the machine", which he described as "the easiest job he has done at Caterpillar for a long period of time." Petitioner indicated he was unclear as to whether he wanted to consider surgery at that time. Upon examination, Petitioner demonstrated full motion of elbows, forearms, wrists and hands bilaterally, minimal tenderness over the lateral epicondyles bilaterally, no significant increase in pain with resisted wrist extension, and full motion in his right shoulder with mild pain with Hawkins impingement test and good strength. Dr. Greatting stated that "he is actually doing very well at this point and I would not recommend surgery. I would just recommend observation. If his symptoms would worsen over time, this could be re-evaluated at a later date." PX 1.

Petitioner testified that as of May 14, 2012, he had transitioned to a stud machine operator position within the assembly department, which he described as less labor intensive and involved less use of his arms than his previous positions required. He explained that in operating the stud machine, he placed bolts into a machine and operated the controls on the machine. He stated that he performed that job for approximately six to eight months prior to his retirement on June 30, 2012. Petitioner testified that he did not believe that he was working in the same capacity at the time of his visit on May 14, 2012 as he was as of his visit of October 13, 2011.

Respondent obtained a second utilization review for Petitioner's proposed surgical procedures pursuant to Section 8.7(b) of the Act, and Dr. James Anderson, board-certified orthopedic surgeon, authored a report dated January 2, 2013. Therein, Dr. Anderson opined that Petitioner's proposed procedures were not recommended given that Petitioner was doing very well with full range of motion of the elbows, forearms, wrists and hands bilaterally and with no evidence of failed conservative care to the lateral epicondyle. He stated that "there is no red flag symptom or evidence of failed conservative care to the lateral epicondyle/elbow warranting a surgical procedure. Also, with limited evidence to support the efficacy of surgery in addressing lateral epicondylitis, the need for fasciotomy, partial ostectomy, lateral epicondyles is not recommended." PX 3.

Dr. Anderson testified by way of evidence deposition on March 10, 2014. Dr. Anderson testified that the relevant standard indicating medical necessity of surgery for epicondylitis, pursuant to the ODG-TWC guidelines, is for six months of conservative treatment and that surgery may be considered thereafter if the condition remains recalcitrant. He opined that at the time of his report, surgery was not indicated for Petitioner's bilateral epicondylitis condition in light of his positive response to conservative treatment and lack of symptomatology as of May 14, 2012. Dr. Anderson testified that he did not review Dr. William's Section 12 examination in formulating his opinions, nor did he review any of Petitioner's medical records subsequent to May 14, 2012. Dr. Anderson acknowledged that Petitioner had undergone all of the recommended conservative modalities for epicondylitis indicated in the Guidelines. Dr. Anderson testified that if Petitioner's pain complaints became moderate to severe subsequent to his visit with Dr. Greatting on May 14, 2012, then his opinion regarding the necessity of the surgery may change with that new information. RX 2.

On January 17, 2013, Petitioner returned to Dr. Greatting for bilateral elbow pain that continued to persist. Petitioner reported that his pain increased in both arms with "heavier activities." On examination, Petitioner exhibited tenderness over the lateral epicondyle bilaterally and pain with resisted wrist extension in both arms. Dr. Greatting opined that it was reasonable to proceed with surgical treatment of Petitioner's lateral epicondylitis "based on the fact that since he has retired, he still continues to have persistent pain and problems in his elbows." PX 1.

Petitioner retired from Respondent's employment on June 30, 2012. He testified that subsequent to retiring, he refinished woodwork using primarily a paintbrush and paint stripper. Petitioner testified that he did not have medical insurance benefits until January 2015 when he obtained medical coverage through Kentucky Kynect, Kentucky's health insurance marketplace.

On September 8, 2014, Dr. Joseph Monaco performed a records review upon request of Respondent pursuant to Section 12 of the Act. Dr. Monaco reviewed Petitioner's treating medical records, Incident Reports of April 3, 2003 and April 23, 2007, and a statement of the Essential Job Functions & Requirements of Product Group: Lower Powertrain, Section: 8767, Job Title: Assembly, which was signed by an Ergonomic Coordinator, Cara Blaudow, on November 11, 2011.

Based upon his review of the foregoing, Dr. Monaco opined that Petitioner's elbow complaints at that time were not causally related to his work duties or to the work-related incident of April 4, 2007. He noted that on May 14, 2012, Petitioner indicated to Dr. Greatting that he was performing the "easiest job he had ever had at Caterpillar and any discomfort in his elbows was minimal; then retired two months later. He did not return to see Dr. Greatting until January of 2013, six months after retirement, with complaints of pain. This record does not state what may have provoked the onset or recurrence of symptomatology following his retirement other than stating symptoms come on when he 'does heavier activities'." Dr. Monaco cited the AMA Guides to the Evaluation of Disease and Injury Causation, Second Edition, which concluded that there was insufficient evidence that highly repetitive work alone or vibration were risk factors for the development of lateral epicondylitis. He also found insufficient medical evidence to support the use of pneumatic tools as causative of lateral epicondylitis. Dr. Monaco stated that "there was strong evidence that a combination of risk factors, for example, force and repetition, or force and posture, were risk factors for causation of lateral epicondylitis." Dr. Monaco opined that the position of an assembler a lower power train is not consistent with the medical evidence for an occupational risk factor in the development of lateral epicondylitis. He also noted that with respect to Petitioner's left elbow, "there is no evidence in the medical records to indicate what possible work-related activity would have provoked the problems with his left elbow. As noted above, the medical evidence supports a combination of risk factors (force and repetition or force and posture) as occupational risk factors for developing lateral epicondylitis. The only risk factor cited by Mr. Lane of the use of air guns was not consistent with this criteria. Furthermore, this does not involve the use of both hands." RX 4.

On March 12, 2015, Petitioner presented to Dr. Greatting and indicated that he wished to proceed with surgical intervention through his health insurance. PX 1. On April 29, 2015, Petitioner underwent a fasciotomy and partial ostectomy on his right lateral epicondyle and on June 10, 2015, Petitioner underwent a fasciotomy and partial ostectomy of the left lateral epicondyle. Petitioner returned to Dr. Greatting post-operatively and he testified that he performed home exercises. On June 24, 2015, Dr. Greatting noted that Petitioner had responded well to surgery. PX 1.

Petitioner denied suffering any pain in his right or left elbows after undergoing surgery. He continues to perform a home exercise program. Petitioner denied sustaining any accident or injuries involving his right or left arms between the date he retired and his surgical procedures. Petitioner testified that he did not perform any major home projects subsequent to retiring.

OPINION AND ORDER

Under the Workers' Compensation Act, it is axiomatic that a claimant maintains the burden of proving all the elements of his claim by a preponderance of credible evidence. *Hannibal v. Industrial Comm'n*, 38 Ill. 2d 473 (1967). While medical testimony is not required to establish causation, in cases relying upon a theory of repetitive trauma, "the claimant generally relies on medical testimony establishing a causal connection between the work performed and claimant's disability." *Nunn v. Industrial Comm'n*, 157 Ill. App. 3d 470, 478 (4th Dist. 1987). Where the question is one within the knowledge of experts, and not within the common knowledge of laypersons, expert testimony is necessary to show that claimant's work activities caused the condition complained of. "Cases involving aggravation of a preexisting condition primarily concern medical questions and not legal questions…This is especially true in repetitive trauma cases." *Id.*

In regard to disputed issue (F), the Arbitrator concludes that Petitioner failed to prove by a preponderance of the credible evidence that his job duties as an assembler were a causative factor in the development of his bilateral upper extremity conditions. In so concluding, the Arbitrator finds no credible medical opinion in the record causally relating Petitioner's bilateral upper extremity conditions to his work activities for Respondent. The Arbitrator notes that the records of Dr. Greatting do not reflect a causation opinion from him and instead, Dr. Greatting only notes Petitioner's subjective beliefs that his job duties are related to his elbow conditions. While Dr. Williams opined that Petitioner's work activities of April 5, 2007 "and current subsequent to that" were causally related to his right and left upper extremity conditions, Dr. Williams fails to enumerate what his understanding was of the duties Petitioner performed at work, whether at the time of his accident of April 4, 2007 or at any point thereafter, and Dr. Williams likewise neglects to state exactly what job duties he believes are causative of Petitioner's condition of ill-being, which goes to the weight of his opinion. Further, the Arbitrator questions the basis of Dr. Williams' opinion that Petitioner's left elbow is causally related to his job duties when he himself notes that "[t]here is no documented epicondylitis in the left elbow other than from the October 13, 2011 note." PX 2. Dr. Williams fails to appreciate that the absence of specific complaints or treatment prior to October 13, 2011 regarding Petitioner's left elbow suggests a lack of a causal relationship between those complaints and his work accident four years prior. Dr. Williams also appears to ignore the two-year gap in Petitioner's treatment from 2009 to 2011 relative to his right elbow, which the Arbitrator finds significant. PX 2. Further, Dr. Williams reviewed Petitioner's medical records through October 13, 2011, and did not have the opportunity to review Petitioner's subsequent medical records of May 14, 2012 in which Petitioner was doing well, declined surgery, and demonstrated full motion of elbows, forearms, wrists and hands bilaterally, only minimal tenderness over the lateral epicondyles bilaterally, and no significant increase in pain with resisted wrist extension. Dr. Williams similarly was unable to review the record of January 30, 2013, subsequent to Petitioner's retirement, at which time he returned to Dr. Greatting with renewed elbow complaints that were incited by "heavier activities." PX 1, 2. In light of the aforementioned, the Arbitrator does not find the opinions of Dr. Williams to be persuasive, well-informed or reliable, and the Arbitrator accordingly declines to give them evidentiary weight.

The Arbitrator instead recognizes the opinions of Dr. Monaco. Dr. Monaco opined that Petitioner's current condition in his bilateral upper extremities was not related to his job duties as an assembler. In formulating his opinions, Dr. Monaco reviewed Petitioner's treating medical records dating back to 1978 as well as a position description of an assembler in Respondent's lower powertrain product group. Although Dr. Monaco reviewed a position description for an assembler in "Section: 8767", there is no evidence in the record to suggest a distinction between that position from an "Incident Dept/Shift 8941" noted on Petitioner's Incident Reports. PX 4, RX 1. Certainly, Petitioner did not testify at Arbitration that the position description relied upon by Dr. Monaco was inaccurate or was not a position in which Petitioner worked for Respondent. The Arbitrator notes that the essential job functions of an assembler performed by Petitioner in the course of his employment for Respondent, as Petitioner testified to at trial, reasonably correspond to the position description upon which Dr. Monaco relied, albeit with somewhat differing verbiage, including but not limited to, the placement of bolts in the part, securing them into place, and utilizing power grip wrenches and hoists. The Arbitrator further notes that Dr. Monaco understood that Petitioner utilized air guns in the performance of his job duties as an assembler, yet he nonetheless found insufficient medical evidence to support the use of air guns and pneumatic tools as causative factor in the development of lateral epicondylitis. Dr. Monaco also found insufficient evidence of a combination of risk factors, such as force and repetition or force and poster, indicative of causing

lateral epicondylitis in this case. Dr. Monaco noted that Petitioner's treating records demonstrate that Petitioner had an excellent response to conservative care with injections of cortisone and that his symptoms resolved over a period of time. Dr. Monaco found significant, as does the Arbitrator, that Petitioner reported on May 14, 2012 performing "the easiest job" for Respondent, he reported minimal discomfort in his elbows, and he declined surgical intervention at that time. As Dr. Monaco notes, it was not until Petitioner retired that he presented with renewed complaints in his right elbow with "heavier activities" of an unspecified nature (RX 4) and necessitated surgery, which the Arbitrator finds undermines a causal relationship between Petitioner's current condition of ill-being, and his need for surgical treatment, to his work duties as an assembler.

Moreover, Dr. Monaco found "no evidence in the medical record to indicate what possible work-related activity would have provoked the problems with his left elbow." RX 4. Like Dr. Monaco, the Arbitrator finds insufficient evidence of the presence of left arm complaints in the record following his April 4, 2007 accident to warrant a finding that his left upper extremity is causally related to his job duties as an assembler. Although Petitioner completed an Incident Report on April 4, 2007 and listed "right and left elbow" as being affected, his treatment for the preceding several years focused exclusively on his right elbow. Upon presenting to Respondent's medical facility on April 5, 2007, Petitioner complained of only right elbow pain and he was assessed with right elbow epicondylitis. PX 4, RX 1. Although Petitioner testified that he had left elbow pain on that date less severe than on his right, his records do not corroborate his testimony. PX 4, RX 1. Petitioner's left elbow is not mentioned until October 13, 2011, more than four and a half years after his work accident, and even on that date, Petitioner does not voice any complaints specifically regarding his left elbow. PX 1. The Arbitrator finds the temporal disparity between any notation of left arm condition and Petitioner's work accident probative, as is the lack of any significant complaints in Petitioner's left arm through the duration of his treatment, in finding his left upper extremity condition unrelated to his work accident.

In light of the aforementioned, and given that Dr. Monaco had an understanding of Petitioner's job duties as an assembler, his history and totality of medical treatment, the Arbitrator places weight on the opinions of Dr. Monaco.

Based upon the foregoing and the record in its entirety, the Arbitrator concludes that Petitioner failed to prove by a preponderance of the credible evidence that his job duties as an assembler, the subject of his work accident of April 4, 2007, were a causative factor in the development of his bilateral upper extremity conditions. The claim is denied. The remaining issues of medical benefits and the nature and extent of the injury are moot, and the Arbitrator makes no conclusions as to those issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Allan Dennis,
Petitioner,

vs.

NO: 08 WC 49020

17IWCC0195

Charles Michaels d/b/a C Michaels Roofing IL State Treasurer And Ex-Officio Custodian of The Illinois Injured Workers' Benefit Fund,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, medical care, notice, employee/empolyer relationship, jurisdiction, service 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 31, 2014, 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 the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $12,200,00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 31 2017
o032317
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DENNIS, ALLAN
Employee/Petitioner

Case# **08WC049020**

CHARLES MICHAELS D/B/A C MICHAELS ROOFING IL STATE TREASURER AND EX-OFFICIO CUSTODIAN OF THE ILLINOIS INJURED WORKERS' BENEFIT FUND
Employer/Respondent

17IWCC0195

On 1/31/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1836 RAYMOND M SIMARD PC
221 N LASALLE ST
SUITE 1410
CHICAGO, IL 60601

CHARLES MICHAELS D/B/A
C MICHAELS ROOFING
3145 PEORIA
STEGER, IL 60475

5165 ASSISTANT ATTORNEY GENERAL
JEANNINE D SIMS
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

17IWCC0195

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Allan Dennis
Employee/Petitioner

v.

Case # **08** WC **49020**

Consolidated cases: _____

Charles Michaels d/b/a C.Michaels Roofing, IL 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 **Gregory Dollison**, Arbitrator of the Commission, in the city of **New Lenox**, on **December 10, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☒ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☒ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the 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 **Insurance**

FINDINGS

On **October 29, 2008**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$13,728.00**; the average weekly wage was **$264.00**.

On the date of accident, Petitioner was **41** years of age, ***single*** with **0** children under 18.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $206.67/week for 7-2/7 weeks commencing October 30, 2008 through December 19, 2008, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services pursuant to the medical fee schedule of $2,493.92 to St. James Hospital and $1,854.36 to Well Group Health Partners, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $206.67/week for 51.25 weeks, because the injuries sustained caused the 25% loss of use of the right hand, as provided in Section 8(e) of the Act.

The Illinois State Treasurer as 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 §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owning the Petitioner. 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.

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

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

Signature of Arbitrator

1/30/14
Date

JAN 31 2014

 17IWCC0195

STATEMENT OF FACTS:

This action was pursued under the Illinois Workers' Compensation Act by Petitioner, Allan Dennis, and sought relief from Respondent-Employer, Charles Michaels d/b/a C. Michaels Roofing. This action also sought relief from the Injured Workers' Benefit Fund because the employer did not maintain workers' compensation insurance. (PX E). Petitioner notified the employer of the hearing by mail. The employer did not appear for any of the arbitration proceedings and was not represented by an attorney. The Illinois Attorney General's Office appeared on behalf of the Illinois State Treasurer, as *ex-officio* custodian of the Injured Workers' Benefit Fund, and participated in the arbitration proceedings.

Petitioner testified that on the date of accident he was 41 years old, unmarried, and had no dependent children. Petitioner was born on March 7, 1967. Petitioner testified that he is a roofer by trade. Petitioner testified that he had worked sporadically for the employer, Charles Michaels, for several years. He further testified that he first met Mr. Michaels in 1987. Petitioner testified that Mr. Michaels owned C. Michaels Roofing and that the company was a roofing company. Petitioner testified that sometimes he would go long periods of time without working with Mr. Michaels. Petitioner testified that on October 28, 2008 he received a phone call from Mr. Michaels. According to Petitioner, Mr. Michaels asked if Petitioner would be available for a three day roofing job in Manteno, Illinois. Petitioner testified that he last worked with Mr. Michaels approximately three weeks prior to this phone call.

Petitioner testified that Mr. Michaels was to pay him $11 per hour for eight hours a day for the duration of the three day project. According to Petitioner, $11 per hour represented his usual agreement with Mr. Michaels regarding wages. Petitioner testified that Mr. Michaels usually paid him in cash and in the past had provided a 1099 tax form for Petitioner's tax filings. Petitioner testified that he last received a 1099 tax document in 2007 and did not remember receiving one in 2008. Petitioner further testified that Mr. Michaels did not withhold any taxes from his wages.

Petitioner testified that on October 29, 2008 Mr. Michaels drove Petitioner to the designated worksite as Petitioner does not have a driver's license. Petitioner testified that his job duties included tearing off a building's old roof and installing a new rubber roof in its place. According to Petitioner, this project proceeded in the same manner of all of his previous projects with Mr. Michaels. Petitioner testified that he brought many of his own roofing tools to the job site including but not limited to hammers, pry bars, and a pitchfork. Michaels supplied some of the tools including the torch and ladders. Petitioner testified that he is a roofer by trade but he is not in the roofing business. He worked on buildings owned by customers of C. Michaels Roofing. He considered Michaels to be his boss for whom he has worked on and off since 1987. Petitioner also testified that he received instructions from Mr. Michaels' client as well as Mr. Michaels directly. Petitioner testified that on October 29, 2008 he had helped to tear off a building's old roof and was in the process of installing a new rubber roof. As part of the installation Petitioner had to use a torch. Petitioner testified that the hose for the torch became tangled and Petitioner tripped on the hose and fell off the roof. Petitioner testified that Mr. Michaels was present when the accident occurred and Petitioner initially told Mr. Michaels that he was fine. Petitioner eventually visited the ER after experiencing continued right wrist pain. Petitioner testified that he is right hand dominant.

On October 29, 2008 Petitioner presented to the emergency room at St. James Hospital complaining of right wrist pain. (PX 1). The medical records show Petitioner's chief complaint was "right wrist deformity at

work independent worker." X-rays of the right forearm and wrist revealed a comminuted intra-articular fracture of the distal radius with minimal separation of the main fracture fragments as well as a slightly displaced ulnar styloid fracture with about 2mm displacement in the radial direction. (*Id.*). Petitioner was diagnosed with a right wrist fracture. (*Id.*). The doctor prescribed pain medication, placed Petitioner's wrist in a cast, and referred Petitioner to an orthopedic doctor. (*Id.*).

On October 30, 2008 Petitioner presented to the orthopedic department at Well Group Health Partners. (PX 2). There, Dr. Payne prescribed Vicodin and reviewed the x-rays of Petitioner's right wrist and arm. Dr. Payne diagnosed an inarticulate distal radius fracture of the right wrist. Dr. Payne also recommended surgery and explained that Petitioner would most likely have a stiff and painful wrist and may not be able to continue working as a roofer. (*Id.*). Petitioner agreed to the recommended surgery. (*Id.*). Petitioner returned to St. James on November 2, 2008 for additional pain medication. (PX 1).

Petitioner returned to Dr. Payne on November 11, 2008 complaining of continued soreness. (PX 2). Dr. Payne noted a loss of reduction in Petitioner's right wrist. (*Id.*). Dr. Payne performed a closed reduction and noted some improvement of the dorsal tilt. Dr. Payne also prescribed additional pain medications including Darvocet-N 100. (*Id.*).

Petitioner returned to St. James Hospital on November 14, 2008 complaining of pain and swelling to his right hand. (PX 1). The hospital contacted Dr. Payne who requested the ER doctor cut the cast on the ulnar side if it felt too tight. (PX 2). The doctor removed the case on the ulna side. (PX 1). Petitioner returned yet again to the ER on November 16, 2008 complaining of continued right arm swelling. (*Id.*). A cast bivalve was performed and the arm was wrapped with ACE bandages. Dr. Payne examined Petitioner on November 18, 2008. Updated x-rays of the right wrist showed some dorsal tilt and also revealed that Petitioner's scapholunate may have been incompetent. (PX 2). Dr. Payne again recommended that Petitioner visit a hand surgeon to have his wrist repaired. Dr. Payne indicated Petitioner would most likely need an open reduction internal fixation and possible evaluation of his scapholunate ligament. Petitioner indicated he would visit Oak Forest Hospital to explore surgery since he did not have insurance to pay for the surgery. (*Id.*).

Petitioner presented to St. James Hospital ER on November 20, 2008. (PX 1). Petitioner told the medical personnel that he had fallen that day and reinjured his right arm. (Id.). Petitioner also told the ER personnel that he had cut off part of his cast. (Id.). The doctor removed the remainder of Petitioner's cast, took additional x-rays, and applied a posterior mold on the right arm. The updated x-rays showed no new fractures or dislocation. The doctor also prescribed additional pain medication. According to the records, Petitioner was scheduled to have surgery on his wrist on November 29, 2008. (*Id.*).

Petitioner again returned to St. James Hospital on November 29, 2008 complaining of continued discomfort. (*Id.*). The medical records reveal Petitioner informed the doctor that he was scheduled to have surgery at County Hospital on December 4, 2008. (*Id.*). The doctor prescribed additional pain medication and told Petitioner to be sure to follow up with his surgeon.

Petitioner presented to the orthopedic clinic at Oak Forest Hospital on December 1, 2008. (PX 3). Petitioner complained of a pain level of 8 on a scale of 1-10. Dr. Schiappa reviewed Petitioner's x-rays and conducted a physical examination. Dr. Schiappa also applied a short arm cast. The operative notes reveal that the doctor attempted a closed reduction. After removing Petitioner's splint, Dr. Schiappa inspected the wrist and noted no neurovascular deficit. Dr. Schiappa then applied a short arm cast and told Petitioner to return in three weeks for cast removal. (*Id.*).

Finally, Petitioner returned to St. James Hospital on January 6, 2009. (PX1). Petitioner told medical personnel that his cast was removed on December 19, 2008. The doctor referred Petitioner to Cook County Hospital for pinning, but Petitioner never followed up. He complained of continued pain. (*Id.*). Petitioner was prescribed additional pain medication and was told to follow up at Cook County Hospital in one to two days and to return to the ER if symptoms worsened. (*Id.*).

Petitioner testified that the submitted medical records encompass all of his treatment for this injury. Petitioner testified that he never underwent surgery.

Petitioner testified that he has sought no additional treatment since January 6, 2009. Petitioner testified that he was unable to work from October 29, 2008 until January 6, 2009. Petitioner testified that following his January 6, 2009 doctor visit, he resumed his profession as a roofer. Petitioner further testified that although he is able to continue as a roofer, he still experiences pain in his right wrist after using tools such as hammers and pitchforks. Petitioner also testified that it takes him a longer time to complete various roofing activities and also testified that he experiences periodic pain as a result of different weather conditions. Petitioner testified that he is not currently taking any prescription medications; however, he did testify that he occasionally takes over the counter Tylenol to limit his pain. Petitioner testified that the pain in his right wrist could be as high as a 6 on a scale of 1-10. Petitioner testified that he has not worked with Mr. Michaels since the date of accident.

Petitioner presented evidence of unpaid medical bills from two medical providers. Petitioner presented medical bills from St. James Hospital for services rendered from October 29, 2008 through January 6, 2009 for a total amount of $2,493.92. (PX 4a). Petitioner also presented a medical bill from Well Group Health Partners for services rendered from October 30, 2008 through November 18, 2008 for a total amount of $1,854.36. (PX 5). Petitioner testified that these bills remained unpaid and that he did not receive any money from Mr. Michaels for either missed wages or the accrued medical bills. Petitioner did not present any medical bills from Oak Forest Hospital.

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

Petitioner testified that he was hired by Mr. Michaels to work for C.Michaels Roofing. Petitioner testified that this is a roofing company and he performed various jobs involved in removing and installing roofs on buildings. Petitioner testified that he was required to use various tools including a torch during the installation of the new roof. The Arbitrator notes that these activities are types of services provided in the construction business. The Arbitrator finds that the removal and installation of roofs are sufficient for Mr. Michaels to be subject to the automatic coverage provision of Section 3 of the Act.

B. Was there an employee-employer relationship?

The existence of an employment relationship is a prerequisite for any award of benefits under the Act. There is no specific litmus test for determining whether an employer-employee relationship exists. Rather, such a relationship, if one exists, must be inferred from the conduct of the parties. There are multiple factors to consider in assessing the nature of the relationship between the parties. *Ware v. Indus. Comm'n.*, 318 Ill. App. 3d 1117, 1122 (1st Dist. 2000). Among these are: (1) whether the employer may control the manner in which the person performs the work; (2) whether the employer dictates the person's schedule; (3) whether the employer pays the person hourly; (4) whether the employer withholds income and social security taxes from the person's compensation; (5) whether the employer may discharge the person at will; (6) whether the employer

supplies the person with materials and equipment; and (7) whether the employer's general business encompasses the person's work. *See Roberson v. Indus. Comm'n.*, 866 NE.2d 191, 200 (Ill. 2007). The right to control work is perhaps the primary factor in determining the existence of an employment relationship. However, no single factor is determinative and the significance of the factors changes depending on the type of work involved. The determination rests on the totality of the circumstances. *Roberson*, 866 NE.2d at 200.

Petitioner testified that he had known Mr. Michaels since around 1987. Petitioner testified that he worked off and on for Mr. Michaels over several years. Petitioner testified he had last worked for Mr. Michaels on a project approximately three weeks prior to the October 29, 2008 alleged date of accident. Petitioner testified that on October 28, 2008, Mr. Michaels hired him to work on a project that would last three days. Petitioner brought many of his own tools for use on the project including his hammers, pry bars, and a pitchfork. Petitioner testified that Mr. Michaels also supplied some tools for Petitioner's use including a torch and ladders. Petitioner testified that Mr. Michaels and Mr. Michaels' client advised Petitioner as to what tasks needed to be completed. Michaels paid Petitioner $11.00 per hour in cash. Petitioner testified that he is a roofer by trade but he is not in the roofing business. He worked on buildings owned by customers of C. Michaels Roofing. He considered Michaels to be his boss for whom he has worked on and off since 1987. Michaels would send him an IRS form 1099 some years but not others.

The Arbitrator finds that Michaels exercised sufficient direction and control over Petitioner to establish an employer-employee relationship. The method of payment and the relationship between Petitioner's trade and the nature of Michaels' business also support this conclusion.

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

Petitioner testified that he was installing a new rubber roof on a building on October 29, 2008. Petitioner testified that as he was using the torch to aid in the installation, the hose for the torch became tangled and Petitioner tripped over the hose and fell off the roof. Petitioner testified that he initially told Mr. Michaels that he was fine but his right wrist continued to hurt throughout the day. Petitioner visited the ER and was diagnosed with a fractured right wrist that same day. (PX 1). Petitioner was treated with a splint and cast and was given pain medication.

The Arbitrator finds that Petitioner sustained an accident on October 29, 2008 which arose out of and in the course of his employment with Mr. Michaels and C.Michaels Roofing.

D. What was the date of the accident?

Petitioner testified that the accident occurred on October 29, 2008. This testimony is supported by the medical records and there is no evidence to the contrary. The Arbitrator finds that the accident occurred on October 29, 2008.

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

Petitioner testified that Mr. Michaels was present at the job site when the accident occurred. It is unclear whether Mr. Michaels witnessed the actual accident; however, Petitioner testified that Mr. Michaels did see the aftermath of the accident and discussed the accident with Petitioner. The Arbitrator finds that Petitioner did provide timely notice of the accident.

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

Petitioner testified that he was using a torch supplied by Mr. Michaels to complete the installation of the new rubber roof on a building. Petitioner further testified that he tripped on the hose for the torch and fell off the roof and hurt his wrist. The medical records support that Petitioner suffered a fractured right wrist. Petitioner's wrist was splinted and placed in a cast. The Arbitrator finds that Petitioner's injury is causally connected to his work accident.

G. What were Petitioner's earnings?

The Arbitrator finds that Petitioner had an average weekly wage of $264.00 at the time of the accident.

Petitioner testified that he has worked intermittently for Michaels since the 1980's. He had last worked for Michaels approximately one month before the accident. Michaels would always pay him in cash. He received an IRS 1099 form for the year 2007 but not in 2008. On October 28, 2008 Michaels offered Petitioner employment for a three day job. Petitioner was to work three 8 hour days at $11.00 per hour. (3 x 8 x $11.00 = $264.00). Petitioner was injured on his first day on the job.

In Nancy Demas vs. James Cape & Sons 08 IWCC 598, the claimant was injured on her first day at work at a scheduled five day 40 hours per week job. The Commission found an average weekly wage of $1,160.00 by multiplying the claimant's daily wage of $232.00 by five. In the present matter, Petitioner had a daily wage of $88.00 and he was scheduled to work 24 hours over 3 days. (3 x $88.00).

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

Petitioner testified that his date of birth is March 7, 1967. Petitioner testified that he was 41 years of age on October 29, 2008. The Arbitrator finds Petitioner was 41 years of age on October 29, 2008.

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

Petitioner testified that he was single and had no dependent children on October 29, 2008. The Arbitrator finds that Petitioner was single with no dependents on October 29, 2008.

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

Petitioner underwent an x-ray of his right forearm and wrist at the hospital. The doctor at the ER diagnosed Petitioner with a right wrist fracture, prescribed pain medication, placed Petitioner's wrist in a cast, and referred Petitioner to an orthopedic doctor. Petitioner followed up with the orthopedic doctor and received additional pain medication and a recommendation for surgery. The orthopedic doctor later performed a closed reduction on Petitioner's right wrist and again recommended surgery. Petitioner later returned to the ER complaining of pain and selling due to the cast. The cast was adjusted. Petitioner continued to complain of pain and additional x-rays were taken. Eventually, Petitioner's cast was replaced and another closed reduction of the fracture was attempted in December. Petitioner's cast was finally removed that same month. Petitioner last visited the ER in January 2009 with complaints of continued pain. The Arbitrator finds that, given the nature of the injury, the medical services rendered were reasonable and medically necessary.

Petitioner testified that Mr. Michaels has never given him any money toward any medical bills and all of his medical bills relating to this accident remain outstanding. Petitioner presented medical bills from St. James

Hospital for services rendered from October 29, 2008 through January 6, 2009 for a total amount of $2,493.92. (PX 4a). Petitioner also presented a medical bill from Well Group Health Partners for services rendered from October 30, 2008 through November 18, 2008 for a total amount of $1,854.36 (PX 5). The Arbitrator finds that the St. James Hospital bills totaling $2,493.92 has not been paid. The Arbitrator also finds that the Well Group Health Partners bill in the amount of $1,854.36 has not been paid.

Based on the foregoing, the Arbitrator finds Respondent will pay the outstanding St. James Hospital and Well Group Health Partners bills directly to the providers and pursuant to the fee schedule.

K. What temporary benefits are in dispute?

Petitioner is seeking benefits claiming he was totally and temporarily disabled for 11-2/7 weeks following the work accident. Petitioner presented no proof of providing any off work notes to Mr. Michaels following the accident. The Arbitrator finds Petitioner was temporarily and totally disabled from October 30, 2008 through December 19, 2008, a total of 51 days, or 7-2/7 weeks. Although the medical records do not include any off work notes, the Arbitrator notes that Petitioner is right handed and is a roofer. His right wrist was splinted or in a cast from the date of accident until December 19, 2008 when the cast was finally removed. Although Petitioner returned to the ER on January 6, 2009 requesting additional medication, there is nothing in the medical records indicating Petitioner was unable to work once the cast was removed.

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

Petitioner, a 41 year old roofer, sustained a comminuted intra-articular fracture of the right distal radius and a displaced fracture of the right ulnar styloid in a fall from a roof. (PX1). Dr. Mehl performed a closed reduction of the fractures on November 11, 2008 (PX2). Petitioner received follow-up care from Dr. Mehl and at the emergency room at St. James Hospital. Dr. Mehl recommended to Petitioner on November 18, 2008 that he see a hand surgeon at Oak Forest Hospital for an open reduction of the distal radius fracture. The emergency room physician at St. James Hospital made the same recommendation on January 6, 2009. Petitioner did not follow-up with a hand surgeon.

Petitioner testified that he is right hand dominant. He performs roofing work when it is available. He notices constant pain in the right hand and wrist. The pain is aggravated when he pounds with a hammer and with changes in weather. The grip strength in his right hand is decreased and especially noticeable when he tears off roofs using bars or a pitchfork. He takes over-the-counter medication for the pain.

Based on the foregoing, the Arbitrator finds Petitioner sustained a 25% loss of use of his right hand pursuant to Section 8(e) of the Act.

O. Other: Insurance

Petitioner provided proof of non-insurance for Respondent Charles Michaels as provided by the Insurance Compliance Division. (PX E)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ron Ward,

Petitioner,

vs. NO: 09 WC 22717

17IWCC0167

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 7, 2015, 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.

17IWCC0167

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: MAR 22 2017
TJT:yl
o 3/14/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WARD, RON
Employee/Petitioner

Case# **09WC022717**

AMERICAN COAL COMPANY
Employer/Respondent

17IWCC0167

On 12/7/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0536 RON D COFFEL & ASSOC
502 W PUBLIC SQUARE
BENTON, IL 62812

0299 KEEFE & DePAULI PC
GREG KELTNER
@2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

17IWCC0167

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

Ron Ward,
Employee/Petitioner

v.

American Coal Company
Employer/Respondent

Case # 09 WC 22717

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Herrin**, on **April 9, 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 **3-09-09**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$53,077.96**; the average weekly wage was **$1020.73**.

On the date of accident, Petitioner was **37** years of age, ***married*** 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 **$-0-** for TTD, **$-0-** for TPD, **$-0-** for maintenance, and **$-0-** for other benefits, for a total credit of **$-0-**.

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $276,080.76, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $680.49/week for 93 4/7 weeks, commencing 5/20/09 through 7/28/10, (62 2/7 weeks) and 8/22/12 through 3/27/13 (31 2/7weeks) as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $612.44/week for 125 weeks, because the injuries sustained caused the 25% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Arbitrator Michael K. Nowak

11/28/15
Date

DEC 7 – 2015

ICArbDec p. 2

FINDINGS OF FACT

Petitioner was employed by Respondent as a roof bolter. On March 9, 2009 he injured his back while tugging on the dust box door of a roof bolter machine. He said he tugged on the dust box door several times to try to open the door. He explained the dust box door stuck because of vapor lock, mud, and/or debris. While tugging on the dust box door, the door opened from the tugging force he applied. The force caused him to fall into the coal rib and twist his body. Petitioner had immediate onset of back pain.

On the day of the injury, Petitioner completed an accident report. The mechanism of injury is consistent with Petitioner's testimony. The report included a pain diagram on which Petitioner indicated an immediate onset of mid back pain with an arrow drawn toward his right hip. (PX 2) A Form 45 was completed March 12, 2009 by Anita Day of Respondent. The report stated Petitioner was pulling insert out of dust box and felt pain his back. (*Id.*)

On the day of accident Petitioner was taken to Harrisburg Medical Center by ambulance. He provided a consistent history of the injury. He complained of low back pain, exacerbated by movement. A physical examination was positive for bilateral muscle spasms in the low back, reduced lumbar range of motion, L4-5 tenderness, difficulty walking, and he was observed to have an antalgic gait. X-rays of the spine, both lumbar and cervical, were negative for fractures. He was drug tested, then released home to bedrest, and placed on restrictions of no driving and no bending, stooping or lifting. (PX 3)

The next day, 3/10/09, Respondent sent Petitioner to their company doctor, Dr. James Alexander. Dr. Alexander's physical examination was consistent with that of the ER physician. He indicated Petitioner told him "it doesn't hurt like his usual back strains." (PX 4, p.2) He gave Petitioner a pain injection and medications which included Medrol Dosepak, Vicodin, Flexeril, and Mobic. He also recommended physical therapy. Dr. Alexander found Petitioner was able to return to work to sedentary transitional duty on 3/10/09 with minimal walking. Petitioner testified he worked a transitional job of sitting in the guard shack. (PX 4, p. 2, 6) The physical therapy was performed on site at the coal mine facility under the mine location therapy site for Occupational Performance Rehabilitation.

When Petitioner returned to Dr. Alexander on 3/13/09 he indicated he had been experiencing numbness and tingling in his left leg. Straight leg raising (SLR) was negative. He was to continue PT and his medication. On 3/20/09 Dr. Alexander noted Petitioner was experiencing increasing symptoms. The doctor indicated he was tender over both SI joints. By the time Petitioner returned to see Dr. Alexander on 3/31/09 the symptoms had increased to the point he was having numbness in his left thigh and tingling in his right leg. SLR was now positive bilaterally. The diagnosis was low back pain with radiculopathy. An MRI was ordered. (PX4, pp. 2-3)

On 4/8/09, the first L/S MRI ordered by Dr. Alexander was performed at Saline Valley Radiology. The film showed degenerative changes at L5-S1 with mild annular disc bulging and small central broad based disc protrusion abutting the inner medial margin of the left S1 nerve root, as well as minimal disc bulging L3-4 and L4-5. Following the MRI, Dr. Alexander referred Petitioner to an orthopedic surgeon, Dr. James Coyle. On 4/17/09, Dr. Alexander noted that his referral to Dr Coyle was approved by Respondent and "...Lynette will be making that appointment." (PX4, pp. 3-4)

Petitioner attended physical therapy at Respondent's facility from 3/11/09 through 4/21/09. On 3/11/09, the therapy record indicates Petitioner had positive bilateral straight leg raising tests. On 3/19/09 the therapist documented left leg numbness and Petitioner's complaint that both knees feel like they are going to buckle and feel shaky when he is standing on them. He was discharged from therapy on 4/21/09 on the basis that "he is no longer an employee." (PX5, pp. 13-14)

On 5/4/09, Petitioner returned to Dr. Alexander complaining primarily of symptoms down his left leg into the anterior aspect of his left thigh. Dr. Alexander increased his transitional duty restriction to no lifting over 25 lbs. (PX4, p. 4, 11) On 5/18/09 Petitioner returned to Dr. Alexander. Up to this visit the doctor had not lifted Petitioner's 25lb weight restriction. He was noted to have continuing symptoms. Dr. Alexander performed no examination and made the following entry:

> Back pain. I told him he needed to take this up with Lynette. I Spoke with Anita and Oletha because he was positive for cocaine. He is no longer part of the problem at the mine, but is under the care of Rockwood. I spoke to Lynette at Rockwood. She asked that I not give him any narcotics and we will try to get him in to see IME. (PX4, p. 5)

Petitioner testified that Dr. Alexander told him to leave his office premises and further stated he would not get any help from any other doctor in the Harrisburg area. It is not lost on the Arbitrator that Dr. Alexander did not provide a note continuing Petitioner's work restrictions at this visit. However, there is no evidence indicating Petitioner's condition had improved in any way. His diagnosis remained the same. In addition the recommendation for Petitioner to be evaluated by a surgeon was still pending. Respondent, however did not authorize any further treatment or evaluation of Petitioner following the termination of his employment despite the recommendations of their own company physician.

Petitioner had a number of exacerbations of his symptoms following Respondent's refusal to provide additional care after he was terminated. Respondent argues that these incidents represent intervening accidents which break the causal connection between Petitioner's condition and the accident of 3/9/09. On 5/19/09 Petitioner sought treatment at the emergency room of Ferrell Hospital due to an increase in his low back pain while sweeping his garage floor.

For the ensuing period from 5/19/09 until 6/28/10 Respondent continued to deny Petitioner any medical care and did not schedule the evaluation with a surgeon. Petitioner testified that during this time he remained symptomatic. There was no medical evidence offered to indicate any change in Petitioner's underlying low back condition.

On 6/28/10, Petitioner came under the care of Dr. Peterson for an injury to his left knee in an ATV accident. There was no treatment for low back pain. However, Dr. Peterson's chart contains a Patient Information sheet signed by Petitioner on 7/29/10. (RX 3, p. 8) This form indicates Petitioner was self-employed as a brick layer. (*Id.)*

On 8/25/10 Dr. Peterson noted Petitioner returned complaining of back pain after laying block overhead. Dr. Peterson ordered an L/S MRI which was performed on 10/15/10 at Ferrell Hospital in Eldorado. This, the second lumbar spine MRI, continued to show a central broad based disc protrusion at L5, S1. The radiologist

was impressed that the MRI showed compression of the thecal sac and encroaching upon the right and left traversing S1 nerve roots. Following the MRI Dr. Peterson referred Petitioner to a spine surgeon. An appointment appears to have been scheduled for 1/11/11. (PX 7, pp. 20-22) It does not appear that this appointment occurred.

On 12/7/10 Petitioner returned to Dr. Peterson complaining of right leg pain, low back pain, and that his left leg feels as though it is out of socket. The note indicates Petitioner had been hanging drywall by himself and experienced an increase in his symptoms. (PX 7, p. 25)

Petitioner denied he was hanging drywall, and further denied the earlier history of laying block overhead. Petitioner testified that he did not report the history of injury 3/9/09 to Dr. Peterson at the time of the ATV incident because he presented for symptoms associated with bruising of his left knee not his back. Petitioner further testified he didn't report history of the work injury 3/9/09 to Dr. Peterson because he was fired from American Coal and he was not receiving any benefits from them, and because Dr. Alexander told him he would see to it that Petitioner wouldn't see another doctor around there.

On 2/11/11 Petitioner had ongoing symptoms and was given pain medication by Dr. Peterson. On 4/8/11 Petitioner continued to complain of back pain and right leg pain. The Medical note discusses surgical consultation once again. (PX 7, p. 28) The May note indicates he must quit smoking and lose weight before they will do the back surgery. (PX 7, p. 29)

Although Respondent never authorized the evaluation by Dr. Coyle which their own company doctor recommended back in May of 2009, Respondent sent Petitioner for a §12 examination by Dr. Coyle on 6/1/11. Dr. Coyle examined Petitioner and wrote a report in which he opined there is a medical causal connection between Petitioner's work injury of 3/9/09 and his current condition of ill-being. The basis of his opinion was that Petitioner remained symptomatic two (2) years out from the injury and the diagnosis of a transitional level L5 disc protrusion with left lower extremity radiculopathy and radiographic evidence of an S1 nerve impingement. His diagnosis was "L5 transitional level disc protrusion with left lower extremity radiculopathy and radiographic evidence of S1 nerve root impingement." (PX 11) The doctor concluded he was a potential surgical candidate at the L5 transitional level. He indicated Petitioner could not return to work as a roof bolter and placed work restrictions on him of no repetitive bending at the waist and no lifting over 20 lbs. Dr. Coyle specifically found that he was not at maximum medical improvement. At Arbitration, Petitioner testified that at the time of the first independent medical examination Dr. Coyle told him that he was a surgical candidate and discussed the procedure he would perform, actually showing him the plates and screws he would use for an L5 fusion surgery. Petitioner's testimony in this regard is consistent with the first IME report of Dr. Coyle dated 6/1/11.

Even after Dr. Coyle's evaluation Respondent persisted in its denial of any medical care. Instead, Respondent's nurse case worker requested an addendum to the 6/1/11 report. The report dated 6/23/11 indicates Dr. Coyle was allegedly presented with additional medical information which included the records of Dr. Peterson and the MRI of 10/15/10 (which he incorrectly writes was obtained 8/15/10). Supposedly relying on this information, Dr. Coyle wrote: "if Mr. Ward was in fact working laying block or brick for a year and a half

after his injury claim at American Coal Company, the event of March 9, 2009, is not implicated in his current condition and the need for treatment." (PX12)

Following Respondent's §12 exam Petitioner returned to Dr. Peterson on 7/25/11 the doctor noted "Pt. reported to me this was a work comp case." (PX 7, p. 30). On the visits which followed on 10/7/11, 11/28/11, and 1/17/12 Petitioner's symptoms remained consistent and his medications were continued. When Petitioner returned on 3/26/12 he requested a refill of his medication and a referral to Dr. Kube. (PX 7, p. 38)

On 6/13/12, Petitioner came under the care of Dr. Kube, an orthopedic surgeon. Dr. Kube examined Petitioner and found he had a positive straight leg raise test on the right, positive Faber's test on the right, and tenderness at L5-S1. Dr. Kube diagnosed Petitioner with Lumbago pending review of MRI studies. When Petitioner returned on 6/27/12, after the doctor had the opportunity to review the MRI studies, his diagnosis was chronic low back pain secondary to trauma, degenerative disc disease, spinal stenosis, sprain/strain, thoracic or lumbosacral neuritis or radiculitis, unspecified, and lumbago. His review of the MRI indicated degenerative disc disease, and a disc protrusion at L5-S1 that was contacting the S1 nerve roots bilaterally. (PX8, p.42) Dr. Kube indicated that "...given the couple year's [sic] duration he has dealt with this and the imaging studies that we have and failure of conservative measures," his recommendation was decompression and fusion at L5-S1. (*Id.*)

On 8/8/12, Dr. Kube performed a discogram at L4-5 and L5, S1 which was positive for concordant pain at L5, S1.

Surgery was performed by Dr. Kube on 8/22/12. The surgery performed was a combined transforaminal lumbar interbody fusion, poster spinal fusion at L5-S1, right minimally invasive technique, and a laminectomy for decompression of the traversing exiting nerve root at L5-S1. (*Id.*, at 73)

On November 6, 2012, Dr. Coyle issued a supplemental report following review of Dr. Kube's records and the operative report. Dr. Coyle opined that neither the discogram nor the surgery performed by Dr. Kube were necessary as a result of the March 9, 2010 accident.

Petitioner followed up with Dr. Kube postoperatively and underwent physical therapy at Harrisburg Medical Center from February 11, 2013 through March 11, 2013. The therapist's note from March 11, 2013 reflects that at the February 11 visit Petitioner reported pain at a level of 6/10, pain when sitting for long periods of time and difficulty getting comfortable when lying down. Petitioner also reported constant discomfort. On March 11, 2013 he reported a pain level of 1/10 and stated that he was able to perform all activities without difficulty.

Petitioner's final visit with Dr. Kube occurred on March 27, 2013. Dr. Kube indicated Petitioner was doing great. He noted that therapy had given him a release, and he looked absolutely excellent. Dr. Kube commented that given Petitioner's pain scores and his report of feeling like he could do most anything, a functional capacity evaluation was unnecessary. Pursuant to his standard procedure following fusion surgery, he imposed a 75 pound lifting restriction as a precaution against juxtafusional complications. He placed Petitioner at maximum medical improvement and instructed him to return on an as needed basis.

Petitioner returned to Dr. Coyle for yet another §12 examination on September 9, 2013. Petitioner advised Dr. Coyle that he was "...doing absolutely fine." Petitioner advised Dr. Coyle that he was taking no medications, had no numbness, tingling or weakness in his lower extremities and had no complaints of back pain. Physical examination revealed excellent upper body musculature, ability to forward flex and touch his toes and extension to 30 degrees. Petitioner was able to toc walk and squat without difficulty. Straight leg raising test was negative bilaterally. Dr. Coyle opined that Petitioner was at maximum medical improvement and that the 75 pound lifting restriction was arbitrary and unnecessary. Dr. Coyle maintained his previously expressed opinion that the need for surgery was unrelated to the March 9, 2009 accident.

Dr. Kube testified by deposition in this matter. He indicated that he had compared the MRI studies of April 8, 2009 and that of October 15, 2010. He stated "he had bilateral nerve root encroachment at L5--or at the L5-S1 level, namely encroachment on the S1 nerve roots bilaterally. And the disc protrusion is fairly central. And when I look at those side-by-side, there's not really an appreciable difference between the MRs (sic) when I'm looking at these." (PX 9, p. 10) He also reviewed the records of Dr. Alexander and noted bilateral leg symptoms and a bilateral SLR on 3/31/09. (*Id.*, at 14)

He indicated that on both MRIs the central disc protrusion "relatively splits the goalposts" and is in contact with both the right and left S1 nerve roots. (*Id.*, at 12 – 13) He indicated that with such a presentation you can see bilateral or unilateral symptoms on either side.

Following his review of Petitioner's prior treatment records and the MRI films Dr. Kube suspected the L5-S1 level was the pain generator, but he recommended a provocative discogram to confirm his suspicion. The discogram did confirm the L5-S1 level as the pain generator, and was consistent with the MRI findings. (*Id.*, at 18 – 20) He indicated surgery was recommended and the doctor stated that they used a right-sided approach since at the time of surgery "the symptoms tended to be more right-sided." (*Id.*, at 22) Dr. Kube discussed the incidents of laying block, the four wheeler, and the drywall which were contained in Dr. Peterson's records. He indicated that each episode "at most, maybe they just irritated him at the time of the event, but it doesn't sound like, based upon any of these events, he was all of a sudden— his level of treatment was escalated.... Based upon that, he still had the same kind of condition." (*Id.*, at 25-26) He indicated that his opinion that the three incidents were simply transient irritations of his existing condition is also based upon the fact that the records of Dr. Alexander and those of Dr. Peterson show that other than the fact that the radiating symptoms were more bilateral early on, his symptom complex was consistent before and after each of the incidents (*Id.*) In addition, there was no change in the MRI findings before and after the incidents. (*Id.*)

Dr. Kube indicated both the right and left side leg symptoms are consistent with Petitioner's broad-based central disc protrusion. (*Id.*, at 30) He explained why the symptoms could be right-sided at times, left-sided at times, and bilateral at yet other times. (*Id.*, at 31) Ultimately it was Dr. Kube's opinion that the accident of March 9, 2009 caused the central disc protrusion which precipitated the need for the surgery he performed. (*Id.*, at 30) He further indicated that the surgery performed was both reasonable and necessary. (*Id.*, at 33) When he released Petitioner Dr. Kube placed a 75 pound lifting restriction upon him, as this was his practice.

Respondent's §12 examiner, Dr. Coyle also testified by way of deposition. Dr. Coyle testified that on the April 8, 2009 MRI the broad-based disc protrusion "was abutting the the left S1 nerve root.... There was no

evidence of compression on the right S1 nerve root." (RX1, p. 14, 16). With regard to the October 15, 2010 MRI Dr. Coyle indicated "there was compression on the right." (*Id.*, at 17)

At the time of his 6/1/11 §12 exam Dr. Coyle noted Petitioner complained of only left lower extremity symptoms which was consistent with the 4/8/09 MRI. (*Id.*) His diagnosis was "L5 transitional level disc protrusion with left lower extremity radiculopathy and radiographic evidence of S1 nerve root impingement." (*Id.*, at 18) At the time of his 6/1/11 exam Dr. Coyle opined "based on the history he gives, the work injury was an aggravation of the L5 transitional level with resultant lumbar radiculopathy.... He could potentially be a candidate for surgery at this level, but he should quit smoking first." (*Id.*) At this point, after looking at both MRIs and examining the Petitioner Dr. Coyle found the Petitioner's condition of ill-being was causally related to the work accident and that he was a surgical candidate if he quit smoking.

The doctor alleges that then, on 6/23/11, he was given some additional records to "take a look at." These allegedly new records were the records of Dr. Peterson. The Arbitrator notes that it is unclear why Respondent would not provide these records at the time of or prior to the §12 examination which occurred three weeks earlier. Upon review of Respondent's exhibits it appears clear that the custodian of records of Dr. Peterson completed the affidavit on 4/7/11 (RX 3, p. 3) Further, the date stamps on counsels request letter indicate that the request was made 3/31/11; received by the doctor on 4/4/11; and the records were received by Respondent's counsel on 4/14/11. (RX 3, p. 1) The Arbitrator finds it significant that in the very first paragraph of his 6/1/11 §12 report Dr. Coyle states:

> I have had the opportunity to take Mr. Ward's history pertaining to his injury claim of March 9, 2009, to perform a physical examination, to review a lumbar MRI obtained March 8, 2009 (sic), a second MRI obtained October 15, 2010... the lumbar MRI report from April 2009 at Celine Valley Radiology and MRI Center and to review the records from Dr. Peterson and Dr. James Alexander. (PX 11, p.1, emphasis added)

Dr. Coyle then prepares a report dated 6/23/11 in which he reverses his opinion regarding causal connection between the accident of March 9, 2009 and Petitioner's condition. In the second paragraph of this letter the doctor writes "when I evaluated Mr. Ward, he stated that his employment was terminated and he had not worked for an extended period of time." (PX 12) Dr. Coyle next mentions the April 2009 MRI. Then, in the third paragraph, he writes "you have subsequently provided additional information including notes from Dr. Peterson...." (*Id.*, emphasis added) The doctor then goes on to change his original opinion based upon information which, according to his own first report, he reviewed before rendering his opinion that Petitioner's condition of ill-being was causally related to the work accident. The doctor also addresses the "August 15, 2010" lumber MRI. The Arbitrator notes the second MRI was in fact ordered in August 2010 but not actually performed until October 2010. There are only two MRI studies involved in this case. Although Dr. Coyle alleges to have again reviewed the October MRI he does not mention whether the disc protrusion was causing compression on the right side, the left side, or bilaterally. (*Id.*) In the June 23, 2011 report Dr. Coyle indicates Dr. Peterson evaluated the Petitioner on 8/25/10 and "noted that he had complaints of back pain due to laying block overhead. This indicates that Mr. Ward was sufficiently functional to be working laying blocks and that he injured his back at that time." (*Id.*) Dr. Coyle then concludes "based on his history, if Mr. Ward was in fact

laying block or brick for year and a half after his injury claim at American Coal Company, the event of March 9, 2009 is not implicated in his current condition and need for treatment." (*Id.*)

Dr. Coyle testified that when he reviewed the "additional records" which, according to his very own report he had reviewed prior to drafting his 6/1/11 report, his previously stated opinion changed. He indicated that the basis for this change of opinion was the fact that Petitioner had worked between his termination and the section 12 exam. The doctor noted he was doing a number of things in the interim according to Dr. Peterson's records. He points out that "on 8/25/10 he had complaints of back pain due to laying block overhead. In addition, he had seen Dr. Peterson several times previous to that for other problems and wasn't complaining of back pain or sciatica." (RX1, p. 19) The Arbitrator notes that the Petitioner originally came under the care of Dr. Peterson for treatment of a knee injury caused when a friend rode past Petitioner's stationary four wheeler and struck his knee. Dr. Coyle also testified "he had participated in a number of activities in the interim. He was four wheeling. He had been doing drywall work and there was no evidence that he was having problems with his back that prevented him from doing this." (*Id.*, at 20)

He testified that when he wrote in his 6/23/11 report that the March 2009 incident "was not implicated in his current condition and need for treatment" he meant "it was not the cause of his need for any further treatment. He was sufficiently functional to engage in some fairly heavy recreational and work activities." (*Id.*, at 21) The Arbitrator notes that the record contains four isolated entries to support this opinion, the 8/25/10 note previously discussed, the 5/19/09 note which reflects increased back pain when sweeping his garage, a 6/28/10 note regarding the knee pain from the four wheeler incident, which does not indicate an increase in his back pain, and a 12/7/10 incident of increased symptoms after hanging drywall. There is no evidence of repeated engagement in these activities as Dr. Coyle suggests. Petitioner credibly testified that following the March 2009 accident his symptoms never resolved.

Dr. Coyle then performed a records review following the surgery performed by Dr. Kube and issued a third report on 11/6/12. It is in this report that Dr. Coyle first addresses what he claims to be the significance of Petitioner complaining of right-sided radicular symptoms when he saw Dr. Kube and previously having only left-sided complaints when the initial section 12 examination was performed. Dr. Coyle disputes the fact that Petitioner ever complained of bilateral lower extremity symptoms. Instead he claims the Petitioner symptoms were all left-sided until after the August 2010 block laying incident when they suddenly became right-sided only. (RX1, p. 22) This assertion is simply not supported by the record. There were clearly bilateral symptoms recorded in the notes of Dr. Alexander as well the physical therapy notes. There were also notes which recorded positive bilateral straight leg raise tests.

Respondent then sent Petitioner back to Dr. Coyle for a second §12 exam on 9/9/13 and a fourth report was generated. In essence, Dr. Coyle's opinion, other than at the time he prepared his first report following the first §12 examination, was that Petitioner's condition of ill being is not related to the accident of 3/9/09. He further indicated that surgery was not reasonable and necessary and that the 75 pound lifting restriction placed by Dr. Kube was not reasonable and necessary. (*Id.*, at 25-28)

Petitioner testified that when he saw Dr. Kube on March 27, 2013 he was experiencing difficulty with bow hunting, fishing, etc. He agreed that he advised Dr. Kube that he was doing great and that Dr. Kube's

description of his appearance as "absolutely excellent" was accurate. He indicated that despite having some residual symptoms he has not returned to Dr. Kube.

At the time of the hearing Petitioner testified that the surgery resolved his right leg pain, left leg pain and mid back pain. He indicated he still had some aches and pains. He testified that he is no longer able to perform activities that he engaged in prior to the injury such as bow hunting and bank fishing. He has not returned to work since Dr. Kube's release nor has he looked for work.

CONCLUSIONS OF LAW

While the Arbitrator found the credibility of Petitioner suspect in some regards, the credibility of Respondent's doctors in this matter is also less than stellar. Dr. Alexander's notes, particularly the entry of 5/18/09, indicate his ongoing relationship with Respondent and his apparent willingness to acquiesce to the demands of Respondent rather than provide treatment to a patient whose care he had undertaken. Dr. Coyle discussed his ongoing relationship with Respondent in his deposition. Dr. Coyle's credibility in this matter is also suspect. Dr. Coyle reversed his causation opinion three weeks after it was rendered, allegedly based upon some "additional records" he was given "to take a look at." His own initial report, however clearly states he had reviewed these same records prior to formulating his initial opinion. Further, Dr. Coyle initially writes that his reversal of opinion is based upon the fact that Petitioner was working as a brick layer from the time he was fired by Respondent in May of 2009 and the initial §12 exam on 6/6/11. The Arbitrator notes that the only evidence in the record which is supportive of Dr. Coyle's revised opinion are the 8/25/10 note of Dr. Alexander which indicates Petitioner experienced back pain after laying block overhead and the Patient information sheet signed by Petitioner which indicates that as of 7/29/10 he was self-employed as a brick layer.

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

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

At the time of hearing, Petitioner offered medical bills into evidence totaling $276,080.76. (PX10) Respondent does not dispute the amount of the bills, but does dispute their liability for payment based upon the reasonableness and necessity of the treatment and causal connection.

The Arbitrator found the testimony and opinions of Dr. Kube much more persuasive than those of Dr. Coyle. The findings on the MRI from April, 2009 are consistent with the findings on that of October, 2010. The Arbitrator finds that the three incidences of increased back pain noted in the medical records were not intervening accidents severing the causal tie between Petitioner's agreed work accident of 3/9/09 and his current condition of ill-being. The Arbitrator finds these incidents to have been transient increases in symptoms Petitioner consistently experienced from the time of the work accident until the condition was surgically corrected. Further, at the time Respondent cut off all benefits following Petitioner's termination Petitioner was still under a "transitional" duty restriction and had a pending recommendation that he see a surgeon both of which emanated from Respondent's own company doctor. As discussed at length above, even Dr. Coyle initially indicated Petitioner was a surgical candidate.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that his current condition of ill-being is causally related to the work accident on 3/9/09 and that the treatment provided has been both reasonable and necessary.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $276,080.76 as set forth in Petitioner's exhibit 10, as provided in Sections 8(a) and 8.2 of the Act

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

Petitioner claims he is entitled to temporary total disability benefits for the periods of 5/20/09 through 11/07/11 and 1/12/12 through 3/27/13. Petitioner testified that he had part time work as a brick hander from 11/8/11 through 1/11/12.

The unrefuted evidence in the record establishes that Petitioner was discharged while he was on transitional duty with a 25 lb weight restriction by company Dr. Alexander. This took place on 5/19/09. The evidence in the record does, however indicate that Petitioner was working, at least part of the time between his termination and his surgery. On 7/29/10 Petitioner signed a Patient Information sheet indicating as of that time, he was self-employed as a brick layer. (RX 3, p. 8) Thereafter on 8/22/12 Petitioner underwent surgery by Dr. Kube. He was released from care by Dr. Kube on 3/27/13.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner is entitled to TTD benefits from 5/20/09 through 7/28/10 (62 2/7 weeks) and 8/22/12 through 3/27/13 (31 2/7 weeks).

Respondent shall pay Petitioner temporary total disability benefits of $680.49/week for 93 4/7 weeks, commencing 5/20/09 through 7/28/09, and 8/22/12 through 3/27/13, as provided in Section 8(a) of the Act.

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

Petitioner has undergone an L5-S1 lumbar fusion surgery. He was treated by Dr. Kube post operatively and released with a permanent restriction of no lifting over 75 lbs. Dr. Coyle indicated that the restriction was arbitrary and found Petitioner could work without limitation. Dr. Kube did admit that the restriction was one which he places of all patients with surgery similar to the one Petitioner has undergone. The restriction is a precautionary measure and not necessarily a true reflection of Petitioner's actual lifting ability.

Petitioner testified that the surgery resolved the radicular symptoms in both of his legs and his mid back pain. He still has aches and pains which have caused him to give up bow hunting, bank fishing, and motorcycle and 4 wheeler riding.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that the injuries sustained caused 25% permanent loss of use of Petitioner's whole body.

Respondent shall pay Petitioner permanent partial disability benefits of $612.44/week for 125 weeks, because the injuries sustained caused the 25% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

KAREN IZYDORSKI,

Petitioner,

vs.

NO: 09 WC 26088

17IWCC0140

SCHOOL DISTRICT 111,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the circuit court. The circuit court reversed the Commission's finding that Petitioner's fall and injuries did not arise out of her employment with Respondent, and remanded the matter for further proceedings consistent with its order of October 7, 2016. The Commission hereby complies with the order of the circuit court.

The following evidence is pertinent on remand. On December 11, 2008, Petitioner sustained injuries when she fell on some ice in the school parking lot on her way back to school from CPR training, which was required. The CPR class was held in the administration building. When Petitioner fell, her feet slipped out from underneath her and she fell forward. Her knees, elbows and wrists hit the ground. Petitioner was on the ground for about five minutes before she was able to get up. When Petitioner did get up she felt pain in her elbows, wrists, knees, and low back.

Petitioner admitted a prior low back injury more than ten years earlier. At the time of the accident, she had been symptom free from that injury for years. Petitioner denied prior problems with her knees. Petitioner returned to work the next day and worked through the pain. Petitioner was seen by her primary care group on December 15, 2008. She was prescribed pain

medication and the use of a cane was recommended. Petitioner received conservative treatment for her injuries on and off over the course of several years. She treated with her primary care physician, Dr. Olmstead, or his associate, with Dr. Lim, with Dr. Branovacki and with Dr. Kim. Dr. Lim had previously treated Petitioner for problems with her back and leg.

Petitioner returned to work in January of 2009, after the winter break. She still had pain in her back and left knee. She intermittently missed work because of the pain. In March of 2009, Petitioner took a leave of absence from her job because of the pain and because she was taking care of her mother-in-law, who had cancer. In August of 2009, the beginning of the new school year, Petitioner did not return to work. Petitioner testified she was in "too much pain" and could not sit or stand for prolonged periods of time. The medical records from Dr. Lim show that he took Petitioner off work attributing her symptoms to the work accident when she told him that she felt unable to work because of the severity of her pain. However, Dr. Lim noted a recent lumbar MRI showed only mild degenerative changes.

Dr. Branovacki, with whom Petitioner began treating for knee pain in December 2009, was reluctant to provide a causal connection opinion. Dr. Weber, who examined Petitioner at Respondent's request on April 16 and December 23, 2009, causally connected Petitioner's low back and left knee complaints to the accident based upon the history Petitioner provided. In her evidence deposition, Dr. Weber opined the work accident only temporarily aggravated Petitioner's pre-existing conditions.

In May of 2010, Dr. Zelby examined Petitioner at Respondent's request. The section 12 report from Dr. Zelby dated May 26, 2010 was entered into evidence. Petitioner complained of back pain with numbness and tingling in the right thigh to the work accident. Petitioner rated the pain an 8/10. "However, she rests and moves comfortably, with no pain behaviors during the exam to suggest this is an accurate representation of her pain." Dr. Zelby noted that Petitioner was 5 feet 7 inches tall and weighed 385 pounds. Her BMI was 60.52. Lying straight leg raise test was positive for back pain only, while sitting straight leg raise test was negative. The examination was notable for "[i]nconsistent behavioral responses [that] are positive for diminished pain on distraction." Dr. Zelby reviewed the MRI from August of 2009, noting mild degenerative disc disease throughout the lumbar spine, without loss of disc space height. He also noted broad based bulging discs at L4-L5 and L5-S1, without compromise of the spinal canal or neural impingement. Further, Dr. Zelby reviewed the medical records. Dr. Zelby concluded: "[The patient] had a slip and fall at work almost 1-1/2 years ago. Her MRI following this slip and fall showed modest degenerative disc disease, less than would be expected for her age and body habitus. She has no herniated discs and no neural impingement. While [the patient] may be interested in proceeding with surgery, she does not have a surgically correctable problem and no surgery should be pursued. She requires no additional diagnostic studies. Her diagnosis is a lumbar strain in the context of pre-existing and mild lumbar degenerative disc disease and pre-existing morbid obesity. Her morbid obesity places a strain on the spine in a manner that the spine was not designed to withstand, and represents a constant source of aggravation to her spine. Any infirmity associated with her fall easily resolved within 12 weeks of her injury, and

there is no objective abnormality to explain her ongoing subjective complaints. She was easily at maximum medical improvement by March 2009." Dr. Zelby further opined the fall "did not aggravate, exacerbate or accelerate [the patient's] pre-existing condition," and noted "a constellation of subjective complaints without objective basis." He opined Petitioner could return to work full duty.

The supplemental report from Dr. Zelby dated October 17, 2011 was received into evidence. Dr. Zelby reviewed additional medical records and diagnostic studies, which did not change his opinions.

The evidence deposition of Dr. Zelby was taken on December 17, 2012. Dr. Zelby, a neurosurgeon, testified consistently with his reports. He reiterated that although Petitioner had "a tremendous number of subjective complaints," her examination was essentially normal, and her complaints were unsupported by the objective findings. On cross-examination, Dr. Zelby clarified: "[E]ven with her super morbid obesity, her mild degeneration, none of that explains her constellation of symptoms."

The Commission relies on the opinions of Dr. Zelby and finds that Petitioner was at MMI and able to return to full duty as of March 11, 2009, when she took a leave of absence to take care of her mother- in- law. The Commission also notes the gap in treatment between December 19, 2008 and May 13, 2009.

Accordingly, the Commission awards no temporary total disability benefits. Petitioner is awarded medical expenses incurred commencing December 15, 2008 through March 11, 2009. Lastly, the Commission finds the injuries Petitioner sustained on December 11, 2008 caused no permanent disability.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay the medical bills incurred commencing December 15, 2008 through March 11, 2009 pursuant to Sections 8(a) and 8.2 of the Act, subject to Section 8(j) credit and hold harmless.

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

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

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

DATED: MAR 3 - 2017
SM/msb
d-2-23-17
44

Stephen Mathis

David Gore

Mario Basurto

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 ROCK ISLAND	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Patricia Goodman,
Petitioner,

vs.

NO: 09 WC 48836

Norcross Safety Products, LLC
Respondent.

17IWCC0157

DECISION AND OPINION ON REVIEW

Respondent appeals the decision of Arbitrator Erbacci finding Petitioner sustained an accidental injury arising out of and in the course of her employment on May 14, 2008. As a result Petitioner is entitled to $400.00 in current medical expenses and Respondent shall authorize and pay all reasonable and necessary medical expenses associated with bilateral knee replacement surgery recommended by Dr. Wynn. The issues on Review are whether Petitioner's current condition of ill-being is causally related to the May 14, 2008 accident and, if so, the amount of reasonable and necessary current medical expenses and whether Petitioner is entitled to future medical expenses. The Commission, after reviewing the entire record, modifies the Arbitrator's decision and finds Petitioner failed to prove her left knee condition is causally related to the May 14, 2008 work accident. In addition, while Petitioner proved her right knee condition is causally related to the May 14, 2008 work accident, Petitioner reached maximum medical improvement as a result of the May 14, 2008 work accident on April 7, 2009 and as such Petitioner is not entitled to any medical expenses thereafter.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner, a 56 year old team leader in charge of an assembly line, testified that on May 14, 2008 she was walking through a hallway when she tripped on something, which in

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hindsight she thought was a bolt. She testified that she fell forward and tried to catch her balance. She stated she fell on her right knee and then her left knee with her hands out in front of her. She did not fall straight forward. She went back to see what she tripped over. She guessed that a bolt used to hold down the floor came up and she caught her shoe on the bolt. Immediately after the fall, her right knee hurt. Her left knee did not hurt as much. Petitioner testified and her medical records support the fact that she never had any treatment with her knees before the fall.

2. On June 3, 2008, two weeks after the accident, Petitioner was seen at Concentra Medical Center where she was diagnosed with a sprain of her right knee. A right knee x-ray was taken, Petitioner was told to return to work and she was provided a prescription for a knee brace. Two weeks later Petitioner followed up with Concentra. At that time, the doctor prescribed physical therapy, which Petitioner reported she did a couple of times. On June 18, 2008, the doctor sent her for a right knee MRI which showed an osteochondral defect located within the medial aspect of the medial femoral condyle. It was noted that this was a stable lesion. The radiologist opined that there was a 30% chance of a tear of the posterior horn of the lateral meniscus which was only seen on one slice. The radiologist concluded that this did not represent a true meniscal tear. At most, Petitioner has a large joint effusion.

3. After the MRI results, Petitioner was referred to Dr. Wynn, an orthopedic surgeon. She saw Dr. Wynn on July 8, 2008. At which time, he took x-rays of her right knee which showed some mild patellofemoral joint changes consistent with degeneration as well as some mild medial space narrowing. He reviewed Petitioner's right knee MRI and found it showed an osteochondral defect within the medial aspect of the medial femoral condyle. There were no signs of instability noted in this region. Dr. Wynn noted that he did not see a specific tear of the lateral or medial meniscus. However, there was a large joint effusion. He opined that all of Petitioner's major ligaments appeared to be intact. He opined that at that time he did not believe Petitioner was a surgical candidate. He stated that so far she has only undergone a short course of physical therapy and he opined that this is not adequate. He offered and Petitioner accepted an aspiration of her large effusion. He told her to return in 6 to 8 weeks for a recheck.

4. On July 15, 2008, Petitioner returned to Concentra for physical therapy. The physical therapy took place from August 11, 2008 through October 30, 2008. On October 16, 2008, Petitioner mentioned that she was having some left knee pain. She did not mention any left knee pain in the remaining physical therapy sessions.

5. On August 21, 2008, Petitioner followed up with Dr. Wynn. Again, right knee x-rays were taken and they showed some mild patellofemoral joint changes consistent with degeneration, some mild medial space narrowing and no significant changes were noted laterally nor were there any loose bodies or any significant bone-on-bone arthritis. Dr. Wynn noted that Petitioner has questionable loose body symptoms and continued pain

post conservative treatment. They discussed an operative intervention which would consist of a right knee arthroscopy with chondroplasty versus a micro-fracture of medial femoral condyle along with possible loose body removal.

6. On September 11, 2008, Petitioner underwent surgery on her right knee which consisted of a right knee arthroscopy with partial medial meniscectomy, debridement of loose articular cartilage, trochlea. Her post-operative diagnosis was a medial meniscus tear, grade 2-B patellar chondromalacia, grade 3-4 trochlear chondromalacia, grade 2-B medial femoral condyle and medial tibial plateau chondromalacia and a small area of 2-A chondromalacia was seen on the lateral femoral condyle and at the far lateral position.

7. Post-surgery, Petitioner underwent physical therapy at Rock Valley Physical Therapy. On the September 16, 2008 Rock Valley physical therapy questionnaire, Petitioner reported she fell at work and landed on her knees with her right knee hitting first. However, a review of her initial evaluation letter only shows she fell on her right knee.

8. Petitioner reported that after her right knee surgery her right knee was somewhat better but it still hurt. The more she walked on it the more it hurt. Dr. Wynn returned her to light duty on September 22, 2008 and full duty work on October 31, 2008.

9. On October 10, 2008, Dr. Wynn noted that Petitioner was following up today and she stating she was feeling good about her right knee. He noted Petitioner is ambulating on one crutch and overall her right knee is doing very well. He noted that Petitioner reported she is apprehensive about using her right knee. Dr. Wynn noted that Petitioner is also complaining of some left knee pain today. She is wondering if she injured her left knee at the same time she injured her right knee. He noted that this is really the first time she has mentioned anything about her left knee. She reported that she thinks she has been relying on her left knee lately as her right knee is recovering. She pointed to the medial side of her left knee as the source of her left knee pain. Dr. Wynn noted that he would see her back in three to four weeks to check her progress.

10. The October 14, 2008 physical therapy questionnaire indicated that Petitioner reports her main complaint is her right knee and her left knee also hurts.

11. Petitioner again saw Dr. Wynn on October 31, 2008. At that time he noted that overall Petitioner is doing very well with her right knee. She mentioned that she is having some left knee pain. He noted that again, she mentioned this for the first time at her October 10, 2008 visit. Dr. Wynn noted that she made no claim to the workers compensation carrier regarding her left knee so he was going treat her left knee as a separate visit and was going to dictate a separate note for her left knee.

12. Petitioner reported her left knee kept hurting. The more she tried not to use her right knee and the more she used her left knee the more her left knee started hurting. Petitioner

reported she favored her left knee before and after her right knee surgery. She talked to Dr. Wynn about her left knee on October 10, 2008 and he checked it out.

13. On April 7, 2009, Dr. Wynn released her from his care. She went back to her regular job at work and she continued to be seen at the company medical department on April 22, 2009 and September 2, 2009 because her knees were hurting when she tried to work. During the April 2009 visits she was issued an elevator pass. She tried to see Dr. Wynn, but she had to see the company doctor first and he would not make an appointment with Dr. Wynn. She contacted her attorney and she went back to Dr. Wynn on January 14, 2010. Although she had no new injury, her knees continued to bother her between January 14, 2010 and April 7, 2010.

14. The November 11, 2008 Concentra entry shows that Petitioner had been discharged from physical therapy and had been released to return to work. Petitioner reported that because of her right knee surgery she has been limping and she has been having some pain in the left knee for the last few weeks. She also reported that when she fell, she twisted her left knee. On examination, her left knee showed no swelling. She reported mild tenderness in the medial lower attachment of the medial collateral ligament. Her range of motion on her right knee was normal. She demonstrated full flexion and extension. Her McMurray, drawer and Lachman are all negative. She did have some crepitus on palpation. The doctor noted that Petitioner's left knee etiology was undetermined. Petitioner was instructed to continue with her regular work and to use the freight elevator when she needed. She was told to continue with her home exercises and to follow up in two to three weeks.

15. On November 25, 2008, Petitioner returned to Concentra. At that time, she reported she has been having no problems since returning to her regular activities and she reported that she is actually surprised that it has gone so well. It was noted that her left knee symptoms have resolved and the doctor opined that she had reached maximum medical improvement.

16. From November 26, 2008 through January 5, 2009, which is approximately a six week period, Petitioner received no medical treatment.

17. On January 6, 2009, Petitioner returned to Concentra. It was noted that she returned unexpectedly for a follow up and that she had been released from care at her last visit. On January 6, 2009, Petitioner reported experiencing a generalized right knee soreness and swelling. It was noted that her operative reported showed moderate tri-compartmental degenerative joint disease. On examination, the doctor noted some mild swelling in right knee. Her range of motion showed a hard endpoint with flexion at 130 degrees. Dr. Garrels indicated that he attributed this to the arthritic state of her right knee. He diagnosed her as having moderate right knee degenerative joint disease. He instructed her to continue to exercise and return to the clinic in six weeks for a follow up visit. He

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also indicated he was going to leave the elevator pass in place due to the severity of her degenerative joint disease.

18. On February 5, 2009, Petitioner followed up with Dr. Wynn. He noted that Petitioner reported on her last visit her right knee was progressing well and she had more complains about her left knee. At that time, she stated that her right knee was doing okay. She did complain that at the end of her work shift she experienced some swelling and she also experienced pain upon climbing up an down stairs. Dr. Wynn noted that overall Petitioner has mostly had medial tenderness. She reported that "she would like to get her right knee in order before she addresses her left knee." Dr. Wynn noted that he did not believe that her left knee would be covered under workers' compensation and at this time and because of this she did not want to proceed with any treatment of her left knee. Dr. Wynn opined that at this time she is overall better than she was before the right knee surgery but she still reports experiencing some patellofemoral pain, some swelling in her knee and some arthritic changes in the trochlea. He instructed her to return to his office in three months for a check-up.

19. On February 17, 2009, Petitioner returned to Concentra where she reported that she was doing better since her surgery and she indicated that Dr. Wynn reassured her condition should get better. She did not report any complaints today. On examination, she reported no tenderness in her right knee. It was noted that during her range of motion test she continued to lack about 20 degrees of full extension. Petitioner was instructed to continue her regular work and to return to the clinic in two months for a final assessment.

20. On April 7, 2009, Petitioner followed up with Dr. Wynn. At that time, she reports that overall her knee was doing much better and she was experiencing very little pain. She reported she had some soreness around the patellofemoral joint and she felt this especially when she went up and down stairs, but otherwise she was happy with her results and felt that her knee has continued to improve. Dr. Wynn opined that Petitioner was doing fine. He noted that she was back performing full duty work. He opined that Petitioner had reached maximum medical improvement and he released her from his care at that time with instructions to return as needed.

21. On April 22, 2009, Petitioner returned to Concentra. At that time, she reported that at times she was still experiencing a little soreness along the inner knee. It was noted that Dr. Wynn had fully released her from care. On examination, it was noted that her right knee range of motion was full. Her meniscal signs were negative and her gait was normal. Petitioner was instructed to continue with regular work. She was granted a long term elevator pass and Dr. Garrels' opined that Petitioner had reached maximum medical improvement.

22. Petitioner did not follow up with Concentra until August 26, 2009 at which time she reported that she was under the assumption that her right knee pain would eventually go

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away and it has not. Petitioner reported a localized discomfort in the inside aspect of her right knee. On examination, the doctor noted that Petitioner reported some mild tenderness in the medial joint line. Her range of motion was restricted to 150 degrees on flexion. The doctor noted that upon reviewing her prior imaging studies he saw that there was an osteochondral defect. He recommended that Petitioner undergo a repeat x-ray of her right knee.

23. Petitioner returned to Concentra on September 2, 2009. At that time it was noted that Petitioner's symptoms were intermittent and they did not limit her activity. On examination, it was noted that she had mild anterior medial joint tenderness. The doctor noted that he had no additional treatment to offer and he instructed her to continue with her regular work and to follow up as needed.

24. The September 23, 2009 Concentra Communication Log indicated that Petitioner requested Naprosyn. Petitioner reported that she knew another employee who was taking this for swelling. Petitioner reported she also was experiencing swelling at the end of her work day. It was noted that the doctor advised Petitioner to take an over-the-counter dose. On September 30, 2009 Petitioner told Concentra that her husband was using a Lidocaine patch for chronic pain and she would like the same for herself. Petitioner was told that she may come in for samples or use one of husband's and then replace with sample if she is unable to come into the clinic.

25. On November 25, 2009 Petitioner filed her Application for Adjustment of Claim in which she listed the body part affected by the May 14, 2008 work accident as her right knee. There was no mention of a left knee injury.

26. On January 14, 2010, Petitioner returned to Dr. Wynn. He noted that Petitioner is back today because she still has pain in her right knees and she reports her left knee is also problematic. Dr. Wynn noted that Petitioner's right knee condition is under workers' compensation while her left knee condition is under her group insurance. Dr. Wynn took x-rays of both her knees and he noted that both knees show osteoarthritis, which is greater on the right than the left. He noted that in particular there was essentially medial bone on bone on the right knee. He further noted that there was also a large OCD on the medial femoral condyle. He diagnosed her with patellofemoral degenerative disease and he noted that Petitioner had not really improved since her right knee surgery. He noted that Petitioner's left knee is also symptomatic and shows osteoarthritis. He noted that Petitioner did have arthritic changes when he initially saw her. He further noted that the osteoarthritic changes seen in the September 8, 2008 x-ray have progressed in her right knee over the last year and a half. Dr. Wynn aspirated and injected both of her knees. He told her to follow-up in six to eight weeks.

27. On March 9, 2010, Dr. Wynn noted that Petitioner reported that the cortisone injection had not helped. He prescribed Synvisc injections which were given on June 16, 2010, June 23, 2010 and July 1, 2010.

28. On or about July 20, 2010, Petitioner filed an amended Application for Adjustment of Claim listing the parts of her body affected by the May 14, 2008 accident as bilateral knees.

29. On September 20, 2010, Petitioner again saw Dr. Wynn. Petitioner reported that the injections really did not help. She reported she is in constant pain with activities of daily living. Dr. Wynn noted that Petitioner's x-rays today show fairly significant amounts of osteoarthritis in both knees, mostly in the medial compartment and patellofemoral joint. Dr. Wynn commented that he thinks she is heading toward knee replacement surgery. In the interim, he recommended that she try a knee unloader brace and Voltaren gel.

30. The medical records indicate that Petitioner did not treat for the next seven months.

31. On April 8, 2011, April 15, 2011 and April 22, 2011, Dr. Wynn administered Orthovisc injections.

32. On April 14, 2011, Dr. Wynn composed a letter addressed To Whom It May Concern and sent it to Petitioner's attorney's firm. In the letter, Dr. Wynn noted that Petitioner reported she had injured her right knee when she fell on May 14, 2008. In October she also mentioned her left knee was bothering her and she thinks she injured that essentially at the same time. Dr. Wynn opined that there is a direct correlation between her fall and her knee pain. He noted that they have documented osteoarthritic changes of her knee on both of her MRIs and her x-rays. He lastly indicated that Petitioner may require a bilateral total knee replacement in the future. The Commission notes that Petitioner's left knee MRI was never entered into evidence.

33. On May 25, 2011, Petitioner returned to Dr. Wynn and reported that she was not doing much better. Dr. Wynn noted that at this time she has failed conservative management and she is a candidate for a bilateral total knee replacement.

34. Petitioner testified that she last worked for Respondent on September 30, 2011 when the plant shut down.

35. On November 15, 2011, Petitioner was evaluated by Dr. Coe. At the time of the evaluation, Petitioner reported to Dr. Coe that she sustained a work accident where she fell forward striking both knees. Petitioner further reported that following her right knee surgery she began to note increasing pain in her left knee. Dr. Coe opined that Pet. suffered bilateral knee contusions in the trip/fall on May 14, 2008. He opined that the contusions Petitioner incurred as a result of the May 14, 2008 accident resulted in an

aggravation of the degenerative arthritis in both her knees which caused bilateral knee chondromalacia and synovitis with both acute and chronic bilateral knee pain. He further opined that there is a causal relationship between the bilateral knee contusion on May 14, 2008 and her current condition knee symptoms and impairment. Lastly, he opined that the appropriate treatment would be bilateral total knee replacement surgery.

36. The Commission notes that there is a 27 month gap in treatment between Petitioner's April 2011 visits with Dr. Wynn and her March 2014 visit with Dr. Wynn.

37. On March 11, 2014 Petitioner returned to Dr. Wynn for treatment. He noted that he had last seen Petitioner on May 25, 2011. Dr. Wynn opined that her fall has caused her arthritis to progress at a quicker rate than what one would normally expect. He noted that Petitioner's x-rays show severe medial compartment osteoarthritis with her right knee being a little bit worse than her left knee. There is severe patellofemoral osteoarthritis as well and as a result of these diagnoses he is recommending a bilateral total knee replacement.

38. The medical records show that from August 30, 2012 through February 14, 2014 while Petitioner treated with Dr. Khalafallah, her primary care physician, there was no treatment administered for her bilateral knee condition.

39. Petitioner testified that she has not worked at all since she last worked for Respondent. She still gardens but she does it by standing on her legs and not kneeling on her knees. Petitioner testified that most of her medical bills have been paid. She did pay $400.00 out-of-pocket for her last visit with Dr. Wynn which took place on March 28, 2014.

40. Dr. Coe, a board certified occupational medicine doctor, was deposed on November 30, 2012. Petitioner reported to him that on May 14, 2008 she hit both of her knees while at work. She reported after that she used one crutch. Upon recovery from her right knee surgery and with her post-operative physical therapy she began noticing an increased pain in her left knee. She reported that Dr. Wynn did not prescribe any left knee treatment because of insurance related issues. On April 7, 2009, Dr. Wynn found that she had reached maximum medical improvement. Thereafter, she returned to work and upon returning to work she still experienced some pain and stiffness in her right knee along with experiencing symptoms in her left knee.

Dr. Coe opined that there is a causal relationship between Petitioner's May 14, 2008 work accident and the condition of both her knees. Specifically, he opined that the May 14, 2008 work accident aggravated the pre-existing asymptomatic arthritis of her right knee causing the need for treatment including surgery. Additionally, through the injury, the use of a crutch, the surgery and recovery from surgery, it aggravated the degenerative arthritis in her left knee causing her left knee to be symptomatic as well.

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Dr. Coe further opined that Petitioner is in the need of additional treatment for her knees.

On cross examination, Dr. Coe agreed that he is not certified in orthopedic medicine. Nor has he ever performed orthopedic surgery or any knee surgery. He further agreed that 2-2.5% of his practice is devoted to treating patients with knee injuries.

Dr. Coe agreed that the history Petitioner reported to him is significant and that if her history is inaccurate then there is also a possibility that his causation opinion could be inaccurate.

Dr. Coe testified that Petitioner reported she fell and struck both knees on the floor. She reported she had immediate pain in both knees, with greater pain in the right knee than the left knee. She reported that while both knees were initially looked at she only received treatment for her right knee. Dr. Coe agreed that in reviewing Petitioner's records that her initial treatment records did not contain any complaints related to her left knee. He further agreed that a direct blow to the knee such as Petitioner had would not cause the meniscus fraying that was seen on her operative report.

Dr. Coe agreed that while Petitioner reported to him that she injured both her knees in July of 2008 she only reported to Dr. Wynn a history of accident that resulted in an injury to her right knee. Dr. Coe also testified that he does not know if the physical therapy records contain any complaints related to her left knee. He agreed that if the records do not contain such a history then they would be inconsistent with the history she reported to him. He also did not believe that Petitioner's post-surgical physical therapy records contained any complaints of a left knee problem. He noted that Petitioner first complained of left knee pain to Dr. Wynn on October 10, 2008. While Dr. Wynn sent her for a left knee MRI, he never saw any records from the left knee MRI and it is never mentioned in Dr. Wynn's later records. Dr. Coe agreed that Petitioner never reported a history to him of twisting her left knee on May 14, 2008. He also agreed that if Petitioner denied any further problems with her right knee on November 25, 2008 it would be inconsistent with what she reported to him. If she denied problems to Dr. Garrels with her knee since returning to full duty it was inconsistent with what she told Dr. Wynn on February 5, 2009 and what she told him.

On April 7, 2009, Petitioner reported to Dr. Wynn that she was doing much better and had very little pain. At that time Dr. Wynn released her at maximum medical improvement, which means it is as good as it is going to get. It does not mean that a person is cured or healed or all the problems have resolved. Dr. Coe agreed that there were no complaints regarding the left knee on April 7, 2009 but it is clear from the prior discussion that Dr. Wynn was separating his treatment of her right knee from that of her left knee. It was not again until January of 2010 that she went back to Dr. Wynn regarding her left knee. There is not any way to tell if Petitioner's knee was related to

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arthritis other than serial testing over periods of time and unfortunately there are no serial MRI scans here. He agreed that there is a possibility, although it is not his opinion, that what Petitioner reported to Dr. Wynn in January of 2010 was simply the natural progression of underlying degenerative arthritis unchanged or uninfluenced by her accident. He agreed that Petitioner's x-rays showed significant osteoarthritis and Petitioner reported her arthritis as being aggravated by activities of daily living. He agreed that she was not seen for five months after September 20, 2010. His record does not reflect any specific history that she reported on that date as to what was aggravated her pain. He stated that people in their fifth decade or older are at increased risk for symptoms of degenerative arthritis. He agreed that Petitioner's reported worsening of symptoms with standing, walking stair climbing and descending which are activities all of us commonly perform in our daily lives. He agreed that she is clinically obese and he further agreed that carrying too much weight can increase the risk of knee pain. This is especially the case if someone has a pre-existing degenerative condition in their knees.

The thing that was most relevant to him was that Petitioner reported that she had no significant knee symptoms before the accident and she continued to complain of some ongoing knee symptoms with her activities. The basis for his opinion is that she was having continuing complaints after the accident. Also, while she reported improvement, she never reported being free of right knee symptoms flowing from the May 24, 2008 accident. He agreed that his opinions are all based on her history to him and to her treating doctor. It is also his opinion that using a crutch and trying to limit pressure on her right knee would be a factor aggravating her left knee.

41. Dr. Wynn, a board certified orthopedic surgeon, was deposed on August 8, 2013. Dr. Wynn testified that on October 10, 2008, at the end of the appointment, Petitioner mentioned her left knee had been bothering her because she felt maybe that she had been relying more on her right knee during her recovery. In a subsequent visit, Petitioner mentioned she thought she had been injured it at the time of the accident. At that time, we just thought she was just favoring her left knee and that is why it was symptomatic.

Dr. Wynn testified that on April 7, 2009 he felt Petitioner had reached maximum medical improvement. While he opined that she was at maximum medical improvement, she reports she still experienced some mild soreness with going up and down stairs. The soreness was mostly in the anterior and patellofemoral joint. Even though she was having some minor knee symptoms at that time, he felt that overall she was significantly improved from her pre-operative state.

On January 14, 2010, Petitioner complained of increasing right and left knee pain since her last visit. She reported no specific re-injury. He opined that she was experiencing just some generalized progression of symptoms. He opined that Petitioner had some pre-existing arthritic changes of her right knee and the fall exacerbated those arthritic symptoms in her knee and accelerated her arthritic change over the course of

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three years more rapidly than if she had not had an injury. He would probably consider her meniscus tear as more a degenerative type of meniscal tear than resulting from a specific trauma event. He opined that Petitioner's left knee symptoms were likely exacerbated by the fall but also probably made indirectly worse because of her right knee recovering from the injury and the surgery resulting therefrom. Dr. Wynn opined that Petitioner's need for her knee replacements are causally related to her May 14, 2008 injury.

Dr. Wynn agrees that Petitioner mentioned her left knee in a delayed fashion. He recollects that she injured her left knee at the same time but that her right knee was more symptomatic was not documented in any of his treatment notes. Upon looking at his first note, he agreed that he just examined her right knee because she had not complained of any left knee symptoms. He agreed that his opinion that she is in need of bilateral knee replacement surgery as a result of the May 14, 2008 accident is partially based on the history Petitioner provided to him as to how her injury occurred on May 14, 2008. He further agreed that the history that a patient reports to medical providers, such as himself, is important in determining whether a condition is causally related to the accident. He stated that it may be the single most important thing that a patient is reporting to him. Conversely, if the history is inaccurate then the causal relationship opinion may also be inaccurate. It is not uncommon for us to see patients who have more than one issue going on. They do not mention a more minor issue at that time because they are trying to get the more major issue treated.

Dr. Wynn agreed that when Petitioner reported the history of the fall she never reported that she fell on both knees and struck both knees on the ground. He agreed that when she first started complaining of her left knee pain she was simply "wondering" whether she may have perhaps also injured it when she fell and hit her right knee. He believes that it was a fair assessment to suggest to her that her left knee pain may be due to her relying on her right knee. The only record he had for review from her initial treatment was a right knee MRI. He thinks the osteochondral defect was a "possible" caused by the fall. The basis for osteochondral defects in adults are usually more of a traumatic type of injury. The meniscus tear he saw during surgery had the appearance of more of a degenerative type of tear. He agreed that at no point prior to the September 2008 surgery did she mention any complaints related to the left knee. He also agreed that the initial treatment of her left knee was through her group insurance. He reviewed the physical therapy records from 2008. He also reviewed Petitioner's post-surgery physical therapy records and agreed that they did not reveal any left knee complaints. He did not review Drs. Garrels or Mahadevia's records and does not know the histories she gave these doctors. If she reported to Dr. Mahadevia that she has a twisting injury that would have been inconsistent with the first time he saw her. He agreed that he did not see her for three months leading up to February 5, 2009. At that time, he assumed she was working within the restrictions. He did not know if he made a specific diagnosis of her left knee on that visit. He would say that the MRI diagnostics could be more accurate in

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diagnosing an exacerbation of an arthritic component of someone that has pre-existing arthritis and reported an injury. He agreed that he found her to be at maximum medical improvement and he released her on April 7, 2009 after she reported she was doing much better and she had very little pain. He further agreed that the April 7, 2009 visit was generally for her right knee. He agreed that he recorded at that time that she had some mild soreness going up and down the stairs but she was overall happy with her results. He agrees that she also did not come back to see him for almost seven months and he does not know what, if any, treatment she had at that time. He agreed she may be classified as being obese. He agreed that carrying too much weight could cause or increase the risk of knee pain. This is especially the case with people who have pre-existing degenerative conditions of their knees. He does not think the seven month gap in treatment for a patient with arthritis is that unusual. He does not think it is terribly unusual for someone who has arthritis to have periods of time where they feel pretty good and periods of time that they feel terrible. Dr. Wynn testified that it has been a more accelerated progression of arthritis than he would normally see in a patient.

42. Dr. Player, a board certified orthopedic surgeon, was deposed on January 16, 2014. He testified that knee surgery was between 25-35% of his practice. He evaluated Petitioner on September 12, 2011. The initial diagnosis was right knee sprain instead of internal derangement, which means the diagnosis was more consistent with a contusion or a direct blow. The records document the mechanism of injury. Petitioner also reported that she fell directly forward onto the knee striking the anterior tibial tubercle, which is the front of the tibia bone located below the knee as well as the front/anterior aspect of the patella, which is the protective sesamoid bone located in front of the knee. She did not report any twisting or turning of the mechanism of injury. The June 18, 2008 right knee MRI documented quite a large osteochondral defect/large chunk of bone that released/let go on the inner side of the medial femoral condyle. Dr. Player found that this finding is a congenital/developmental problem that has been in existence for decades prior to the work exposure. Osteochondral defects are well-known. They are located in the inner side/medial side of the Petitioner's medial femoral condyle, which is actually a protected location. It is protected from any kind of trauma or anything that could affect the knee from the outside. Primarily, it is protected because it is located on the inner side of the knee behind the kneecap. Dr. Player noted that Petitioner's trauma was to the front of the knee. Using an analogy of a map, the trauma would be in California while the Osteochondral defect would be in Illinois. So the osteochondral defect is something that is unaffected by trauma. This pre-existing and chronic condition markedly predated the injury and had no bearing on the injury at all. Dr. Player testified that he thinks the important thing in the operative report was that all of the findings in the knee were degenerative or arthritic. Even the tear on the undersurface of the medial meniscus was a degenerative tear. So the fact that the operative report confirmed only degenerative findings and not traumatic finding supports his contention that this was a pre-existing chronic condition that was affecting this lady's knee and not an acute trauma.

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The left knee pain was first documented by Dr. Wynn on October 10, 2008, which was 21 weeks and 1 day after the injury. Furthermore, Dr. Garrels' November 25, 2008 record indicated that Petitioner stated she had no problems since returning to regular activities and it was noted that Petitioner was actually surprised that her recovery had gone so well and that her right knee symptoms had resolved. On April 7, 2009, Dr. Wynn indicated Petitioner had achieved maximum medical improvement. At that time, she was working full duty. She had minimum to no complaints. She had a normal right knee exam. She had no left knee complaints or findings documented in that medical record. The fact that she was asymptomatic with the left knee and the right knees for a relatively long period, that she had a resolution of the left knee findings on January 25, 2008, that her gait was documented to be normal on April 22, 2009 and again on September 2, 2009 with no limitation on her activities all indicate that the work injury was a soft tissue contusion and that there was no rapid progression of degenerative arthritis following this arthroscopy. He had had many patients who have developed a rapid progression of degenerative arthritis after an arthroscopic surgery and they do not get better. In those instances, within three to four weeks post-surgery one is already starting to educate the patient that they are going to be a candidate for a total knee replacement. That is clearly not the situation in Petitioner's case where the medical records document that both of the knees were doing very well with a normal gait in the expected post-operative time. Petitioner reported that she hit the floor with her right knee first followed by her left knee. She subsequently indicated that her pain was in the anterior tibia, tibial tubercle and prepatellar regions, which are all in front of and below the knee. The medial meniscus is located on a different plane. It is 90 degrees plane from the front of the knee. It is located on top of the tibia and well behind the patella. So it would not have been affected at all by her fall. Petitioner indicated that the pain was worse on the inner lower aspect of each knee, not over the front aspect of each knee. So, the pain was worse where you typically see degenerative arthritis not where the accident occurred. All of the findings were consistent with chronic and long-standing degenerative arthritis. So the findings were supportive of his opinion that this was all a degenerative condition and not a traumatic or traumatic degenerative condition. Petitioner was 60 years old and clinically obese. People with degenerative arthritis who are well over their ideal body weight frequently do have more problems with degenerative arthritis. Additionally, the mechanism of injury was not the type of mechanism of injury that would tear a meniscus or cartilage. Rather, it was a direct blow or contusion to the anterior/front aspect below the knee. The surgical findings were completely supportive of a direct blow/soft tissue injury. Dr. Player opined that the fall did not aggravate Petitioner's pre-existing problem. In order for a joint to have a worsening the degenerative condition, there has to be a disruption of the joint, which means the joint has been dislocated or there has to be a sufficient trauma to fracture the bone that goes into the joint which would cause a malalignment or disruption of the bearing surface. Absent that bearing surface being disrupted or thrown out of alignment, there is no possibility that degenerative arthritis could be made worse. Dr. Player opined that Petitioner's condition was not caused by or aggravated by the May 14, 2008 accident. The mechanism of injury was a direct fall onto the front of the knee. There was no twisting while the knee was loaded. This mechanism of injury could not have cause injury to the medial compartment. The September

11, 2008 surgery report documented degenerative findings but no acute traumatic findings. The immediate post-accident medical records documented the diagnosis of a right knee sprain, which is a soft tissue contusion and not the kind of injury that could cause a meniscal tear or aggravation of an arthritic condition. The osteochondral defect noted on the MRI of the medial side of the medial femoral condyle was quite large it is a common cause of degenerative arthritis. It was not affected in any way by a contusion to the front of the knee based upon its location on the inner or medial side of the medial femoral condyle. Dr. Player said his opinion was also based on the fact that the patient's recovery from the surgery was sufficient to allow her to return to full and regular duty. It was supported by the fact that Drs. Garrels and Wynn subsequently documented little or no right knee symptoms and no negative post-operative sequelae following the right knee surgery. Additionally, Petitioner's current right knee condition was not caused or aggravated by her continued work duties. This opinion is based on the fact that her current duties involved walking and normal activities of daily living. Dr. Player opined that Petitioner has a chronic and pre-existing bilateral degenerative condition that had progressed by virtue of the natural history of degenerative arthritis in both knees, not just the right knee, to the point where she is considering total knee replacement surgery regardless of this injury event and regardless of her work activities.

Dr. Player does not believe Petitioner's left knee condition was causally related to the May 13, 2008 accident. In the first place the left knee complaints did not occur or were not documented until 21 weeks and 1 day after the accident. Secondly, although she did have a limp secondary to the use of crutches in the post-operative period, this is expected. She was weaned off crutches one month and three days after surgery. She was documented to be limping on November 11, 2008 but by November 25, 2008 Dr. Garrels documented that the left knee symptoms had resolved. Dr. Wynn's April 7, 2009 notes documented no left knee complaint or findings. On April 22, 2009 and September 2, 2009, Dr. Garrels documented a normal gait of the left lower extremity with no limitations of activities in any way. As a result, there is no indication that this surgery in any way, other than for a very temporary, short period following surgery, affected the left knee. Dr. Player opined that Petitioner had no overuse injury to her left knee as a result of the surgery and the surgery did not aggravate her pre-existing arthritis. He agreed that there is a certain period of time following surgery when a patient is using crutches where one expects some overuse due to not being able to use the right knee, but the fact that Petitioner was only on crutches for one month and three days at which time the right knee had completely recovered and the left knee symptoms had totally resolved means there was no overuse of either knee as a result of or following the surgery. The acceleration of arthritis was not possible primarily because there was no disruption of the joint through a subluxation, dislocation, fracture or damage to the articular surface as a result of this knee sprain mechanism of injury.

Dr. Player testified he has not performed surgery since December 12, 2006. His current practice consists of 50% evaluations for litigation and 50% non-operative orthopedics. He agreed that the majority of his evaluations are performed for Respondent's insurance carriers. He further agreed that Petitioner's medical records indicate that Petitioner did not receive

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treatment for her knees before the accident. He agreed that Petitioner sustained a very specific type of trauma. It is not the kind that would cause an aggravation to a degenerative arthritic condition of the knee. In the report, he documented a direct blow and contusion which is a non-twisting mechanism of injury. Her fall did not indicate she was twisting while loaded her knee, which is the type of mechanism which would be required to cause internal derangement. He knows she did not twist by virtue of the fact that she described a direct blow or contusion to the anterior aspect of the knee. While Petitioner told him that she struck both of her knees when she fell, her initial treatment records do not indicate that she hit her left knee when she fell.

Having reviewed the medical records, the Commission concludes that they support the fact that Petitioner sustained a right knee sprain as a result of her May 14, 2008 work accident. In reviewing her condition further, the right knee MRI showed osteoarthritis on the medial side of her knee and a possible tear of the meniscus. When Petitioner saw Dr. Wynn, an orthopedic doctor, she reports an injury to her right knee with no report being given of a fall on or an injury to her left knee. Nor does she provide any indication that she "twisted" her left knee when she fell. On July 8, 2008, Dr. Wynn found Petitioner was not a surgical candidate and on September 9, 2008 Dr. Wynn notes there is "no significant bone-on-bone arthritis" seen in the right knee. Even with these findings and as a result of Petitioner's continued complaints, Dr. Wynn performs arthroscopic surgery on Petitioner's right knee which elicits a finding of what he subsequently characterizes as a meniscus tear resulting from a degenerative condition and consisted of a whole lot of exploration of and cleaning up of a degenerative chondromalacia of the posterior and medial portions of the right knee.

The first mention of landing on "both" knees does not occur until approximately four months after the accident. The very first time she mentions landing on both knee is in her initial September 16, 2008 physical therapy intake questionnaire. Interesting enough, the initial physical therapy evaluation letter from the same date contradicts this and only shows she fell on her right knee. The next mention of the left knee occurs during her October 10, 2008 visit with Dr. Wynn when she complaints at the tail end of the visit about some left knee pain and she "wonders" if she injured her left knee at the same time as her right knee. Dr. Wynn finds her statement to be remarkable enough to note that this is the first time she mentioned anything about her left knee. He, again, repeats this statement in the follow up visit of October 31st along with the statement that he is treated the left knee under Petitioner's group insurance since she has not claimed this to be a workers' compensation accident. Dr. Wynn then speculates that she has been over relying on her left knee lately as a result of recovering from her right knee surgery. Next, Petitioner tells the Concentra doctor that not only did she fall on her left knee but she "twisted her left knee" when she fell. With the exception of Petitioner's testimony during the Arbitration hearing, the Commission notes this is the one and only time there is a mention of a twisting mechanism while falling. Her left knee etiology is classified as "undetermined" at this time. Additionally, only two weeks later it is reported that not only has her left knee symptoms resolved but she has reached

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maximum medical improvement in terms of her right knee. This period is followed by a six week gap of no treatment what so ever.

When the treatment picks up again in January or February of 2009, Petitioner alternatively reports generalized right knee soreness/swelling and greater pain in the left knee than the right but with the focus still primarily on the right knee complaints that have arisen both while at work and during activities of daily living such as stair climbing and descending, which more probably than not took place outside of work since Petitioner was given an elevator pass to use at work.

This period of treatment is next followed by not one but two different doctors finding that Petitioner reach maximum medical improvement in April of 2009. The only concession given at that time is Petitioner should continue to use of the elevator pass at work and the only complaint Petitioner registered at that time is some mild soreness while going up and down stairs. There is then another four month gap without treatment. When Petitioner does seek treatment again in August and September of 2009 it is for some intermittent symptoms and/or discomfort in the knee. The treatment is limited to over the counter medication and/or no treatment what so ever. Following this period, Petitioner filed her first Application for Adjustment of Claim and only listed her "right" knee at that time. This is supported some two months later when Dr. Wynn notes that Petitioner's right knee is being attributed to workers' compensation while her left knee is being attributed to her group insurance. Of interest, is also the fact that during the 1-1/2 years post-accident period Petitioner is consistently noted to be obese and is now 58 years of age and the doctor finds there is a "bone-on-bone" condition of the right knee along with osteoarthritic changes in the left knee.

From this point forward, Petitioner contends that both knees are related to her work injury. This is evidence by the amended July 20, 2010 Application for Adjustment of Claim and the solicitation from Dr. Wynn of a April 14, 2011 "To Whom It May Concern" letter in which he lays out that Petitioner "thinks" she injured her knees at the same time along with a history given to Dr. Coe of striking both her knees and/or experiencing a pain in her left knee after the right knee surgery.

The Commission finds Petitioner provided three alternative theories of this case in regard to the left knee. One, being a subsequent reporting of a left knee injury as well as a right knee injury. Two, Petitioner "twisted" her left knee prior to falling to the ground and Three, Petitioner overused her left knee upon recouping from the right knee surgery. Of the three theories, the first two are the hardest to explain away. The first theory is difficult because the medical evidence supports the fact that Petitioner did not report any left knee symptoms until some four months after her work accident, until have having treated extensively only for her right knee, having undergone surgery for her right knee and having treated with and received objective testing from several occupational and orthopedic doctors and physical therapist alike. When Petitioner does bring up the left knee, it is interesting to note the verbiage surrounding this reporting. Petitioner first brings up the fact that she fell on her left knee in

the September 16, 2008 physical therapy questionnaire, which is not supported by the evaluation letter of the same date. Alternatively, Dr. Wynn notes that Petitioner reported she is having left knee problems for the first time at the end of the October 10, 2008 appointment that she "wonders" if she is overusing her left knee. She repeats the same at the next encounter where it is noted that they will be treating it as a non-workers' compensation claim. Then again she reports that she fell on her left knee and she reports for the first and only time that she twisted her left knee.

With these competing theories in mind, Dr. Wynn makes the best of it during his deposition by accepting Petitioner testimony of a fall and twisting mechanism of the left knee injury while appearing to ignore the fact that his records let along the contemporaneous medical records, which he was not given, are devoid of any report of a left knee injury, let along a "twisting" type injury. A review of his deposition shows that Dr. Wynn was not provided with Petitioner's contemporaneous medical records. Rather, he was only given Petitioner's right knee MRI. Thus, the Commission finds that he is lacking some necessary foundational materials in which to base his causation opinion upon. Instead, he had to concede that a patient's history is very important to a medical provider to determine whether a condition is causally related to an accident. He also has to further admit that he partially relied on the history that Petitioner provided to him and has to concede if the history is inaccurate that the causal connection opinion may also be inaccurate. Having conceded as such, Dr. Wynn tries to make the best of not addressing the twisting theory and latching onto the overuse theory and Petitioner's delayed reporting that Petitioner believes that she injured her left knee at the time of the accident. When Dr. Wynn is questioned on the fall theory, Dr. Wynn agrees that his initial treatment records do not indicate that Petitioner fell on both knee and he was not privy to the prior treaters' records. At best, all he can testify to is that Petitioner "delayed" her reporting of the left knee injury. In terms of the overuse theory, Dr. Wynn is standing on a little firmer ground. However, he cannot explain the two times in which there was a finding that Petitioner had reach maximum medical improvement as expressed first in November of 2008 and twice again in April of 2009. The Commission finds Dr. Wynn's testimony lacked sufficient medical foundation in which to support his causation opinion between the left knee and Petitioner's work accident. Thus, he was forced to adopt a couple of Petitioner's histories and in doing so he could not support the theory that Petitioner injured her left knee at the time of the May 14, 2008 work accident and was best left with providing a "speculative" overuse theory which appeared to be temporary in nature. Given the totality of the evidence, the Commission believes that Dr. Wynn's causation opinion in regard to the left knee condition and its relationship to the work accident should be given little, if no, weight.

Just as Dr. Wynn's causation opinion is problematic, so to a greater extent is Dr. Coe's causation opinion. The major difference between the two is based on the history Petitioner gives to Dr. Coe. Petitioner tells Dr. Coe at the outset that she hit both knees as a result of the fall. She also for the first time reports that she experienced "immediate" pain in both knee with the right being worse than the left, which begs the question of why she did not receive

any treatment for her left knee right after the accident. Moreover, she reports that she was initially looked at for both her knees, which is not supported by the medical records. Alternative, like Dr. Wynn, Petitioner set forth an overuse theory as well. The rest of the deposition follows the same path as Dr. Wynn's. The major difference is that Dr. Coe is further removed from an understanding of the mechanics of the knee by virtue of being an occupational doctor as opposed to an orthopedic doctor. He also testifies that he was not provided with Petitioner's physical therapy records, her left knee MRI, which was supposedly taken but never commented on by Dr. Wynn, was not given a job description or told if she had to traverse stairs at work, was not provided with a series of MRI scans to show the progression of the arthritis and was told by Petitioner that her daily living activities were aggravating her condition. Thus, the best Dr. Coe can support is a chain of events theory. Namely, that Petitioner had had no significant knee symptoms before the work accident and she had continued complaints of some ongoing knee symptoms with her activities thereafter. Like Dr. Wynn, the Commission finds that Dr. Coe's testimony lacked sufficient medical foundation in which to support his causation opinion in regard to the left knee and Petitioner's work accident. Furthermore, the Commission finds that his causation opinion is based on an erroneous history from the Petitioner and as such should be given even less weight that Dr. Wynn's causation opinion.

Dr. Player's deposition is distilled down to the fact that the site of the acute trauma at the front of the knee is geographically removed from the degenerative condition of the side of the knee. As such the fall did not aggravate Petitioner's pre-existing right knee arthritic condition. Additionally, Petitioner's left knee condition is not related to the May 14, 2008 work accident because it was not reported for a significant period thereafter. Nor did Petitioner sustain an overuse injury to her left knee as evidence by the short duration in which the weight was placed on the left knee and the fact that the doctors found Petitioner had reached maximum medical improvement shortly thereafter. Furthermore, there was no damage to the left knee arthritic site and as such there could be no aggravation of this pre-existing left knee arthritic condition. In all, the medical records do not support Petitioner's versions of how that accident transpired.

What becomes somewhat lost in the whole discussion of the left knee is whether Petitioner's current right knee condition is causally related to the May 14, 2008 work accident. In a nutshell, Dr. Wynn is advancing the theory that the work accident accelerated Petitioner's progression of arthritis to a greater degree than is normal. In other words, but for the accident, Petitioner would not be in need of total knee replacement as soon as she is now. Dr. Wynn is asked the basis for supporting his position and he claimed that the radiographic documentation from early in her treatment to his last treatment supports the same. When he is asked specifically which diagnostic tool more accurately diagnoses an exacerbation of an arthritic condition he initially states it is an x-ray and then he immediately states it is an MRI. Given that statement, the Commission should take note of the fact that the evidence supports the fact that only one right knee MRI was taken on June 18, 2008, early in the process with no subsequent right knee MRIs being tendered. Thus, there is no series of MRIs in which to

compare the progression of Petitioner's arthritic condition. Furthermore, while there is a reference in Dr. Coe's deposition that Dr. Wynn sent Petitioner for a left knee MRI, he also notes that he, Dr. Coe, never saw the result of the left knee MRI and the MRI results were never mentioned in Dr. Wynn's records. Thus taking Dr. Wynn at his word that MRIs are better than x-rays to support the basis of his theory and given the fact that the Commission was only given one right knee MRI, it appears that his position is not supported by the evidence in the record. As an aside, the Commission notes that there are two x-ray reports that show a progress. The first is the September 9, 2008 right knee x-ray where Dr. Wynn noted no bone-on-bone arthritis and the January 14, 2010 right knee x-ray where Dr. Wynn noted bone-on-bone arthritis. This does show that in an approximately over a one and one half year period Petitioner's arthritic condition deteriorated, but without any testimony of how the same deterioration of Petitioner's condition post work accident compares to the "normal" deterioration of a similarly situated individual, it appears that Dr. Wynn's theory of progressive deteriorating resulting from the accident is not substantiated by the evidence. This situation furthermore must be viewed in the context of the fact that Petitioner is 58 years old, consistently viewed as obese during her treatment and has established at the time of the accident to have a pre-existing arthritic condition. Thus, in the end, it appears that there is insufficient evidence to support Dr. Wynn's theory that but for the accident, Petitioner would not be in need of total knee replacement as soon as she is now. Rather, the Commission finds that it is more in line with Dr. Player's opinion that Petitioner has a chronic and pre-existing bilateral degenerative condition that had progressed by virtue of the natural history of degenerative arthritis in both knees, not just the right knee, to the point where she is considering a candidate for a total knee replacement surgery regardless of this injury event and regardless of her work activities.

Given all of the above, the Commission finds that Petitioner failed to prove the proposed bilateral total knee replacement surgery is causally related to the May 14, 2008 work accident. Therefore, the Commission modifies the Arbitrator's causation findings and finds that while Petitioner sustained an accident result in injuries to her right knee she reasoned maximum medical improve as of April 7,2009 and she is not entitled to any medical expenses thereafter.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner is entitled to medical expenses through April 7, 2009, at which time she reached maximum medical improvement for her right knee.

IT IS FURTHER ORDERED BY THE COMMISSION that since Petitioner failed to prove she sustained an accidental injury to her left knee arising out of and in the course of her employment on May 14, 2008 her claim for compensation as it related to the left knee is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that this case is 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.

The party commencing 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: MAR 15 2017
MB/jm

O: 2/9/17

David L. Gore

Stephen Mathis

SPECIAL CONCURRING OPINION

This case was scheduled for Oral Arguments on February 23, 2017 before a three-member panel of the Commission including members Mario Basurto, Stephen J. Mathis and David L. Gore, at which time Oral Arguments were either heard, waived or denied. Subsequent to Oral Arguments and prior to the departure of Mario Basurto on March 3, 2017, a majority of the panel members had reached agreement as to the results set forth in this decision and opinion, as evidenced by the internal Decision worksheet initialed by the entire three member panel, but no formal written decision was signed and issued prior to Commissioner Basurto's departure.

Although I was not a member of the panel in question at the time Oral Arguments were heard and I did not participate in the agreement reached by the majority in this case, I have reviewed the Decision worksheet showing how Commissioner Basurto voted in this case, as well as the provisions of the Supreme Court in *Zeigler v. Industrial Commission*, 51 Ill.2d 137, 281 N.E.2d 342 (1972), which authorizes signature of a Decision by a member of the Commission who did not participate in the Decision. Accordingly, I am signing this Decision in order that it may issue.

L. Elizabeth Coppoletti

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS,
ILLINOIS WORKERS'
COMPENSATION COMMISSION,
INSURANCE COMPLIANCE DIVISION

Petitioner,

vs.

NO. 10 INC 233

ROBERT HILLERY, individually, and
d/b/a HILLERY'S BARBEQUE OF NORTH
CHICAGO and HILLERY'S BARBEQUE
OF WAUKEGAN

Respondent,

DECISION AND OPINION RE: INSURANCE COMPLIANCE

Petitioner, the Illinois Workers' Compensation Commission (the Commission), Insurance Compliance Division, brings this action, by and through the Office of the Illinois Attorney General, against the above-captioned Respondent, alleging violations of Section 4(a) of the Illinois Workers' Compensation Act (the Act) and Section 9100.90 of the Rules Governing Practice Before the Industrial Workers' Compensation Commission (the Rules), codified as Title 50 of the Illinois Administrative Code, Chapter 6. Proper and timely notice was given to all parties.

An Insurance Compliance Hearing on the Merits was held before Commissioner Michael J. Brennan on January 13, 2017, in Chicago, Illinois. Respondent was not present at the hearing despite being personally served with notice of said hearing on December 22, 2016. (T.5-7; PX1).

Petitioner has requested penalties for a period of 1,280 days of non-compliance with the Act from July 1, 2007 through December 31, 2010. The Commission, after considering the record in its entirety and being advised of the applicable law, finds that Respondent, ROBERT HILLERY, individually, and doing business as HILLERY'S BARBEQUE OF NORTH CHICAGO and HILLERY'S BARBEQUE OF WAUKEGAN, knowingly and willfully violated Section 4(a) of the Act and Section 9100.90 of the Rules during the period of July 1, 2007 through December 31, 2010.

As a result, Respondent shall be held liable for his non-compliance with the Act and shall pay a penalty in accordance with Section 4(d) of the Act and 9100.90(b) of the

Rules. The Commission hereby assesses the penalty of $669,785.51 against the above-named Respondent for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1) On May 14, 2007, Articles of Incorporation were filed on behalf of Hillery's Barbeque of Waukegan, Inc. and Hillery's Barbeque of North Chicago, Inc. Respondent Robert Hillery was listed as the Registered Agent for both businesses. (PX14-15).

2) Records from the Illinois Department of Revenue showed that Hillery's Barbeque of Waukegan and North Chicago paid compensation subject to income tax withholding from June 2007 through the March 2011 quarter. Each of the Illinois Quarterly Withholding Income Tax Return forms (IL-941) was signed by Respondent. (PX16).

3) Records from the Illinois Department of Employment Security further showed that Hillery's Barbeque of Waukegan and North Chicago had up to 10 employees from March 2008 through December 31, 2010, each of whom received certain wages. The records also specified Respondent as either the employer or owner of said businesses. (PX17).

4) On May 7, 2009, Maggie Wheeler, Respondent's employee, filed two work injury claims, namely 09 WC 19785 and 09 WC 20344. In each claim, Ms. Wheeler named Robert Hillery, doing business as Hillery's Barbeque of North Chicago, Hillery's Barbeque of North Chicago, Inc., and the Illinois State Treasurer and ex-officio custodian of the Injured Workers' Benefit Fund (IWBF) as Respondents. (T.10-11; PX4-7).

5) The second claim was consolidated into the first claim, 09 WC 19785. The consolidated matters proceeded first to a Section 19(b) arbitration hearing, on August 17, 2010, before Arbitrator Robert Lammie; and then a final arbitration hearing, on April 17, 2014, before Arbitrator Robert Falcioni. Respondent appeared at the first hearing, but did not formally testify. (PX 4-5).

6) In separate Decisions, both Arbitrators found Hillery's Barbeque of North Chicago operated under and was subject to the automatic coverage provisions of Section 3, specifically paragraphs eight and 14, of the Illinois Workers' Compensation Act. Petitioner prevailed in each instance and Arbitrator Falcioni ordered the award entered against the IWBF to the extent permitted and allowed under Section 4(d) of the Act. The IWBF indeed paid the award in the amount of $29,785.51. (PX4-6).

7) Petitioner presented Michael Cummins, an Investigator for the Commission, as a witness at the Insurance Compliance Hearing before Commissioner Brennan on January 13, 2017. Respondent was not present at the hearing although he was served personally with notice of said hearing on December 22, 2016. (T.5-7; PX1).

8) Mr. Cummins testified he began investigating Respondent in 2015. Mr. Cummins confirmed that throughout his investigation, the individual he was pursuing was Robert Hillery who had a date of birth of February 12, 1934. At one point, Mr. Cummins personally visited Respondent at his home. Mr. Cummins testified that Mr. Hillery identified himself as the owner of both Hillery's Barbeque locations. (T.62-63).

9) The purpose of Mr. Cummins' investigation was to determine if Respondent was in compliance with the Act. Mr. Cummins requested information from the National Council on Compensation Insurance (NCCI), the Illinois Secretary of State, the Illinois Department of Employment Securities, and the Self-Insurance unit of the Commission. (T.8-9)

10) On August 10, 2015, Maria Sarli-Dehlin, from the Office of Self-Insurance, certified that no certificate of approval to self-insure was issued by the Commission to "Hillary's BBQ" in North Chicago, IL. Robert Hillery was named as "President" on the certification. (PX8).

11) On November 12, 2015, Esteban Ortiz, Proof of Coverage Analyst for NCCI Holdings, Inc., conducted a thorough search of the NCCI database. The search revealed that Respondents "Hillary's Barbeque of North Chicago," "Hillery's BBQ of Waukegan," and Robert Hillery had no proof of workers' compensation insurance from June 29, 2007 through March 19, 2015. The NCCI database did show a policy cancellation effective June 28, 2007. (PX9).

12) The Commission has designated NCCI Holdings, Inc. as its agent for the purpose of collecting proof of coverage information on Illinois employers who have purchased workers' compensation insurance from carriers. (PX9).

13) Mr. Cummins testified he also conducted a "Proof of Coverage Search" using the NCCI website. His analysis showed Respondent consistently carried workers' compensation insurance from 1989 through 2002. Thereafter, the insurance coverage was non-renewed, then active for a year, and then cancelled again. The last policy effective date was June 28, 2007. (T.22-23; PX10).

14) Throughout the various documents to which Mr. Cummins testified to, Respondent was identified as Robert Hillery, Hillary S BB Q, Robert J. Hillery, Robert Hillery DBA Hillery, or Hillery. Mr. Cummins testified that

notwithstanding such variations, each listing utilized the same FEIN – 362669378.

15) As part of his investigation, Mr. Cummins stated he personally visited both business locations in Waukegan and North Chicago around September 2015. At the Waukegan location, he spoke with Jeff Hillery, the restaurant manager. Jeff Hillery informed Mr. Cummins that his father, John Hillery, was the current owner and not Robert Hillery. Jeff Hillery also stated that the North Chicago location was no longer in operation. Mr. Cummins personally visited the North Chicago business and confirmed that it was shut down. Jeff Hillery did not know Robert Hillery's whereabouts. (T.28-30).

16) Mr. Cummins stated he also observed three or four employees working during his visit to the Waukegan restaurant. The employees were preparing and cooking food on an open-flame pit and using knives. (T.29-30).

17) The Insurance Compliance Department of the Commission sent Respondent a Notice of Non-Compliance under Section 4(a) of the Act via Certified Mail on March 10, 2010. Mr. Cummins testified he hand-delivered a second Notice of Non-Compliance to Jeff Hillary when he saw him in 2015. (PX11-12).

18) On October 16, 2015, Respondent appeared for an Insurance Compliance Hearing before Commissioner Brennan. Following that hearing, Mr. Cummins testified he spoke with Respondent:

> We discussed the fact that the Injured Worker's Benefit Fund had to pay an award on behalf of his former employee, Ms. Wheeler, and that the Commission would be seeking reimbursement for that amount of money. He acknowledged that Ms. Wheeler had been his employee, he agreed to pay. We reached a settlement agreement for that same amount that the fund paid out. (T.48-49).

19) On October 23, 2015, Respondent signed an Insurance Compliance Settlement Agreement. (T.49; PX18).

20) As of the January 13, 2017 hearing date, no amount towards satisfaction of said settlement agreement had been paid. (T.51-52).

21) Finally, Mr. Cummins stated he reviewed information on the NCCI website to determine the cost of workers' compensation insurance during Respondent's non-compliance period. Using data as to the most recent policy that existed for Respondent, the premium would have cost $3,227.00 per year. (T.52-53; PX19).

Pursuant to Section 3 of the Act, certain employers and their employees are automatically subject to the provisions of the Act if they engage in specific businesses, including: "Any enterprise in which sharp edged cutting tools, grinders or implements are used . . ." 820 ILCS 305/3(8); and,

> Any business or enterprise serving food to the public for consumption on the premises wherein any employee as a substantial part of the employee's work uses handcutting instruments or slicing machines or other devices for the cutting of meat or other food or wherein any employee is in the hazard of being scalded or burned by hot grease, hot water, hot foods, or other hot fluids, substances or objects. 820 ILCS 305/3(14).

The Commission finds that Respondent's business falls under Section 3(8) and Section 3(14) of the Act. While there was no direct testimony as to the nature of the businesses during the period of non-compliance, the Commission takes judicial notice of the findings by the Arbitrators in this regard and as contained in the Decisions rendered in 09 WC 19785 and 09 WC 20344. By application of Section 3, Respondent was required to maintain workers' compensation insurance. The Respondent has offered no evidence to the contrary.

The Commission's authority and jurisdiction over insurance non-compliance cases is authorized by the Act, as well as the Rules. Under Section 4 of the Act, all employers who come within the auspices of the Act are required to provide workers' compensation insurance, whether this is done through being self-insured, through security, indemnity or bond, or through a purchased policy. Under Section 4(d):

> Upon a finding by the Commission, after reasonable notice and hearing, of the knowing and willful failure or refusal of an employer to comply with any of the provisions of paragraph (a) of this Section . . . , the Commission may assess a civil penalty of up to $500 per day for each day of such failure or refusal after the effective date of this amendatory Act of 1989. The minimum penalty under this Section shall be the sum of $10,000. Each day of such failure or refusal shall constitute a separate offense. The Commission may assess the civil penalty personally and individually against the corporate officers and directors of a corporate employer, the partners of an employer partnership, and the members of an employer limited liability company, after a finding of a knowing and willful refusal or failure of each such named corporate officer, director, partner, or member to comply with this Section. The liability for the assessed penalty shall be against the named employer first, and if the named employer refuses to

> pay the penalty to the Commission within 30 days after the final order of the Commission, then the named corporate officers, directors, partners, or members who have been found to have knowingly and willfully refused or failed to comply with this Section shall be liable for the unpaid penalty or any unpaid portion of the penalty.

Section 9100.90 of the Rules codifies the language of the Act, and additionally describes the notice of non-compliance required, as well as the procedures of the Insurance Compliance Division, and how hearings are to be conducted. Reasonable and proper notice, as noted above, was provided to Respondent. Section 9100.90(d)(3)(D) of the Rules indicates that "A certification from an employee of the National Council on Compensation Insurance stating that no policy information page has been filed in accordance with Section 9100.20 shall be deemed prima facie evidence of that fact." Petitioner's Exhibit 9 contains the certification from NCCI Holdings, Inc. indicating that Respondent did not have workers' compensation insurance from June 29, 2007 through March 19, 2015. Respondent failed to offer any evidence of compliance with the Act.

In *State of Illinois v. Murphy Container Service, et al.*, 2007 Ill.Wrk.Comp.LEXIS 1216, the Commission considered the following factors in assessing penalties against an uninsured employer: 1) the length of time the employer had been violating the Act; 2) the number of workers' compensation claims brought against the employer; 3) whether the employer had been made aware of his conduct in the past; 4) the number of employees working for the employer; 5) the employer's ability to secure and pay for workers' compensation coverage; 6) whether the employer had alleged mitigating circumstances; and, 7) the employer's ability to pay the assessed amount.

In the instant case, the Commission finds that the length of time in which the Respondent had been violating the Act in failing to obtain workers' compensation insurance was significant. The Respondent failed to have insurance for 1,280 days, from July 1, 2007 through December 31, 2010. The Respondent employed up to 10 employees, as listed in the Illinois Department of Employment Security records. In fact, one of Respondent's employees, Maggie Wheeler, did sustain a work injury. Respondent was even notified of his non-compliance under the Act by the Insurance Compliance Department of the Illinois Workers' Compensation via Certified Mail on March 10, 2010. Despite this, Respondent elected to not obtain workers' compensation insurance.

Having reviewed the record, the Commission finds no evidence as to Respondent's inability to secure and pay for workers' compensation coverage and no evidence of mitigating circumstances.

The Commission finds Respondent knowingly and willfully failed to comply with the Act. Based on the significant period of time that Respondent failed to comply with the Act, the Commission assesses a penalty of $669,785.51 against Respondent, ROBERT HILLERY, individually, and doing business as HILLERY'S BARBEQUE OF NORTH CHICAGO and HILLERY'S BARBEQUE OF WAUKEGAN.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent, ROBERT HILLERY, individually, and doing business as HILLERY'S BARBEQUE OF NORTH CHICAGO and HILLERY'S BARBEQUE OF WAUKEGAN is found to be an employer who was in non-compliance with the insurance provisions of Section 4(a) of the Act and Section 9100.90 of the Commission Rules, and is hereby ordered to pay the Commission a fine of $669,785.51 pursuant to Section 4(d) of the Act and Section 9100.90 of the Commission Rules. This amount represents 1,280 days of non-compliance with the Act, at $500.00 per day, from July 1, 2007 through December 31, 2010, as well as the arbitration award previously paid by the IWBF in the amount of $29,785.51.

Pursuant to Commission Rule 9100.90(f), once the Commission assesses a penalty against an employer in accordance with Section 4(d) of the Act, payment shall be made according to the following procedure: 1) payment of the penalty shall be made by certified check or money order made payable to the Commission; 2) payment shall be mailed or presented within thirty (30) days of the final order of the Commission or the order of the court of review after final adjudication to:

Workers' Compensation Commission
Insurance Compliance Division
100 West Randolph Street, Suite 8-328
Chicago, Illinois 60601

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

DATED: MAR 2 3 2017
MJB/pm
D: 3/14/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS,
ILLINOIS WORKERS' COMPENSATION COMMISSION,
INSURANCE COMPLIANCE DIVISION

Petitioner,

vs.

NO. 10 INC 233

ROBERT HILLERY, individually, and d/b/a HILLERY'S BARBEQUE OF NORTH CHICAGO and HILLERY'S BARBEQUE OF WAUKEGAN

17IWCC0181

Respondent,

DECISION AND OPINION RE: INSURANCE COMPLIANCE

Petitioner, the Illinois Workers' Compensation Commission (the Commission), Insurance Compliance Division, brings this action, by and through the Office of the Illinois Attorney General, against the above-captioned Respondent, alleging violations of Section 4(a) of the Illinois Workers' Compensation Act (the Act) and Section 9100.90 of the Rules Governing Practice Before the Industrial Workers' Compensation Commission (the Rules), codified as Title 50 of the Illinois Administrative Code, Chapter 6. Proper and timely notice was given to all parties.

An Insurance Compliance Hearing on the Merits was held before Commissioner Michael J. Brennan on January 13, 2017, in Chicago, Illinois. Respondent was not present at the hearing despite being personally served with notice of said hearing on December 22, 2016. (T.5-7; PX1).

Petitioner has requested penalties for a period of 1,280 days of non-compliance with the Act from July 1, 2007 through December 31, 2010. The Commission, after considering the record in its entirety and being advised of the applicable law, finds that Respondent, ROBERT HILLERY, individually, and doing business as HILLERY'S BARBEQUE OF NORTH CHICAGO and HILLERY'S BARBEQUE OF WAUKEGAN, knowingly and willfully violated Section 4(a) of the Act and Section 9100.90 of the Rules during the period of July 1, 2007 through December 31, 2010.

As a result, Respondent shall be held liable for his non-compliance with the Act and shall pay a penalty in accordance with Section 4(d) of the Act and 9100.90(b) of the

17IWCC0181

Rules. The Commission hereby assesses the penalty of $669,785.51 against the above-named Respondent for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1) On May 14, 2007, Articles of Incorporation were filed on behalf of Hillery's Barbeque of Waukegan, Inc. and Hillery's Barbeque of North Chicago, Inc. Respondent Robert Hillery was listed as the Registered Agent for both businesses. (PX14-15).

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5) The second claim was consolidated into the first claim, 09 WC 19785. The consolidated matters proceeded first to a Section 19(b) arbitration hearing, on August 17, 2010, before Arbitrator Robert Lammie; and then a final arbitration hearing, on April 17, 2014, before Arbitrator Robert Falcioni. Respondent appeared at the first hearing, but did not formally testify. (PX 4-5).

6) In separate Decisions, both Arbitrators found Hillery's Barbeque of North Chicago operated under and was subject to the automatic coverage provisions of Section 3, specifically paragraphs eight and 14, of the Illinois Workers' Compensation Act. Petitioner prevailed in each instance and Arbitrator Falcioni ordered the award entered against the IWBF to the extent permitted and allowed under Section 4(d) of the Act. The IWBF indeed paid the award in the amount of $29,785.51. (PX4-6).

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15) As part of his investigation, Mr. Cummins stated he personally visited both business locations in Waukegan and North Chicago around September 2015. At the Waukegan location, he spoke with Jeff Hillery, the restaurant manager. Jeff Hillery informed Mr. Cummins that his father, John Hillery, was the current owner and not Robert Hillery. Jeff Hillery also stated that the North Chicago location was no longer in operation. Mr. Cummins personally visited the North Chicago business and confirmed that it was shut down. Jeff Hillery did not know Robert Hillery's whereabouts. (T.28-30).

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19) On October 23, 2015, Respondent signed an Insurance Compliance Settlement Agreement. (T.49; PX18).

20) As of the January 13, 2017 hearing date, no amount towards satisfaction of said settlement agreement had been paid. (T.51-52).

21) Finally, Mr. Cummins stated he reviewed information on the NCCI website to determine the cost of workers' compensation insurance during Respondent's non-compliance period. Using data as to the most recent policy that existed for Respondent, the premium would have cost $3,227.00 per year. (T.52-53; PX19).

Pursuant to Section-3 of the Act, certain employers and their employees are automatically subject to the provisions of the Act if they engage in specific businesses, including: "Any enterprise in which sharp edged cutting tools, grinders or implements are used . . ." 820 ILCS 305/3(8); and,

> Any business or enterprise serving food to the public for consumption on the premises wherein any employee as a substantial part of the employee's work uses handcutting instruments or slicing machines or other devices for the cutting of meat or other food or wherein any employee is in the hazard of being scalded or burned by hot grease, hot water, hot foods, or other hot fluids, substances or objects. 820 ILCS 305/3(14).

The Commission finds that Respondent's business falls under Section 3(8) and Section 3(14) of the Act. While there was no direct testimony as to the nature of the businesses during the period of non-compliance, the Commission takes judicial notice of the findings by the Arbitrators in this regard and as contained in the Decisions rendered in 09 WC 19785 and 09 WC 20344. By application of Section 3, Respondent was required to maintain workers' compensation insurance. The Respondent has offered no evidence to the contrary.

The Commission's authority and jurisdiction over insurance non-compliance cases is authorized by the Act, as well as the Rules. Under Section 4 of the Act, all employers who come within the auspices of the Act are required to provide workers' compensation insurance, whether this is done through being self-insured, through security, indemnity or bond, or through a purchased policy. Under Section 4(d):

> Upon a finding by the Commission, after reasonable notice and hearing, of the knowing and willful failure or refusal of an employer to comply with any of the provisions of paragraph (a) of this Section . . . , the Commission may assess a civil penalty of up to $500 per day for each day of such failure or refusal after the effective date of this amendatory Act of 1989. The minimum penalty under this Section shall be the sum of $10,000. Each day of such failure or refusal shall constitute a separate offense. The Commission may assess the civil penalty personally and individually against the corporate officers and directors of a corporate employer, the partners of an employer partnership, and the members of an employer limited liability company, after a finding of a knowing and willful refusal or failure of each such named corporate officer, director, partner, or member to comply with this Section. The liability for the assessed penalty shall be against the named employer first, and if the named employer refuses to

> pay the penalty to the Commission within 30 days after the final order of the Commission, then the named corporate officers, directors, partners, or members who have been found to have knowingly and willfully refused or failed to comply with this Section shall be liable for the unpaid penalty or any unpaid portion of the penalty.

Section 9100.90 of the Rules codifies the language of the Act, and additionally describes the notice of non-compliance required, as well as the procedures of the Insurance Compliance Division, and how hearings are to be conducted. Reasonable and proper notice, as noted above, was provided to Respondent. Section 9100.90(d)(3)(D) of the Rules indicates that "A certification from an employee of the National Council on Compensation Insurance stating that no policy information page has been filed in accordance with Section 9100.20 shall be deemed prima facie evidence of that fact." Petitioner's Exhibit 9 contains the certification from NCCI Holdings, Inc. indicating that Respondent did not have workers' compensation insurance from June 29, 2007 through March 19, 2015. Respondent failed to offer any evidence of compliance with the Act.

In *State of Illinois v. Murphy Container Service, et al.*, 2007 Ill.Wrk.Comp.LEXIS 1216, the Commission considered the following factors in assessing penalties against an uninsured employer: 1) the length of time the employer had been violating the Act; 2) the number of workers' compensation claims brought against the employer; 3) whether the employer had been made aware of his conduct in the past; 4) the number of employees working for the employer; 5) the employer's ability to secure and pay for workers' compensation coverage; 6) whether the employer had alleged mitigating circumstances; and, 7) the employer's ability to pay the assessed amount.

In the instant case, the Commission finds that the length of time in which the Respondent had been violating the Act in failing to obtain workers' compensation insurance was significant. The Respondent failed to have insurance for 1,280 days, from July 1, 2007 through December 31, 2010. The Respondent employed up to 10 employees, as listed in the Illinois Department of Employment Security records. In fact, one of Respondent's employees, Maggie Wheeler, did sustain a work injury. Respondent was even notified of his non-compliance under the Act by the Insurance Compliance Department of the Illinois Workers' Compensation via Certified Mail on March 10, 2010. Despite this, Respondent elected to not obtain workers' compensation insurance.

Having reviewed the record, the Commission finds no evidence as to Respondent's inability to secure and pay for workers' compensation coverage and no evidence of mitigating circumstances.

The Commission finds Respondent knowingly and willfully failed to comply with the Act. Based on the significant period of time that Respondent failed to comply with the Act, the Commission assesses a penalty of $669,785.51 against Respondent, ROBERT HILLERY, individually, and doing business as HILLERY'S BARBEQUE OF NORTH CHICAGO and HILLERY'S BARBEQUE OF WAUKEGAN.

17IWCC0181

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent, ROBERT HILLERY, individually, and doing business as HILLERY'S BARBEQUE OF NORTH CHICAGO and HILLERY'S BARBEQUE OF WAUKEGAN is found to be an employer who was in non-compliance with the insurance provisions of Section 4(a) of the Act and Section 9100.90 of the Commission Rules, and is hereby ordered to pay the Commission a fine of $669,785.51 pursuant to Section 4(d) of the Act and Section 9100.90 of the Commission Rules. This amount represents 1,280 days of non-compliance with the Act, at $500.00 per day, from July 1, 2007 through December 31, 2010, as well as the arbitration award previously paid by the IWBF in the amount of $29,785.51.

Pursuant to Commission Rule 9100.90(f), once the Commission assesses a penalty against an employer in accordance with Section 4(d) of the Act, payment shall be made according to the following procedure: 1) payment of the penalty shall be made by certified check or money order made payable to the Commission; 2) payment shall be mailed or presented within thirty (30) days of the final order of the Commission or the order of the court of review after final adjudication to:

Workers' Compensation Commission
Insurance Compliance Division
100 West Randolph Street, Suite 8-328
Chicago, Illinois 60601

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

DATED: MAR 2 3 2017
MJB/pm
D: 3/14/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kelly Ramirez,
Petitioner,

v. Case No. 10 WC 29830

Community Unit School District,
Respondent.

ORDER

This matter comes before the Commission on Petitioner's Petition for Penalties and Attorney's Fees for the Non-Payment of Medical Bills. Due notice having been given, this cause came before Commissioner Thomas J. Tyrrell for hearing on September 22, 2016 in Chicago, Illinois. The Commission having jurisdiction over the persons and subject matter and after being advised in the premises, partially grants said Petition, for the reasons set forth below.

1. Petitioner filed an Application for Adjustment of Claim on 8/4/10 alleging a date of injury of 4/16/10.
2. The parties eventually agreed to settle the case and a Lump Sum Settlement Agreement was approved by Arb. Flores on 2/27/14. As part of this agreement, Respondent agreed "... to pay Health Benefits Physicians $20,689.42 as per the Fee Schedule, and $7,275.39 in disputed medical bills as per the attached medical bills exhibit as per the Fee schedule and Respondent to hold Petitioner harmless on Blue Cross/Blue Shield payments of $469.58, $603.90 and $63.90 for a total of $1,137.38."
3. On 7/2/15 Petitioner filed the instant Petition for Penalties and Attorney's Fees for the Non-Payment of Medical Bills alleging that Respondent had failed to pay a portion of the aforementioned medical expenses.
4. A hearing was held before Commissioner Tyrrell on 9/22/16 regarding the Petition.
5. At the time of the hearing, Petitioner submitted an affidavit by Suzanne Arata, the medical bill technician at Petitioner counsel's law firm. (PX1). In that affidavit, Ms. Arata represented that her investigation, commencing in June of 2015, found

that as of 7/2/15 there were unpaid medical bills concerning the claim totaling $29,502.11. (PX1). She indicated that subsequent follow up revealed that as of 1/19/16 the amount of $6,497.58 remained unpaid. Finally, Ms. Arata noted that on 2/17/16 she was supplied additional information from opposing counsel regarding bill payments, and that on 3/24/16 she "... called to the last six medical providers" and determined that "... all medical bills listed on Exhibit B to settlement contract had been finally paid in full." (PX1).

6. Respondent also submitted an affidavit at the time of the hearing, this one by Kathleen Kallas, an employee of CCMSI, the third-party administrator for Respondent. Ms. Kallas represented that "... once approved settlement contracts were received, medical providers were contacted to obtain information to process payment of the medical bills referenced on the approved settlement contract", noting that documentation had been requested from Health Benefits Physician Service as early as October of 2013 and that a response was not received until 5/29/15 after which payment was processed and issued on 7/1/15 for those balances. (RX1). In addition, Ms. Kallas noted that the same provider did not reconcile the account with the fee schedule until 1/15/16. (RX1). Furthermore, Ms. Kallas indicated that the billing information from Fox Valley Orthopedic was not tendered to the adjustor until 1/8/16 and bills were not provided until 1/20/16. (RX1). Ms. Kallas also represented that the rest of the Blue Cross/Blue Shield medical charges were placed in line for payment after receipt of itemization on 1/8/16, that no additional bills were provided from Summit Pharmacy and Injured Workers Pharmacy after contracts were approved, necessitating the use of archived bills to process the payments, and that medical information from Sherman Hospital was not received until 2/12/15. (RX1). As a result, Ms. Kallas maintained "[t]hat there was no intentional delay in payment of any medical provider listed on the approved settlement contract" and "[t]hat upon information and belief there remain no unpaid balances due under the Illinois fee schedule pursuant to the approved contract at this time." (RX1).
7. At the review hearing, counsel for Petitioner represented that it came to his attention in December of 2014 "... that the bills of the drug company had not been paid; and [he] contacted [Respondent's counsel] by letter; and [he] advised him of that; and [he] asked [Respondent's counsel] to put it in line for payment ..." (T.5). Counsel for Petitioner also noted that Ms. Arata contacted the medical providers on 6/9/15 "... and at that time she found that Health Benefits were not paid $20,689.42... [a]nd the other medical providers that were listed on the settlement contract rider were not paid $6,938.87." (T.6). He indicated that Ms. Arata called again on 1/19/16 and found that Health Benefits "... had been paid in full, however, there remained outstanding balances on the other bills in the amount of $6,497.58." (T.6).
8. At the same hearing, counsel for Respondent represented that as early as October of 2013 the adjustor contacted Health Benefits to request appropriate documentation to pay the medical bills and that a response was not received until 5/29/15, at which time payment for those bills was issued on 7/1/15. (T.11). In addition, counsel for Respondent stated that per the affidavit of Ms. Kallas "... the only delay for the payment of these benefits was that the doctors were not

responding timely to requests for information needed to get payment" and that "[a]t one point an old bill had to be reconstructed through the insurance company's system for the pharmacy records ..." (T.12-14). As a result, counsel for Respondent argued that while there admittedly was a delay in the ultimate payment of medical expenses said delay was neither unreasonable or vexatious (T.12-13).

§19(l) provides in pertinent part that "[i]n case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or Commission shall allow to the employee additional compensation in the sum of $30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay." 820 ILCS 305/19(l) (West 2000).

It has been held that the section 19(l) penalty is in the nature of a late fee. *Mechanical Devices v. Industrial Commission*, 344 Ill.App.3d 752, 763, 800 N.E.2d 819,829, 279 Ill.Dec.531 (2003); citing *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 515, 234 Ill. Dec. 205, 702 N.E.2d 545 (1998). Assessment of the penalty is mandatory "if the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay." *McMahan*, 183 Ill. 2d at 515. In determining whether an employer has "good and just cause" in failing to pay or delaying payment of benefits, the standard is reasonableness. *McMahan*, 183 Ill. 2d at 515.

Imposition of section 19(k) penalties is discretionary. *McMahan*, 183 Ill. 2d at 515. They are assessed when a benefit payment delay is deliberate or results from bad faith or "improper purpose." *McMahan*, 183 Ill. 2d at 515. Section 16 applies in the same circumstances. *McMahan*, 183 Ill. 2d at 515. The imposition of section 19(k) penalties and section 16 attorney fees requires a higher standard of proof than an award of additional compensation under section 19(l). *McMahan*, 183 Ill. 2d at 514.

In the present case, settlement contracts were approved by the arbitrator on 2/27/14. These contracts specifically set forth the providers and the amount of medical expenses that were to be paid by Respondent. Absent a review, those settlement contracts became final 30 days after approval, or on 3/29/14. Pursuant to §19(l) a delay in payment of 14 days or more created a rebuttable presumption of unreasonable delay on the part of Respondent. The evidence suggests that the medical bills set forth in the contract were not paid in full until sometime after February of 2016, per Ms. Arata's affidavit, or almost two (2) years later.

Respondent presented the affidavit of the adjustor in an attempt to explain this delay, placing the blame squarely at the feet of the various providers for failing to provide requested information regarding the bills in a timely fashion. While the Commission finds that this conduct did not rise to the level of vexatiousness needed to impose §19(k) and/or §16 fees, Respondent's lack of follow-up and less than proactive response to this

delay, even after counsel for Petitioner's renewed request for payment in December of 2014, was decidedly unreasonable under the circumstances.

As a result, the Commission finds that Respondent failed to rebut the presumption that its delay in payment of the medical bills set forth in the settlement agreement was unreasonable, and that Petitioner is therefore entitled to additional compensation pursuant to §19(l) of the Act in the amount of $10,000.00, or $30.00 per day for each day said benefits have been withheld. The Commission notes that since this delay in payment lasted almost two (2) years, the statutory cap of $10,000.00 would apply.

The Commission further finds that Petitioner failed to prove that Respondent's conduct was vexatious so as to warrant the imposition of additional compensation pursuant to §19(k) and/or attorneys' fees pursuant to §16 of the Act. As a result, Petitioner's claim for same is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner additional compensation of $10,000.00 as provided in Section 19(l) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Petition for additional compensation as provided in Section 19(k) and/or attorneys' fees as provided in Section 16 of the Act is hereby denied.

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

DATED: MAR 8 - 2017

r-09/22/16
TJT/pmo
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Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Franciszek Kusyk,

Petitioner,

NO. 10 WC 34909

vs.

Tool King, Inc.,

Respondent.

ORDER

Petition for Penalties and Attorney fees under §19(k), §19(l), & §16 and Petition to enforce settlement §8(a) and the case having been filed by Petitioner's attorney herein and due notice given, this cause came before Commissioner Gore September 15, 2015, October 20, 2015, February 9, 2016, March 1, 2016, May 3, 2016, June 7, 2016, and July 12, 2016, in Chicago, Illinois. The Commission having jurisdiction over the persons and subject matter and after being advised in the premise finds:

1. This matter was timely and properly filed before the Commission for an accident date July 23, 2010, which arose out of and in the course of employment.

2. The underlying matter was settled via settlement contract approved by Arbitrator Hegarty August 25, 2014. The terms of the contract noted, in part, that Respondent was to pay the settlement total of $32,705.00 to Petitioner (20% loss of Petitioner's person as a whole for permanent partial disability-[PPD]), plus Respondent was to fund a Medicare Set Aside (MSA) of $4,092.21. The PPD settlement amount was tendered after approval of the settlement contract but Respondent did not submit the MSA set aside funding.

3. Petitioner filed their Petition for Penalties and attorney fees and Petition to enforce settlement August 15, 2015, which initially came before the Commission September 15, 2015 and the matter had been continued multiple times until the ultimate hearing of this Petition July 12, 2016.

4. Respondent's counsel agreed that the case had been settled via contract containing the stated terms. Respondent noted in their brief that an internal error delayed the submitting of the MSA for review and approval to the Centers for Medicare & Medicaid Services (CMS); this was without bad faith. Respondent stated that the projection had become 'stale' such that new records for the past two years needed to be obtained from Petitioner's primary care physician (PCP) and pharmacy prior to submitting to CMS for review. Respondent indicated that the need to obtain an updated Consent to Release form to obtain Petitioner's records had been brought to the attention of Petitioner's attorney. Respondent stated they made diligent and good faith attempts to obtain records for submission but neither Petitioner nor his counsel provided the updated records despite a cooperation clause in the settlement contract. Respondent stated that there was unreasonable resistance by Petitioner's PCP and pharmacy to obtain records but eventually records were received and projections updated for an updated MSA to be submitted as soon as Petitioner executed a release of information authorization. Respondent noted during the pendency of the dispute Petitioner's rights had remained open, per the settlement contract, but at no time did Petitioner tender any medical bills for reimbursement since the settlement contract had been approved. Respondent noted numerous exhibits presented regarding the issues and communications to the parties involved. Respondent noted after multiple subpoena requests (with HIPPAA authorization) to Petitioner's PCP, records were finally received after March 15, 2016; not from the pharmacy. Respondent noted ultimately on May 3, 2016, in light of the ongoing litigation, Respondent issued a check for the original MSA funding amount of $4,092.21 to Petitioner's attorney. Respondent noted that finally on June 8, 2016 Respondent received pharmacy records for an updated MSA projection. Respondent indicated that the projected estimate was found to be higher at $4,681.97 and that was circulated to Petitioner's attorney in early July 2016. Respondent indicated that its adjuster simultaneously requested a status update on execution of the Consent to Release form required for the submission to CMS and advising that an updated MSA would be referred to CMS on receipt of that release authorization form. Respondent stated that there had been no unreasonable, frivolous, or vexatious delay and that Petitioner had failed to identify any bills submitted to Respondent that had been denied. Furthermore, Respondent stated that Petitioner's petition for fees makes no mention of any denied bills. Respondent noted that at no time did Petitioner's counsel make any demand in writing as to payment of benefits and again that Petitioner made no mention of any such unpaid medical expenses. Respondent stated Petitioner's medical rights had remained open and noted that it had outlined actions needed to be taken by Petitioner and Petitioner's counsel to update the MSA estimate for submission. Respondent stated there had been no unreasonable of vexatious delay in payment or intentional underpayment and Petitioner's medical rights had remained open since approval of the settlement contract.

5. Petitioner's counsel noted that the case had been resolved by way of settlement and Respondent had not complied with the MSA portion of the settlement contract and requested $2,046.10 in §19(k) penalties, $10,000.00 in§19(k) penalties, and $818.44 in §16 attorney fees, based on the unfunded $4,092.10 MSA.

6. The Commission thereafter took the matter under advisement.

The Commission finds that the settlement contract indicated Respondent was to pay the settlement amount of $32,705.00 for PPD plus the MSA set aside amount of $4,092.21. The Commission finds that Respondent did not really act in an unreasonable or vexatious manner to warrant penalties and attorney fees here as there were some internal issues and then the issues obtaining releases and the records for a re-estimation of the MSA (which ultimately Respondent calculated as higher). Moreover, Respondent ultimately tendered a check to Petitioner's counsel for the original estimate for the MSA. Further, delays were partially due to timely obtaining releases, and cooperation issues with the PCP and pharmacy. More importantly, Petitioner was not harmed in any way as there was never any claim against the set aside to warrant any penalties imposed against Respondent; there were never any bill issues to even potentially harm Petitioner in any way. The Commission finds that Petitioner is not entitled to penalties and attorney fees, and, herein, Petitioner's Petition for penalties and attorney fees is denied and dismissed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's petition for penalties under §19(k), & §16, of the Act is denied and dismissed.

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 injuries.

DATED: MAR 2 - 2017

David L. Gore

Stephen Mathis

Mario Basurto

DLG/jsf
7/12/16
045

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Octavio Salinas, Jr.,

Petitioner,

vs.

NO: 10 WC 7293

17IWCC0159

Quality Assurance Staffing,

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 nature and extent of permanent disability and medical expenses and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the Arbitrator's Decision by awarding temporary total disability benefits from February 2, 2010 through July 24, 2010, a period of 24-5/7 weeks. The parties stipulated that Petitioner was temporarily totally disabled for that period of time and that all temporary total disability benefits had been paid. However, the Arbitrator did not award this and gave Respondent a credit of $7,644.87 for temporary total disability benefits paid. There cannot be a credit when there is no award made. The payment of $7,644.87 divided by 24-5/7 weeks (24.714 weeks) is $309.33 per week.

The Commission affirms the Arbitrator's finding that the following medical expenses were reasonable and necessary: the initial clinical evaluations, lumbar x-rays and the first 6 chiropractic or physical therapy sessions rendered by Marque Medicos; x-ray review by Specialized Radiology Consultants on February 5, 2010; lumbar MRI performed at Delaware

17IWCC0159

Place MRI on February 16, 2010; the initial office visit with Dr. Engel at Medicos Pain & Surgical Specialists on February 25, 2010; EMG/NCV performed at Marque Medicos on February 26, 2010; office visits with Physician Assistant Pond at Medicos Pain & Surgical Specialists on March 5, 2010 and March 11, 2010; Dr. Engel office visit at Medicos Pain & Surgical Specialists on April 1, 2010; prescribed medications obtained from Prescription Partners LLC between February 25, 2010 and April 1, 2010; office visits with Dr. Gireesan from June 9, 2010 through July 21, 2010; work conditioning and functional capacity evaluation performed at Elite Physical Therapy from June 18, 2010 through July 19, 2010. The Arbitrator awarded the above medical expenses and gave Respondent credit of $22,665.03 for the medical expenses paid. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $309.33 per week for a period of 24-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $309.33 per week for a period of 50 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability of the person as a whole to the extent of 10%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. The Commission notes that Respondent paid $7,644.87in TTD benefits and $22,665.03 in medical expenses.

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 $15,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 17 2017
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David L. Gore

Stephen J. Mathis

17IWCC0159

SPECIAL CONCURRING OPINION

This case was scheduled for Oral Arguments on February 23, 2017 before a three-member panel of the Commission including members Mario Basurto, Stephen J. Mathis and David L. Gore, at which time Oral Arguments were heard. Subsequent to Oral Arguments and prior to the departure of Mario Basurto on March 3, 2017, a majority of the panel members had reached agreement as to the results set forth in this decision and opinion, as evidenced by the internal Decision worksheet initialed by the entire three member panel, but no formal written decision was signed and issued prior to Commissioner Basurto's departure.

Although I was not a member of the panel in question at the time Oral Arguments were heard and I did not participate in the agreement reached by the majority in this case, I have reviewed the Decision worksheet showing how Commissioner Basurto voted in this case, as well as the provisions of the Supreme Court in *Zeigler v. Industrial Commission*, 51 Ill.2d 137, 281 N.E.2d 342 (1972), which authorizes signature of a Decision by a member of the Commission who did not participate in the Decision. Accordingly, I am signing this Decision in order that it may issue.

L Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SALINAS JR, OCTAVIO
Employee/Petitioner

Case# **10WC007293**

QUALITY ASSURANCE STAFFING
Employer/Respondent

17IWCC0159

On 5/31/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5317 JOHN J CASTANEDA PC
514 W STATE
SUITE 210
GENEVA, IL 60134

1120 BRADY CONNOLLY & MASUDA PC
PAUL W PASCHE
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

17IWCC0159

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

OCTAVIO SALINAS, JR.
Employee/Petitioner

v.

QUALITY ASSURANCE STAFFING
Employer/Respondent

Case # 10 WC 07293

An *Application for Adjustment 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 September 11, 2014. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On January 18, 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 $18,447.00; the average weekly wage was $354.75.

On the date of accident, Petitioner was 33 years of age, *married* with 2 dependent children.

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

Respondent shall be given a credit of $7,644.87 for temporary total disability benefits paid, and shall further be given a credit of $22,665.03 for medical benefits that have been paid.

The Parties stipulated that Petitioner was temporarily totally disabled from February 2, 2010, through July 24, 2010, representing 24 5/7 weeks, and all temporary total disability benefits have been paid.

ORDER

Respondent shall pay Petitioner **permanent partial disability benefits of $309.33/week for 50 weeks**, because the injuries sustained resulted in permanent partial disability to the extent of **10% loss of use of the person as a whole, in accordance with §8(d)2 of the Act.**

Respondent shall pay, pursuant to **Sections 8(a) and 8.2 of the Act**, the costs of medical services approved by Respondent's utilization review, Dr. Kornblatt, and Dr. Gireesan, namely: the initial clinical evaluations, lumbar x-ray, and first six chiropractic or physical therapy sessions rendered by Marque Medicos; x-ray review by Specialized Radiology Consultants on February 5, 2010; MRI at Delaware Place MRI on February 16, 2010; the initial office visit with Dr. Engel at Medicos Pain and Surgical Specialists on February 25, 2010; the EMG/NCV study at Marque Medicos on February 26, 2010; office visits with PA Pond at Medicos Pain and Surgical Specialists on March 5, 2010 and March 11, 2010; the office visit with Dr. Engel at Medicos Pain and Surgical Specialists on April 1, 2010; prescription medications obtained at Prescription Partners, LLC between February 25, 2010, and April 1, 2010; office visits to Dr. Gireesan on June 9, 2010, through July 21, 2010; and work conditioning and functional capacity evaluation at Elite Physical Therapy from June 18, 2010, through July 19, 2010. This award of medical expenses is subject to a credit for the medical benefits that have already been paid.

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

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

Signature of Arbitrator

May 27, 2016
Date

MAY 31 2016

FINDINGS OF FACT

Petitioner, Octavio Salinas, was employed by Respondent, Quality Assurance Staffing, on January 18, 2010. The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on that date. Petitioner slipped while cleaning carts and felt pain in his low back. Petitioner did not seek immediate medical attention for his injury. He initially took Tylenol for the pain and used "Ice Hot." Petitioner apparently continued to work his regular job until February 2, 2010. Petitioner denied prior low back injuries or treatment.

Per the stipulation of the Parties, Petitioner was temporarily and totally disabled from work as a result of the accident from February 2, 2010 through July 24, 2010 (24 5/7 weeks). The Parties further stipulated that the petitioner was permanently partially disabled to the extent of 10% loss of the person as a whole as a result of the injuries sustained.

Petitioner is unsophisticated and some of his answers to questions were a little confusing. The Arbitrator does find that Petitioner was competent to testify and makes the Findings of Fact and Conclusions of Law herein based upon the Petitioner's testimony and supporting documentary evidence.

Medical Treatment per Petitioner's Testimony and Medical Records

Petitioner was referred by a receptionist to Marque Medicos ("Marque"). Petitioner's first visit for treatment of his injuries was on February 2, 2010 at Marque. Petitioner testified that at Marque, "they" referred him for physical therapy. Petitioner was seen by Dr. Perez, a chiropractor at Marque Medicos, and Dr. Perez ordered a MRI of Petitioner's back, and physical therapy. Petitioner was advised by Dr. Perez not to work. The records of Dr. Perez include an x-ray report indicating that no evidence of fracture, dislocation, or osseous or joint pathology was found, and the soft tissue structures were unremarkable. The physical therapy recommended by Dr. Perez was performed at Marque. It consisted of exercises, electrical stimulation, and hot/cold packs. (RX10; RX 11)

The MRI which was obtained on February 16, 2010, at Delaware Place MRI, and showed a three- to four-millimeter "protrusion/herniation" at L5-S1, without significant spinal stenosis nor significant neural foraminal narrowing." (PX 1; RX 10)

Dr. Perez referred Petitioner to see a specialist, Dr. Engel, of Medicos Pain and Surgical Specialists (MPSS). He also recommended an EMG/NCV study of the bilateral lower extremities. (PX 4; RX 10) Petitioner first saw Dr. Engel on February 25, 2010. Dr. Engel noted pain complaints rated at 7 out of 10 and prescribed medication. (PX 5; RX 10) Petitioner could not remember where he filled the prescription, but it was in a different building than Dr. Engel's office.

The EMG was performed at Marque on February 26, 2010, and was normal with no evidence of acute denervation of the nerve roots (i.e., no evidence of radiculopathy.) (PX 4; RX 10)

Petitioner continued to attend physical therapy sessions at Marque and chiropractic visits with Dr. Perez at the same place. (PX 4; RX 10) At his next visit, on March 11, 2010, Dr. Engel's physician assistant, Stacy Pond, noted that Petitioner had pain at 7 of 10 that was reduced to 4 of 10 with medication. She agreed that the

EMG showed no evidence of radiculopathy. Nevertheless, she recommended an epidural steroid injection. The Arbitrator notes that at no point in the records did PA Pond recommend or mention any medical necessity for transportation services. (PX 5; RX 10)

On March 12, 2010, Petitioner returned to MPSS for pre-operative history and physical by Dr. Nandra. The Arbitrator notes again that at no point in the records did Dr. Nandra recommend or mention any medical necessity for transportation services. (PX 5; RX 10)

The injection to Petitioner's low back was given by Dr. Engel on March 15, 2010. Petitioner testified that his back pain did not improve at all after this injection. On April 1, 2010, Dr. Engel noted that Petitioner's pain was 5 out of 10 with medication, which was worse than before the injection. He increased the dosage of pain medication and recommended a second injection. (PX 5; RX 10)

On April 5, 2010, Petitioner was examined at the request of Respondent by Dr. Michael Kornblatt pursuant to Section 12 of the Act. Petitioner told Dr. Kornblatt how the accident happened and where his pain was. The examination lasted about two hours. Dr. Kornblatt issued a report in which he found the Petitioner had continued low back pain and utilized pain medication; however, the physical examination resulted in no abnormal objective findings. Dr Kornblatt found lumbar flexion at 90 degrees, lumbar extension at 30 degrees and lumbar side-bending at 30 degrees bilaterally. Dr. Kornblatt opined that Petitioner had reached maximum medical improvement and required no further medical care. He also noted that Petitioner had undergone excessive treatment, including excessive chiropractic and physical therapy, along with an unnecessary epidural injection. He further opined that the findings noted on the MRI were consistent with pre-existing degenerative disk disease, and that the work incident did not cause, aggravate, or accelerate this pre-existing condition. (RX 5, Dep. Ex. 2)

After Dr. Kornblatt's examination, Petitioner continued to attend physical therapy at Marque, and he underwent the second low back injection by Dr. Engel on April 12, 2010. Petitioner testified his low back pain did not improve after this injection. On April 22, 2010, Dr. Engel again noted pain at 5 of 10, and then recommended a discogram. (PX 4; PX 5; RX 10)

The discogram was performed on April 28, 2010, and included a CT scan. T. 22, PX 5, RX 10. During the procedure, Dr. Engel recorded the petitioner had "concordant" central back pain at L5-S1, but this was listed at 10 of 10, which was twice as much as the petitioner's previous pain rating (5 of 10). Dr. Engel recorded no pain at L4-5. The CT scan showed a moderate, Dallas type-3 annular tear at L5-S1 and a normal disk (Dallas type-0) at L4-5. Petitioner continued to undergo physical therapy until his next visit with PA Pond on May 5, 2010. This was the same type of therapy as before—massage and stimulation. (PX 4; PX 5; RX 10)

On May 5, 2010, PA Pond noted full range of motion regarding lumbar flexion, lumbar extension, and lumbar rotation, all without pain. She noted some pain with side bending, but "minimal-to-no deficits in mobility" there. She noted the pain was still rated at 5 out of 10. She referred Petitioner to a spine surgeon, Dr. Gireesan. Petitioner continued with the therapy at Marque and saw Dr Engel in follow-up after the referral. (PX 4; PX 5; RX 10)

Dr. Gireesan examined Petitioner on June 9, 2010, diagnosed discogenic low back pain, and recommended four weeks of work conditioning followed by a functional capacity evaluation. Dr. Gireesan found lumbar flexion at 40 degrees, lumbar extension at 10 degrees and lumbar side-bending at 15 degrees bilaterally. Petitioner underwent work conditioning from June 18, 2010, through July 16, 2010, at Elite Physical Therapy. (PX 2; PX 3) On July 19, 2010, a therapist at Elite performed the FCE, finding that Petitioner

could return to his usual occupation, which required lifting occasionally up to 50 pounds. The therapist noted that Petitioner exhibited no significant deficits on examination. (PX 2; PX 3)

On July 21, 2010, Dr. Gireesan released Petitioner to return to work full duty, within the parameters of the FCE. (PX 3)

On July 22, 2010, Petitioner returned to Dr. Engel, who also released him to work per the FCE. (PX 5) "Round trip transportation" was offered to and from the clinic, but no apparent reason for this service is stated in the records, other than "this injection". However, no specific injection was identified, and no injection or other procedure was performed on that date. (PX 5)

Petitioner returned to work as of July 25, 2010 and has lost no more time from work as a result of the injury. He apparently is able to do his regular work.

On August 16, 2010, Petitioner was examined by Dr. Edward Goldberg at Respondent's request, pursuant to §12. (RX 10) Dr. Goldberg apparently did not review any records after the June 9, 2010, appointment with Dr. Gireesan. Dr. Goldberg concurred with Dr. Gireesan's recommendation for work conditioning followed by the FCE. Dr. Goldberg Thought that Petitioner was at MMI and was not in need of further treatment. The work injury aggravated degenerative disc disease at L5-S1 and this aggravated DDD condition was causally related to the accident. (RX 10)

For reasons he could not remember, Petitioner returned to Dr. Engel on September 2, 2010, and no further treatment was recommended. There has been no further medical treatment after September 2, 2010. (PX 5)

Utilization Review of Medical Treatment

On August 10, 2011, Respondent retained GENEX services to perform utilization review of Petitioner's medical treatment and expenses. (RX 11 & 12) In particular, the review focused on five items: 1.) Physical Therapy/chiropractic treatment (hot/cold packs, electrical stimulation, and exercise) from February 2, 2010 to June 2, 2010; 2.) EMG/NCV of the bilateral lower extremities on February 26, 2010; 3.) Transport services on March 12, 2010, March 15, 2010, April 12, 2010, April 28, 2010, and May 5, 2010; 4.) Lumbar epidural steroid injections on March 15, 2010, and April12, 2010; and 5.) Lumbar discography on April 28, 2010. The first of these items occurred at Marque Medicos and the other four occurred at MPSS and at facilities to which MPSS had referred Petitioner. (RX 11; RX 12)

After a peer review by Dr. Humberstone, DC, the physical therapy/chiropractic visits were partially certified to include six visits. After a peer review by Dr. Skaredoff, the EMG/NCV, transport services, epidural injections, and lumbar discography were all non-certified. Both medical providers appealed. After a further peer review by Dr. Cox, DC, the original partial certification of physical therapy/chiropractic treatment was sustained. After further peer review by Dr. Blum, the EMG/NCV was certified, but the non-certifications of the ESIs and transportation were sustained. (RX 11; RX 12)

Dr. Maury Guzick, DC, testified at trial that he is the Manager of Physician Services at GENEX. He manages reviews that physicians perform for GENEX for a number of services including Utilization Review. He has been involved in utilization review activities since 1990. He has managed or handled utilization review in different states since then, including in Illinois. He testified that GENEX became URAC certified in 1994. GENEX was still accredited at the time of this accident, as confirmed by its URAC accreditation certificate

covering 2009 through 2012. (RX 9) One of the criteria for certification includes how physicians are chosen for peer reviews. If a company uses vendors to assist with finding such physicians, then the vendor must also be URAC accredited. In 2010, GENEX was following URAC procedures for all utilization reviews it performed in Illinois. At that time, this procedure involved a nurse reviewing the medical records and determining if the proposed treatment could be approved; if so, the nurse would certify the treatment and send appropriate letters of approval to the medical care provider, the adjuster, the patient and the patient's representative. If the nurse could not approve the procedure, then she would refer the case for a peer review and based on the peer review report would disseminate a determination to the involved parties. The peer review physician would be someone skilled in the same procedures as the treating provider. The peer review physician would be provided with medical records and would base the peer opinion on a nationally-recognized guideline, such as ODG.

Dr. Guzick testified that he reviewed the records of GENEX with regard to the utilization review performed in this case. (RX 10; RX 11 & RX 12) He identified the five retrospective items that were being reviewed. Dr. Guzick confirmed that GENEX followed URAC procedures for each of the five medical procedures. He also confirmed that GENEX followed URAC procedures with regard to the appeals that were filed following the initial determinations that GENEX had issued. With regard to Marque Medicos, its appeal request included only an additional peer review, and this was done by GENEX. MPSS requested both a peer review and an interview with the peer reviewer, and this was done. URAC does not allow for any further review beyond these appeals. Dr. Guzick testified that the physicians chosen for the peer review came from ClaimsEval and Network Medical Review and all physicians were licensed in the State of Illinois.

Testimony of Reviewing Physicians

Dr. Michael Kornblatt MD (RX 5)

Dr. Kornblatt is a board-certified orthopedic surgeon licensed to practice medicine in Illinois since 1979. In addition, Dr. Kornblatt is a member of the American Academy of Orthopedic Surgeons. The AAOS publishes treatment guidelines. In general, over the past ten years, Dr. Kornblatt's practice has consisted of 98% treating and evaluating conditions of the spine, with 80% of his patients presenting with lumbar problems and 20% with cervical spine problems.

Dr. Kornblatt reviewed records from Marque and MPSS, including the MRI report and films dated February 16, 2010, and the EMG report dated February 26, 2010. Of significance, on February 2, 2010, the Petitioner presented with low back pain. On February 12, 2010, he described the low back pain as greater on the right. He underwent chiropractic and physical therapy treatment, with 11 treatments in February and one in March prior to visiting Dr. Kornblatt. The MRI scan reportedly showed a subligamentous posterior disc protrusion or herniation at L5-S1, elevating the posterior longitudinal ligament without significant spinal stenosis or significant neuroforaminal narrowing. Following the MRI, pain management and electrodiagnostic studies were ordered and physical therapy was to continue. Dr. Engel had first examined Petitioner on February 25, 2010, and noted an absence of any neurologic deficit. Anti-inflammatory medication was prescribed and an EMG was ordered. The EMG was noted to be normal with no evidence of radiculopathy. X-rays from February 2, 2010, were of poor quality, but did not appear to show any pathology. Dr. Kornblatt also reviewed the MRI films himself and noted findings of disc desiccation at the L5-S1 level without herniated disc, spinal stenosis, or nerve root impingement. Dr. Kornblatt obtained the following history: the patient had been working for Respondent since mid-September of 2009, and in October 2009, he began working in sanitation at Joseph Foods. On January 18, 2010, he slipped on grease while cleaning parts and twisted his low back, but did not fall. He noted middle low back pain. He continued working for one week and then sought evaluation and

treatment at Marque Medicos on February 2, 2010, and had been off work ever since. He attended treatment three times per week, consisting of physical therapy with passive modalities and exercise. He performed no exercise at home. He underwent an injection (which sounded like an epidural steroid injection) on March 15, 2010, which did provide some relief, and was scheduled for a second injection on April 12, 2010. At the time he saw Dr. Kornblatt, Petitioner stated he was improved, but continued to note middle low back pain. However, he denied radicular leg pain. He stated the back pain was worse with sitting, bending, twisting and walking. He utilized pain medication three times per day, but did not know the name. His past medical history was negative for previous back injury or similar symptoms. Dr. Kornblatt felt that Petitioner's subjective complaints at the time of his examination were not all consistent with the histories recorded in the medical records. In particular, Petitioner reported low back pain both in the records and to Dr. Kornblatt, but he denied right leg pain to Dr. Kornblatt, whereas there was some mention of right leg pain in the records. Dr. Kornblatt's physical examination of Petitioner revealed no abnormal objective findings. Dr. Kornblatt checked for radiculopathy. Straight leg raising was negative, reflexes were normal, muscle strength was normal, the sensory examination was normal, and Petitioner's general gait and movement was normal. Dr. Kornblatt felt that Petitioner's subjective complaints were not consistent with the objective findings and his review of the diagnostic studies, because the studies and examination were normal, but Petitioner continued to complain of low back pain.

When asked if he had formulated a diagnosis, Dr. Kornblatt stated that he never really did, because he had made no findings. In the section of his report labeled "Opinion," Dr. Kornblatt mentioned a minor lumbosacral strain, but this was not a diagnosis, more of a description of what Dr. Kornblatt believed may have occurred. If he had made a diagnosis at the time, it would have been of mechanical low back pain with degenerative disc disease and a history of a lumbosacral strain. It was Dr. Kornblatt's opinion to a reasonable degree of medical and surgical certainty that there was a causal relationship between the incident of January 18, 2010, and the lumbosacral strain. However, there was no causal relationship between that incident and the degenerative disc disease. Dr. Kornblatt opined that not all of the treatment and testing that Petitioner had received prior to the examination was medically necessary and reasonable. He felt Petitioner needed a certain amount of conservative management, mostly consisting of a home exercise program and posture training. Dr. Kornblatt would not have ordered the MRI, the EMG, or the epidural steroid injections. He may have considered trigger point injections in a lumbosacral strain case, but these were not indicated here. The indications for an epidural steroid injection are that these injections typically are for treatment of radiculopathy. Here, the patient had no radiculopathy, and an epidural steroid injection would therefore not be indicated. The indications for an EMG would be if a patient's case clinically did not make sense. Dr. Kornblatt stated that some doctors do "cookbook-style" medical practice, ordering the same tests for all patients, looking for impingement or radiculopathy. Dr. Kornblatt prefers not to order the testing unless the clinical picture does not add up. Here, there was clearly no evidence of radiculopathy on clinical examination, and Dr. Kornblatt would not have ordered an EMG. With regard to the chiropractic treatment and physical therapy, Dr. Kornblatt felt that this treatment was not reasonable and necessary, and was excessive. Based upon his experience and training, Dr. Kornblatt stated that a lumbar strain should require six to eight sessions of either chiropractic or physical therapy, but not both. The patient needs to be taught appropriate mechanics and exercise. In this case, when asked if Petitioner had a home exercise program, Dr. Kornblatt stated the records indicated he was not performing one, but he clearly should have been exercising. Dr. Kornblatt opined that Petitioner did not require any further medical treatment or testing as a result of the injury of January 18, 2010. This was based upon his experience, training and review of the MRI scan. Dr. Kornblatt felt that Petitioner had reached maximum medical improvement as of April 5, 2010, with regard to the injury of January 18, 2010, again based upon his experience and training.

On cross-examination, Dr. Kornblatt defined degenerative disc disease as a finding on x-ray or MRI, but noted that it could also be a clinical finding. The phrase means the wearing out or loss of water content in an intervertebral disc. "Desiccation" is defined as an MRI finding that shows there is less water in the disc. This is part of the normal aging process. In this case, the finding of desiccation was insignificant. Dr. Kornblatt stated that radiculopathy is a symptom of nerve irritation. When asked if an MRI was better than an x-ray for diagnosing degenerative disc disease, Dr. Kornblatt stated that he can use both. When asked if weakness or diminished sensation is a finding of radiculopathy, Dr. Kornblatt stated that they can be. When asked if trauma can cause degenerative disc disease, Dr. Kornblatt stated that he did not think so. Dr. Kornblatt did not note that Petitioner was malingering. When asked if he saw symptoms of L5 radiculopathy in Petitioner's left buttock area, Dr. Kornblatt stated he could not see those. When asked if findings of symptoms of pain or decreased sensation are the same as left buttock pain, Dr. Kornblatt disagreed. Dr. Kornblatt noted right leg pain had been reported to Dr. Engel, but when Petitioner saw him, Dr. Kornblatt stated that Petitioner reported no buttock pain, and denied such pain. Dr. Kornblatt felt that Petitioner's degenerative disc disease pre-existed his injury. The symptoms of a strain can last up to six months, but should resolve within four weeks. Dr. Kornblatt is familiar with other doctors in this case. He has seen their records in the past. He is also familiar with Dr. Goldberg at Midwest Orthopedics. When asked if Dr. Goldberg had a reputation as a qualified physician, Dr. Kornblatt stated that "we are equally qualified." When asked if his reading of the MRI was different from the radiologist's, Dr. Kornblatt agreed that they used different words. Dr. Kornblatt did not mention the term "protrusion." When asked what a bulge on the thecal sac meant, Dr. Kornblatt stated, "not a thing." When asked what a 3mm to 4mm protrusion meant, Dr. Kornblatt stated that basically to him it meant nothing. Dr. Kornblatt did confirm that he receives substantial income from testifying and performing IMEs.

On re-direct examination, Dr. Kornblatt stated that a protrusion of any size is not significant. It only becomes significant if there is impingement. Here, the protrusion was part of the aging process. The typical symptoms of radiculopathy are pain in the extremity with possible referral of numbness, tingling, or weakness. Here, there were none of those complaints noted by Petitioner. If a patient has radiculopathy, he will have diminished sensation, but will also have findings consistent with these. In this case, he checked for diminished sensation and did not find any. A protrusion in and of itself is insignificant. It is part of degenerative disc disease. It is a finding found in 30% to 40% out of every 100 patients (if the control group is greater or less than 110, is the percentage higher, or lower?), and is considered a normal finding. The causes of radiculopathy are impingement on the nerve. This can be caused by a herniated disc, a bone spur, a tumor, a fracture, or a cyst, none of which was present in this case.

Dr. Lawrence Humberstone, DC (RX 6)

Dr. Humberstone is a chiropractic physician, licensed to practice in the State of Illinois since 1986. He is board certified, as are all chiropractors licensed by the State of Illinois, and he has the certification status of "diplomat." In an evaluation such as this one, Dr. Humberstone is requested to apply nationally recognized, evidence-based standards to render opinions on the propriety of certain chiropractic treatment. When he receives such requests, it is his protocol to review the medical records provided, the appropriate treatment standards, and any additional information that he is provided. Next, he applies the standards to the treatment that is either proposed or has been performed, and renders his opinion in answer to the question requested of him. Lastly, he prepares a written report containing his findings and opinion, as well as the basis for his opinion. He followed that protocol in this case. Dr. Humberstone was retained for involvement in this case by a vendor known as Network Medical Resource, or NMR. NMR requested that Dr. Humberstone review certain medical records and render an opinion on the medical necessity of chiropractic and physical therapy treatments rendered to the petitioner. Dr. Humberstone reviewed records from Marque Medicos, MPSS, Dr. Gireesan, Elite Physical Therapy, Dr. Kornblatt and Dr. Goldberg. Dr. Humberstone noted that there were several

diagnoses listed for Petitioner in the records he reviewed. In his report, he listed a diagnosis of lumbago, or low back pain, because this was the diagnosis used in the initial physical therapy evaluation on February 2, 2010. The specific question Dr. Humberstone was asked to address was whether 43 physical therapy and chiropractic visits at Marque Medicos and Elite Physical Therapy were medically necessary. Dr. Humberstone's short answer was, "No." Based on evidence-based guidelines, including the "ODG," the Official Disability Guidelines, if a patient does not improve after six therapy visits, the therapy is not to continue. The upper limits according to the ODG would be 18 visits. Here, the medical records clearly showed there was no improvement after the first six visits. Dr. Humberstone's opinion was based upon his clinical experience and reinforced by the ODG guidelines. Dr. Humberstone also reviewed Respondent's Exhibit 10 (the complete records of Marque Medicos and Medicos Pain and Surgical Consultants). He indicated that he reviewed this exhibit in preparation for his deposition testimony. This exhibit contained some additional records to the ones he originally reviewed when he prepared his report in August 2011. After reviewing these additional records, Dr. Humberstone stated that his opinions had not changed. In fact, he stated that his opinions were reinforced by the records in Respondent's Exhibit 10.

It is noted that Dr. Engel believed that Dr. Humberstone violated UR guidelines by considering Dr. Kornblatt's report of 4/10/2010 because Dr. Kornblatt's report was not available to the treating physicians at the time that they ordered treatment and Humberstone's UR review was retrospective. (PX 4)

Dr. Michael Nicholas Skaredoff MD (RX 7)

Dr. Skaredoff has been licensed to practice medicine in Illinois since 1987, and was licensed to practice in New York prior to that and several other states. He is an anesthesiologist with a subspecialty in pain management, with board certifications in both areas. He received an assignment from NMR and it included the records contained in RX 10. He was asked to answer the four questions concerning the procedures at MPSS. With regard to the discography, Dr. Skaredoff noted the MRI was of sufficient quality to rule out the need for a discogram to identify a pain generator. In addition, there had not been a recommendation for surgery prior to ordering the discography. Also, Petitioner had not undergone any psychosocial screening to rule out secondary gain. According to ODG guidelines, these three factors made a discography inappropriate in Petitioner's case. Regarding the EMG/NCV study, Dr. Skaredoff found this to be non-certified, because the MRI had already ruled out nerve compression or radiculopathy. Again, the ODG guides only recommend the EMG/NCV study if there is no definitive conclusion as to the existence of the radiculopathy. Here, both the clinical complaints of Petitioner and the MRI ruled out radiculopathy. With regard to the transport services, Dr. Skaredoff noted the ODG guides did not address this service. Dr. Skaredoff noted that without radiculopathy, Petitioner could have been transported by a friend or a cab, and there was no medical indication he needed special transit in an ambulance. Dr. Skaredoff felt that unless a patient was bed-ridden and cannot be moved, he did not see a reason for an ambulance. With regard to the epidural injections, Dr. Skaredoff again noted that the ODG guidelines require documented radiculopathy before that type of injection is indicated. Furthermore, the failure of the first injection to relieve any symptoms clearly showed that neither was indicated in this case.

Dr. Steven L. Blum MD (RX 8)

Dr. Blum is a physician anesthetist practicing in Skokie, Illinois. He has been licensed to practice medicine in Illinois since 1993. However, prior to that, he has been licensed to practice medicine and worked in California since 1973. He is board-certified in three areas: family practice (1976, recertified 1997), anesthesiology (1984), and pain management (1998, recertified 2008). In addition to that, he is an Assistant Professor at Rush Medical College in Chicago. He has been an Assistant Professor since 1993. He is responsible for practical teaching in the fields of anesthesiology and pain management. This includes training in

the use of epidural steroid injections. Over the past 10 to 15 years, Dr. Blum's practice included treating patients at the Rush pain center and in the hospital. In the hospital, he mostly works in the operating room. In the pain center, he treats patients with chronic and acute pain conditions. He was asked to perform a utilization review by ClaimsEval, the only company for whom he performs such requests. He reviewed the materials and the guideline information provided by ClaimsEval, in the form of summaries of the Official Disability Guidelines applicable to the procedures being questioned. The Official Disability Guidelines are recommendations for appropriate resources for pain management, and were developed from review of medical literature. The guidelines, or "ODGs," are medically accepted standards. The ODGs are nationally recognized peer review and treatment guidelines. The ODGs are considered to be based upon evidence-based medicine. When asked if his own treatment of patients complies with the ODGs, Dr. Blum stated that often it does.

In the present case, Dr. Blum was retained by ClaimsEval in approximately September 2011. He was asked to review the propriety of certain medical procedures ordered by MPSS. Dr. Blum identified Respondent's Exhibit 10 as the records that were provided to him. The only other things provided were the ODG summaries. He followed his protocol for utilization review in reviewing this case. He also directly contacted Dr. Engel, but only after Dr. Blum had submitted his report to ClaimsEval. Dr. Blum prepared a written report for each of the four questions he was asked.

Dr. Blum first identified his report concerning the EMG. In this report, he opined that the EMG test was warranted. His opinion was based upon the ODG concerning verification of radiculopathy. Because there was a question at the time as to whether Petitioner in fact had lumbar radiculopathy, the EMG was an appropriate test to answer the question. In fact, the EMG showed that Petitioner had no lumbar radiculopathy.

Dr. Blum's second report addressed the issue of the epidural steroid injections. Dr. Blum opined that these procedures should be non-certified, because the ODGs stated that such injections were inappropriate for a patient without radiculopathy. Because the EMG confirmed that Petitioner did not have radiculopathy, the injections were not warranted. The second set of injections were further unwarranted, based upon a separate ODG. This ODG provides that a second injection would only be appropriate if the first injection resulted in 50% improvement in symptoms that lasted at least six weeks. In this case, the second injection was performed only four weeks after the first injection and, therefore, the second injection was non-compliant with this second ODG. However, both injections were inappropriate, given the lack of radiculopathy. Dr. Blum defined radiculopathy as an injury to the nerve root that caused pain, weakness and numbness. The EMG measures electrical velocity, which can show if the appropriate nerve has been injured. A clinical finding of normal muscle strength would be relevant, because radiculopathy would normally impact strength. An injury to a nerve should affect motor and sensory nerves, and if the nerve has been pinched, Dr. Blum would expect weakness. Therefore, normal muscle strength, or an absence of weakness, would imply that there was no radiculopathy. This normal strength finding was, in fact, consistent with the EMG results that also showed no radiculopathy in the case of Mr. Salinas.

Dr. Blum's third report addressed the lumbar discography procedure. Dr. Blum non-certified this procedure. The ODGs refer to the discogram procedure as being highly controversial. Discography is only warranted in patients who have been previously recommended for fusion surgery. Even then, the discography is done to possibly rule out the need for the surgery itself. In other words, if the discography is negative, then the fusion surgery should not be performed as contemplated. However, because a positive finding on a discography study still has controversial meaning, there is no medical significance to such a finding. In this case, Petitioner has never been a surgical candidate. This has been the consensus of Dr. Engel, Dr. Kornblatt and Dr. Goldberg. Therefore, the discography should not have been performed. Dr. Blum disagreed with Dr. Engel's conclusion that Petitioner had a lumbar herniated disc. Based upon the review of the MRI by himself, as well as Dr.

Kornblatt, Dr. Blum saw no herniated disc. Dr. Blum reviewed the actual MRI films. He did concede that the radiologist's report provided to him by Dr. Engel did show a disc protrusion. However, this was not a disc herniation. Dr. Blum further felt that when Dr. Skaredoff referred to a psychological evaluation, that this was to be taken in the context of the non-existent fusion surgery recommendation. Because a discography is only appropriate in cases where a fusion surgery has already been recommended, and because psychological or psychiatric evaluations are performed in conjunction with a fusion surgery preparation, the absence of a psychological or psychiatric evaluation confirmed that no such surgery was even being contemplated. This was further indication that lumbar discography was inappropriate for Petitioner.

Dr. Blum's fourth and last report dealt with the issue of medical transportation. Dr. Blum felt that this treatment should be non-certified. There is no ODG applicable to medical transportation. However, Dr. Blum based his decision on his own experience, stating that transport services are not appropriate for outpatient epidural steroid injections in general. He noted that Petitioner had managed to get to and from all of his prior treatment thus far. Dr. Blum agreed there was no medical literature regarding the need for transportation. When asked if he agreed with Dr. Engels' statements that a failure to provide transportation to a patient who has undergone anesthesia would be "outside the standard of care," Dr. Blum stated that he had two problems with the statement. First, the term "anesthesia" is vague. No specific details as to the type or duration of anesthesia were provided. Second, the only possible side effect of anesthesia that would warrant professional medical transportation would be leg weakness, and Dr. Blum did not find in the medical records any evidence of leg weakness following the procedures that Petitioner underwent. The Arbitrator also notes that Petitioner did not receive anesthesia on every date when transportation services were provided. Dr. Blum felt that the only finding that would render a patient incapable of taking public transportation would be if the patient was incapable of walking. There was no documentation in the medical records that Petitioner ever lost the ability to walk.

Medical Bills Paid

The Parties stipulated that the following amounts had been paid by respondent to these care providers (RX 1):

PROVIDER/PAYEE	AMOUNT
Marque Medicos LLC	$6,911.60
Medicos Pain and Surgical Specialists	$2,110.11
Prescription Partners	$1,621.86
Specialized Radiology	$55.00
Dr. Giri Gireesan	$462.91
Elite PT DBA Maldonado O'Connell, LTD	$9,901.98
Delaware Place MRI	$1,601.57
Total:	$22,665.03

Petitioner claimed balances due on various medical bills totaling $82,830.08. (PX 8)

CONCLUSIONS OF LAW

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

In support of the Arbitrator's decision regarding (F), is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

Having carefully observed Petitioner's demeanor and considered the entire Record, the Arbitrator finds Petitioner's testimony to be credible. However, the Arbitrator notes that Petitioner's testimony did not match the findings in the medical records of Marque Medicos or those of Medicos Pain and Surgical Specialists. With respect to Petitioner's low back condition, the Arbitrator relies on the opinions of Dr. Kornblatt, Dr. Gireesan, and Dr. Goldberg and finds that Petitioner sustained a lumbar strain that did not aggravate or accelerate his pre-existing condition of lumbar degenerative disk disease. The Arbitrator further concludes that Petitioner reached maximum medical improvement for his lumbar strain on July 22, 2010, when he was released from care by Dr. Gireesan, and no treatment after that date is causally related to the work accident. This conclusion is further supported by the negative MRI and EMG tests which did not establish either radiculopathy or any acute injury to the L5-S1 disc itself.

In support of the Arbitrator's decision regarding (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 conducted a utilization review of the treatment performed or recommended by the physicians at Marque Medicos and at Medicos Pain and Surgical Specialists. Utilization Review approved only the following: 6 physical therapy sessions for the low back condition at Marque Medicos and the EMG study at Marque Medicos. Utilization Review denied certification for the two epidural injections performed by Dr. Engel, the discogram performed by Dr. Engel (and post-discogram CT scan), and the transportation services provided by MPSS. The Arbitrator finds that the utilization procedure was performed pursuant to URAC standards and nationally recognized peer review guidelines and evidence-based medicine, as attested to by Drs. Guzick, Humberstone, Skaredoff and Blum (perhaps the Kornblatt report should not have been considered by Humberstone, but the Arbitrator finds that Humberstone's URAC opinion is still persuasive). The Arbitrator finds that each of the peer review physicians relied on competent, objective medical evidence in the records and testified in a credible and persuasive manner. The Arbitrator further notes that Petitioner offered no testimony to contradict the testimony or opinions of the peer review physicians. Engel and Perez did follow the UR appeal process, but they were unsuccessful, except for the EMG. Lastly, the arbitrator notes that the opinions and orders of Dr. Perez, Dr. Engel and PA Pond were not supported by objective evidence. Pursuant to Section 8.7 of the Act, as it existed in 2010 applicable to this matter, the utilization review was valid, and the not certified treatment (excessive chiropractic/PT in excess of 6 visits; 2 ESI procedures, discogram and related CT; and transportation services) is found to be not reasonable and necessary and the claims for same are denied. *Roberto Ramirz Lopez v. KIMCO*, 13 IWCC 800 (2013).

The Arbitrator further finds the opinions of Dr. Kornblatt to be more credible than those of Dr. Perez, Dr. Engel, and PA Pond. There is no dispute that the EMG study ruled out any evidence of radiculopathy. Therefore, the fact that Dr. Engel proceeded with the epidural injections and discography defies justification. There is no dispute that Petitioner's symptoms did not improve with any of the injections, nor with any of the physical therapy or medication treatment that he underwent at either Marque Medicos or MPSS. Dr. Kornblatt noted all of this and his opinion was corroborated by the utilization review results. Dr. Kornblatt opined that the Petitioner's medical treatment prior to April 5, 2010, was excessive, and the Arbitrator finds this opinion to be credible and supported by the medical evidence, as well as by the Petitioner's testimony at trial. Therefore the Arbitrator concludes that the respondent is not liable for any of the treatment recommended by Dr. Perez, Dr. Engel or PA Pond that was not certified by utilization review. *Faber v. State*, 14 IWCC 707 (2014).

Lastly, the arbitrator is persuaded by the opinions of Dr. Gireesan and Dr. Goldberg that Petitioner was in need of work conditioning and thereafter the functional capacity evaluation that he underwent at Elite Physical Therapy. This treatment was warranted after physical therapy had concluded.

All other medical bills and the charges for the non-emergency, round trip ground transportation are denied.

In support of the Arbitrator's decision regarding (L), what is the nature and extent of the injury, the Arbitrator finds as follows:

The Parties stipulated that Petitioner had suffered the 10% loss of use of a person as a whole as a result of the injuries sustained and the Arbitrator awards same.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt	☐ 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

Martha Hamilton,
Petitioner,
vs.

17IWCC0148

NO: 10 WC 21939
11WC 29409

State of Illinois,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 25, 2016 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.

DATED: MAR 8 - 2017
KWL/vf
O-2/28/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

17IWCC0148

HAMILTON, MARTHA
Employee/Petitioner

Case# **10WC021939**

11WC029409

STATE OF ILLINOIS
Employer/Respondent

On 2/25/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
HANIA SOHAIL
3100 N KNOXVILLE AVE
PEORIA, IL 61603

5273 ASSISTANT ATTORNEY GENERAL
MEGAN MURPHY
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

FEB 25 2016

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

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

17IWCC0148

MARTHA HAMILTON
Employee/Petitioner

Case #10 WC 21939
#11 WC 29409

V.

STATE OF ILLINOIS
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on January 29, 2016. After reviewing all of the issues, the stipulations of the parties and the evidence, it is hereby found and ordered as follows:

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

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

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

M. ☐ Is the respondent due any credit?

N. ☒ Prospective medical care?

FINDINGS

- On December 23, 2008, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $45,744.00; the average weekly wage was $879.69.
- At the time of injury, the petitioner was 56 years of age, married with no children under 18.
- The parties agreed that the respondent paid $21,448.34 in temporary total disability benefits.

ORDER:

- The petitioner's request for temporary total disability benefits after January 19, 2009, is denied.
- The medical care rendered the petitioner for her left knee and left shoulder through January 19, 2009, was reasonable and necessary and is awarded. The medical care rendered the petitioner for her right hip and for her left shoulder and left knee after January 19, 2009, was not reasonable or necessary and is denied. The respondent shall pay the medical bills in accordance with the Act, the medical fee schedule or any prior adjustments or negotiated rate. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.
- The petitioner's request for an award for the cost of left knee and right hip replacements is denied.

- In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of temporary total disability, medical benefits, or compensation for a permanent disability, if any.

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

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

Robert E. Williams

Signature of Arbitrator

February 25, 2016
Date

FEB 25 2016

FINDINGS OF FACTS:

On December 24, 2008, the petitioner sought medical care at Midwest Physician Group/Advocate Medical Group (AMG) for left knee pain and reported falling and striking her knee the previous afternoon. The injury is the subject of claims #10 WC 21939, for a date of accident on December 24, 2008, and #11 WC 29409, for a date of accident on December 23, 2008. X-rays were negative for an acute injury but positive for tricompartment degenerative changes with a small joint effusion. She was prescribed work restrictions and medication for a knee contusion. The petitioner reported some left shoulder and upper arm, and right groin pain on January 5, 2009. The petitioner reported continued left knee and left shoulder pain on January 12th and right hip pain. On January 19th, the petitioner reported some left shoulder and knee pain but overall improvement. The doctor noted a full range of motion with her shoulder, negative shoulder tests and no left knee effusion or ambulation difficulties. The petitioner was discharged without restrictions or further medical care for her injury.

The petitioner saw Dr. Durkin at Hinsdale Orthopedics on January 21, 2009, and complained of anterior pain deep in her shoulder and several episodes of locking and catching, and left knee and left shoulder pain. The doctor opined that x-rays of her left shoulder showed a fairly severe arthritic AC joint and of her right hip, showed mild arthritis and a spur of the inframedial acetabulum. A left knee MRI on July 24th showed a medial meniscal tear with a parameniscal cyst, probable lateral meniscal tear and moderate tricompartmental osteoarthritis.

Dr. Durkin noted at the petitioner's next follow-up on August 5th that the MRI showed spots with bone-on-bone, extruded meniscus and large bone spurs medially. He

opined that her hip had a large inferior medial bone spur and that it looked okay. She received a cortisone injection into her left knee on August 5th, which provided her only two weeks of relief and a Synvisc injection on August 26th, which provided little improvement. On October 27th, Dr. Durkin provided an unloader knee brace and recommended a total left knee replacement. The petitioner reported some benefit from the unloader knee brace on November 24th and no change on December 29th.

Dr. Durkin noted a mass on the petitioner's right thigh on January 26, 2010, and no change in her left knee condition on February 23rd, March 23rd, April 27th, May 25th and June 29th. She received cortisone injections into her left knee on July 27th and August 24th. The petitioner returned to AMG on July 10, 2010, for heartburn, depression and fibromyalgia and on August 10, 2010, for right leg weakness.

Pursuant to the request of the respondent, the petitioner was evaluated by Dr. Jacobs on August 23, 2010, who opined that the petitioner's left knee tricompartmental osteoarthritis was pre-existing and was only temporarily aggravated by her fall on December 23, 2008, and that she needed only six weeks of medical care to reach maximum medical improvement from the injury. The petitioner reported very little relief from the knee injections to Dr. Durkin on September 21st. The petitioner continued to follow up with Dr. Durkin monthly for her left knee from October 19, 2010, through April 26, 2011. Dr. Durkin prescribed no work for the petitioner on April 26, 2011. She followed up on June 7th and July 28th, at which time, she was released to sedentary work. X-rays on September 27th showed progression of the petitioner's tricompartmental arthritis. She continued her monthly follow-ups through December 16th, at which time she reported right-sided leg pain for two to three weeks.

On December 20, 2011, the petitioner complained of hip pain going down her groin. She was given an intraarticular injection into her hip. The petitioner followed up for her right hip and left knee on January 31, 2012. Dr. Durkin recommended a right hip replacement on February 28th and reiterated his recommendation for the left knee replacement. She followed up on March 20th and April 26th. The petitioner saw Dr. Domb at Hinsdale Orthopedics for her right hip on May 5th and reported falling on her knee three years earlier, getting up and falling backward onto her right hip. A right hip x-ray on May 7th showed an inferior osteophyte. She continued approximately monthly follow-ups for her left knee and right hip. She received a right hip injection on January, 25, 2013, which was reported as providing only a week of relief. A right hip MRI on May 22, 2013, revealed joint space narrowing and osteophyte formation, a tear along the anterior superior acetabular labrum with undersurface fraying along the superior lateral and posterior superior labrum, a probable tear involving the posterior inferior labrum, high-grade chondromalacia along the lateral aspect of the acetabulum and gluteus medius insertional tendinosis with mild trochanteric bursitis. She continued her follow-ups for her left knee and right hip with Dr. Durkin through April 22, 2014, at which time she received another left knee injection.

The petitioner sought care at AMG on April 20, 2014, for right shoulder pain. She continued treating with AMG for a myriad of medical conditions including for left hip problems periodically through 2014. Pursuant to the request of the respondent, the petitioner was evaluated by Dr. Primus on July 15, 2014, who opined that the petitioner's right hip condition was not related to her fall on December 23, 2008. On August 5, 2014,

the petitioner reported right thigh pain and swelling at AMG. She returned to AMG on September 18, 2014 for left posterior shoulder pain and tightness.

The petitioner stopped working on many occasions for health reasons prior to December 23, 2008, and also sought an authorized disability leave multiple times for fibromyalgia, depression and other medical conditions since 2003. Dr. Kale at Arthritis & Internal Medicine noted in the petitioner's medical records diagnoses of fibromyalgia, headaches, leg cramps, anxiety, weakness, chronic pain syndrome, chronic fatigue and cervical radiculopathy.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner for her left knee and left shoulder through January 19, 2009, was reasonable and necessary and is awarded. The medical care rendered the petitioner for her right hip and for her left shoulder and left knee after January 19, 2009, was not reasonable or necessary and is denied. On January 19, 2009, the petitioner was discharged without any recommendation for further medical care for her left knee and shoulder.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that her current condition of ill-being with her left knee and shoulder and her right hip is causally related to the work injury.

The petitioner had pre-existing osteoarthritis in her right hip prior to December 2008. She did not report a trauma or injury to her right hip or complain of any significant symptoms or problems with her right hip at her initial care at AMG on December 24,

2008, or when she followed up on January 5, 2009. Also, when the petitioner started care with Dr. Durkin on January 21, 2009, she did not report a trauma or injury to her right hip. Moreover, the petitioner followed up with Dr. Durkin almost monthly from July 2009 without any additional medical care, complaints, symptoms or problems with her right hip until December 20, 2011. When the petitioner saw Dr. Jacobs on August 23, 2010, she reported only left knee pain and swelling. Also, Dr. Primus' opinion that a hip labral tear is almost a 100% degenerative process unless there is a subluxation of the hip joint is credible and persuasive.

On January 19, 2009, the petitioner reported overall improvement and she had a full range of motion with her left shoulder and negative shoulder tests. Her left knee had no effusion and she had no difficulty ambulating, and she was discharged without restrictions or further medical care. After seeing Dr. Durkin on January 21, 2009, she did not seek further medical care until August 5, 2009. The evidence does not support the petitioner's testimony.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

The petitioner failed to prove that she is entitled to temporary total disability benefits after January 19, 2009. The petitioner's request for temporary total disability benefits after January 19, 2009, is denied.

FINDING REGARDING PROSPECTIVE MEDICAL:

The petitioner failed to prove that the left knee and right hip replacements recommended by Dr. Durkin is reasonable medical care necessary to relieve the effects of the work injury. The petitioner's request for an award for the cost of left knee and right hip replacements is denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michelle Jeffers,
Petitioner,

vs.
Choate Mental Health & Development Center,
Respondent,

NO: 10 WC 29686

17IWCC0135

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 2, 2016 is hereby affirmed and adopted.

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

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

No bond or summons required for State of Illinois cases.

DATED: MAR 3 - 2017

MB/mas
o:2/9/17
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JEFFERS, MICHELLE
Employee/Petitioner

Case# 10WC029686

17IWCC0135

CHOATE MENTAL HEALTH & DEVELOPMENTAL CENTER
Employer/Respondent

On 6/2/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

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

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

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

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUN 2 - 2016

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

17IWCC0135

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

MICHELLE JEFFERS
Employee/Petitioner

v.

CHOATE MENTAL HEALTH & DEVELOPMENT CENTER
Employer/Respondent

Case # 10 WC 29686

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Herrin**, on **March 8, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **June 25, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$75,036.00**; the average weekly wage was **$1,443.00**.

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.

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 $ **Unknown** for other benefits, for a total credit of **$0**.

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

ORDER

The Arbitrator finds that the Petitioner sustained accidental injuries arising out of and in the course of her employment with the Respondent on June 25, 2010.

Respondent shall pay Petitioner temporary total disability benefits of **$962.00** per week for **34-1/7 weeks**, from **March 12, 2012 through July 25, 2012 and from April 22, 2013 through August 2, 2013**, as provided in Section 8(b) of the Act.

The Petitioner stipulated that (if TTD is awarded) she would reimburse the Respondent for any nonoccupational disability benefits she received related to the lost time in this case.

Respondent shall pay reasonable and necessary medical services totaling **$147,768.88**, pursuant to the medical fee schedule or PPO agreement, whichever is less, as provided in Sections 8(a) and 8.2 of the Act. The parties stipulated that these expenses shall be paid by the Respondent directly to the medical service providers. Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving credit for medical expenses previously paid, as provided in Section 8(j) of the Act, as well as for any outstanding bills paid directly to the providers pursuant to stipulation of the parties.

Respondent shall pay Petitioner permanent partial disability benefits of **$664.72** per week, the maximum allowable rate, for **75.25 weeks**, because the injuries sustained caused the **35% loss of the right leg**, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

May 24, 2016
Date

ICArbDec p 2

JUN 2 - 2016

STATEMENT OF FACTS

On June 25, 2010, Petitioner, a registered nurse, alleges that she was injured at her place of employment, the Choate Mental Health and Development Center. While working overtime on her second shift, she had been working at cottages on the facility grounds and drove back to the parking lot adjacent to the main building at approximately 9:00 p.m. As she was getting out of her car she saw a skunk. She proceeded to get a recycling bin out of her trunk which contained supplies she had obtained from the cottages to return to the main building. She closed her trunk and began walking with the bin towards the concrete flight of stairs leading up to the main building to complete her shift.

As Petitioner was walking towards the stairs, she testified that the skunk was coming towards her, so she tried to run up the stairs, missed the first stair and tripped, striking her right knee on the step. That step was the bottom one, which was larger and wider than the other stairs. Petitioner testified that the bin that she was carrying weighed approximately 8 to 10 pounds and blocked her view as she was walking. Petitioner also testified that she was carrying the bin with both of her hands which kept her from using the rails up the staircase which was attempting to ascend. She testified that she would use the stairs she was attempting to ascend on that date multiple times a day.

Petitioner testified that she immediately felt pain in her right knee and it began to swell, but she was able to complete her shift. The next day the Petitioner tried to work but continued to experience pain, and she sought medical treatment from the doctor assigned to the Respondent's facility.

The Employee's Notice of Injury, signed by Petitioner on 7/26/10, states that she was leaving her car to walk up the steps to the cypress lower building in the parking lot steps out front of the sycamore lower building, she was approached by a skunk, attempted to get away by running up the steps, missing one and striking her right knee. (Rx1). A similar history was noted in the Supervisor's Report of Injury (Rx2).

On 7/1/10, Petitioner was seen by Dr. Strack, her primary care doctor, indicating that she had injured her right knee at work on 6/25/10 and was continuing to have pain and swelling. Petitioner was prescribed pain medications and was referred for an MRI and physical therapy. The 7/30/10 right knee MRI revealed a large effusion, bone bruising in the mid tibial plateau and a small benign tibial cyst, with some cartilaginous signal changes in the patellofemoral articulation. Petitioner thereafter attended physical therapy at Carbondale Memorial Hospital.

Dr. Strack referred her for an orthopedic evaluation with Dr. Matava on 8/23/10. Petitioner provided a history that she was running from a skunk on the premises of her employer, missed a step and fell onto her flexed right knee sustaining a contusion. After performing a physical examination, Dr. Matava recommended that Petitioner continue with physical therapy and provided to her anti-inflammatory medication.

The Petitioner testified she then started treating with orthopedic surgeon Dr. Golz, as he was geographically closer to her home than St. Louis. On 4/6/11, x-rays were taken which showed early degenerative arthritis. After performing a physical examination and reviewing Petitioner's previous MRI, Dr. Golz diagnosed an exacerbation of right patellofemoral arthrosis. The right knee was injected and Voltaren gel was recommended.

Petitioner returned to Dr. Golz on 2/22/12 still complaining of pain in her right knee. She indicated that the Voltaren gel did not help and that the previous injection only provided relief for a day or two. Given the failure of conservative treatment, Dr. Golz recommended surgical intervention, which was performed on 3/12/12. The

pre and post-operative diagnosis was lateral meniscus tear and retropatellar pain syndrome, right knee. The surgery involved a partial lateral meniscectomy and arthroscopic lateral retinacular release. Dr. Golz recommended post-operative physical therapy which Petitioner attended at Heartland Rehabilitation Services.

Petitioner continued to treat with Dr. Golz post-surgery. On 6/12/12, Petitioner reported that she was still having intermittent episodes of sharp pain with pivoting, twisting, turning-type maneuvers. Dr. Golz released Petitioner to return to work light duty of 8 hours per day with no squatting, kneeling, running and limited lifting. As the Respondent could not accommodate those restrictions, Petitioner remained off work. On 7/24/12, Dr. Golz noted that she continued to have mild twinges in her right knee and noted some swelling. He released her to return to full duty with 8-hour days and progression to 1 to 2 overtime shifts a week.

Petitioner returned to work on 7/26/12. She testified that when she returned to work she was required to be on her feet and that she continued to experience pain and swelling in her right knee. On 9/4/12, Dr. Golz recommended protective mechanics and a home exercise program and continued her on Daypro, and again injected the knee. On 10/10/12, Dr. Golz suggested further diagnostic serological studies and provided her with a compressive sleeve and a compressive ice wrap. On 11/13/12, Petitioner reported continued burning and stiffness. Dr. Golz offered another aspiration and steroid injection but Petitioner declined. He offered her Celebrex as an additional anti-inflammatory and encouraged her to continue with home exercises, protective mechanics and fall precautions.

Petitioner's treating physician, Dr. Strack, referred Petitioner to Dr. Stahle for a second opinion. Petitioner first met with Dr. Stahle on 12/3/12. Dr. Stahle examined Petitioner and noted knee pain, soreness, tenderness, and discomfort. X-rays revealed a linear tear with some patellofemoral issues. Dr. Stahle felt that she had a right meniscus tear and recommended a new MRI. The 12/11/12 repeat MRI revealed tricompartmental degenerative changes, chronic degradation of the medial and lateral menisci with superimposed postoperative changes in the lateral meniscus but no evidence of acute meniscal tear, signficiant patellofemoral chondromalacia and joint effusion. Dr. Stahle performed Orthovisc injections on 12/17/12, 1/7/13 and 1/14/13. On the latter date, Dr. Stahle discussed surgical options with Petitioner.

Dr. Stahle performed a total right knee arthroplasty on 4/22/13. Following surgery, Petitioner was prescribed pain medications and physical therapy which she attended at the Orthopedic Institute of Western Kentucky.

Petitioner continued to treat with Dr. Stahle following surgery and on 8/2/13 was released to return to work. The Petitioner was doing well overall and was to continue with her home exercise program. Petitioner testified that she did return to work at that time. She returned to Dr. Stahle on 4/4/14 for her six month follow up, at which time it was noted that she was doing well but did have occasional pains in the knee. She was to continue with exercises as tolerated and to return in one year.

On 7/16/14, Petitioner was seen at the request of the Respondent by Dr. Nogalski for a Section 12 examination. Dr. Nogalski took a history of the injury from Petitioner noting that she saw a skunk, was carrying a box, ran to some stairs, missed a step and then landed on her right knee. Dr. Nogalski opined that Petitioner suffered a contusion on 6/25/10 as well as an aggravation of her osteoarthritic knee condition.

Petitioner testified that she had no injuries or problems with her right knee prior to the accident date. Petitioner testified that her knee is better since undergoing the knee replacement, but that she still has stiffness and swelling, especially with prolonged standing and sitting. There are certain things that she must concentrate on doing with regards to her right knee, like getting on and off the floor. For pain, Petitioner still takes anti-inflammatories such as Advil or Ibuprofen.

Respondent called Chris Doctorman, Respondent's Chief Engineer in charge of the grounds at Respondent's Choate facility. It is his responsibility to respond to any wildlife issues on the grounds at Choate. Mr. Doctorman testified that in his 16 years at Choate, he has only had two skunk complaints. Mr. Doctorman testified that Choate does not have a skunk infestation and the amount of skunks on the grounds at Choate is normal for a rural area such as Anna, Illinois. Mr. Doctorman testified that he is familiar with the steps at both the east and the west entrance at Cypress Lower. Mr. Doctorman testified that there are no defects in those stairs that he is aware of. Mr. Doctorman also testified that there are lights by the stairs at nighttime as that is a requirement. Mr. Doctorman testified that he would know about any complaint that came in as that is his department.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner sustained her burden of proof with regard to accident, and that she sustained accidental injuries arising out of and in the course of her employment with Respondent on 6/25/10. She testified that she was carrying a box of supplies after returning from her duties at the cottages on the Respondent's facility campus. She saw a skunk coming towards her, and decided to run to try to get away. Because she was holding the box, she testified she both was unable to use the hand rails on the stairway, and was unable to see where she was walking. The Arbitrator finds that, based on these facts, the Petitioner has shown that her activities resulted in an increased risk of injury over and above that of the general public.

As argued by Respondent, it is true that the initial accident reports from Respondent, as well as the medical records, did not provide a history of the Petitioner carrying a box. The Arbitrator notes that the primary focus at the time seemed to be that she was trying to avoid a skunk encounter. The Arbitrator found the Petitioner's testimony in this regard believable, and doesn't believe that the fact this information was not included in the history of accident in the medical records defeats the claim. There would really be no particular reason for a doctor to inquire about such information in the course of determining treatment. The fall on the knee would seem to be sufficient information for their purposes. As to the accident reports of the Respondent, admittedly such information could well have been included since the purpose of the report was to include the facts surrounding the accident. That said, again, it appeared that the focus was on the fact that she was trying to avoid the skunk, and that is consistently noted in the initial reports. Overall, the Arbitrator believes the greater weight of the evidence supports the fact that the Petitioner had a box or bin in her hands when she fell on her knee.

The Arbitrator notes that causation was a stipulated issue, and that this stipulation is supported by the report (Rx6) and testimony (Rx7) of Dr. Nogalski.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

The Petitioner submitted her bills in Px24, which total $147,768.88. The Arbitrator finds that the Respondent is liable for all bills in this exhibit which relate to the right knee treatment and any related sequelae.

The Arbitrator notes that the parties have stipulated that, with regard to any awarded medical bills, said bills will be paid by Respondent directly to the providers per the Medical Fee Schedule in Section 8.2 of the Act or via a PPO agreement, whichever is less. As a result, the Respondent shall hold the Petitioner harmless with regard to same.

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:

The evidence indicates the Petitioner initially went off work at the time of her initial right knee surgery on 3/12/12. She was released to return to work on 7/24/12, and the Petitioner testified that she returned to work on 7/26/12. As such, she is entitled to temporary total disability benefits from 3/12/12 through 7/25/12, a total of 19-3/7 weeks.

The Petitioner again was off work for the second surgery from 4/22/13 through 8/2/13, and is entitled to TTD for this period, a total of 14-5/7 weeks. Thus, for both periods of off work status, the Petitioner is entitled to a total of 34-1/7 weeks of TTD.

The Petitioner testified that she was paid non-occupational disability benefits, but was not paid any temporary total disability benefits from workers' compensation, and that she agreed to reimburse the Respondent for the non-occupational disability benefits she received.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011. Because the accident in this case occurred prior to September 1, 2011, §8.1b is not applicable to this case.

The Arbitrator concludes that Petitioner has sustained permanent partial disability to the extent of 35% loss of use of the right leg.

Petitioner injured her right knee on 6/25/10. Petitioner did not have any problems with her right knee prior to this date. After failing conservative treatment, Petitioner underwent a right knee arthroscopy, partial lateral meniscectomy and arthroscopic lateral retinacula release on 3/12/12. Petitioner continued to complain of pain in her right knee after surgery. Petitioner was eventually recommended for a total knee replacement which was performed on 4/22/13. This was performed based on degeneration which clearly existed prior to the accident, but was aggravated by the accident. Following surgery, Petitioner went through both at-home and formal physical therapy and was eventually released to full duty on 8/2/13 by Dr. Stahle. Petitioner testified that her knee is better since undergoing the knee replacement, and she has been able to return to her regular work duties. She still has stiffness and swelling especially when she is on it for long periods of time. She indicated that there are certain things that she must concentrate on doing with regards to her right knee, like getting on and off the floor. Additionally, she indicated that she does continue to have swelling, stiffness and pain. For her pain, Petitioner still takes anti-inflammatories, such as Advil or Ibuprofen. The Arbitrator believes this award is proper based on the fact that much of the degeneration in the right knee was preexisting, and the fact that she appears to have done quite well following surgery, including continuing to work ongoing full duties.

STATE OF ILLINOIS)	☐ Affirm and adopt	☐ 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

KIEZEL MALGORZATA,

Petitioner,

17IWCC0188

vs.

NO: 11 WC 000928

GEPCO INTERNATIONAL,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission pursuant to the Opinion and Order of Judge Carl Walker of the Circuit Court of Cook County, Illinois. Judge Walker, on February 18, 2016, issued the above-referenced Opinion and Order by which the Commission's My 21, 2015, Decision and Opinion was reversed on the issue of causal connection concerning Petitioner's left ulnar nerve condition and affirmed on all other issues. In conformance with this Opinion and Order, the Commission revisits this matter to determine the benefits due Petitioner.

Petitioner underwent surgeries performed by Dr. Thomas Karnezis of the Illinois Orthopaedic and Hand Center to release her left carpal tunnel and her left cubital tunnel as well as debridement of the medial epicondyle on June 17, 2010, and experienced pain to her left elbow and numbness and tingling into her left hand. Despite these symptoms, Petitioner continued working without restrictions. Petitioner also continued to follow-up with Dr. Karnezis until March 7, 2011. At that time, Petitioner was diagnosed with a recurrent compression of the ulnar nerve.

Petitioner sought a second opinion from Dr. Prasant Atluri of the Hand Surgery Associates on August 16, 2016, and, upon examination, was found to have a positive left wrist Tinel's Sign as well as digital compression as revealed by Guyon's canal testing. Those findings, coupled with Dr. Atluri's review of Petitioner's 2010 operative reports, led Dr. Atluri to diagnose Petitioner as having left distal ulnar neuropathy, right thumb arthritis, and possibly left cubital tunnel syndrome. Dr. Atluri concluded Petitioner's then-current left ulnar nerve problem at Guyon's canal was a direct result of the carpal tunnel release Petitioner underwent in 2010 and recommended a left ulnar nerve compression at the left wrist, believing that procedure carried less risk of complication than would a left elbow ulnar nerve release.

17IWCC0188

The presiding arbitrator and the Commission both concluded that the past treatment and the proposed treatment of Petitioner's left ulnar neuropathy were not causally connected to her employment. Judge Walker of the Circuit Court of Cook County found otherwise. In compliance with the Order and Opinion of the Circuit Court of Cook County, the Commission authorizes both the left ulnar nerve decompression at the left wrist as is recommended by Dr. Atluri as well as payment to Petitioner of $7,297.82, the amount currently due and owing as a result of Petitioner's treatment with Illinois Orthopedic and Hand as well as with Hand Surgery Associates.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent authorize and pay for the left ulnar nerve decompression as is recommended by Dr. Atluri as well as any reasonable and necessary related postoperative aftercare.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $7,297.82 for medical expenses under Section 8(a) of the Act.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit in the amounts of $8,476.88 for TTD benefits paid to Petitioner, $122,254.47 in medical expenses paid to date, and $7,764.04 for medical expenses paid by group insurance pursuant to Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with the 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 for 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 $7,000.00. 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: MAR 29 2017
KWL/mav
O: 10/25/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

17IWCC0188

KIEZEL, MALGORZATA
Employee/Petitioner

Case# **11WC000928**

GEPCO INTERNATIONAL
Employer/Respondent

On 9/2/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2553 LAW OFFICES OFJAMES P McHARGUE
BRENTON M SCHMITZ
123 W MADISON ST SUITE 1000
CHICAGO, IL 60602

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
JOSEPH D'AMATO/MATTHEW GORSKI
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

# ILLINOIS WORKERS' COMPENSATION COMMISSION
# ARBITRATION DECISION
19(b)

17IWCC0188

Malgorzata Kiezel
Employee/Petitioner

v.

Gepco International
Employer/Respondent

Case # **11** WC **928**

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 **Joshua Luskin**, Arbitrator of the Commission, in the city of **Wheaton**, on **August 7, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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 1, 2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being ***is in part*** 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.

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

Respondent shall be given a credit for $**8,476.88** in TTD and $**122,254.47** in medical benefits paid to date, as well as further credit of $**7,764.04** paid by group medical insurance pursuant to Section 8(j) of the Act.

ORDER

For reasons set forth in the attached decision, the requested medical expenses and prospective medical services 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

August 29, 2014
Date

SEP 2 - 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MALGORZATA KIEZEL,	)	17IWCC0188
	)	
Petitioner,	)	
	)	
vs.	)	**No. 11 WC 00928**
	)	
GEPCO INTERNATIONAL,	)	
	)	
Respondent.	)	

ADDENDUM TO ARBITRATION DECISION

This matter was heard pursuant to Sections 8(a) and 19(b) of the Act.

STATEMENT OF FACTS

The petitioner, a left-hand-dominant woman, fifty years old on the asserted date of loss in April 2009, began working for Gepco International, a/k/a General Cable, in February 2008. She usually worked first shift, Monday through Friday, eight hours per day. Her job duties included receiving and finishing fiber optic and copper cables, which consisted of connecting and polishing cables, assembling the connectors, and preparing them for testing. She also worked with TV boxes that ordered the cables, inserting them into the boxes. She testified she would use tools such as strippers, pliers, and a lathe, and noted there was a machine that stripped the cables automatically as well. She testified she was still employed at the respondent as of the trial date. The petitioner asserts repetitive trauma as her theory of injury; accident and notice were not disputed at trial.

The petitioner testified that she began experiencing bilateral wrist pain as well as numbness and tingling at night in approximately March 2009. The petitioner apparently saw a family physician first; those records are not present, but she was referred to Dr. Iwona Sobczak, a neurologist, for evaluation. Dr. Sobczak saw the claimant on February 1, 2010, noting a history of hypothyroidism and symptoms in both hands, left worse than right, which had begun several months prior and then worsened since. Dr. Sobczak noted somewhat elevated blood pressure and Tinel's sign bilaterally. Dr. Sobczak prescribed medication, splints, physical therapy and an EMG test. The EMG took place the next day, on February 2, 2010. It indicated moderate bilateral carpal tunnel syndrome, worse on the left, with no evidence for ulnar neuropathy or cervical radiculopathy. PX1.

On February 9, 2010, the claimant presented at Advanced Physical Therapy for an intake evaluation. They noted a history of three shoulder surgeries from 2004 through 2006 and present complaints in all five fingers bilaterally over the prior two months. She

underwent care there until March 2, 2010. See PX2; the prior shoulder surgeries are also further referenced in PX6.

On March 1, 2010, Dr. Sobczak received a letter from Dr. Lastowiecki, an endocrinologist who was treating the petitioner for chronic hypothyroidism; he noted that the claimant had an increased dosage of medication at approximately the same timeframe as the increase in symptoms related by the claimant to Dr. Sobczak. Dr Lastowiecki further noted symptoms suggestive of early menopause and had other nonspecific complaints including intermittent myalgias. See PX1.

On March 8, 2010, Dr. Sobczak noted no relief from night splints and referred the claimant to Dr. Karnezis for carpal tunnel injections and possible surgery. PX1.

The claimant saw Dr. Tom Karnezis on March 17, 2010. He noted a history of bilateral hand numbness over the last eighteen months which had gradually progressed. He noted a three-year history of medication usage for her thyroid. Following physical examination and review of the EMG results, he assessed bilateral carpal tunnel syndrome and provided bilateral wrist injections at that time. He prescribed medications and opined that her condition was due to fine manipulation at work and that she would in all likelihood eventually require surgery. See PX3.

On May 21, 2010, the petitioner presented to Dr. Karnezis. She noted four weeks relief from the injections but symptoms had recurred since. At this time he assessed her with bilateral cubital tunnel syndrome as well as carpal tunnel syndrome. He recommended surgery on both wrists and both elbows, with the left side first; while he reiterated his causal opinion as to her work activities, he did not comment on the negative EMG analysis of the elbows nor explain the change in diagnosis. See PX3.

On June 17, 2010, the claimant underwent left carpal and cubital tunnel release surgery as well as debridement of the medial epicondyle. A median nerve neuroma was observed during the procedure and neuroplasty was performed; no complications were noted during the procedure. See PX3, PX6. The petitioner began postoperative therapy on June 23, 2010. See PX7.

On June 30, the claimant advised Dr. Karnezis that she had increasing pain to the left elbow. Clinical examination noted full function and no evidence of infection. He provided support pads and instructed her to follow up, with no use of the left arm at that point. On July 19, 2010, the claimant complained of pain at the left wrist incision site; sutures were removed without incident at that point. It appears she was also treating for the right ankle, as notes of an ankle wound are present; the Arbitrator notes it is unclear if this is an error or if those records were not provided as unrelated to the case. PX3. On July 28, 2010, it was noted that the petitioner's left carpal and cubital tunnel symptoms were "resolving nicely" and the epicondylar pain had vanished. The wound was redressed and the right side was scheduled; it was noted that a small ganglion cyst was present at the right wrist and would likely be excised at that time as well. PX3.

On September 9, 2010, Dr. Karnezis performed right wrist carpal tunnel release and excision of the ganglion cyst, coupled with right elbow cubital tunnel surgery. The petitioner also was noted to have trigger finger in her bilateral ring fingers; the right ring finger had an A1 pulley release at this time and her left ring finger was injected. See PX3, PX6. On September 13, her symptoms were noted to be improved and she was referred for therapy, which she underwent. See PX3, PX7.

On September 29, 2010, she presented to Dr. Karnezis in follow-up. She was neurologically intact and her symptoms were improved. She was maintained in therapy with instructions to concentrate on strengthening. PX3. On October 27, 2010, she presented with redness and irritation to the incision site. Range of motion was full. She was instructed to continue a strengthening program and given cream for dermatitis. PX3.

On November 10, the petitioner presented to Dr. Karnezis with a small abscess in the stitch area. Debridement of this was performed that day. See PX3, PX6. The petitioner followed up for treatment for that area and was noted to have no evidence of any persistent infection on November 30, 2010. PX3. She was maintained in therapy thereafter and released to light duty. PX3.

On January 10, 2011, the petitioner presented with complaints of pain while doing fine manipulation. She was maintained in therapy. PX3, PX7. On January 31, Dr. Karnezis noted she "has done remarkably well" and assessed full duty work as of February 7, 2011. He told her to follow up in three to four weeks. PX3. The petitioner did return to work for the respondent thereafter.

On February 28, 2011, the claimant reported having been working full duty for the last month. She noted some locking in the left ring finger, which was assessed as tenosynovitis and was injected at that time. She was also noted to have some right thumb symptoms and told to return for an injection, but was otherwise maintained on full duty. The right thumb was injected on March 4, 2011, and she was later provided thumb spica splints. See PX3.

Another right thumb injection, this time to the CMC joint, was provided on May 18, 2011 by Dr. Karnezis. On July 15, 2011, he recommended ongoing therapy and splinting. On August 24, 2011, she complained of bilateral thumb tenderness and recurrent complaints in the left ring trigger finger. Dr. Karnezis recommended six additional therapy visits and maintained full duty work. PX3, PX7.

On October 19, 2011, the petitioner presented to Dr. Karnezis with ongoing hand complaints. He assessed her with ganglionic cyst formations in both ring fingers, which he opined were due to her work activities. He recommended ongoing medication use and noted she may require excision of the cysts. PX3.

On February 1, 2012, the petitioner returned to Dr. Karnezis. He noted the right elbow and wrist were doing "remarkably well" and the left ring trigger finger was "completely absent with excellent results." The ganglion cysts were "currently stable and

not bothersome." The left carpal tunnel surgery was "healed without incident" and the left cubital tunnel was healed fully and nonproblematic but she still reported complaints of numbness to the fourth and fifth digit. He recommended a repeat EMG and an ultrasound evaluation of the left cubital tunnel. See PX3.

On February 7, 2012, the petitioner underwent the EMG. It showed neuropathy at both wrists, suggestive of either persistent or recurrent carpal tunnel syndrome, as well as left elbow ulnar neuropathy. PX4. On February 24, 2012, Dr. Karnezis noted the EMG results. She apparently complained of recurrent pain to the wrists as well. He maintained his recommendation for the elbow ultrasound and provided wrist splints. PX3.

On March 7, 2012, Dr. Karnezis reviewed ultrasound results which he characterized as showing a left elbow neuroma impinging on the left ulnar nerve as well as ossification in that area. He recommended neuroplasty at that area and a left Guyon's canal release. Curiously, he specifically advised that he would recommend no use of the right arm post-surgically as well as no use of the left arm, though she did not make any complaints of right arm or hand issues at this point. See PX3. The petitioner did not treat further with Dr. Karnezis after that appointment.

On May 17, 2012, the petitioner saw Dr. John Fernandez at her employer's request pursuant to Section 12 of the Act. See generally RX1. After examining her and reviewing the medical records to date, Dr. Fernandez diagnosed symptomatic basilar joint arthritis at the right thumb, left elbow hetertopic ossification, left ring and small finger numbness and tingling status post cubital tunnel and carpal tunnel release and a probable neuroma at the left elbow. Dr. Fernandez opined the neuroma and ossification at the left elbow were likely post-surgical in nature but was unconvinced this was the source of discomfort. He opined that a revision left elbow decompression was appropriate but that she was at MMI regarding the right elbow, both wrists and the right ring finger. Regarding causation, he noted multiple idiopathic risk factors and opined that based on the job description she provided him, there would not be a causal connection to the cubital tunnel syndrome because there were no risk factors such as direct pressure, repetitive extension and flexion, or prolonged hyperflexion posture. He also opined that the thumb arthritis was not related to her work activities. However, he believed there was a relationship between the carpal tunnel syndrome and her work activities. RX1.

The respondent subsequently provided Dr. Fernandez with a job video analysis and written job description. On July 23, 2012, Dr. Fernandez produced an addendum to his earlier report, noting that the activities depicted on the video and related in the written descriptions would be a causal factor in the claimant's carpal tunnel condition, but not to her cubital tunnel condition. See RX1.

The petitioner elected to seek a second opinion and began treating with Dr. Prasant Atluri on August 16, 2012. Following his examination, Dr. Atluri assessed a left ulnar nerve lesion and status post bilateral carpal and cubital tunnel surgery, as well as right thumb arthritis. He noted he lacked the preoperative EMG and medical records. He opined she may require ulnar nerve surgery. See PX4. On August 23, 2012, Dr. Atluri

saw the petitioner in follow-up and reviewed the preoperative EMG study. He opined the carpal tunnel releases had resolved her carpal tunnel symptoms. He recommended no further treatment to the right arm and symptomatic care for the right thumb. Relative to the left arm, he recommended monitoring it for now and possible further EMG testing or revision surgery to the left elbow or wrist. PX4.

On October 4, 2012, Dr. Atluri saw the claimant, who continued to describe bilateral hand pain. However, following discussion of surgery and the relative likelihood of improvement, the claimant was uncertain as to whether she wanted to proceed with surgery. Dr. Atluri told her to follow up after she decided. On November 1, 2012, the petitioner reported worsening symptoms in her left hand. Following a discussion of treatment alternatives, Dr. Atluri recommended surgical decompression at the Guyon's canal at the left wrist and neuroplasty at the left elbow. See PX4.

On April 25, 2013, Dr. Atluri saw the claimant. She reported left hand weakness, a new finding. She reported that the workers' compensation carrier had denied the ulnar surgery and she wanted to proceed under private insurance. PX4. However, on May 30, 2013, Dr. Atluri noted that a request for surgical approval remained pending; a similar reference is present on August 22, 2013. See PX4.

On September 12, 2013, at the request of the petitioner's attorney, Dr. Atluri reviewed Dr. Fernandez' reports and medical records from Dr. Karnezis and authored an opinion report. Dr. Atluri noted similar medical diagnoses to Dr. Fernandez. Dr. Atluri opined that the petitioner's job duties did contribute to the carpal tunnel diagnosis as well as the trigger finger condition. He opined that the right thumb arthritis was chronic and degnerative but could have been aggravated by her work duties. Regarding the cubital tunnel syndrome, Dr. Atluri noted no forceful pushing, pulling, or persistent hyperflexion which would typically be associated with the development of that condition. He opined that the symptoms did not appear directly attributable to the work activities. However, he noted the ulnar symptoms may represent a complication of the original elbow surgery and opined the neuropathy at the left wrist "may represent a complication of her left carpal tunnel surgery." PX4, PX9. He recommended symptomatic treatment for the carpal tunnel symptoms, conservative care for the thumb arthritis with potential surgery if symptoms did not recede, and recommended additional EMG testing of the left ulnar nerve prior to consideration of surgical intervention, noting it was unclear if surgery would practically improve her condition. He opined, regarding her prior treatment, that while the carpal tunnel releases were reasonable and necessary, he was "unable to determine at this time whether the other interventions were reasonable and appropriate." See PX4, PX9. Dr. Atluri testified in deposition on November 13, 2013; his findings will be discussed in more detail below. See generally PX9.

On December 10, 2013, Dr. Atluri recommended a short course of physical therapy and symptom control but reiterated his surgical recommendation. PX4. The petitioner underwent physical therapy for about a month thereafter. PX5.

On February 4, 2014, Dr. Fernandez saw the petitioner again for a repeat Section 12 examination. Following discussion with and repeat physical examination of the claimant, Dr. Fernandez noted persistent left hand numbness with a possible residual ulnar neuropathy of the elbow or wrist as well as right thumb basilar joint degeneration. He noted the beginnings of Dupuytren's fibromatosis without contracture. He opined that the new medical records and examination did not change his earlier diagnosis or conclusions. He opined she could consider a revision to the left elbow ulnar release, but she should have an EMG test prior to any intervention to distinguish entrapment at the wrist from elbow pathology. He opined there was no causal connection between the claimant's work and the ulnar pathology and basilar joint degeneration. RX1.

DR. ATLURI'S DEPOSITION TESTIMONY

Dr. Atluri testified that the anomalies in the EMG of February 2012 relative to the carpal tunnel were most likely residual since the symptoms had improved significantly following the surgery, and therefore were not clinically significant. See PX9 p.17-18. He opined the Guyon's canal findings at the wrist were a new abnormality. He opined that the abnormalities at the left elbow identified on that EMG were "trickier" in determining whether it was an ongoing issue with the elbow or merely residual findings that had not resolved. PX9 p.19. He opined that the claimant's overall diagnoses were of left distal ulnar neuropathy, bilateral carpal and cubital tunnel syndrome, and right thumb arthritis; of those, the right thumb arthritis, the left ulnar neuropathy, and possibly the left cubital tunnel were active. See PX9 p.22. Relative to causation, Dr. Atluri testified to his opinion that the carpal tunnel syndrome was related to work activities, as were the trigger fingers, and that while the right thumb arthritis was a chronic degenerative process, her work activities could have aggravated it, depending on whether the symptoms arose at work or during convalescence. See PX9 pp.33-35, 40. He opined that the cubital tunnel syndrome was not related to work. See PX9 p.36. He further opined that the ulnar tunnel syndrome at the wrist was not related to work, but opined it was a complication arising from the carpal tunnel surgery. See PX9 pp.36-37. At the time of his deposition he recommended further treatment for the left ulnar nerve, but not for the carpal tunnel syndrome. PX9 pp.25-26. His recommendation was for her to have further electrodiagnostic studies to determine whether surgery should be targeted at both the elbow and wrist or only one. See PX9 pp.27, 31. However, he opined she should have left wrist decompression. PX9 pp.40-42. He further noted that the left elbow surgery, should she have it, would be strictly related to the cubital tunnel surgery only. PX9 p.43.

On cross-examination, Dr. Atluri acknowledged that the right thumb arthritis apparently began troubling the claimant in 2010 or thereafter, and that therefore the arthritis was not likely related to her 2009 work activities:

> Q: But is it your opinion that her right thumb symptoms can then be relatable to her job duties in 2009?
> A: No.
> Q: It's your opinion that they are not?
> A: Correct.

See PX9 pp.46-47. Dr. Atluri later went on to note, regarding the right thumb, that "I just don't know enough information about what she was doing at the time when those symptoms actually developed to know within a reasonable degree of certainty whether or not it's related to her job activities." See PX9 p.57. Dr. Atluri testified that he could not state with certainty whether the cubital tunnel release procedures were reasonable and necessary, and could not determine from the documentation what the specific indication was for the cubital tunnel release surgery. See PX9 pp.48-49. Dr. Atluri acknowledged that ulnar neuropathy at the Guyon's canal can be idiopathic and relatable to such things as cyst formation or thyroid conditions; he noted the claimant's risk factors included age and gender, but did not specifically mention her hypothyroidism. PX9 pp.53-54.

Dr. Atluri was asked about the specific surgical procedure which Dr. Karnezis performed that Dr. Atluri believed caused the current left wrist condition, and noted:

> A: I do not [know exactly what that procedure was]. You know, his operative report is a little bit difficult to decipher. He does talk about a Guyon's canal release ...but then when you actually look at the operative note details, I can't exactly figure out what he means, you know, what was actually released, what was actually done.

See PX9 pp.54-55. Dr. Atluri went on to note that had the ring and small finger immediately had a change in their symptoms at once following the surgery, that would make it more likely that it was a surgical complication, but if that was not the case it would be less likely. PX9 pp.55-56.

OPINION AND ORDER REGARDING DISPUTED ISSUES

As stipulated, the petitioner is due 33 & 2/7 weeks of temporary total disability benefits, a total of $8,476.87. The parties acknowledged that respondent has previously tendered the claimant $8,476.88, thus extinguishing TTD liability to date.

Causal Connection to Employment

In cases relying on the repetitive trauma concept, the claimant generally relies on medical testimony to establish a causal connection between the claimant's work and the claimed disability. See, e.g., *Peoria County Bellwood*, 115 Ill.2d 524 (1987); *Quaker Oats Co. v. Industrial Commission*, 414 Ill. 326 (1953). When the question is one specifically within the purview of experts, expert opinion is mandatory to establish that the claimant's work activities caused the condition of which the employee complains. See, e.g., *Nunn v. Industrial Commission*, 157 Ill.App.3d 470, 478 (4th Dist. 1987).

In this case, there is a general consensus among the opining physicians that the claimant's carpal tunnel syndrome and the resultant surgery was causally related to the claimant's work, and as such, causation has been established relative to that condition. For similar reasons, causal connection to the bilateral ring trigger finger condition, as well as the surgery and injection for same, has similarly been established.

In Dr. Karnezis' appointment of May 21, 2010, he diagnosed a condition of cubital tunnel syndrome and opined it was related to the claimant's employment. However, this conclusion stands at odds with a contemporaneous negative EMG study and his causal assessment is disputed by both the claimant's second choice of physician as well as the respondent's evaluating physician, who saw the claimant on more than one occasion and also had the opportunity to view the claimant's job description in detail. Dr. Karnezis' opinion is given little weight, and the Arbitrator finds no causal relationship between the claimant's work and any cubital tunnel condition has been credibly demonstrated; similarly, no relationship between her work and the resultant elbow surgeries has been proven.

Regarding the right thumb basilar arthritis, Dr. Fernandez concludes that there was no causal connection between her work and the arthritic condition. Dr. Atluri agrees that the thumb arthritis was chronic and degenerative in nature, but believed it was possible that her work conditions had aggravated the symptoms in the thumb. Examining Dr. Atluri's deposition testimony in detail, he acknowledges he lacked solid information as to what activities she was doing when the thumb symptoms arose, which was information to which Dr. Fernandez had far greater access to when he rendered his analysis. Moreover, a review of Dr. Fernandez's opinion report shows it to be thorough and well-informed, and he is deemed credible. The causal opinion rendered by Dr. Atluri is too tenuous to establish a causal link between the petitioner's employment and the right thumb, as the right to recover benefits cannot rest upon speculation or conjecture. *County of Cook v. Industrial Commission*, 68 Ill.2d 24 (1977). As such, causal connection to the thumb arthritis is denied.

Lastly, Dr. Atluri has assessed her with ulnar nerve pathology at the left wrist, which he notes is distinct from the carpal tunnel syndrome, but believes was due to the left wrist surgery performed by Dr. Karnezis. Dr. Atluri admits that he cannot discern with certainty the exact surgery done or how it was the it became complicated, but bases his conclusion in large part on the claimant's assertion of an immediate change in her medical condition following the surgery – to wit, immediate numbness in her left small and middle fingers post-surgically, a new finding. PX9 p.54-56.

However, the medical records prior to the surgery belie this history. Dr. Karnezis, when he assessed her as having cubital tunnel in the first place on May 21, 2010, clearly noted she "has numbness to all five digits" bilaterally and has "numbness and pain to both fourth and fifth digits with the left greater than the right." PX3. Moreover, this is not an isolated reference. The physical therapist she saw in February 2010 clearly noted symptoms in all five fingers of each hand. See PX2 p.13. And Dr. Fernandez noted a history of symptoms in "all the digits" when he interviewed her originally. RX1. Given that the basis for his opinion of a post-surgical complication has been thus undermined, and further given Dr. Fernandez' credible opinion to the contrary, the Arbitrator finds no causal connection has been proven by a preponderance of the credible evidence between the left carpal tunnel surgery and the asserted ulnar condition at the left wrist.

Medical Services (Past and Prospective)

The Arbitrator has reviewed the asserted outstanding medical bills submitted by the petitioner, as well as the respondent's list of medical payments made. See PX3, PX4, RX2. Substantial expenses incurred for treatment have been paid to date; the Arbitrator's assessment of the unpaid balances submitted indicates these are for treatment related to conditions which have been deemed unrelated to her employment, and as such are denied. Regarding the 8(j) credit incurred to date, the respondent is entitled to same against any related medical costs, but shall hold the claimant harmless against recoupment efforts for same.

The future medical treatment requested is potentially threefold: 1) An electrodiagnostic study (EMG/NCV); 2) Left wrist surgery to address the ulnar nerve at that area; and 3) Left elbow surgery to revise the ulnar release. Medically speaking, both Dr. Atluri and Dr. Fernandez recommend the electrodiagnostic study and are hesitant to consider surgery without it, though Dr. Atluri is willing to proceed with the left wrist surgery at this time. The Arbitrator will address each of these individually.

Regarding the EMG study, Dr. Fernandez opines that the EMG study is not causally related to the petitioner's work activities. RX2. As it does not appear that the EMG is targeted at the carpal tunnel or trigger finger conditions, and given Dr. Fernandez' credible opinion, the prospective EMG is denied.

The left wrist surgery is denied for reasons set forth in the above section on causal connection to her employment.

Both Dr. Atluri and Dr. Fernandez acknowledge that the left elbow surgery, if it were to be pursued at all, would only be related to the cubital tunnel syndrome and the surgery she underwent for it, and therefore not related to her work. It is therefore denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Paulino Gamez,
Petitioner,

vs. NO: 11 WC 17737

17IWCC0152

Elite Staffing and Nation Pizza,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b), having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, medical expenses, prospective medical expenses, wages, rate and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 9, 2016, is hereby affirmed and adopted.

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

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.

17IWCC0152

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

DATED: MAR 10 2017

Joshua D. Luskin

Charles J. DeVriendt

Kevin W. Lamborn

o-03/08/17
jdl/wj
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

GAMEZ, PAULINO
Employee/Petitioner

Case# **11WC017737**

ELITE STAFFING AND NATION PIZZA
Employer/Respondent

17IWCC0152

On 2/9/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1922 STEVEN B SALK & ASSOC LTD
150 N WACKER DR
SUITE 2570
CHICAGO, IL 60606

1980 STEVEN J TENZER LAW OFFICE
20 S CLARK ST
SUITE 700
CHICAGO, IL 60603

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STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Paulino Gamez
Employee/Petitioner
v.
Elite Staffing and Nation Pizza
Employer/Respondent

Case # 11 WC 17737

17IWCC0152

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **10-29-15 and 1-26-16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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17IWCC0152

FINDINGS

On the date of accident, **3-4-11**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$4593.93**; the average weekly wage was **$183.76.**

On the date of accident, Petitioner was **49** years of age, ***single*** with **4** dependent children.

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

Respondent shall be given a credit of **$6160.00** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of **$6160.00.**

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

ORDER

Respondent shall pay reasonable and necessary medical services of $39,075.05, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit o
f $39,075.05 for medical benefits that have been paid.

Respondent shall pay Petitioner temporary total disability benefits of $183.76/week for 20 weeks, commencing 5-9-11 through 9-25-11, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $6160 for temporary total disability benefits that have been paid.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

David A. Kane
Signature of Arbitrator

February 9, 2016
Date

FEB 9 - 2016

FACTS

The Petitioner testified that on March 4, 2011, he was employed by Elite Staffing. He was sent by Elite to Nation Pizza to work. His job was cleaning, taking out garbage and cleaning dough containers. Some of the containers he was required to move weighed as much as 800 to 1000 pounds. He was also required to collect dough in cans and put them back in the machine, weighing 150 to 200 pounds. He testified that he worked 8 hours per day, 5 to 6 days per week for Elite. He further stated that he earned $8.25 per hour at Elite.

Petitioner testified that prior to March 4, 2011, he also worked at Labor Network, another employment agency, earning $8.25 per hour and worked 8 hours per day, 5 to 6 days per week, working a total of 16 hours per day for both jobs. He had told Christina Pabon at Nation Pizza that he was not able to work on the schedule at one point during the summer of 2010 because he was working at Labor Network. The Petitioner alleged on several court documents that his Average Weekly Wage was $330 (Resp. Exs. #9, 10 and 11). Petitioner also stipulated at trial that the Petitioner's Average Weekly Wage for the Respondent was $183.76 (Arb. Ex. #1). Petitioner testified that he had never been diagnosed with spondylolysis or spondylolisthesis prior to March 4, 2011. Nor had he been diagnosed with discogenic low back pain, an annular tear, a lumbar or cervical disc protrusion, partial thickness tear of the right shoulder, or had any prior MRIs. He had no prior treatment to his back or right shoulder.

On March 4, 2011, the Petitioner was lifting a tub of dough with another person when the other person let go. It weighed 280 to 300 pounds. Both of the Petitioner's hands were over his head at the time. The Petitioner felt a crack in his back and noticed burning and pain in the back and right shoulder. He continued to work and finished his shift. The following day he noticed difficulty bending and sitting. The first medical care he underwent was not until one month later, on April 4, 2011 when he went to Alexian Brothers Medical Group. He testified that he complained of low back and right shoulder pain as well as pain in both of his legs. He was prescribed physical therapy for 2 weeks. He continued to return to work with no heavy lifting. The medical records indicate that the Petitioner complained of only back pain on his April 4, 2011 visit (Pet. Ex. #1, p. 1 and 10). The first mention of any shoulder pain in the medical records was not until April 21, 2011, when he underwent physical therapy, 6 weeks after his injury (Id. at p. 18).

The Petitioner continued to treat at Grandview Health Partners where he initiated his treatment on May 4, 2011, two months after his accident, with a chiropractor, Dr. Nellie Christ. By then, he had a much longer list of complaints. He testified that he continued to have back and right shoulder problems and that he provided an accurate description of his complaints to Dr. Christ. However, the records show he complained of thoracic spine pain, lumbar spine pain with no radiation, right shoulder pain, headaches and numbness and tingling to the upper extremity to the elbow on the right (Pet. Ex. #2, p.1). According to the Petitioner, x-rays as well as MRIs of the right shoulder and back were taken. Dr. Christ recommended exercise and electrical stimulation. Dr. Christ also took the Petitioner off of work effective May 4, 2011. The Petitioner did notice improvement with the therapy.

On May 24, 2011, Dr. Christ referred the Petitioner to Dr. Christopher Morgan, a pain doctor. For the first time since his accident, the Petitioner started complaining of left shoulder pain, as noted in the records of Dr. Morgan at the Chicago Pain and

Orthopedic Institute. His complaints had expanded even further when the doctor noted in his history that the Petitioner complained of back pain, right shoulder pain, neck pain, left shoulder pain and pain in his left wrist which began before the accident (Pet. Ex. #3, p.15). Dr. Morgan requested numerous tests: a lumbar MRI, which was taken on May 13, 2011 (Pet. Ex. #3, p. 11), an MRI taken of the left shoulder taken on May 26, 2011; MRIs of the left wrist and cervical spine which were performed on June 13, 2011(Id. at p. 13 and 14), and some type of electrodiagnostic exams taken of the cervical spine and upper extremities the specific types of which were not identified (Pet. Ex. #2, p. 111-115). The lumbar MRI taken on May 13, 2011 showed hypertrophic spurring at multiple levels representing spondylosis; a 2-3 mm subligamentous posterior annular disk bulge slightly indenting the thecal sac without spinal stenosis nor significant neuroforaminal narrowing at the L4-L5 level; a 3-4 mm subligamentous posterior disk protrusion/herniation indenting the ventral surface of the thecal sac without spinal stenosis nor significant neuroforaminal narrowing at the L5-S1 level; and mild facet arthrosis at multiple levels (Pet. Ex. #2, p. 12). The Petitioner testified that Dr. Morgan performed two injections on his back with some improvement.

According to the Petitioner, Dr. Morgan then referred the Petitioner to Dr. Freedberg for pain to the right shoulder. He first saw Dr. Freedberg on May 31, 2011. At that time, the Petitioner complained of pain in his back and both shoulders. Dr. Freedberg performed an examination in which there were no positive findings (Resp. Ex. #2, p. 1-7). After review of his x-rays and MRIs, Dr. Freedberg diagnosed the Petitioner with degenerative joint disease of both shoulders and degenerative disc disease of the cervical and lumbar spine (Id. at p. 6). He prescribed additional physical therapy and performed an injection to the Petitioner's right shoulder. He kept him off of work. The Petitioner continued to treat at Grandview Health Partners until he was discharged by the chiropractor, Tyra Horner, on September 27, 2011 and told to follow up with his orthopedic (Pet. Ex. # 2, p.22). By the July 19, 2011 visit with Dr. Freedberg, he had

the Petitioner return to work light duty, lifting less than 10 pounds and by his September 27, 2011 visit he gave the Petitioner a full release with no restrictions (Id. at p. 42).

However, the Petitioner did continue to treat. According to the Petitioner, Dr. Morgan referred him to Dr. Lorenz, at Hinsdale Orthopedics, for continued treatment. He saw Dr. Lorenz for the first time on August 11, 2011 where he took a history, performed an examination and took x-rays of the cervical spine. Upon review of the x-rays and previous MRI of the lumbar spine, he noted that they showed mild degenerative changes of no significance. He indicated that the Petitioner had a shoulder issue that was being treated by Dr. Freedberg and a strain of the lower back which should respond well to conservative therapy, recommended an EMG, that he return to his treating physician and undergo a functional capacity examination (Resp. Ex. #3, p. 2-4). The Petitioner returned to Dr. Lorenz on March 19, 2012 wherein he noted an EMG with no significant radicular component and returned him to his treating physician (Id. at p.3).

The Petitioner continued to treat with Dr. Freedberg during 2012 and Dr. Freedberg continued to recommend physical therapy and that he work full duty all the way up to his last visit on July 17, 2012 (Resp. Ex. #2, p. 63, 74, 85 and 96).

The Petitioner testified that he returned to work on October 3, 2011 for Elite. When he did, he complained that it was too cold and he had to stand for a long time and that his back hurt, so he was let go. He testified that he also worked for Labor Network after Dr. Freedberg gave him the full duty release. The Petitioner testified that he continued to work at many jobs since then, including Kyoto Japanese Restaurant, Wedgewood Stables and Joseph's Marketplace.

According to the Petitioner, he chose to see Dr. Giri Gireesan for a second opinion. By the time he first saw Dr. Gireesan on July 23, 2012, all of his previous treating doctors had discharged him from their care and returned him to full duty work (Pet. Ex. #2, p. 22; Pet. Ex. #3, p.6; Pet. Ex. #4, p.43; Resp. Ex. #3, p.3). Upon his first visit with Dr. Gireesan, he complained of pain in his back and his shoulder. By that time, he was working at the horse stable, feeding horses, carrying wheelbarrows and taking out the trash. Dr. Gireesan's findings upon examination were completely normal. He prescribed a back x-ray. He diagnosed him with discogenic pain (Pet. Ex. #7, p. 1-2). He recommended another lumbar MRI and a lumbar CT Scan, work conditioning and a functional capacity evaluation. The Petitioner underwent the work conditioning and functional capacity evaluation at Accelerated. After the work conditioning and functional capacity evaluation on October 18, 2012, the records show that the Petitioner's work status was lifting up to 20 pounds (Pet. Ex. #8). After being given the 20 pound lifting restriction, he continued to work at the horse stable for another fifteen days. The Petitioner underwent another lumbar MRI on April 24, 2013 (Pet. Ex. #7, p.20) and a third MRI in 2014 (Id. at p. 44) as well as the lumbar CT Scan (Id. at p. 48) all prescribed by Dr. Gireesan. The lumbar MRI taken on April 24, 2013 showed a 3-4 mm subligatmentous posterior disk protrusion/herniation elevating the posterior longitudinal ligament and indenting the ventral surface of the thecal sac without significant spinal stenosis, nor significant neuroforaminal narrowing at the L5-S1 level; facet arthrosis at the L5-S1 level and otherwise unremarkable (Pet. Ex. #7, p. 43). A third lumbar MRI was taken a year later on April 10, 2014. Under the Findings, it was noted that there was disc desiccation with minimal disc bulge and arthropathy at the L4-L5 level, disc desiccation with a shallow broad based posterior disc protrusion and a tiny posterior left paracentral disc annular tear (approximately 5 o'clock position), and facet degenerative changes. However, in the Impression section of the report, it was noted only as bony edema in bilateral L4 and L5 pedicles, no significant spondylolisthesis and multilevel degenerative changes (Pet. Ex. #7, p. 45). By the

time the Petitioner underwent the CT Scan on September 13, 2014, the Impression was anterolisthesis and spondylolisthesis at the L5-S1 level; spondylolysis at the L5-S1 level; a 3-4 mm posterior disk protrusion/herniation without stenosis with facet arthrosis at the L4-L5 level; and a 3-4 mm disk protrusion/herniation also indenting the thecal sac without significant spinal stenosis with some facet arthrosis at the L5-S1 level (Id. at p. 49).

The Petitioner testified that subsequent to those tests, Dr. Gireesan had prescribed surgery for his back. Dr. Gireesan provided his evidence deposition in which he testified that the Petitioner suffered an annular tear and that he was recommending surgery (Pet. Ex. #26).

The Petitioner testified that in April, 2013, he was working in a restaurant. He felt bad, had headaches and back pain. He called an ambulance and was taken to the hospital. The hospital records indicate he was working for Kyoto Steak and Sushi at the time (Resp. Ex. #4). He further testified that on the day of trial, he noticed that he felt bad, not able to sit too long and had pain in his back.

On cross examination, the Petitioner testified that he usually got to work by driving or getting a ride. However, he did not undergo medical care for a month because he said he had no transportation. Upon his first visit to Alexian Brothers, he could not recall complaining of any pain to his shoulders, neck or left wrist.

When he started treatment at Grandview Health Partners two months after his accident, he testified that he told Dr. Nellie Christ that he had pain in his back, right shoulder and left shoulder. He also received therapy to those parts of his body. Yet he did not recall having his shoulders examined. The therapy he received was massages but he did not remember receiving any other type of therapy.

He felt about 60% better after the therapy but he was referred to the orthopedic, Dr. Freedberg for further treatment. When the Petitioner first saw Dr. Freedberg on May

31, 2011, he examined his neck, back and right shoulder. He gave him an injection in his right shoulder. He also recommended continued therapy with Dr. Christ. He continued to see Dr. Freedberg and also complained of his back hurting when he would trip or slip on the wet snow. He testified that it occurred about three or four times. By September 27, 2011, Dr. Freedberg had returned the Petitioner to full duty. He did not recommend surgery.

When questioned about who Dr. Morgan was and what treatment he received from him, the Petitioner could not recall. He did recall receiving two injections in his back, the first of which helped and the second which did not.

He remembered being referred to see Dr. Lorenz and saw him on two occasions. He did not recall whether he was examined, what type of treatment he prescribed or whether he returned him to work.

By the time he started seeing Dr. Gireesan on July 13, 2012, he was on his sixth or seventh doctor who has treated him. He complained of pain in his back, neck, right shoulder and left leg. Dr. Gireesan prescribed Tramadol.

On September 26, 2011, the Petitioner was examined by Dr. Avi Bernstein for an independent medical examination pursuant to Section 12. At that time, the doctor examined the Petitioner. Dr. Bernstein testified by evidence deposition that the Petitioner had a normal orthopedic and neurological examination with good strength and normal reflexes in his lower extremities as well as a negative straight leg raising exam (Resp. Ex. #5, p. 8-9). He further testified that he reviewed the MRI scans of the lumbar spine that were taken on May 13, 2011 and April 23, 2013 and that they were normal with no disk herniation (Id. at p. 13 and 19). His assessment was that the Petitioner was fine and there was nothing objective to support his complaints and there was no reason why he could not perform his normal job requirements (Id. at p. 15). He was also of the opinion that the Petitioner had a resolved lumbar strain and was in

need of no further medical treatment and certainly not a surgical candidate (Id. at p. 16-19). Dr. Bernstein's opinion regarding the negative orthopedic findings and the full duty release is consistent with that of the Petitioner's own treating doctor, Dr. Freedberg, who saw the Petitioner only one day later and released him to full duty as well (See Resp. Ex. #2, p. 34-43).

The Petitioner also recalled being examined by Dr. Carl Graf on two separate occasions, April 17, 2013 as well as January 22, 2015 at the request of the Respondent, pursuant to Section 12. On both occasions, Dr. Graf performed orthopedic examinations. Dr. Graf testified by evidence deposition on August 27, 2014, regarding the examination of April 17, 2013. He testified that he performed an orthopedic examination of the Petitioner and that it was completely negative. He also reviewed several treating medical records, including the report of Dr. Avi Bernstein; those of Grandview Health Partners; Dr. Gireesan; lumbar MRIs taken on April 24, 2013 and April 10, 2014; Dr. Christopher Morgan; Dr. Jain; Dr. Freedberg; and Accelerated Rehab Centers. His opinion was that the Petitioner was at MMI, that he could return to full duty work, that he was in no need of surgery, should not undergo any vocational training, that there was no permanency to his back injury (Resp. Ex. #6, p. 18-21). Dr. Graf provided a report for his second examination which took place on January 22, 2015. He performed a neurologic examination of the Petitioner, reviewed additional records from Dr. Gireesan, x-rays of the lumbar spine taken on August 3, 2012, MRI films and reports taken of the lumbar spine taken on April 24, 2013, April 10, 2014 and a CT Scan film of the lumbar spine taken on September 15, 2014. His opinion at that time was unchanged from his previous opinion. He was of the opinion that the Petitioner's current complaints are in no way related to the March 2011 injury; that he has long been at MMI; that he is not a surgical candidate; and that the Petitioner has no work restrictions.

The Respondent also submitted several chiropractic visits as well as the work conditioning to Dr. Edwin Rabin, a chiropractor, for Utilization Review. Records from Alexian Brothers Medical Group and Grandview Health Partners were provided to aid in his review. He gave an evidence deposition by phone on May 8, 2015. It was his opinion that only 18 of the 43 chiropractic treatments from May 4, 2011 through August 3, 2011 were certified and the12 work conditioning visits from August 8, 2011 through September 8, 2011 were not certified (Resp. Ex. #13, Dep. Ex. # 5).

Subsequent to the Petitioner obtaining light duty releases from Dr. Gireesan, the Petitioner failed to contact the Respondent, Elite Staffing to return to work even though he was notified by his attorney that light duty was available. His reason was that he lost their phone number. When asked about other employers from which he sought employment, he responded that there were many—that he had pages of listings, but that he left those pages at home. When asked repeatedly where he looked for jobs and what names he contacted, he could not come up with one name.

He recalled returning to Centegra Hospital on one occasion, on April 23, 2013. He was working at Kyoto Steak and Sushi at the time, but he called the ambulance from his home on that morning because he was in extreme pain.

The Petitioner testified that at the time of the hearing, he was employed at Joseph's Market. His job duties were to place the fruit and produce out on the line. He had most recently seen Dr. Gireesan in August and October, 2015. At those visits, he told the doctor that he did not have any further unusual complaints. The Petitioner denied having any accidents or injuries or filing any claims after the accident on March 4, 2011. He denied ever going back to Centegra after the 2013 incident when he called the ambulance. The Petitioner was then shown Respondent's Exhibit # 19, an Application for Adjustment for Claim that was filed for an injury which occurred on August 9, 2015 while in the course of his employment at Joseph's. He admitted that his signature appeared on the bottom of the Application. It showed that he was

claiming injuries to his back, neck, hip, head and right shoulder from falling off a ladder. It also indicates that the case was filed on September 15, 2015 and given the number of 15 WC 29867. After being confronted with the fact that there was knowledge of his subsequent claim being filed, he admitted to falling 8 to 9 feet from a ladder and landing on his back. He then admitted to being taken to the emergency room at Centegra Hospital. He was taken by the manager of the meat department. Upon further questioning regarding his follow up care and which doctors he saw, he was evasive and forgetful. However, when reminded of whether he went to Herron, he acknowledged that he had gone there. He was prescribed physical therapy and medicated patches. He did not recall where he went for the physical therapy. Even when asked if he went to Total Rehab in Schaumburg, he could not recall. After further questioning, he finally remembered the doctor who treated him at Herron as being Dr. Chunduri.

On further re-direct and cross examination, the Petitioner testified that due to the medications that he took, the Tramadol and Norco, he had problems with his memory. He could not remember the dates he saw Dr. Bernstein or Dr. Graf, but he could remember that each of those exams took only 5 to 10 minutes.

Records show the Petitioner underwent emergency care at Centegra for a fall from a ladder at work on August 9, 2015, just two months prior to Petitioner's testimony at the hearing (Resp. Ex. #15). They confirm that Petitioner fell off a ladder while working for Joseph's (Id. at p. 19). Also confirmed was that he suffered a back injury that was moderate in degree and noted to be sharp. He was diagnosed with a contusion to the lumbar spine with radiation into the left leg (Id. at p. 34, 36). Additional records confirm follow up care to his new injury. He subsequently treated at Herron Medical Center, starting on August 12, 2015. The history given there was that he fell from a ladder while working for Joseph's, injuring his right shoulder, back and neck. He was diagnosed with a long list of issues involving the brain, right shoulder, cervical spine,

thoracic spine and lumbar spine (Resp. Ex. #16, p.4). Therapy and testing were prescribed. Petitioner underwent CT Scan and a fourth MRI to the lumbar spine on August 13, 2015, and an MRI to the brain. The Impression on the lumbar MRI was a 2-3 mm subligamentous posterior disk protrusion/herniation noted to indent the ventral surface of the thecal sac with mild bilateral neuroforaminal narrowing at the L4-L5 level; and a 3-4 mm broad-based subligamentous posterior disk protrusion/herniation with mildly extruded nucleus pulposus noted to indent the thecal sac, also with mild bilateral neuroforaminal narrowing seen (Id. at p. 9).

The Petitioner underwent physical therapy at Total Rehab in Schaumburg. He attended from August 17, 2015 at least through October 13, 2015 when the records were provided. They indicate that he was to continue until at least October 20, 2015 (Resp. Ex. #17, p. 18). Upon the last visit documented on October 13, 2015, the Petitioner indicated that he was still having pain and tenderness in his neck, right shoulder and low back; radiating pain on the right lower extremity; muscular weakness on the neck, right shoulder, low back and right lower extremity; limited motion on the neck, right shoulder and low back; and decreased tolerance in self-care, mobility, changing and maintaining positions, and carrying and lifting objects (Id.). Petitioner was also referred to the pain doctor, Dr. Chunduri, who performed an epidural steroid injection to the L4-L5 level on September 28, 2015 based on the pre- and post-operative diagnosis of lumbar disc herniation with left radiculitis (Resp. Ex. #22, p. 4).

Respondent has provided a wage statement which indicates that the Petitioner's AWW was $183.76 (Resp. Ex. #1). The Petitioner has stipulated that his AWW is $183.76 (See Arb. Ex. #1). The Respondent has paid TTD at a rate of $220, from May 4, 2011 until September 25, 2011, for a total of $6160 (Resp. Ex. #8), when he was given a full release by Dr. Avi Bernstein as well as his own treating doctor, Dr. Freedberg. Respondent has also paid the medical bills for treatment incurred in the amount of $55,582.95 as confirmed in the itemized statement provided (Id.).

ISSUES

CAUSAL CONNENCTION

The Petitioner claims that he injured his lumbar spine, that his injury has caused continuing problems necessitating the ongoing care that he has received and that at the recommendations of Dr. Gireesan, he is need of surgery and the need for surgery is causally connected to his injury of March 4, 2011. A review of the medical indicates a significant amount of treatment. He has had an extensive amount of physical therapy by Grandview. He has been referred to many doctors--Dr. Morgan for injections, Dr. Freedberg for a shoulder injection and back treatment and further recommendations for therapy, Dr. Lorenz for additional orthopedic care. All of these doctors have discharged the Petitioner from their care with full duty no restrictions. Not one of them has recommended any surgery. Even Dr. Gireesan, who the Petitioner has last chosen to treat with, has mentioned in his records that it is the Petitioner who wants the surgery. Respondent has had the Petitioner examined on three separate occasions—Dr. Avi Bernstein and Dr. Carl Graf, twice--and on each one they have opined that the Petitioner is in no further need for any treatment, could return to full duty work and was at MMI. The Petitioner's demeanor and testimony have been noted. It has become clear throughout the hearing that the Petitioner is not credible. There are numerous instances that confirm that the Petitioner was not truthful. He is not to be believed. He has claimed on numerous occasions that he had earned an AWW of $330 (Resp. Exs. #9, 10 and 11). He also testified at the hearing that he worked 8 hours per day, 5-6 days per week for the Respondent. Yet he stipulated to the fact that he only earned $183.76 on the stipulation sheet (Arb. Ex. #1). This is also confirmed by the wage statement submitted (Resp. Ex. #1).

Another instance in which the Petitioner was less than truthful was when he indicated that he looked for work and had many pages of places he searched, yet he did not bring his list to the hearing, nor could he remember one place he searched. But most importantly, the Petitioner testified that he sustained no subsequent injuries and had filed no subsequent claims after the March 4, 2011 injury. He was caught up in a lie and had to finally admit that his signature did appear on a subsequent filing of an Application for Adjustment for Claim and that he did actually sustain another injury. This was not some obscure injury that occurred many years ago that could have been overlooked. This had occurred only two months prior to the Petitioner's testimony and he was still treating for it at the time of the hearing.

Based on the demeanor and lack of credibility of the Petitioner, as well as the overwhelming medical, from the Respondent's medical opinions as well as that of the own Petitioner's treating doctors, it is determined that there is no causal connection between his injury of March 4, 2011 and the need for any additional treatment, including surgery.

AVERAGE WEEKLY WAGE

The Petitioner has stipulated that he earned $183.76 while working for the Respondent (Arb. Ex. #1). That amount is confirmed by the wage statement provided by Respondent (Resp. Ex. #1). The Petitioner has attempted to claim that he was concurrently employed by Labor Network and his wages should be an additional $321.24, as claimed on the stipulation sheet (Arb. Ex. #1). The Petitioner testified that he worked 8 hours per day, 5-6 days per week at $8.25 per hour for Labor Network. However, the Petitioner has failed to provide any documentation of any concurrent employment. He claimed on numerous occasions that his earnings were $330 (Resp. Exs. 9, 10 and 11). Then at trial he finally, for the first time attempted to add additional wages to his claim. He testified that he worked 8 hours per day for Labor Network and also 8 hours per day for the Respondent. Yet even his claim for wages earned for Respondent are only $183.76, nearly half of what he testified to. His testimony is not credible. At best, it is exaggerated and at worst, fabricated. It is determined that he did not have any concurrent wages and his AWW is $183.76.

MEDICAL

The Petitioner claims $41,782.93 in unpaid medical. The Respondent claims that it paid all the reasonable and necessary medical up to $39,075.05 (Resp. Ex. #8). When the Petitioner initially sought out medical care one month after his injury, he complained of low back pain only. As he continued on with his treatment, he started adding on various parts of his body that he claimed were related to his accident. His treating doctors treated every part of his body that he complained of. He did not have any complaints initially of either of his shoulders or his neck, yet he was given therapy to neck and shoulders and injections to his right shoulder. He claimed that he had improvement of 60% yet continued to treat for his back. The Respondent provided

Utilization Review of his treatment and it was determined to be unnecessary after 12 treatments (Resp. Ex. #13). Dr. Bernstein as well determined that any further treatment after his examination on September 26, 2011 was not necessary and that the Petitioner had reached MMI. This was further confirmed by Dr. Graf in his two examinations in which he agreed with the findings of Dr. Bernstein that the Petitioner was at MMI and in no further need for medical care.

The Petitioner is not credible. For the same reasons as previously mentioned, his testimony is not to be believed. The medical bills of the Petitioner that remain unpaid for which he is claiming are the responsibility of the Respondent are deemed to be not reasonable or necessary.

TTD AND TPD

The Petitioner claims TTD from May 4, 2011 through October 2, 2011 and the TPD from October 18, 2012 to October 29, 2015. Both Respondent and Petitioner agree that Respondent has paid a total of $6160 in TTD benefits. Based on the previous reasoning, it has been established that the Petitioner's average weekly wage was $183.76. The Petitioner has not met his burden of proof that he was temporarily partially disabled from October 18, 2012 through October 29, 2015. He testified that he looked for many jobs but he did not bring his list to the hearing and when asked to provide even one name of where he searched for a job, he could not provide one. In addition, he is claiming to be temporarily partially disabled as a result of the March 4, 2011 injury during the time period when he was actually unable to work due to a new injury which he specifically denied under oath. The Petitioner is not credible nor did he sustain his burden of proof in showing that he was temporarily partially disabled. Therefore his claim for TPD is denied. Regarding TTD, since it has been determined

that the Petitioner's AWW was $183.76 and he was unable to work from May 9, 2011 through September 25, 2011, or 20 weeks, the Respondent is responsible to pay Petitioner $3675.20. Since the Respondent has paid $6160, the Respondent is entitled to a credit of $2484.80.

PROSPECTIVE MEDICAL

The Petitioner claims that the Respondent should be responsible for surgery that Dr. Gireesan has recommended and the Respondent denies that it should be responsible. Out of the six or seven doctors that the Petitioner saw prior to seeing Dr. Gireesan, every one of them had discharged the Petitioner from their care and returned him to full duty. Not one doctor mentioned the need for any surgery. Petitioner last saw Dr. Morgan at Chicago Pain and Orthopedic on August 2, 2011 when he referred the Petitioner to Dr. Freedberg at Suburban Orthopedics (Pet. Ex. #3, p. 17) and to Dr. Lorenz at Hinsdale Orthopedics (Resp. Ex. #3, p. 1). Petitioner last attended Grandview Health Partners on September 26, 2011 when he was released from their care and sent to an orthopedic follow up (Pet. Ex. #2, p. 22). After treating with Dr. Freedberg, the Petitioner never returned after he was returned to full duty on July 17, 2012 (Resp. Ex. #2, p. 96). Dr. Lorenz saw the Petitioner on two occasions, August 11, 2011 and on the second visit on March 19, 2012. On the first visit, he indicated that the Petitioner had a strain to the lower back that should respond well to conservative therapy based on the fact that "in regards to the lower spine, the patient has mild degenerative changes of no significance on the MRI (Resp. Ex. #3, p. 4), and on the second visit released him back to his treating physician (Id. at p. 3).

Further, the Respondent's Section 12 doctors both opined that the Petitioner was in no further need of any medical care and at MMI at the time of their examinations and specifically not in need of any surgery (Resp. Exs. #5, 6 and 7).

Also, and of great significance, is the demeanor and credibility of the Petitioner. As stated previously, he proved on many occasions during his testimony not to be credible. Of most importance was when he was caught in a lie when he denied experiencing a new accident only two months before his testimony at the hearing and for which he was still under the doctor's care. That injury was very significant. He fell 8 to 9 feet off of a ladder and fell directly onto his back. His attempt at denial is an affront to the judicial system and was an attempt to commit a fraud. Any further prospective benefits are denied.

PENALTIES AND ATTORNEY FEES

The Petitioner claims that the Respondent has failed to pay for reasonable and necessary medical and failed to pay for TTD and TPD that is due and that such failure shall result in penalties being assessed against the Respondent. It has been determined that the medical treatment which was considered reasonable and necessary has already been paid by the Respondent. In addition, it has been determined that all TTD owed has been paid by the Respondent. In fact, there is actually a credit of overpayment of TTD that Respondent is entitled to in the amount of $2484.80. The Petitioner's testimony is not credible and at times, outwardly false. He is not entitled to any penalties or attorney fees.

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 ROCK ISLAND)	☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dave Bixby,

Petitioner,

17IWCC0124

vs.

NO: 11 WC 24414

City of Moline,

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

In a Decision issued December 4, 2015, the Arbitrator awarded PPD benefits representing 5% loss of use of the left leg for injuries sustained on August 6, 2009. The Arbitrator relied on Petitioner's treating physicians as well as Respondent's §12 examiner, Dr. Fossier, in finding that Petitioner failed to prove that his current left knee condition of ill-being is causally related to the accident and that Petitioner's left knee condition resolved by the time she was released from care by Dr. Lindaman in 2010.

We note that during the year following the work-related injury on August 6, 2009, Petitioner was able to continue working his regular job and he reported performing activities outside of work such as tree trimming, mowing, and heavy yard work. When he was released from care for the second time, on October 15, 2010, Petitioner reported only occasional symptoms of dull aching pain. After considering all of the evidence, we modify the Arbitrator's award of permanent partial disability to 2.5% of the left leg where we find that the credible evidence shows a lesser extent of disability than that which was found by the Arbitrator.

17IWCC0124

All else is otherwise affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $664.72 per week for a period of 5.375 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 2.5% loss of use of the left leg.

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

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

DATED: MAR 1 - 2017
RWW/plv
o-1/18/17
46

Ruth W. White

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0124

BIXBY, DAVE
Employee/Petitioner

Case# **11WC024414**

CITY OF MOLINE
Employer/Respondent

On 12/4/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0412 RIDGE & DOWNES
KARIN CONNOLLY
101 N WACKER DR SUITE 200
CHICAGO, IL 60606-7307

2119 CALIFF & HARPER PC
STEVEN L NELSON
506 15TH ST
MOLINE, IL 61285

17IWCC0124

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

Dave Bixby
Employee/Petitioner

v.

City of Moline
Employer/Respondent

Case # 11WC 24414

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Rock Island, Illinois**, on **10/06/2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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 **08/06/2009**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**65,972.87**; the average weekly wage was $**1,268.71**.

On the date of accident, Petitioner was **57** years of age, married, with **1** children under 18.

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $664.72/week for 10.75 weeks, because the injuries sustained caused the 5% loss of the left leg, as provided in Section 8(e) of the Act.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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

11/30/15
Date

DEC 4 - 2015

17IWCC0124

Findings of Fact:

Petitioner, worked for Respondent as a plant mechanic, for approximately 24 years. He worked at the south slope waste management water treatment center. He performed maintenance on pumps, motors, samplers and drives.

Petitioner testified that on August 6, 2009, he was assigned to weld channel iron onto a hopper. A hopper is a large metal container used for recycling. It holds 12-15 tons of processed sludge. He was using a jack to push wooden cribbing (4 foot long 8x8 raw lumber) to shape the metal, before welding. Petitioner stated that the wood was discharged, "kicked out", from the jack and hit him in the leg.

Petitioner testified that he immediately felt significant pain near his knee cap on the inside part of his knee. He discussed the accident with the plant manager and was referred to the company nurse, "Pam." Records submitted show Petitioner presented to the company nurse, Pam Rudsell, on August 18, 2009 with complaints of discomfort and tightness in the inner lateral left knee, distal thigh and proximal lower leg. The nurse recorded that Petitioner indicated that a 4 X 6 wood beam fell off a jack and struck his inner left leg below the knee. An examination noted a very faint light yellowish area of resolved ecchymosis about the size of a fifty cent piece on the inner left proximal leg, just below the knee. At that area, there was a small soft mass about the size of a small marble with minimal tenderness. Petitioner was referred to Concentra and advised to avoid twisting the knee. (RX 4)

Petitioner presented to Concentra on August 20, 2009 where he was examined and treated by Dr. Patricia Dunbar. Dr. Dunbar initially assessed left knee/lower leg contusion 2 weeks old with increased pain focally at the area of impact and the distal quadriceps and calf musculature. The doctor felt this likely represented resolving hematoma and bone edema. Later that day, the doctor amended her assessment to indicate soft tissue injury with boney contusion. She ordered physical therapy and continued his regular duty work status. (PX 1)

On August 31, 2009, Dr. Dunbar recorded that Petitioner reported some lower knee and leg soreness which he attributed to heavy yard work over the weekend. He complained of focal knee joint pain, locking, catching or instability. Dr. Dunbar performed an examination and provided that Petitioner's left lower leg contusion and knee sprain had resolved. Petitioner was placed at maximum medical improvement and discharged from care. (PX 1)

Petitioner testified that he continued to work full duty. He stated that while doing so, he noticed that his left knee looked metallic black and blue. He stated that going up and down stairs caused pain; he favored his left leg and limped while walking.

On May 3, 2010, Petitioner saw Pam Rudsell, the company nurse, reporting that his left knee remained sore; that ascending and descending stairs caused difficultly; and at times, he felt a sharp knife sensation into both sides of the left knee. Nurse Rudsell assessed left knee pain and noted Petitioner was scheduled to see Dr. Dunbar. (RX 4)

On May 6, 2010, Petitioner returned to Dr. Dunbar reporting pain on and off in the knee, especially over the outer aspect of the knee. Petitioner also reported the knee sometimes tends to lock with weight bearing and

ambulatory activities. Dr. Dunbar wrote that Petitioner had persistent lateral knee pain. She indicated that because of Petitioner's focal complaints and long-standing unremitting complaints, a diagnostic MRI was necessary. The doctor added that it was quite possible, with the mechanism of injury, Petitioner had a lateral meniscal tear. (PX 1) The MRI when completed on May 10, 2010 demonstrated joint effusion and Baker's cyst. There was increased signal in the posterior horn of the medial meniscus suggesting myxoid degeneration. Also noted was a bipartite patella and changes in the trochlear groove. (PX 1)

On May 14, 2010, Dr. Dunbar recorded that Petitioner's complaints were supported by the MRI. She indicated the myxoid degeneration was suggestive of trauma as well as degenerative changes. Petitioner was referred to an orthopedist. (PX 1)

On August 13, 2010, Petitioner presented to Orthopedics and Rheumatology (ORA) where he saw Dr. Matt R. Lindaman for additional treatment. Petitioner complained of the feeling that the knee might give way. He reported aching and occasional sharp exacerbating pain. His symptoms were worsened by stairs or directly kneeling or pressure against the knee. After performing an examination and reviewing the diagnostic studies, Dr. Linderman assessed 1.) anterior left knee pain; 2.) bipartite patella; 3.) synovitis left knee; and 4.) posttraumatic weakness. Dr. Linderman noted the MRI scan showed degenerative medial meniscus with no frank tear with chondral injury to the patella. The doctor injected the knee with Depo-Medrol and ordered additional physical therapy. (PX 2)

Records submitted show Petitioner continued to treat conservatively with Dr. Lindaman. On October 15, 2010, Dr. Lindaman noted that the August 2010 injection provided about 70% improvement. Petitioner reported that his symptoms were minimal. He had occasional intermittent dull, aching pain in the knee, but generally he was back to normal activities. Dr. Lindaman's impression at that time was improved left knee synovitis with posttraumatic weakness. Petitioner was released and was advised to return on a p.r.n. basis. (PX 2)

Petitioner returned to Dr. Dunbar on November 2, 2010. At that time Petitioner reported that his symptoms had improved but he still, on occasion, had a sense of instability. The doctor assessed resolved left knee sprain noting that degenerative changes were seen and interpreted upon review of the MRI. Petitioner was placed at MMI, returned to regular activities and his case was closed. (RX 3)

On February 3, 2011, Petitioner returned to ORA Orthopedics where he was seen by Physician Assistant James Earel. Records show Petitioner reported that although his pain had been relatively well controlled, he had a constant ache on the medial and lateral side. Petitioner provided that two weeks prior to the visit, he had sudden increase pain in the knee which wakes him from sleep. Petitioner was seeking a repeat injection, noting that the previous injection provided relief. An examination revealed exquisite pain to palpation along the medial line. Numbness was noted laterally around the patellofemoral joint. There was slight crepitus in the pateallfemoral joint with flexion and extension. Physician Assistant Earel felt that an injection was appropriate and as such the procedure was carried out. (PX 2)

Petitioner returned to Dr. Lindaman on June 10, 2011 with left knee pain which he rated at 4/10 on the pain scale. Petitioner complained of catching and grinding in the knee and also occasional giving way. After obtaining a x-ray, which showed mild to moderate medial joint space narrowing, and reviewing the previous MRI, which the doctor indicated showed a definite meniscal tear and mild osteoarthritis in the medical compartment, Dr. Lindaman assessed 1.) persistent left knee pain, medial meniscal tear; and 2.) chondomalacia patella in medial compartment. Dr. Lindman felt that Petitioner's symptoms were not severe enough to consider joint replacement at that time. The doctor however noted that since conservative measures had failed, a diagnostic and operative left knee arthroscopy with joint debridement was appropriate. (PX 2)

At Respondent's request Dr. Clarence Fossier performed at records review on August 23, 2011. According to Dr. Fossier, he reviewed the medical records of Dr. Dunbar of Concentra, the records of Respondent's nurse, and the records of Dr. Lindaman, for the period of August 20, 2009 through August 12, 2011. Dr. Fossier opined that the accident on August 6, 2009 was not responsible for the bipartite patella and myxoid degeneration. The doctor provided that a bipartite patella is a developmental finding and the condition is not one traumatically induced or worsened. He indicated that myxoid degeneration of the posterior horn of the meniscus is a degenerative condition not a traumatic one. The doctor added that the initial injury was a contusion to the proximal lower leg, not a twisting injury to the knee, which potentially could have injured a meniscus. Dr. Fossier felt that any aggravation to Petitioner's pre-existing degenerative changes ended when he was released at MMI on August 31, 2009 and again on September 20, 2010. The doctor stated that twice Petitioner's knee was treated successfully and there was no history of repeated injuries which could be related to work. The doctor felt that any additional treatment to the knee is not related to the date of injury. Lastly, the doctor stated "...this is not a causally related work injury on a more probable than not basis." (RX 1)

On November 14, 2011, Dr. Lindaman authored a letter to Petitioner's attorney. In his letter Dr. Lindaman provided that he diagnosed Petitioner with 1.) anterior left knee pain; 2.) bipartite patella; 3.) left knee synovitis; 4.) posttraumatic weakness; 5.) left knee osteoarthritis; and 6.) persistent left knee pain, medial meniscus tear. The doctor wrote that "A tear of the meniscus is a diagnosis which is made typically arthroscopically. Tears may be either traumatic or degenerative and in this case I would favor a degenerative tear of the meniscus." Dr. Lindaman added, "Having not seen this patient for a year following the injury, it would be difficult to determine whether the diagnosis was caused, aggravated, or accelerated by the accident on August 6, 2009. I would have no basis for determining that." The doctor further commented that on June 10, 2011, Petitioner was having symptoms which he felt was based mainly on degenerative arthritis. The doctor felt Petitioner was at MMI. (RX 2)

Petitioner testified that he retired from Respondent on December 6, 2012. He indicated that his symptoms had not improved since the accident and he still limped. He also provided that he had suffered significant medical issues unrelated to this incident following his retirement including cardiac issues and a head trauma.

Petitioner testified that he continued to have ongoing left knee complaints and as a result, he sought treatment from Dr. Tuvi Mendel at Orthopedic Specialists. On September 23, 2015, Petitioner presented to Dr. Mendel with left knee pain which he rated at 7/10 on the pain scale. Petitioner complained of difficulty walking, going up and down stairs with most of his pain located in the medial aspect of the knee. Dr. Mendel assessed left knee pain, internal derangement. The doctor injected the knee indicating that he would not recommend surgical management at that time due to Petitioner's non-work related medical condition. (PX 3)

Petitioner testified that he had no left knee injuries or problems before this injury and no intervening knee incidents.

With respect to (F.) Is Petitioner's current condition of ill-being causally related to the injury and (L.) What is the nature and extent of the injury, the Arbitrator finds as follows:

Petitioner sustained an accident on August 6, 2009, when a 4 X 6 wood beam fell off a jack and struck his inner left leg below the knee. Petitioner initially sought treatment with Respondent's Pam Rudsell, on August 18, 2009 who referred Petitioner to Concentra. Petitioner began treating with Dr. Patricia Dunbar at Concentra on August 20, 2009. Dr. Dunbar initially assessed left knee/lower leg contusion 2 weeks old with increased pain

focally at the area of impact and the distal quadriceps and calf musculature. The doctor felt this likely represented resolving hematoma and bone edema. The doctor amended her assessment to indicate soft tissue injury with boney contusion. By August 31, 2009, Dr. Dunbar recorded that Petitioner reported some lower knee and leg soreness as well as focal knee joint pain, locking, catching or instability. Dr. Dunbar performed an examination and provided that Petitioner's left lower leg contusion and knee sprain had resolved. Petitioner was placed at maximum medical improvement and discharged from care.

Petitioner continued to work full duty. On May 6, 2010, Petitioner returned to Dr. Dunbar reporting pain on and off in the knee. Because of persistent complaints, Dr. Dunbar ordered a diagnostic MRI. At that time, the doctor also noted that it was quite possible, with the mechanism of injury, Petitioner had a lateral meniscal tear. The MRI was completed on May 10, 2010 demonstrating joint effusion and Baker's cyst. There was increased signal in the posterior horn of the medial meniscus suggesting myxoid degeneration. Also noted was a bipartite patella and changes in the trochlear groove. On May 14, 2010, Dr. Dunbar recorded that Petitioner's complaints were supported by the MRI. She indicated the myxoid degeneration was suggestive of trauma as well as degenerative changes.

On August 13, 2010, Petitioner began treating with Dr. Linderman. The doctor assessed 1.) anterior left knee pain; 2.) bipartite patella; 3.) synovitis left knee; and 4.) posttraumatic weakness. Dr. Linderman noted the MRI scan showed degenerative medial meniscus with no frank tear with chondral injury to the patella. By October 15, 2010, Dr. Lindaman recorded that Petitioner's symptoms were minimal. Dr. Lindaman's impression at that time was improved left knee synovitis with posttraumatic weakness. Petitioner was released and was advised to return on a p.r.n. basis.

Petitioner returned to Dr. Dunbar on November 2, 2010. At that time Petitioner reported that his symptoms had improved but he still, on occasion, had a sense of instability. The doctor assessed resolved left knee sprain noting that degenerative changes were seen and interpreted upon review of the MRI. Petitioner was placed at MMI, returned to regular activities and his case was closed.

Petitioner did not seek additional treatment again until February 3, 2011 when he returned to ORA Orthopedics. Records show Petitioner had an increase in symptoms and was seeking a repeat injection, noting that the previous injection provided relief. After an examination it was determined that an injection was appropriate and the procedure was carried out.

Petitioner last saw Dr. Lindaman on June 10, 2011 with left knee pain. At that visit, Dr. Lindaman reviewed the previous MRI, which the doctor indicated showed a definite meniscal tear and mild osteoarthritis in the medical compartment. In response to an inquiry from Petitioner's attorney, Dr. Lindaman authored a letter on November 14, 2011. In his letter Dr. Lindaman provided that he diagnosed Petitioner with 1.) anterior left knee pain; 2.) bipartite patella; 3.) left knee synovitis; 4.) posttraumatic weakness; 5.) left knee osteoarthritis; and 6.) persistent left knee pain, medial meniscus tear. The doctor explained that a tear of the meniscus is a diagnosis which is made typically arthroscopically and that tears may be either traumatic or degenerative. He provided that "...in this case I would favor a degenerative tear of the meniscus." Dr. Lindaman added, "Having not seen this patient for a year following the injury, it would be difficult to determine whether the diagnosis was caused, aggravated, or accelerated by the accident on August 6, 2009. I would have no basis for determining that." The doctor further commented that on June 10, 2011, Petitioner was having symptoms which he felt was based mainly on degenerative arthritis

At Respondent's request Dr. Clarence Fossier performed at records review on August 23, 2011. Dr. Fossier opined that the accident on August 6, 2009 was not responsible for the bipartite patella and myxoid

degeneration. The doctor provided that a bipartite patella is a developmental finding and the condition is not one traumatically induced or worsened. He indicated that myxoid degeneration of the posterior horn of the meniscus is a degenerative condition not a traumatic one. The doctor added that the initial injury was a contusion to the proximal lower leg, not a twisting injury to the knee which potentially could have injured a meniscus. Dr. Fossier felt that any aggravation to Petitioner's pre-existing degenerative changes ended when he was released at MMI on August 31, 2009 and again on September 20, 2010. The doctor stated that twice Petitioner's knee was treated successfully and there was no history of repeated injuries which could be related to work. The doctor felt that any additional treatment to the knee is not related to the date of injury. Lastly, the doctor stated "...this is not a causally related work injury on a more probable than not basis."

The Arbitrator notes the evidence submitted regarding a causal relationship between Petitioner's current condition of ill-being and the accident sustained is contained in the records of Dr. Dunbar, Dr. Lindaman and Dr. Fossier. On May 6, 2010, Dr. Dunbar ordered a diagnostic MRI noting that it was quite possible, with the mechanism of injury, Petitioner had a lateral meniscal tear. The MRI when completed on May 10, 2010 demonstrated joint effusion and Baker's cyst. There was increased signal in the posterior horn of the medial meniscus suggesting myxoid degeneration. Also noted was a bipartite patella and changes in the trochlear groove. On May 14, 2010, Dr. Dunbar recorded that Petitioner's complaints were supported by the MRI. She indicated the myxoid degeneration was suggestive of trauma as well as degenerative changes.

In his letter dated November 14, 2011, Dr. Lindaman opined that "...in this case I would favor a degenerative tear of the meniscus." Dr. Lindaman added, "Having not seen this patient for a year following the injury, it would be difficult to determine whether the diagnosis was caused, aggravated, or accelerated by the accident on August 6, 2009. I would have no basis for determining that." Also, the doctor noted that when he last saw Petitioner in June 2011, Petitioner was having symptoms which he felt was based mainly on degenerative arthritis.

Respondent's Section12 examiner, Dr. Clarence Fossier indicated the initial injury was a contusion to the proximal lower leg, not a twisting injury to the knee which potentially could have injured a meniscus. Dr. Fossier felt that any aggravation to Petitioner's pre-existing degenerative changes ended when he was released at MMI on August 31, 2009 and again on September 20, 2010. The doctor felt that any additional treatment to the knee is not related to the date of injury. Lastly, the doctor stated "...this is not a causally related work injury on a more probable than not basis."

Relying on Petitioner's treating physicians as well as Respondent's Section 12 examiner, Dr. Fossier, the Arbitrator finds that Petitioner failed to prove that his current left knee condition of ill-being is causally related to the accident sustained. The preponderance of evidence demonstrates that as a result of the accident sustained on August 6, 2009, Petitioner sustained a left lower leg contusion and knee sprain which had resolved by September 20, 2010. As such, the Arbitrator finds Petitioner sustained 5% loss of use of the left leg under Section 8(e) of the Act.

With respect to (J.) Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

A review of the evidence show that Petitioner failed to submit any documentation regarding any unpaid medical expenses. As such, Petitioner's request for medical expenses is denied.

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

Louis Cornell Johnson,

Petitioner,

vs.

NO. 11WC031788

17IWCC0178

State of Illinois/Southwestern Correctional Center,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of 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 11, 2016 is hereby affirmed and adopted.

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

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

No bond is required for removal of this cause to the Circuit Court. The party commencing 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: MAR 2 3 2017
SJM/sj
o-3/9/2017
44

Stephen J. Mathis

David L. Gore

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JOHNSON, LOUIS CORNELL
Employee/Petitioner

Case# **11WC031788**

17IWCC0178

ST OF IL/SOUTHWESTERN CORRECTIONAL CENTER
Employer/Respondent

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

If the Commission reviews this award, interest of 0.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0384 NELSON & NELSON
ROBERT C NELSON
420 N HIGH ST
BELLEVILLE, IL 62222

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

4948 ASSISTANT ATTORNEY GENERAL
WILLIAM H PHILLIPS
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

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

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

AUG 11 2016

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

17IWCC0178

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

Louis Cornell Johnson
Employee/Petitioner

v.

State of Illinois/Southwestern Correctional Center
Employer/Respondent

Case # **11** WC **31788**

Consolidated cases: **n/a**

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

DISPUTED ISSUES

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

FINDINGS

On **July 27, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$57,037.24**; the average weekly wage was **$1,096.87**.

On the date of accident, Petitioner was **51** years of age, ***married*** with **1** dependent child.

The parties stipulated at the time of hearing that Respondent paid **$0** in TTD, **$0** in TPD, **$0** in maintenance, **$0** in non-occupational indemnity disability benefits, and **$0** in other benefits, for which credit may be allowed under Section 8(j) of the Act.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$731.25**/week for **4 weeks** for the timeframe of July 28, 2011 through August 24, 2011, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the sum of **$658.12/week** for a further period of **15 weeks**, as provided in Section 8(d)2 of the Act, because the injuries caused **3% loss of use of the person-as-a-whole.**

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

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

Melinda M. Rose Sullivan

Signature of Arbitrator

8/8/16

Date

ICArbDec p. 2

AUG 11 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Louis Cornell Johnson
Employee/Petitioner

Case # **11** WC **31788**

v.

Consolidated cases: **N/A**

State of Illinois/Southwestern Correctional Center
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that most of his adult life he worked for Respondent and worked there for 21 years. He denied having any prior worker's compensation claims. He testified that before July of 2011, he was in great health except for his hypertension. He testified that he served 10 years in the Army and was stationed at Fort Hood in Texas. He denied having any issues with heat prior to this accident, and testified that prior to July of 2011 he had never had prior heat stroke, chronic headaches, dizziness or fatigue. He further testified, however, that he has had these issues since 2011.

Petitioner testified that at Respondent's facility in East St. Louis on the date of the accident, he was the yard officer and was monitoring the inmates. He testified that on July 27, 2011, the heat index was 112. He testified that he figured they would not put him in the yard that day because it was too hot, but they did. He testified that he was in the yard from 8-10:15 in the morning and then again from 12:30-1:45 in the afternoon and that he could not take it anymore at that point.

Petitioner testified that that morning he was hot but that the afternoon was unbearable, and that he needed to get into the air conditioning and did not care if he got in trouble. He testified that he went into the gatehouse and sat in front of the air conditioner and then started vomiting. He testified that the individual that was in the gatehouse asked him if he was alright, and that he said he would be alright after he went home and took a cold shower. He testified that he should not have driven but did, and that he got home, took a shower and then vomited again. He testified that his wife had called and left a message for him to go to movie to pick up their son, and that when he talked to her he told her to come home because she needed to take him to the hospital.

Petitioner testified that his wife picked him up and took him to Memorial Hospital, and that he did not meet Dr. Chu until after he was admitted. He testified that he was admitted on the 27th, felt better on the 28th and that he woke up and was freezing, so his wife called the doctor who said to take him to the emergency room again immediately. He testified that he was admitted into the hospital again for another week.

Petitioner testified that in the winter time, he is fine. He testified that he sees Dr. Chu twice per year, and that he typically sees him in October and April. Petitioner testified that he has had difficulties in the following summers and that he experiences slight headaches and gets a little dizzy or sluggish. He testified that he cannot tolerate heat in the summers anymore and tries to avoid the heat when necessary. He testified that he brings water with him everywhere. He testified that he can no longer tolerate the same kind of heat that he could tolerate in the first 51-52 years of his life.

Petitioner testified sometimes he stops sweating and has to go inside. He testified that that he used to jog in the summer and used to play basketball with his son competitively. He testified that the "cut off" temperature for him is about 80 degrees.

Petitioner testified that when he was off work for four weeks, he was not paid any worker's compensation benefits. He testified that he was paid his regularly salary. He testified that if he had sick time, he did not think he had enough available to cover the whole time he was off so he used vacation time. He testified that he understood that he could save his vacation time and "trade" it in at retirement for a longer work period. He testified that he retired on May 31, 2016, and that he worked for 21 years and 4 months. He testified that he used 19 days of vacation during the time that he was off work. He further testified that the reference in the medical records to July 20th was incorrect.

On cross examination, Petitioner testified that before the incident he was a yard officer and that after the incident his job duties did not improve much in the housing units, but he was not outside. He denied that there was any duty rotation at Respondent or that there was a reassignment every 90 days. He testified that at Respondent, there were two outside positions and significantly more indoor positions. He testified that after he went back to work, he was mostly in the housing units. He denied that it was an air conditioned environment but stated that they had industrial fans. He testified that the officers might have smaller fans on their desks and in areas where the officers stayed, but it did not matter because the fans were circulating heat.

On cross examination, Petitioner agreed that he had access to water and the ability to get a drink while at work. He agreed that he was a correctional officer both before and after the incident, and that he returned to work full duty. He agreed that he worked until May 31, 2016 which was about five years or so after the accident, and that it had no effect on his ability to promote. He denied taking any prescription medications for his condition.

On cross examination, Petitioner testified that he did not remember how many times he was seen by Dr. Kini, and testified that did not really offer any assistance and only said to take Tylenol for his headaches. He agreed that he was not actively treating with a neurologist for his condition.

On cross examination, Petitioner agreed that he still drives. He testified that the symptoms come and go seasonally with the heat. He testified that his condition has remained about the same since 2011. He testified that his readmission to the hospital in 2011 was not related to this incident. He testified that the incident in December of 2012 when he became nauseated on the way to work occurred after an officer came to his apartment and served a subpoena for his son, after which is blood pressure spiked. He agreed that it was unrelated to this accident.

On cross examination, Petitioner testified that he had many discussions with Dr. Chu about his symptoms and that he would tell him that since the incident when the temperature changed, he got a headache and dizziness. He testified that he repeatedly told Dr. Chu that he had symptoms with heat throughout 2012, 2013 and 2014. He testified that Dr. Chu said there was nothing he could do because he could not control the weather. He denied taking off days from work, and agreed that the incident did not alter his retirement date.

On redirect examination, Petitioner testified that he went from a yard officer to an inside job and that this incident was the basis for that change.

The CMS Claim Documentation was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Workers' Compensation Employee's Notice of Injury was dated August 22, 2011 and alleged a date of accident of July 28, 2011. When asked to describe how the injury occurred,

Petitioner indicated that he was out in the excessive heat monitoring inmates and that he sustained heat exhaustion. The Workers' Compensation Witness Report signed by Theresa Johnson, RN, was completed on August 19, 2011, and noted that she had a voice mail message from Petitioner that was difficult to understand because his words were mumbled. It was noted that Ms. Johnson suspected that Petitioner was suffering from heat exhaustion, so she took him to the emergency room and witnessed him vomit multiple times. The Supervisor's Report of Injury or Illness noted that Petitioner was overheated while working the yard officer post on July 27, 2011. The Worker's Compensation Witness Report completed by LeVon Hudson noted that he observed Petitioner sitting in the gate house by the air conditioning unit with his face against it, and that he complained of being lightheaded and nauseous. (PX1).

The transcript of the deposition of Dr. Chu was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Dr. Chu testified that he is board-certified in internal medicine and is Petitioner's family physician. He testified that he took a history from Petitioner at Memorial Hospital as to the heat exposure incident on July 27, 2011 and that Petitioner reported that he was extremely fatigued, had some confusion when he went to the hospital, and was treated and was diagnosed with very elevated CPK. He testified Petitioner had rhabdomyolysis secondary to dehydration, that CPK is an enzyme produced by muscles and when elevated means damage to either the heart or to the skeletal muscles, and that it was consistent with heat exhaustion or heat stroke. (PX2).

Dr. Chu testified that he observed Petitioner complaining of dizziness, fatigue, left-sided chest pain and headaches which were all consistent with either heat stroke or heat exhaustion. He testified that Petitioner was seen to rule out for myocardial infarction and was put on IV fluids. He testified that Petitioner was kept off work for a period of time and was allowed to return on August 24, 2011, and that it was reasonable because of the exposure he would have had to the heat and humidity in St. Louis in late July and the fact that Petitioner did not feel he was back to his usual state of health. He testified that Petitioner's symptoms were consistent and consistent with his presentation to the hospital diagnosis. (PX2).

Dr. Chu testified that periodically after the incident, Petitioner had always complained of dizziness, unsteadiness and always maintained that he was not back to his usual self. He testified that Petitioner has good times, has learned to "live with it" and was not complaining about it anymore, but if you pressed if he still had the symptoms, Petitioner responded affirmatively. He testified that he diagnosed Petitioner with heat exhaustion, but with the persistence of symptoms it could be a low-grade form of heat stroke. He testified that the persistent symptoms including persistent headaches, occasional dizziness and difficulty with the heat and humidity were more likely than not a result of the diagnosis, and that the symptoms were probably going to be ongoing. He testified that the heat exhaustion was very likely related to the exposure on July 27, 2011 while on the job. (PX2).

Dr. Chu testified that Petitioner was currently without any symptoms that he was complaining about and that usually for heat exhaustion, they expected the individual to return to normal activities. He testified that if it was heat stroke, Petitioner would have residual side effects. He testified that it was more probable than not that he would advise Petitioner to be more cautious in the heat than he might for other patients, but admitted that he was not sure if once a person had it they were more likely to have it again in the future. (PX2).

On cross examination, Dr. Chu testified that since he released Petitioner to work on August 24, 2011, the treatment he has provided for headaches has included symptomatic relief with pain medicine. He testified that Petitioner was not on any longstanding medication that he would attribute to this event. He testified that the retention cyst in the left maxillary sinus as seen on the MRI of the brain in August of 2011 was not related to the accident. He testified that the few small areas of increased signal intensity in

the deep white matter of both hemispheres of the brain could possibly be related to heat stroke, but they were not conditions for which Petitioner might need additional treatment in the future. (PX2).

On cross examination, Dr. Chu agreed that he is Petitioner's primary care physician. He testified that when Petitioner was in the hospital, he was seen by a neurologist, Dr. Kini. When asked if Petitioner had come under the care of any specialist for this condition since his hospitalization, Dr. Chu responded that he was not sure because he had not seen the chart but agreed that he did not have any recollection of referring Petitioner to a specialist after the hospital discharge. He agreed that no operative intervention was recommended. (PX2).

On cross examination, Dr. Chu agreed that Petitioner had pre-existing conditions of hypertension and hyperlipidemia. When asked if there was any correlation between those conditions and the symptoms he experienced, Dr. Chu responded that there can be a correlation and that the event of heat exhaustion or heat stroke could affect it more. He agreed that obesity is a risk factor for stroke as well. He agreed that these factors continued to exist and increase his risk for future incidents. (PX2).

On cross examination, Dr. Chu testified that he recommends that Petitioner does not do any balancing work like going on a roof. When asked if he issued or recommended any type of job change for Petitioner, Dr. Chu responded that he did not recall. He testified that he would not be surprised if Petitioner was working as a corrections officer. (PX2).

On redirect examination, Dr. Chu agreed that he would be surprised if Petitioner was an ironworker walking on a 6-inch beam 100 feet in the air. He agreed that Petitioner had mentioned persistent dizziness throughout and that it was one of the likely sequelae of the exposure. He agreed that Petitioner talked with him on August 27, 2012 about having dizziness when he was in the heat and that this was consistent with his opinion that the dizziness was probably related to this exposure. He agreed that Petitioner complained of vertigo regularly during the course of his treatment since this happened. (PX2).

Attached to the deposition transcript were various medical records for Petitioner. The History and Physical from Memorial Hospital noting a date of admission of July 29, 2011 referenced that Petitioner was discharged from the hospital two days ago for heat exhaustion and had been doing fairly well except that he had been experiencing increasing headaches. It was noted that because of elevated CPK and recurrent headaches, Petitioner was admitted for further evaluation and IV fluids. It was noted that Petitioner complained of left-sided chest pain without any radiation or any other associated symptoms, and that he specifically denied any nausea, vomiting, diaphoresis, shortness of breath, loss of consciousness, near syncopal episode and tiredness. The assessment was that of headaches, currently improving with Norco every six hours. (PX2).

The records reflect that Petitioner was a no call/no show on August 2, 2011. At the time of the August 10, 2011 visit, the assessment referenced sudden left-sided numbness lasting greater than 10 minutes, rhabdomyolysis, heat exhaustion and questionable TIA. (PX2).

The records reflect that at the time of the August 17, 2011 visit, it was noted that the rhabdomyolysis was resolved. The records reflect that Petitioner was seen at Advanced Heart Care Group on September 4, 2012 for a cardiac consultation, which noted that he was referred for non-exertional left-sided chest pain. At the time of the October 2, 2012 visit at Advanced Heart Care Group, Petitioner was noted to be doing fairly well with no new complaints and he was noted to have been fairly active. It was noted that Petitioner denied dizziness, syncope or near syncope, nausea and vomiting and headaches. At the time of the Memorial Hospital emergency room visit on December 7, 2012, Petitioner complained of dizziness. The clinical impression was noted to be that of vertigo. (PX2).

The records reflect that Petitioner was seen on February 16, 2012, at which time it was noted that he denied fatigue, malaise, headache, and dizziness. At the time of the March 12, 2012 visit, Petitioner was seen in follow-up for abdominal pain from the emergency room and it was noted that he denied fatigue, malaise, headache and dizziness. At the time of the August 27, 2012 visit, it was noted that around March 2012 Petitioner started developing dizziness when he was out in the heat and that he had no symptoms when he was away from the heat. The records reflect that Petitioner denied fatigue, malaise, headache and dizziness. It was noted that Petitioner had a completely normal neurological examination and he was to follow-up if the symptoms persisted in two weeks and that if he did not call, Dr. Chu would presume all of his symptoms resolved. (PX2).

The records reflect that Petitioner was seen on October 15, 2012, at which time it was noted that Petitioner had no symptoms of dizziness on that date, and that he further denied fatigue, malaise and headache. At the time of the December 12, 2012 visit, Petitioner denied fatigue, malaise, headache and dizziness. At the time of the April 29, 2013 visit, Petitioner denied fatigue, malaise, headache and dizziness, and it was noted that Petitioner's vertigo was episodic only during the summer or when the climate was hot. At the time of the October 29, 2013 visit, Petitioner denied fatigue, malaise, headache and dizziness, and it was noted that Petitioner denied recurrence of vertigo since July 2013. At the time of the January 13, 2014 visit, Petitioner denied fatigue, malaise, headache and dizziness. At the time of the July 14, 2014 visit, Petitioner denied fatigue, malaise, headache and dizziness. At the time of the October 20, 2014 visit, Petitioner denied fatigue, malaise, headache and dizziness. (PX2).

The records reflect that Petitioner was seen on January 20, 2015, at which time he denied fatigue, malaise, headache and dizziness. At the time of the July 24, 2015 visit, Petitioner denied fatigue and malaise, but it was noted that he had headaches three times per week during the day outside relieved with over-the-counter medications and water, and that he reported occasional dizziness with headaches when it was hot outside. At the time of the October 8, 2015 visit, it was noted that Petitioner had occasional dizziness with headaches when it was hot outside. At the time of the January 20, 2016 visit, Petitioner denied fatigue and malaise, but it was noted that he had headaches three times per week during the day outside relieved with over-the-counter medications and water and that he reported occasional dizziness with headaches when it was hot outside. (PX2).

Various documentation pertaining to the temperature on the day of injury was entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The maximum temperature noted for Cahokia on July 27, 2011 was that of 98 degrees, the mean temperature was that of 86.5 degrees and the minimum temperature was that of 75 degrees. (PX3).

The medical records of Dr. Panduranga Kini were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Petitioner was seen in consultation on July 28, 2011, at which time he was seen for headaches. It was noted that Petitioner probably had heat exhaustion. It was noted that if Petitioner's headache returned, he was to be reevaluated. The records reflect that Petitioner was also seen on August 19, 2011, at which time he complained of daily headaches and it was noted that he was recently discharged from Memorial Hospital after admission for heat exhaustion. It was noted that Petitioner stated his headaches were daily and were sharp in type, that nothing made it worse but laying down made it better, and that he had no other symptoms like problems with vision, speech, focal weakness, numbness or tingling. It was noted that Petitioner stated that he was under a lot of stress, and that he stated he had migraine headaches many years ago. The impression was that of muscle contraction headache. It was noted that Petitioner was to be seen in follow-up in 3-4 weeks. (PX4).

CONCLUSIONS OF LAW

The parties stipulated at the time of arbitration that Petitioner sustained an accident on July 27, 2011 that arose out of and in the course of his employment with Respondent. (AX1).

With respect to disputed issue (F), the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the injury of July 27, 2011. The Arbitrator notes that Dr. Chu, Petitioner's primary care physician, opined that the heat exhaustion was very likely related to the exposure on July 27, 2011 while on the job. (PX2). No evidence was proffered by Respondent to rebut Dr. Chu's opinions. As a result thereof, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the injury of July 27, 2011.

With respect to disputed issue (K) pertaining to temporary total disability benefits, the Arbitrator notes that Petitioner seeks temporary total disability benefits from July 28, 2011 through August 24, 2011, and that Respondent disputed the entitlement to temporary total disability benefits and claimed that Petitioner's full salary was received. (AX1). Although arguably not framed as a request for a credit for the sick and/or vacation time paid while Petitioner was off work after the accident, the Arbitrator notes that according to the decision in *Tee-Pak* "[u]nder the Act, the employer receives no credit for benefits which would have been paid irrespective of the occurrence of a workers' compensation accident." *Tee-Pak, Inc. v. Indus. Comm'n*, 141 Ill.App.3d 520, 490 N.E.2d 170, 95 Ill.Dec. 697 (4th Dist. 1986). In the case at hand, the Arbitrator notes that no evidence was proffered by Respondent regarding any policies regarding how benefits were to be credited in workers' compensation cases, and furthermore notes that Respondent has offered no evidence that the payments of sick and vacation days would have not been payable irrespective of an accidental injury. As a result thereof, the Arbitrator finds that Respondent shall pay temporary total disability benefits for a period of 4 weeks for the timeframe of July 28, 2011 through August 24, 2011.

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, the Arbitrator notes that the injuries occurred before September 1, 2011 as it pertains to Section 8.1b of the Act. The Arbitrator notes that Petitioner testified at the time of arbitration testified that he experiences slight headaches and gets a little dizzy or sluggish and that he cannot tolerate heat in the summers anymore and tries to avoid the heat when necessary. Based on the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of 3% loss of use of the person-as-a-whole under Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STEVEN DUNTEMAN,

Petitioner,

vs.

NO: 11 WC 40320

17IWCC0175

CATERPILLAR, INC.,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Appellate Court of Illinois, Fourth District, Workers' Compensation Commission Division. In its Opinion filed April 29, 2016, the Appellate Court reversed the Circuit Court's Decision confirming the Commission's Decision dated November 25, 2014. The Commission reversed the Decision of the Arbitrator dated August 8, 2013, and found Petitioner failed to establish that his current condition of ill-being was causally related to the June 21, 2011 work accident.

The Appellate Court remanded the matter back to the Commission noting there was a "but for" relationship between Petitioner's work-related blister and subsequent infection:

> [E]ven if the claimant's lancing of the work-related blister with a sterilized needle was the immediate cause of his infection, as the Commission found, the infection would not have occurred 'but for' the existence of the work-related blister. That is because 'but for' the existence of the work-related blister, there would have been no blister to lance. His employment, therefore, remains *a* cause of his current condition of ill-being. The Commission's finding that the claimant's self-treatment was an independent intervening accident

> that broke the chain of causation between his work-related blister and subsequent infection was, therefore, against the manifest weight of the evidence.

From the Commission's perspective, the primary issue before it was one of causal connection. The Appellate Court has made its determination and has reversed the Commission. The previously entered Decision of the Arbitrator was otherwise appropriate and for this reason the Decision of the Arbitrator should be reinstated.

In said Decision, dated August 8, 2013, the Arbitrator found Petitioner's current condition of ill-being was causally related to the June 21, 2011 work accident. The Arbitrator noted Petitioner developed bruising and a blister on the bottom of his left foot after repetitively and forcefully pressing on a steel clutch approximately 200 times per shift for about four weeks.

The Arbitrator further found Petitioner did not commit an injurious or unsanitary practice pursuant to Section 19(d) of the Act, when Petitioner popped the blister at home. The Arbitrator stated Petitioner's conduct of lancing his blister did not rise to the level of intentional endangerment or impedance of his recovery. Petitioner subsequently developed an infection in his left foot. The Arbitrator relied on the opinions of Dr. Jason Anderson, Petitioner's treating surgeon, and Dr. Jeffrey Coe, the Section 12 examiner on behalf of Petitioner, to find causal connection between the resulting infection and Petitioner's work accident of June 21, 2011. The Arbitrator found Dr. Anderson and Dr. Coe's opinions outweighed that of Respondent's Section 12 examiner, Dr. Ernest Chiodo.

The Arbitrator noted Petitioner underwent three surgeries for the ulceration/abscess and infection in his left foot. Petitioner's third toe in the left foot was amputated. Petitioner had post-operative, post-infectious flexion contracture of the second toe in the left foot, swelling in the ankle and foot, as well as weakness and instability. The Arbitrator stated Petitioner testified to having balancing issues, and difficulty with kneeling and putting pressure on his foot. Petitioner stated he noticed numbness in his foot and weather conditions affected his sensitivity. The Arbitrator further noted Petitioner returned to work for Respondent without restriction. However, Petitioner now drove an automatic truck which decreased the amount of left foot activity and clutch work. Petitioner was awarded 100% loss of use of the left third toe and 20% loss of use of the left foot – a total of 46.4 weeks at $428.29 per week.

The Arbitrator also awarded Petitioner $2,117.13 in reasonable and necessary medical services. This is the remaining outstanding balance after taking into account Respondent's credit of $56,395.90 under Section 8(j) of the Act. Petitioner was also entitled to nine (9) weeks of temporary total disability benefits, from July 4, 2011 through September 4, 2011, at $475.87 per week. Respondent was given a credit of $3,464.28 for non-occupational indemnity disability benefits previously paid.

17IWCC0175

Based upon the mandate from the Appellate Court, the Commission reinstates the Arbitrator's Decision dated August 8, 2013.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 8, 2013 is hereby reinstated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical services of $2,117.13, as provided in Section 8(a) of the Act, and subject to the medical fee schedule, Section 8.2 of the Act. The $2,117.13 amount is the remaining balance after taking into account Respondent's credit of $56,395.90 under Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner temporary total disability benefits of $475.87 per week for nine (9) weeks, commencing July 4, 2011 through September 4, 2011, as provided in Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $428.29 per week for a period of 46.4 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused 100% loss of use of the third toe in the left foot and 20% loss of use of the left foot.

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

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

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

DATED: MAR 2 3 2017

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/pm
D: 2/28/17
52

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

Laconda Nicholson,
Petitioner,

vs.
CTA,
Respondent,

NO: 11 WC 42649
17IWCC0145

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 13, 2016 is hereby affirmed and adopted.

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

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

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

DATED: MAR 3 - 2017

MB/mas
o:2/23/17
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NICHOLSON, LACONDA
Employee/Petitioner

Case# **11WC042649**

CTA
Employer/Respondent

17IWCC0145

On 6/13/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1920 BRISKMAN BRISKMAN & GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

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

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

LACONDA NICHOLSON
Employee/Petitioner

Case #11 WC 42649

17IWCC0145

V.

CTA
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on April 29 and June 1, 2016. After reviewing all of the issues, the stipulations of the parties and the evidence, it is hereby found and ordered as follows:

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

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

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

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

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On Ocotober 12, 2011, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $61,672.00; the average weekly wage was $1,186.00.
- At the time of injury, the petitioner was 39 years of age, single with one child under 18.
- The petitioner agreed that the respondent paid $47,213.05 in temporary total disability benefits, $4,255.50 in medical bills and $1,800.00 in non-occupational indemnity disability benefits.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $790.67/week for 44-5/7 weeks, from October 13, 2011, through August 20, 2012, which is the period of temporary total disability for which compensation is payable. The respondent is entitled to an offset for the $47,213.05 in benefits previously paid to the petitioner.
- The respondent shall pay the petitioner the sum of $695.78/week for a further period of 70 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 14% loss of use of the person as a whole.

- The respondent shall pay the petitioner compensation that has accrued from October 12, 2011, through June 1, 2016, and shall pay the remainder of the award, if any, in weekly payments.

- The medical care rendered the petitioner for her neck and right shoulder through August 20, 2012, was reasonable and necessary and is awarded. The medical care rendered the petitioner for her neck and right shoulder after August 20, 2012, and lumbar spine, right leg, hip and foot and other medical conditions was not reasonable or necessary and is denied. The respondent shall pay the medical bills in accordance with the Act, the medical fee schedule or any prior adjustments or negotiated rate. The respondent shall be given credit for the $4,255.50 paid toward the medical bills and any amount paid within the provisions of Section 8(j) of the Act. The respondent shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

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

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

Robert E. Williams

Signature of Arbitrator

June 13, 2016
Date

JUN 13 2016

FINDINGS OF FACTS:

On October 12, 2011, the petitioner, a bus driver for six years, injured her neck when she jerked and twisted in reaction to the windshield on her bus being shattered. She received care at Concentra Medical Center on October 13, 2011, and reported receiving emergency care. The petitioner reported cervical and upper lumbar pain and decreased ROM. Their diagnosis was cervical and trapezius strains and cervicalgia. She was treated with physical therapy, medication and activity modification with no driving. At a follow-up on October 17th, the doctor noted that the petitioner's pain was located in her right neck and shoulder and on October 24th, it was noted that her neck pain was sharp with radiation to her right shoulder and hand. A cervical MRI on October 28th showed a soft central-right paracentral disc extrusion at C3-4 with a 4 mm superior migration causing a mild impression on the ventral surface of the right hemicord and an overall mild/moderate central canal narrowing.

The petitioner saw Dr. Singh on November 9, 2011, who prescribed a cervical epidural injection. She sought emergency care for cervical and shoulder pain at Mercy Hospital on November 26, 2011, and for an abscess on her left posterior thigh on December 25, 2011. On January 9, 2012, the petitioner reported axial neck pain with radiation into her right shoulder to her mid biceps and numbness in her right palm and thumb to Dr. Singh. The petitioner sought emergency care for chronic neck pain at Mercy Hospital on January 23, 2012. She sought care for her neck symptoms with Dr. Edith Chaffin at Community Family Medicine on February 14, 2013. At the request of the respondent, Dr. Goldberg evaluated the petitioner on February 20, 2012, who noted normal ambulation, the ability to fully squat and bend, guarding and weakness of her

right shoulder and an abnormal brachialradialis reflex on her right side. On March 13, 2012, Dr. Singh performed an anterior cervical discectomy and fusion at C3-4 with cage instrumentation. On April 27, 2012, the petitioner started physical therapy with Dr. Michael Foreman at the Beverly Park Medical Center. Dr. Singh noted improvement in her neck symptoms at a follow-up on April 11th and an almost complete resolution of her axial neck pain and right arm pain on May 9th.

On May 4, 2012, the petitioner received emergency care at Mercy Hospital for a small pustule on her face. An FCE on July 9, 2012, recommended a light physical demand capacity. On July 18, 2012, the petitioner sought emergency care for thigh and leg pain at Mercy Hospital. On August 20, 2012, the petitioner reported sharp, shooting, stabbing pain down her right lower extremity and into her foot to Dr. Singh. The doctor opined that a lumbar MRI on June 19, 2012, was normal and her FCE and work conditioning notes revealed that she met her regular job demands. The petitioner was released to work without restrictions.

The petitioner saw Dr. Amit Mehta at the Instant Care Group on September 11, 2012, and reported increased lower back and lower extremity pain over the past few weeks and a resolution of her cervical symptoms. She sought emergency care for lumbar pain down her right side at Mercy Hospital on September 14 and 27, 2012. The petitioner returned to Dr. Chaffin on September 27, 2012, for her right leg pain. Dr. Chaffin noted tenderness from her right foot to her thigh and no back tenderness.

The petitioner saw Dr. Abdul Amine on November 13, 2012, and reported neck pain and right leg weakness with foot drop after her work injury. Dr. Amine opined that a lumbar MRI did not reveal any significant pathology and started steroids medication. On

December 4, 2012, the petitioner reported a complete relief of her numbness and an almost complete relief of her pain and requested a return to work full duty. On December 18, 2012, Dr. Amine noted that the petitioner had a reoccurrence of deep pain in her arm after returning to bus driving and had no feeling in her right arm and right leg. On January 17, 2013, the petitioner told Dr. Amine that she could not drive because of the tingling in her right hand and arm and that she quit driving her bus. Dr. Amine took her off duty until further notice. The petitioner elected to be evaluated by Dr. Jeffrey Kramer on March 20, 2013. Dr. Kramer opined that the petitioner's right lower extremity symptoms were due to deconditioning and that she was capable of returning to her work duties. The petitioner returned to Dr. Chaffin on April 2, 2013, for right upper and lower extremity weakness. The doctor's diagnosis was not specific.

The petitioner had a neurological consultation with Dr. Jeffrey Yu at Sinai Medical Group on June 21, 2013. His assessment was cervical myelopathy. A cervical MRI on July 10, 2013, revealed post-operative changes, mild degenerative spondylosis and no definite spinal or neural foraminal stenosis. The petitioner sought emergency care for right arm pain at Mount Sinai Hospital on July 27, 2013, and reported persistent right arm symptoms since her cervical surgery and after a trauma in March 2012. A lumbar MRI on August 10, 2013, was unremarkable and a cervical MRI the same date did not reveal any changes since the previous MRI. A cervical CT scan on August 14, 2013, revealed the anterior fusion at C3-4 and straightening of her cervical lordosis. She followed up with Dr. Yu on September 6, 2013, without a report of improvement.

An IME of the petitioner was performed by Dr. Herman Martin on December 23, 2013. The petitioner reported two prior accidents resulting in right shoulder and neck

pain, developing new neck and right shoulder pain on October 12, 2011, aggravation of her symptoms with the physical therapy at Concentra and the ESIs by Dr. Mehta, no improvement with the cervical fusion but the development of right leg pain and numbness and hypertension, and the development of facial numbness with the physical therapy after her surgery and worsening leg pain.

The petitioner reported no improvement to Dr. Yu on January 10, 2014. On February 24, 2014, the petitioner saw Dr. Michael Sturgill at Sinai Medical Group for her neck and right arm and reported that her right arm weakness was old but her leg weakness was new. Dr. Sturgill opined that the petitioner had no upper or lower motor neurological findings and signs on examination and no instability on x-rays. A brain MRI on April 2, 2014, was unremarkable. On April 18, 2014, Dr. Yu noted complaints of dysesthesias below her knees contrary to his neuro exam and inconsistencies with the sensory exam particularly with her face and questioned whether her symptoms were psychogenic. The petitioner started physical therapy at Schwab Rehabilitation on April 28, 2014, and treated through February 23, 2015. The petitioner complained of neck, back, shoulder and leg pain that started after her cervical surgery to Dr. Mihaela Mihailescu at Advocate Medical Group on August 21, 2014, and reported only pain in her right upper extremity prior to her work injury. A right shoulder MRI on October 14, 2014, was questionable for a labral tear, showed minimal acromioclavicular joint hypertrophy and trace subacromial/subdeltoid bursal inflammation. Bilateral hand x-rays on November 18, 2014, showed old non-united left ulnar styloid fractures. On February 9, 2015, Dr. Edward Parks at Schwab Rehabilitation evaluated the petitioner. The

petitioner reported right leg pain before her October 2011 injury and surgery but increased pain in her right arm and right leg after her surgery.

Dr. Orhan Kaymakcalan evaluated the petitioner on April 23, 2015, and based on EMGs, diagnosed bilateral carpal tunnel syndrome, cubital tunnel syndrome and C8 cervical radiculopathy. The doctor injected the petitioner's right carpal tunnel. Dr. Nicole Swavely at Northwestern Medical Group saw the petitioner on August 27, 2015, and ordered tests for inflammatory arthritis. On September 8, 2015, Dr. Deanna Marin at Northwestern Medical Group noted that the autoimmune panel was negative. On September 28, 2015, the petitioner reported to Dr. Martin pain in her neck, hips, knees, hands, shoulders and right ankle and foot. The doctor's assessment was chronic polyarthralgias. An ultrasound of her hands on October 28, 2015, revealed moderate inflammatory polyarthritis of her hands and wrists. Dr. Martin started MTX medication with a prednisone bridge for acute relief on October 28, 2015. The petitioner reported significant improvement on December 8, 2015, only swelling and pain in her hands with the rest of her body feeling perfect and improvement in all her joints. Dr. Erin DeBoer and Dr. Hsu recommended cervical facet injections on January 18, 2016, and opined that she was not a surgical candidate. Dr. Saltzman at Northwestern Memorial Hospital started treating the petitioner on February 4, 2016, and noted that her cervical symptoms were improved and that she still had occasional mechanical right shoulder pain and difficulty with overhead activities. A right shoulder MRI arthrogram on March 23, 2016, showed mild supraspinatus tendinopathy with bursal surface fraying of its anterior leading edge and small linear interstitial tear of the central aspect of the tendon, no full thickness rotator cuff tear and a probable small SLAP tear. On March 24, 2016, Dr.

Saltzman informed the petitioner that he recommended exercises and anti-inflammatory medication prior to surgery for the SLAP tear.

The petitioner had prior neck injuries problems in 2008 and 2009, for which she received conservative treatment.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner for her neck and right shoulder through August 20, 2012, was reasonable and necessary and is awarded. The medical care rendered the petitioner for her neck and right shoulder after August 20, 2012, and lumbar spine, right leg, hip and foot and other medical conditions was not reasonable or necessary and is denied.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that her current condition of ill-being with her cervical spine is partially causally related to the work injury. The petitioner failed to prove that her current condition of ill-being with her right shoulder, lumbar spine, right leg, hip and foot and other medical conditions are causally related to the work injury. The petitioner's work injury caused her cervical and upper lumbar symptoms that resulted in an anterior cervical discectomy at C3-4 by Dr. Singh on March 13, 2012. The petitioner reported an almost complete resolution of her axial neck and right arm pain to Dr. Singh on May 9, 2012. On August 20, 2012, Dr. Singh opined that the petitioner's FCE and the work conditioning notes revealed that she could perform her job duties and released her without any work restrictions. When the petitioner saw Dr. Mehta on September 11, 2012, she reported a complete resolution of

her cervical symptoms. The petitioner failed to prove that her condition of ill-being with her lumbar spine, right shoulder and right leg, hip and foot is causally related to the work injury on October 12, 2012. The petitioner's request for benefits for her right shoulder, lumbar spine, right leg, hip and foot and other medical conditions is denied.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

The petitioner was off of work due to her cervical injury from October 13, 2011, through August 20, 2012. The respondent shall pay the petitioner temporary total disability benefits of $790.67/week for 44-5/7 weeks, from October 13, 2011, through August 20, 2012, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

There is no AMA impairment rating. The petitioner was released to bus driving without restrictions on August 20, 2012. The evidence does not support the petitioner's claim that she is unable to drive a bus due to her injuries. Also, there is no evidence concerning the impact of the petitioner's injury in regard to her age or future earning capacity, as delineated in Section 8.1(b)(iii) through (iv) of the Act, nor can any effect be reasonably inferred from the evidence. Regarding Section 8.1(b)(v), the petitioner's complaints of right hand numbness and pain on her right side, neck, shoulder and down her back is not entirely causally related to her work injury.

The respondent shall pay the petitioner the sum of $695.78/week for a further period of 70 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 14% loss of use of the person as a whole.

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

Bobbi Darnell,
Petitioner,

vs.

NO: 11 WC 42877
11 WC 42878
11 WC 42879

Franklin County Probation Department,
Respondent,

17IWCC0128

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 10, 2016, is hereby affirmed and adopted.

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

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

The party commencing 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: MAR 2 - 2017
o020917
DLG/mw
045

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DARNELL, BOBBI
Employee/Petitioner

Case# **11WC042877**

11WC042878
11WC042879

FRANKLIN COUNTY PROBATION DEPARTMENT
Employer/Respondent

17IWCC0128

On 2/10/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

0180 EVANS & DIXON LLC
JAMES M GALLEN
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DARNELL, BOBBI
Employee/Petitioner

Case# **11WC042877**

11WC042878
11WC042879

FRANKLIN COUNTY PROBATION DEPARTMENT
Employer/Respondent

17IWCC0128

On 2/10/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

0180 EVANS & DIXON LLC
JAMES M GALLEN
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

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

Bobbi Darnell
Employee/Petitioner

Case # 11 WC 42877

v.

Consolidated cases: 11 WC 42878 and 11 WC 42879

Franklin County Probation Department
Employer/Respondent

17IWCC0128

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Herrin**, on **December 9, 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 **11-11-08**, Respondent was operating under and subject 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 **$22,907.02**; the average weekly wage was **$440.52**.

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

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

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

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

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

ORDER

Petitioner has failed to prove that she sustained an accident on November 11, 2008 that arose out of and in the course of her employment with Respondent, that her current condition of ill-being in her hands/wrists is causally connected to her alleged accident, or that she gave timely notice of the alleged accident to Respondent. Petitioner's claim for compensation is denied and no benefits are awarded.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 Nancy Lindsay

February 6, 2016
Date

FEB 10 2016

Bobbi Darnell vs. Franklin County Probation Department, 11 WC 42877

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

According to the medical records, on March 18, 2008 Petitioner underwent a CT of her cervical spine due to complaints of left arm numbness and left facial numbness. Mild degenerative changes were noted. (PX 1)

Petitioner was hospitalized for three days in March of 2008 due to facial numbness. In follow-up with her primary care doctors, she reported that two "old" strokes" had been found. Her complaints as of March 27, 2008 included numbness over her right eye and cheek. An exam with Dr. Lori Guyton was noted to be pending. (PX 1)

Petitioner next underwent an EMG/NCS on April 16, 2008 due to complaints of numbness and tingling in her upper extremities, weakness involving her legs, pain in her feet and legs, and occasional neck and back pain. The test revealed no evidence of carpal tunnel syndrome. (PX 1)

Petitioner presented to the office of Dr. Lori Guyton, a neurologist, on September 23, 2008 with a history of neck and arm pain beginning approximately fifteen to twenty years earlier. Petitioner explained that her head would sometimes pull to the side and she was advised that she had muscle spasms for which she was given muscle relaxers and sometimes sent home from her job as a secretary for Respondent due to increasing sleepiness and difficulty working while on medications. An MRI revealed a cervical bulging disc. Her symptoms improved and she underwent a cervical epidural and six months of chiropractic treatment. She then did fairly well until the end of February when her symptoms once again increased. Prior to seeing Dr. Guyton Petitioner had returned to Dr. McGuire for nine additional chiropractic sessions. Petitioner further explained that she awoke one morning and her arms were heavy and she had facial numbness. She was hospitalized and underwent testing all of which was normal and she was advised she had a disc problem. A nerve conduction study was normal. Petitioner's current complaints were many including the pulling sensation in her neck and some difficulties with her legs. She reported a history of Restless Leg Syndrome, a CT of the cervical spine showed mild degenerative changes, and an EMG showed no evidence of carpal tunnel syndrome. Petitioner's occupational history included being a secretary for ten years with Respondent. After a physical examination, Dr. Guyton noted no specific diagnosis as she wished to review various diagnostic films and reports. (PX 1)

Petitioner was then seen by Marci Moore-Connely on October 10, 2008 in follow up for various issues, including lab work. Petitioner also reported bilateral numbness and tingling, worse in the early morning. Petitioner was given splints to wear at night. (PX 1) Petitioner was referred to Dr. Guyton for testing. (PX 1)

Petitioner returned to Dr. Guyton on November 11, 2008, at the request of Dr. Tippy, due to increasing right hand pain and loss of grip in her left hand. Petitioner also reported neck discomfort and bilateral arm pain occasionally. Nerve conduction studies revealed evidence of left sensory carpal tunnel syndrome. (PX 1; PX 3)

Petitioner underwent an MRI of her brain and her cervical spine on November 12, 2008 due to facial numbness and numbness across the back of her head. (PX 3)

Petitioner followed up with Dr. Guyton on November 28, 2008 reporting ongoing facial numbness and hand pain. A diagnosis of left carpal tunnel syndrome was noted. Petitioner was to continue wearing her brace on the wrist. (PX 3)

Dr. Guyton examined Petitioner on March 26, 2009. Petitioner reported injuring her back on Saturday but doing better. She was still wearing her brace on her left hand and noted that the more she sewed, the more she needed it. Her facial numbness was no worse. (PX 3)

Petitioner returned to see Dr. Guyton on July 28, 2009 for neck and arm pain and facial numbness as well as increasing left elbow pain. Petitioner was advised to watch how she positioned her elbow and to wear her carpal tunnel brace. (PX 3)

Dr. Guyton re-examined Petitioner on April 2, 2010 regarding her facial numbness and neck and arm pain. Petitioner's neck complaints included a tingling sensation going down her back. Petitioner still noted some facial numbness but not as much around her eyes. Dr. Guyton also noted that Petitioner's numbness and pins and needles sensation in her back wasn't too bad if Petitioner wasn't doing too many crafts. (PX 3)

Petitioner again met with Dr. Guyton on March 14, 2011 regarding her facial numbness and neck and arm pain. Petitioner reported increasing pain and coldness in her hands. It was noted that Petitioner's thoracic region would hurt when turning at work. (PX 3)

Petitioner returned to Dr. Guyton on March 27, 2011, again at the request of Dr. Tippy, due to a history of neck and arm pain. Dr. Guyton noted, "She has had increasing pain at work and feels that her symptoms are increasing over time." The nerve conduction study results were the same as in November of 2008. (PX 1, PX 2, PX 3; PX 5)

Petitioner was again seen by Dr. Guyton on June 6, 2011 due to facial numbness, neck and arm pain. Petitioner reported right hand symptoms more problematic than the left hand and difficulty picking things up with her left hand. She reported that the wrist brace was of no help and she wanted an evaluation for her left hand. An orthopedic referral was noted. (PX 1; PX 2; PX 3)

Petitioner presented to the office of Dr. Steven Young on June 30, 2011. As part of the examination Petitioner completed a questionnaire (dated 6/27/11) in which she listed her chief complaint as pain in her wrists and hands. Petitioner noted she was dropping things and that her symptoms had been getting more troublesome for years. In response to the question "Where did this happen?", Petitioner replied "Typing, using the mouse." In response to "How did this happen?", Petitioner wrote, "work." Petitioner also noted that her pain would last varying amounts of time depending upon the activity she was engaged in. She completed pain drawings consistent with her areas of complaints. When examined by the doctor, Petitioner gave a history consistent with the information provided in her questionnaire. Additionally, the doctor noted that Petitioner had worked as a checkout person and now as a secretary. X-rays were noted to show a small carpal boss in the posterior aspect of her right hand. Left hand/wrist x-rays were negative. He recommended a left carpal tunnel release and therapy for her right hand. (PX 5)

Petitioner completed a Worker's Compensation Information sheet for Dr. Young's office on August 23, 2011. (PX 5)

According to a Nurse's Note from Southern Orthopedic Associates dated September 15th and 19th, 2011, workers' compensation denied Petitioner's bilateral upper extremity claim. (PX 5)

Petitioner returned to West Frankfort Family Practice on October 7, 2011 regarding hand cramps and occasional bilateral hand numbness. With regard to her hands, Petitioner gave a history of having first experienced symptoms of numbness, tingling, and weakness in 2008 (primarily left-sided but some on the right) and subsequently undergoing nerve conduction studies. Petitioner was unsure of the 2008 findings but the second one done in the spring of 2011 had shown left carpal tunnel syndrome. Petitioner explained that the more recent study was done due to "significant increase in her weakness, both hands 'going to sleep' all the time and cramping." Petitioner had been referred to Dr. Young who recommended right hand therapy and surgery for the left hand. According to the office note, Petitioner had been a secretary for thirteen years and typed, answered phones, handled files, and did computer work. While Petitioner's symptoms were more severe in her left hand, Petitioner noticed more frequent symptoms in her right hand as she used it more. On exam, Petitioner's right hand grip was weaker, Phalen's test was positive bilaterally and she reported tingling in her thumb, index, and middle fingers bilaterally. The doctor's plan was to obtain Dr. Guyton's records and the earlier nerve conduction studies. In the interim, Petitioner was to continue with night splints. It was noted that Petitioner had already made many adjustments to her work site to make it more ergonomic. (PX 2)

Petitioner signed her Application for Adjustment of Claim in 11 WC 042877 on November 4, 2011, alleging repetitive trauma injuries to her hands that manifested on November 11, 2008. (AX 4)

Petitioner signed her Application for Adjustment of Claim in 11 WC 042878 on November 4, 2011 alleging repetitive trauma injuries to her hands that manifested on March 27, 2011. (AX 4)

Petitioner signed her Application for Adjustment of Claim in 11 WC 042879 on November 4, 2011, alleging repetitive trauma injuries to her hands that manifested on July 12, 2011. (AX 4)

Petitioner elected to proceed with surgery under her regular insurance and Dr. Young performed a left carpal tunnel release on November 30, 2011. Intra-operative findings included mild to moderate thickening of the transverse carpal ligament. (PX 5; PX 6)

Petitioner began physical therapy on December 1, 2011. (PX 9)

As of December 14, 2011 Dr. Young noted Petitioner was recovering well. Petitioner also returned to see Dr. Guyton on December 14, 2011, reporting she had undergone left carpal tunnel surgery two weeks earlier. (PX 3)

On January 19, 2012 Petitioner completed a Work History Questionnaire for Dr. Young. In it, she indicated she was right hand dominant and that her problems had been "documented" for four years but had been bothering her for 2-3 years before that. Her primary complaints were pain, numbness and tingling, and stiffness bilaterally (left more than the right, however). Petitioner denied any neck, shoulder, elbow or forearm pain "at this time" but acknowledged being told she had a bulging disc in 2005. Petitioner listed Respondent as her employer, having begun in August of 1998. She described her job as a "Secretary/Receptionist." Her duties included: answering phones; directing calls and people; operating and maintaining all of the office equipment; ordering supplies; maintaining the office area; entering data on the computer; typing reports as ordered by the court; enter cases; maintain client lists; and work with all files (sorting, compiling, organizing, entering data and placing files in the storage area. Petitioner also noted that she would drive to the courthouse and operate a locked door. Petitioner felt that her current symptoms were "influenced" by her work activities as she had to enter data on a

computer daily, type court reports, handle files, answer phones, maintain the office equipment, compile file folders, organize an office of six people, handle supplies, and manage the front office while also driving to the court house and operating a locked door. Petitioner worked 35 hours weekly. Petitioner had been put on lifting restrictions and was told to not do something if it hurt. She was still working under those restrictions. Prior to working for Respondent, Petitioner was a clerk at Big John's Grocery Store for eighteen years. Petitioner noted worse symptoms when driving, sleeping and working. Petitioner further noted increasing symptoms while at work, especially on the computer which she did the biggest part of her day or when filing and handling various sizes and weights of files. Petitioner's hobbies included cooking, caring for her family, reading, and sewing "a little." (PX 6)

Dr. Young re-examined Petitioner on January 19, 2012 at which time Petitioner denied any further numbness or tingling but did note some ongoing weakness and discomfort around the incision site. She could make a full fist and light touch was intact. He noted pain with palpation about the incision. Dr. Young released Petitioner to full duty and instructed her to begin physical therapy for incisional tenderness and to use Mobic and Voltaren gel. (PX 6)

Petitioner had been continuing to undergo physical therapy on a regular basis since it began on December 1, 2011. As of January 24, 2012 Petitioner reported some intermittent "popping" to her wrist, some occasional numbness when driving and doing her hair, pain of "4/10" when typing and some incisional tenderness. Petitioner reported having irritated her incision when picking up a catalog on mailing. Petitioner cancelled her January 27, 2012 therapy appointment and no further visits were noted. (PX 9)

Petitioner returned to see Dr. Young on February 20, 2012. She reported that she was much better and any ongoing tenderness was tolerable. She was engaging the hand/wrist in more activities. Petitioner wished to hold off on any right hand surgery until her left hand was one hundred percent. (PX 6)

Dr. Guyton again examined Petitioner on June 13, 2012 at which time Petitioner reported that her left arm was better after undergoing surgery but her neck pain was continuing and her facial numbness appeared to increase with stress. (PX 3)

At the request of Respondent, Petitioner was examined by Dr. Patrick K. Stewart on June 18, 2013. As part of the examination, Dr. Stewart was provided with Petitioner's medical records dating back to 2008, two nerve conduction studies, Dr. Guyton's records, and records of Dr. Young. He also had the earlier MRIs of Petitioner's brain and neck. Petitioner dated her problems back to March of 2008 when she presented to the emergency room for facial numbness and numbness/weakness in her left arm. Her ongoing problems with facial numbness were noted. Petitioner advised the doctor that her arm, despite surgery, was still not normal but it was better. She also reported ongoing right hand numbness and some pain and discomfort in her index finger on the right side which was somewhat improved now that her mouse at work had been changed. Petitioner was still wearing nighttime splints and using them for lifting activities. With regard to her job duties, Petitioner felt her job duties were consistent with those of a secretary or receptionist. She did data entry, used a mouse a lot, answered phones, and directed clients. She also referenced lifting full length legal files up to twenty times a day and that they could be as thick as 2-3 inches. She recently had put about 100 files away which represented one month's worth of files. Dr. Stewart performed an examination and concluded Petitioner had possible right carpal tunnel syndrome and was recovering from her left carpal tunnel release. (RX 1, dep. Ex.)

Petitioner next returned to see Dr. Young on November 26, 2013 reporting ongoing right hand symptoms. On examination she had a positive Tinel's and median nerve compression test. A new nerve conduction study was ordered. That was performed on December 17, 2013 and was normal. Petitioner then followed up with Dr.

Young on December 19, 2013. The doctor noted that Petitioner had done well with her left carpal tunnel release; however, she was experiencing numbness and tingling in her right hand that awakened her at night and would begin when driving. Activity seemed to exacerbate her symptoms and Petitioner noted some diminished dexterity and strength. On exam she had a positive median nerve flexion compression test. Dr. Young injected Petitioner's right carpal tunnel. If Petitioner had a good response to the injection he felt surgery would be appropriate if she wished to proceed. (PX 6)

Petitioner returned to see Dr. Young on January 16, 23014 reporting ongoing numbness and tingling in her right hand. She reported about three weeks of relief from the earlier injection. Petitioner no longer noted symptoms when driving and wished to forego surgery and continue handling things conservatively. He issued her a short arm removable wrist splint to wear as needed for symptoms. They also decided to wait on any further injections as it was too soon since the first one. She was to call if any issues or concerns arose. (PX 6)

Dr. Young was deposed on December 9, 2014. (PX 8) Dr. Young testified that he first saw Petitioner on June 30, 2011 on a referral from Dr. Guyton, a local neurologist for bilateral wrist and hand pain. Petitioner complained of numbness and tingling in the left upper extremity. She reported that she had worked as a checkout person and then changed to a secretarial type position. She rated her discomfort as 6 to 8 on a scale of 10. She had some numbness and tingling in the right upper extremity but not nearly as bad on the left. On exam he found a positive Tinel's in the carpal tunnel and provocative signs on the right. X-rays of the left hand were essentially negative but she did have a small carpal boss, which he described as basically a boney prominence similar to a bone spur, on the right. Dr. Young set Petitioner up for a left carpal tunnel release and ordered physical therapy for the right. Dr. Young performed a left carpal tunnel release on November 30, 2011.On February 20, 2012 Petitioner felt that she was much improved. Although she still had a little bit of discomfort around the incision, she had improved substantially from the previous visit. Dr. Young released Petitioner to follow up on an as needed basis.

Dr. Young further testified that Petitioner returned to see him on November 26, 2013 at which time she complained of her right upper extremity. At this visit Petitioner filled out a new patient questionnaire in which she indicated that using a mouse and typing made her symptoms worse. On exam she had a positive Tinel's and median nerve compression to provocative maneuvers suggestive of carpal tunnel syndrome. He ordered a nerve conduction study to test for carpal tunnel syndrome. When she returned on December 19, 2013 she complained of numbness and tingling involving the thumb and index and long fingers of the right hand that awakened her at night. She had numbness when driving. She told Dr. Young that activities exacerbated her symptoms and that she felt that she had diminished dexterity and strength. Despite the fact that the nerve conduction study on the right that was negative Dr. Young thought it was likely that she had a carpal tunnel syndrome or peripheral compression neuropathy based on her subjective complaints and her physical exam. He injected Petitioner's right carpal tunnel with steroid. When she returned on January 16, 2014 she reported having received relief for three weeks after her last injection but she continued to have numbness and tingling in her right hand. She was given a splint and discharged to return if symptoms worsened or she decided that she wanted to do additional intervention. As of his deposition of September 9, 2014 she had not returned. (PX 8)

Dr. Young was of the opinion that Petitioner's job activated, contributed or aggravated the carpal tunnel syndrome. He believed that the types of jobs that she performed caused an increased pressure in the carpal tunnel. He believes that secretarial work could have caused or contributed to her condition. He specifically identified typing and handling files, organizing and filing as activities that can contribute. (PX 8)

Dr. Young acknowledged that he had not seen any records of Petitioner's prior treatment. He admitted that his history had that her hands had been getting more troublesome for years and that she engaged in gardening. He

agreed that if done enough gardening probably could contribute to carpal tunnel syndrome. The history also included that Petitioner worked at Big Johns grocery store for 18 years. Dr. Young believed that working as a checkout person in a sort is an occupation that could increase the risk of carpal tunnel syndrome. The history included that a diagnosis of carpal tunnel syndrome was made in 2008. He also believed that Petitioner was likely post-menopausal which placed her at an increased risk for developing carpal tunnel syndrome. He agreed that it is likely that doing a variety of activities would break up the pattern of repeated activities that might be associated with a carpal tunnel syndrome. Dr. Young opined that a disc bulge or herniated disc in the cervical spine could manifest similar to a carpal tunnel syndrome but he did not have enough details to know whether her problems were in her neck or back. He agreed that just because someone has problems while they're doing an activity doesn't necessarily mean that the activity is causing the problem. Dr. Young noted that he was aware of at least one study out of the Mayo Clinic suggesting that typing is not a contributing factor. He respects what comes out of the Mayo Clinic. (PX 8)

The deposition of Dr. Patrick Stewart was taken on June 9, 2015. (RX 1) Dr. Stewart examined Petitioner June 18. During his examination he asked Petitioner specifically in reference to when she developed her symptoms. She was working as a secretary for Franklin County as a receptionist in probation. He asked her if there was a particular activity during her work day that she thought was most problematic or that she felt might have been more of a causal factor for her. She discussed that she did a lot of secretarial date entry type work, computer work, but then she specifically referenced lifting files. She stated these files are essentially put away when they complete the case. She said they are about two to three inches thick. She described a heavy period where they had completed or cleared a bunch of cases. She stated that she put about 100 files away during a week's period and she estimated it was approximately 20 files a day. Dr. Stewart explained that this was about three an hour. There would be sufficient recovery phase well beyond the period time of the lifting. He testified that the weight is the other factor. A two to three inch file has some weight to it but the recovery phase is much greater than the period of time she' manipulating those items. Dr. Stewart stated:

> Pathologic conditions occur when the period of injury or the amount of injury exceeds the ability that the body has to recover from it. So as the period of stress in this -- you know, of lifting or doing activity is limited, and the period of recovery from that is significantly greater, that allows the body to recover from anything that may have occurred during that.
>
> There are some activities which even if we refer to them and say, Well, this was the activity; there may have been no damage or no pathologic occurrence, but even in the case there was, if you're doing something for five or ten minutes a day, and we only look at a work day of eight hours, then you still would have seven hours and 50 minutes, or 7 hours and 55 minutes of recovery from that type of activity. (RX 1, p. 9)

Dr. Stewart had x-rays obtained that revealed mild changes in the thumb CMC joints that could cause some discomfort in the thumb but not numbness and tingling or the other symptoms that Petitioner was complaining of. They did indicate that there would be some tenderness. He did not think that the x-ray findings were very significant. Her sensory examination was normal with the exception of the radial aspects of her right index finger. Dr. Stewart described this as slightly abnormal but it was unrelated to the surgery, the two previous EMGs. The sensory tests did not demonstrate carpal tunnel in the right hand. Tests of Petitioner's strength showed that she was not giving maximum effort.

Dr. Stewart testified to the Mayo clinic study, that he considers authoritative, in the following terms:

> Well, this was a study, and the interesting -- you know, there's -- the interesting

part of it is they went into the study with the expectation of confirming what was a widely held belief or notion was that data entry caused carpal tunnel. That was their hypothesis going in to test and they tested their own employees.

The part that brings the validity of the Mayo Clinic study above other studies is that other studies often times rely on a patient questionnaire. Signs, symptoms, what do you have. And there are classic signs and symptoms of carpal tunnel, nocturnal wakening, numbness and tingling in the thumb, index, and middle fingers, numbness and tingling with prolonged activities, things of that nature, but it is -- it is highly suspect or difficult for a patient to do self-diagnosis.

The Mayo Clinic did the questionnaires. Then they brought the patients in, did a history and physical exam. What they discovered is a lot of what the patients and workers thought were carpal tunnel symptoms were musculoskeletal problems, tendonitis, trigger fingers, other completely unrelated diagnoses. And then they were also able to then do the EMG. So they did the nerve test.

And they had a large enough population, 165 patients, where then they could look and stratify and say, Okay, we're going to compare this to the general population that doesn't do data entry, and is there a significant difference in the rate at which we've diagnosed carpal tunnel. And what they found is there wasn't.

So that trying to stratify for that activity, keeping age, sex, other things comparable, there wasn't an increased incidence of carpal tunnel in those workers. And they were doing six or more hours of data entry a day. (RX 1, pp.14-16)

Dr. Stewart testified that based upon his examination, Petitioner's history and consideration of the studies of the Mayo Clinic he did not believe that Petitioner's job caused or aggravated her carpal tunnel syndrome. He pointed out that while Petitioner's subjective complaints were consistent with carpal tunnel syndrome, they could also be a cervical radiculopathy that has never been investigated beyond 2008. He further found it difficult to give credence to complaints of someone who was not forthright in her effort. He noted that Petitioner's nerve tests improved between 2008 and 2011 on the left and remained normal on the right. He also found it unusual that she had evidence of mild carpal tunnel syndrome and supposedly a full recovery yet she continued to complain of persistent symptoms.

Dr. Stewart was asked about other potential risk factors. He explained that Petitioner's body mass index of over 30 and her activity of gardening, if it is a forceful repetitive activity, had been shown to increase the likelihood of developing carpal tunnel syndrome. He believes that it would have to be done consistently, not occasionally. When asked about Petitioner's 18 years as a grocery checker he responded that if she was very busy and the problems occurred during the activity the carpal tunnel syndrome could be related to the work. If the symptoms developed later it is less likely that they would be related to the work as a checker.

Dr. Stewart explained the concept of the body recovering during times away from an activity that had caused damage in the following terms:

The body -- and I -- you know, a good example would be weight lifting. You know, people who go in and they lift weights, and they actually create some muscular damage, and then you have a period of time for recovery. If you do bicep curls every single day, at some point you're not going

to be able to do bicep curls because you're going to break it down every single day. There has to be a period of recovery.

Now, the other part about that, and I've discovered this personally, is that my period of recovery is different now at 47 than it was at 27. And I think that that is one of the things that is most difficult is that it -- as we age, that – that changes.

But there has to be -- you know, and I think I eluded to it, there has to actually be damage that occurs. And so if you lift something that weighs 250 pounds 20 times a day, you've strained the muscles enough that there likely was some breakdown and there's going to be some soreness which indicates pathology. If I lift a file that weighs 5 pounds 20 times a day, did I likely strain the tendons, the muscle tendon junction, things of that, to cause damage where I'm going to have soreness? Likely not.

So I was saying that in the case where you actually have an activity that causes pathology, causes breakdown, then you're looking for that recovery phase, but the activity in and of itself has to cause that. (RX 1, pp. 20-21)

On cross-examination Dr. Stewart acknowledged that Petitioner performed a lot of the same activities and that "in the extreme" poor positioning of one's hands on a computer can aggravate carpal tunnel symptoms. As an example he referred to a person in a factory setting who had to stand with her wrists fully extended, or cocked up as far as one possibly could, to perform data entry. He further testified that the pads often seen in front of the computer don't really alter position. It's more comfort.

On redirect examination Dr. Stewart explained that he didn't query into how many hours per day Petitioner spent typing because of the Mayo Clinic study that looked at people who typed more than six hours a day and were doing almost exclusively date entry. He did not believe Petitioner was doing more typing that the people participating in the Mayo Clinic study. While there have been other studies that concluded differently than the Mayo Clinic study, the Mayo study was based upon actual employees, and not volunteers, and included more extensive testing and exams. He has not seen any studies done since the 2003 Mayo one that replicated the degree of investigation done at that time.

Petitioner's case proceeded to arbitration on December 9, 2015. All three of Petitioner's repetitive trauma claims against Respondent were consolidated for purposes of the hearing and three separate decisions were to issue. Petitioner was the sole witness at the hearing.

Petitioner testified that she began working for Franklin County in August 1998. Her job until her resignation in 2014 was as a secretary/receptionist. She explained that she was receptionist for the entire office. Petitioner admitted that she performed a wide variety of tasks. She transferred phone calls, buzzed people in at the front door, typed reports and handled files, taking them back and forth to the file room. She testified that she worked seven hours with a one hour, non-paid break per shift and would type most, or a majority, of the day. She also answered the phones, kept track of the drug testing monies so she had to use a calculator, buzz the door and assisted officers in any projects they needed help with. She explained that every individual who entered had to be buzzed in. That included four counselors, clients, and attorneys. She would be interrupted several times an hour to buzz people in. Some days there would be five or six clients while on other days there might be 40. Petitioner would have to handle files on a weekly and perhaps daily basis but a big collection of maybe 100 would be an intermittent thing. She would record drug test payments and would distribute mail throughout the office. She performed any tasks in the front of the office, including fixing the copy machine. Petitioner

identified typing and lifting of heavy files as the activities that caused her to notice her symptoms. She is right-handed.

Petitioner testified that her hands are both weak, but she does not have the electricity through her left hand that she did before. With regard to the right hand she said that she does not have the dexterity she used to have. She said she has problems moping and cooking. She denied having any problems with her neck while doing those activities. Petitioner continues to sew about twice a month.

Petitioner testified that in 2008, when she first knew she had carpal tunnel syndrome she told her supervisor, Steve Buntin, who also happened to be her cousin, that she was having studies done and that she was having pain in her hands. Her supervisor and director changed her work station by giving her a new keyboard and mouse and some cushion things for her wrists and adjusted where the keyboard was located. After she saw Dr. Young in June of 2011 she told her employer that she had seen another doctor.

Petitioner's testimony regarding her discussion with Steve Buntin included telling him she was having problems with her hands for which she was going to be getting testing and seeing a doctor. She assumed that he understand that her problems were associated with her work but acknowledged that she might not have said that "straight out loud". Rather, she may have simply told him her hands hurt and she was going to the doctor. Whether they may have said more she couldn't really recall. He sat across the room from her and that's all she could really remember.

The Arbitrator concludes:

Issues (C) and (F) Accident and Causal Connection.

Petitioner failed to prove she sustained an accident on November 11, 2008 that arose out of and in the course of her employment by Respondent or that her current condition of ill-being in her hands/wrists was causally connected to her alleged accident or her employment with Respondent.

Petitioner failed to establish that any repetitive trauma injury to her hands/wrists manifested itself on November 11, 2008. While Petitioner was examined by a doctor on that date due to bilateral hand complaints, nothing in Dr. Guyton's office note of that date suggests a work-related problem.

Medical records show that Petitioner underwent two EMGs in 2008 – one in April and one in November. The April EMG was negative for carpal tunnel syndrome. The November nerve conduction study revealed sensory left carpal tunnel syndrome. Nothing in the medical records before November 11, 2008 suggests a work-related problem or mentions symptoms or complaints that Petitioner, or anyone, associated with Petitioner's job as a secretary for Respondent. Indeed, the records reflect a constellation of symptoms that Petitioner was experiencing at that time along with treatment by a chiropractor, whose records were not admitted into evidence.

Petitioner is right hand dominant. She provided little, if any, testimony as to how she specifically used each of her hands during the course of her workday. Interestingly, while she is right hand dominant, her greater symptoms have been to the non-dominant extremity. Objectively, she has never been diagnosed with right carpal tunnel syndrome. All EMGs/NCS on the right side have been negative.

Petitioner's job duties for Respondent were varied in nature. She did not engage in one job activity on a repeated and sustained basis throughout the day. Based upon her testimony there is no question that Petitioner was very busy throughout her work day and assigned a great many duties and responsibilities requiring varied and different hand functions. However, these activities and functions were different. Typing is different than lifting. Answering a phone is different than organizing files. All may require the use of one's hands but, generally speaking, one's daily activities of living involve the use of one's hands in a myriad of different positions and motions also.

The Arbitrator finds the opinions of Dr. Stewart on the issue of causation more persuasive than those of Dr. Young. Dr. Young based his opinion on the belief that the type of jobs Petitioner performed could have caused or aggravated her condition. He specifically identified typing and handling file, organizing and filing as activities that can contribute. However, he also acknowledged that just because one notices problems while performing such activities doesn't mean the activity is causing the problem.

Dr. Young was unfamiliar with Petitioner's prior medical history having never seen or reviewed any of her records. Dr. Young acknowledged that Petitioner had mentioned to him that she gardened and he agreed that gardening could probably contribute to carpal tunnel syndrome. Dr. Young acknowledged that Petitioner, as a female and given her age and station in life, was at an increased risk for developing carpal tunnel syndrome. Dr. Young also acknowledged that a cervical disc bulge or herniation could manifest similar to carpal tunnel syndrome.

Dr. Young also agreed that it was likely that performing a variety of activities could break up a pattern of repeated activities that might be associated with carpal tunnel syndrome. He did not know the percentage or order in which Petitioner did things at work. Finally, Dr. Young acknowledged the Mayo Clinic study that suggests typing is not a contributing factor to the development of carpal tunnel syndrome. When asked if he considered the study authoritative, Dr. Young responded that he respected it. All of the foregoing concessions and admissions by Dr. Young diminish the persuasiveness of his causation opinion.

Dr. Stewart, by contrast, took a detailed history from Petitioner. He also reviewed all of her prior medical records. In that history Petitioner identified putting away files. Dr. Stewart cited the Mayo Clinic study, which Dr. Stewart considers to be authoritative for the proposition that secretarial work does not cause carpal tunnel syndrome. He explained why that study is so persuasive because of the methods and controls under which it was undertaken. He pointed out that the Mayo Clinic study found that there was no difference in the incidence of carpal tunnel syndrome between workers who performed data entry up to six hours per day and those who did not. Dr. Stewart explained that when an activity is not being done the body recovers from any damage that may have been caused by the activity.

Issue (E) Notice.

Petitioner failed to prove that she gave timely notice of her alleged accident to Respondent.

Petitioner testified that when she first knew she had carpal tunnel syndrome "in 2008" she told her supervisor and cousin, Steve Bruntin, she was having studies done and experiencing pain in her hands. She also testified that her supervisor and director changed her work station, gave her wrist cushions, and adjusted her keyboard. On further questioning she acknowledged that she never specifically told Mr. Bruntin that she associated her problems with her work; rather, she assumed that he knew that.

Petitioner failed to prove that she gave timely notice of an alleged accident to Respondent. The claimed date of accident is November 11, 2008. Petitioner merely testified that she told her supervisor that she was having studies done and was having pain in her hands. Petitioner presented no evidence that she notified her supervisor that she was claiming an accidental injury or associated her complaints with her work or the exact date when she allegedly provided notice.

Petitioner's claim for compensation is denied and no benefits are awarded.

****

STATE OF ILLINOIS	)	☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF PEORIA	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Wesley Royce,
Petitioner,

vs.

17IWCC0193

NO: 11 WC 43783

Caterpillar, Inc,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, causal connection and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 29, 2016 is hereby affirmed and adopted.

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

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

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

DATED: MAR 29 2017
KWL/vf
O-3/14/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

17IWCC0193

ROYCE, WESLEY
Employee/Petitioner

Case# **11WC043783**

CATERPILLAR INC
Employer/Respondent

On 8/29/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5847 THE LAW OFFICE OF DAVID HUNT
245 N E PERRY AVE
PEORIA, IL 61603

0477 CATERPILLAR INC
AMANDA WATSON
100 N E ADAMS ST
PEORIA, IL 61629

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

17IWCC0193

Wesley Royce
Employee/Petitioner

Case # 11 WC 43783

v.

Consolidated cases: n/a

Caterpillar, Inc.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Peoria, on July 19, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0193

FINDINGS

On the date of accident, October 19, 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 $35,630.40; the average weekly wage was $685.20.

On the date of accident, Petitioner was 51 years of age, single with 2 dependent child(ren).

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

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

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

ORDER

Based upon the Arbitrator's conclusions of law attached hereto, claim for prospective 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.

William R. Gallagher

William R. Gallagher, Arbitrator
ICArbDec19(b)

August 14, 2016
Date

AUG 29 2016

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on October 19, 2011. According to the Application, Petitioner was picking up pipe and sustained an injury to his left upper extremity (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for prospective medical treatment. Respondent stipulated that Petitioner sustained a work-related accident on October 19, 2011; however, Respondent disputed liability on the basis of causal relationship (Arbitrator's Exhibit 1).

At trial, Petitioner testified that on October 19, 2011, he was working with a section of pipe. As he was in the process of lifting it, Petitioner felt a "pop" in his left elbow. Petitioner was seen by the plant nurse on October 19, 2011. According to her record of that date, Petitioner complained of slight pain in the left elbow (Petitioner's Exhibit 1).

On October 21, 2011, Petitioner prepared and signed an Incident Report which stated that Petitioner experienced a sharp pain in his left elbow when he lifted a piece of pipe. Petitioner was also seen by Dr. Christopher Dea in Caterpillar Medical on October 21, 2011. According to Dr. Dea's record of that date, Petitioner reported having left medial elbow pain. Petitioner informed Dr. Dea that he felt a sharp pain in the medial elbow a few days ago. He denied any specific event; however, Petitioner advised that he had been repetitively grabbing and pushing pipe (Petitioner's Exhibit 1).

The last date Petitioner worked for Respondent was October 23, 2011. Petitioner subsequently sought treatment from Dr. C. W. Fisher, his family physician, on November 4, 2011. According to Dr. Fisher's record of that date, Petitioner hurt his left elbow a couple weeks ago while picking up a pipe. Dr. Fisher opined that Petitioner had medial epicondylitis and he indicated he was going to referred Petitioner to Dr. Stephen Garst (Petitioner's Exhibit 2).

Petitioner testified that after he left the employment of Respondent, he worked for Anchor Property Management. Petitioner did general maintenance type work which included painting, landscaping, repairs, etc. Petitioner stated that he continued to have left elbow symptoms, but that he was able to perform all of his job duties because he was right hand dominant.

On September 11, 2012, Petitioner was seen by Dr. Stephen Garst, an orthopedic surgeon. At that time, Petitioner informed Dr. Garst that he had injured his left elbow on October 19, 2011, while working for Respondent. According to the letter from Dr. Garst to Dr. Fisher dated September 11, 2012, Petitioner experienced a sharp pain in his left elbow when he picked up a piece of pipe. Since the time of the accident, Petitioner had experienced pain in the lateral aspect of the elbow. Dr. Garst obtained x-rays which revealed some degenerative changes and some small osteophytes both medial and lateral. Dr. Garst's diagnosis was left lateral epicondylitis and some mild degenerative change at the left elbow. He recommended conservative care (Petitioner's Exhibit 3).

While working for Anchor Property Management, Petitioner sustained a work-related accident which caused an injury to his right elbow. At trial, Petitioner testified that he was in the process of cutting a metal downspout with a hacksaw. When the hacksaw hit a seam in the downspout, it resulted in some resistance which, in turn, caused Petitioner to sustain an injury to his right elbow.

Following the injury to his right elbow, Petitioner was seen by Dr. Garst on October 9, 2012. At that time, Petitioner complained of pain in both elbows. Dr. Garst diagnosed Petitioner with left lateral epicondylitis, mild degenerative changes at the left elbow and right lateral epicondylitis. Dr. Garst ordered MRI scans of both elbows (Petitioner's Exhibit 3).

MRIs of both the right and left elbows were performed on October 16, 2012. The MRI of the right elbow revealed severe lateral epicondylitis and mild medial epicondylitis. The MRI of the left elbow revealed moderate to severe medial epicondylitis, mild lateral epicondylitis and an intra-articular loose body (Petitioner's Exhibit 3).

Petitioner was subsequently seen by Dr. Garst on October 22, 2012. In regard to Petitioner's right elbow, Dr. Garst recommended Petitioner have open right lateral epicondylar release surgery. In regard to the left elbow, Dr. Garst noted that while the MRI revealed left medial epicondylitis, Petitioner did not have much pain on the medial side of the elbow. As to treatment recommendations, Dr. Garst indicated that when Petitioner recovered from the surgery on the right elbow, he would do a left elbow arthroscopy and remove the loose body and a lateral epicondylar release (Petitioner's Exhibit 3).

Dr. Garst performed surgery on Petitioner's right elbow on December 13, 2012. The procedure consisted of a right lateral epicondylar release. Petitioner made a good recovery following that surgery and was able to return to work (Petitioner's Exhibit 3).

When Dr. Garst saw Petitioner on June 25, 2013, most of Petitioner's complaints were in regard to his left elbow. Dr. Garst renewed his recommendation that Petitioner undergo left elbow surgery.

At the direction of Respondent, Petitioner was examined by Dr. Stephen Weiss, an orthopedic surgeon, on October 23, 2013. In connection with his examination of Petitioner, Dr. Weiss reviewed medical records provided to him by Respondent, which included the nurse's note and Dr. Dea's record. Dr. Weiss opined that Petitioner had lateral epicondylitis and a loose body of the left elbow. He agreed with Dr. Garst's treatment recommendation. In regard to causality, Dr. Weiss opined that Petitioner's left elbow condition was not related to the accident of October, 2011. He noted that when Petitioner initially sought medical treatment, Petitioner only had mild complaints referable to the medial side of the elbow, not lateral-sided complaints. Further, Petitioner did not seek treatment for almost a year and, when he did, Petitioner sought treatment for left lateral elbow complaints, not medial elbow complaints. He opined that Petitioner sustained a mild strain as a result of the October, 2011, accident (Respondent's Exhibit 2).

Dr. Garst was deposed on October 28, 2015, and his deposition testimony was received into evidence at trial. Dr. Garst testified that he diagnosed Petitioner with left lateral epicondylitis for which he recommended surgery. In regard to the MRI performed on the left elbow, Dr. Garst opined that it revealed a "...little bit of medial epicondylitis..." and that it had an intra-articular loose body in the medial area as well. He opined that these findings were a "red herring" because Petitioner's complaints were on the inside of the elbow and not on the outside where Petitioner had symptoms (Petitioner's Exhibit 5; pp 8-9).

In regard to causality, Dr. Garst stated that Petitioner informed him that he experienced a sharp pain in his left elbow when he picked up a pipe at work. He opined that Petitioner's left lateral epicondylitis condition could or might be causally related to that work-related accident (Petitioner's Exhibit 5; pp 4-5, 17).

Dr. Weiss was deposed on December 11, 2015, and his deposition testimony was received into evidence at trial. Dr. Weiss' testimony was consistent with his medical report and he reaffirmed the opinions contained therein, in particular, his opinion that Petitioner's left lateral epicondylitis and loose body were not related to the accident of October, 2011.

In regard to the loose body, Dr. Weiss opined that this was old and related to the natural progression of a degenerative condition. In regard to the left lateral epicondylitis, Dr. Weiss specifically noted that Petitioner's complaints were initially on the medial side of the elbow and not the lateral side. Dr. Weiss also reviewed the deposition of Dr. Garst and noted that Dr. Garst did not have the medical records of the treatment Petitioner had received shortly after the accident. In this respect, Dr. Weiss noted that he had more information than what Dr. Garst had to base an opinion regarding causality (Respondent's Exhibit 3; pp 11-12, 15, 18-19).

At trial, Petitioner testified that he still has sharp pain in his left elbow and that he is unable to fully extend it. Petitioner stated that he was presently employed as a limousine driver and could perform all of his job duties. In that regard, Petitioner stated that he was able to pick up customers' luggage, put it in the trunk, etc. because he was right hand dominant did not have to use his left hand to perform those duties. He does want to proceed with the surgery as recommended by Dr. Garst.

Conclusions of Law

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

Arbitrator concludes that Petitioner's current condition of ill-being is not causally related to the accident of October 19, 2011.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner sustained a work-related injury to his left elbow on October 19, 2011.

When Petitioner was seen by Dr. Dea on October 21, 2011, he had complaints referable to the medial side of the left elbow.

When Petitioner was seen by Dr. Fisher on November 4, 2011, he again had complaints referable to the medial side of the left elbow.

When Petitioner subsequently sought medical treatment from Dr. Garst on September 11, 2012, 10 months after he was last seen by a doctor, he had complaints referable to the lateral side of the left elbow.

While Dr. Garst noted that the MRI revealed mild epicondylitis and a loose body on the medial side, he opined that those findings were a "red herring" because Petitioner's complaints/symptoms were all on the lateral side of the left elbow. Further, the surgical treatment he recommended was a lateral epicondylar release.

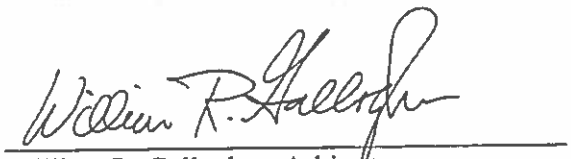
Dr. Garst opined that Petitioner's left elbow condition was related to the accident of October, 2011; however, there was no evidence to Dr. Garst ever reviewed the medical records from October/November, 2011, or that he was aware of the fact that Petitioner's complaints shortly after the accident were to the medial side of the left elbow, not the lateral side.

Respondent's Section 12 examiner, Dr. Weiss, reviewed all of the medical records regarding the Petitioner, including the records of Dr. Dea and Dr. Fisher from October/November, 2011, and was aware of the fact that Petitioner's initial left elbow complaints were in regard to the medial side of the left elbow and not the lateral side.

Based upon the preceding, the Arbitrator finds the opinion of Dr. Weiss to be more persuasive than that of Dr. Garst in regard to causality.

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

Based upon the Arbitrator's conclusion of law in regard to disputed issue (F) the Arbitrator concludes that Petitioner is not entitled to prospective medical treatment.



William R. Gallagher, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sherann Ivy,

Petitioner,

vs. NO. 11WC 46861

17IWCC0130

Streamwood Behavioral Health,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 29, 2016 is hereby affirmed and adopted.

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

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

17IWCC0130

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

DATED: MAR 3 - 2017
SJM/sj
o-2/23/2017
44

Stephen J. Mathis

Marie Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

IVY, SHERANN
Employee/Petitioner

Case# **11WC046861**

STREAMWOOD BEHAVIORAL HEALTH
Employer/Respondent

17IWCC0130

On 6/29/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1869 PRESBREY & ASSOC
CHRIS M WILLIAMS
821 W GALENA BLVD
AURORA, IL 60506

2623 McANDREWS & NORGLE LLC
MICHAEL P LATZ
53 W JACKSON BLVD SUITE 315
CHICAGO, IL 60604

17IWCC0130

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

SHERANN IVY
Employee/Petitioner

v.

STREAMWOOD BEHAVIORAL HEALTH
Employer/Respondent

Case # **11** WC **46861**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **01-20-16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **11-19-11**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$61,900.00**; the average weekly wage was **$1,190.40**.

On the date of accident, Petitioner was **33** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$1,600.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$1,600.00**.

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

ORDER

Petitioner is not due TTD payments beyond December 17, 2011.

Petitioner failed to prove a permanent orthopedic injury or permanent mental condition as a result of the assault on November 19, 2011.

Respondent shall pay PPD benefits of $695.78 for 1 week because the injuries sustained caused a disfigurement of the lip, as provided in §8(c) of the Act.

All outstanding medical bills are to be paid pursuant to the fee schedule.

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

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

Signature of Arbitrator

06-27-16
Date

JUN 29 2016

THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sherann Ivy Employee/Petitioner, v. Streamwood Behavioral Health Services, Inc., Employer/Respondent.	)	Case No. 11 WC 46861

ARBITRATION DECISION

I. FINDINGS OF FACT:

On January 20, 2016, the parties conducted a hearing in this matter. The disputed issues were causal connection, unpaid medical bills, temporary total disability, and nature and extent of the injuries. The following is a summary of relevant facts adduced at the hearing:

On November 19, 2011 Petitioner was employed by Streamwood Behavioral Health as a Registered Nurse. (Tr. Page 7). Petitioner was working in the adolescent girls' psychiatric unit. (Tr. Page 8). On that day, at approximately 3:30 p.m., a 17 year-old patient acted aggressively. (Tr. Page 8). Petitioner called a "Code Green" - a request for staff assistance. Petitioner alleges that no one responded to the "Code Green" request. (Tr. Page 9).

The 17 year-old patient was a large young woman. The patient stood on top of the nurses' station and acted aggressively. Petitioner then called 911. (Tr. 12) The patient swung a piece of wood, at Petitioner, but did not hit her. (Tr. 12-13) The patient fell on top of Petitioner. (Tr. Page 13). Petitioner testified that patient started pounding her head and scratching her face. (Tr. Page 13). The patient bit Petitioner's lip. (Tr. 13) The patient was on top of Petitioner approximately for forty-five seconds to one minute. (Tr. 14)

The police arrived and separated the patient was from Petitioner. Three other staff members were standing close and watched the incident, but did not assist the Petitioner. (Tr. 15, 40) The patient was arrested for aggravated battery. (PX #1) Officer Mary Saczawski observed a 1.5 cm abrasion to the top of the Petitioner's upper lip and several small scratches on her face. (Id.)

Petitioner was transported to St. Alexius Hospital Emergency Room. (Tr. 41) Petitioner was seen by Dr. Karla Dunston and diagnosed with a contusion, neck strain and minor head injury. The Petitioner was noted to be calm and speaking coherently. (PX #2) An abrasion to the upper lip and small, superficial abrasion to the left eye was noted. (Id.) Petitioner stated that she did not remember what diagnosis was made at St. Alexius. No stiches were necessary. (Tr. 41)

Petitioner was told to follow-up with Dr. Thakkar, who examined Petitioner on November 21, 2011 and released her from care with a prescription for hydrocodone and amoxicillin. The Petitioner was not placed off work. (PX #3, Tr. Page 19).

On November 29, 2011, Dr. Thakkar examined the Petitioner and noted that she was very despondent and unable to sleep as a result of the incident (PX #3). His diagnosis was was back pain, dizziness and gastro esophageal reflux disease. The Petitioner was not placed off work. Her prescriptions were refilled and it was noted that she may need to see a psychiatrist. (PX #3)

Petitioner went to see psychologist, Dr. Amy Robinson on December 13, 2011. Petitioner reported to Dr. Robinson that the core of her fear was that she does not feel safe continuing to work on the forensics unit after twice calling a Code Green and having no staff

respond. Petitioner reported to Dr. Robinson that the adolescent who attacked her was given the "run of the hospital," and that the hospital was short-staffed, and that the hospital failed to protect her. (PX #4, p 2-3)

Petitioner testified that after the incident, she was scared, anxious, having nightmares, and could not sleep. When asked what she was scared of, by her counsel, Petitioner testified that she was scared that she would have to change her career choice. (Tr. 22)

On December 15, 2011, Dr. Thakkar wrote that the Petitioner returned to work on December 12, 2011. (PX #3) He wrote that the Petitioner had insomnia, no significant depression, but was afraid to go back to work. His advice was to quit work for now. He also diagnosed stress disorder and anxiety. (PX #3)

Petitioner testified on cross-examination that at the time of the incident, she was going through stressors in her personal life, as she was just divorced from her husband in October of 2011. (Tr. 45-47) Later, Petitioner testified that she did not change her career choice, and returned to work as a nurse in a juvenile psychiatric unit. (Tr. 49)

Petitioner testified that she has a scar on her lip from being bit in the attack. The Arbitrator observed the scar and characterized it as approximately the size of a grain of rice. (Tr. Page 29). However, the slight discoloration viewed at trial does not appear to be in the same location at the laceration depicted in the police photos located in Petitioner's Exhibit #1.

The Petitioner was treated by Dr. Amy Robinson, a licensed psychologist, on December 13, 2011 at Creative Change in Elgin, Illinois. The Petitioner was treated on six occasions. No diagnosis was made, but she initially wrote, "Psychologically, she cannot do

her job if she does not feel that the facility will provide for her safety. Therefore, it my opinion that should not return to work until this condition is met." (PX #4 p.4)

The Petitioner was examined by Dr. Babak Lami, (orthopedic spine surgeon) at respondent's request, on January 12, 2012. (RX #3) At that time, Petitioner informed that Dr. Lami that she was still working at her part-time job as a home health care nurse. (Id.) Her only medications were Aleve, an over the counter drug. Dr. Lami reviewed the medical records, examined the Petitioner and stated that Petitioner was at maximum medical improvement from an orthopedic standpoint. (Id.) He deferred his opinion about the Petitioner returning to work to her old job to a qualified mental health practitioner. (RX #3)

On March 13, 2012, Dr. Robinson referred Petitioner to Dr. Delossantos, a psychiatrist, for further intervention to ameliorate her symptoms of sleeplessness and chronic headaches. (Id.)

Petitioner saw Dr. Renato Delossantos for the first time on March 15, 2012. Dr. Delossantos' records are mostly illegible. (PX # 5) However, it appears that she was initially diagnosed with post-traumatic stress disorder and complained of having sleepless night, nightmares, back pain and spasms, flashbacks, and anxiousness. Petitioner's work status was not addressed. (Id.)

On April 12, 2012, Dr. Delossantos wrote that the Petitioner still had thoughts of hurting others (no one specific). She had increased anxiety, was panicky, and wanted to "hold somebody responsible for what happened to me." No diagnosis was made. The Petitioner's off work status was not addressed. (PX # 5 p.4)

On April 13, 2012, the Petitioner was examined Jeri Morris, a certified neuropsychologist at Respondent's request. Morris concluded that the Petitioner did not have PTSD and was capable of returning to work for Respondent. The Petitioner was no longer having nightmares and was interested in returning to school to pursue an advanced nursing degree. (RX #4 p.15-18)

Petitioner's last visit with Dr. Delossantos was on May 9, 2012, who wrote "no optimal response." Petitioner's prescription for Zoloft was increased. Petitioner's off work status was not addressed and no diagnosis was rendered. (PX #5 p.4)

Petitioner stated at trial that she did not return to work at her then concurrent employer, Care for Life Home Health. This contradicts the medical records of Dr. Thakkar. (PX #3) Petitioner did return to work in July of 2012 at Maryville Scott Nolan Psychiatric Hospital. Petitioner returned to the same employment: a psychiatric nurse for children. (Tr. Page 24).

The parties stipulated that Petitioner received TTD benefits in the amount of $1600.00 for the period through December 17, 2011. Respondent introduced an exhibit which claims payments totaling $2,698.66 to St. Alexius Medical Center.

II. CONCLUSIONS OF LAW

a. Legal Standard

The burden is on the party seeking an award to prove by a preponderance of credible evidence the elements of the claim, particularly the prerequisites that the injury complained

17IWCC0130

of arose out of and in the course of the employment. *Hannibal, Inc. v. Industrial Commission*, 38 Ill. 2d 473 (1967). Liability under the Act cannot rest upon imagination, speculation, or conjecture, or upon a choice between two views equally compatible with the evidence, but must be based upon facts established by a preponderance of the evidence. *Standard Oil Co. v. Industrial Commission*, 339 Ill. 252, 171 N.E. 165 (1930); *McDonald v. Industrial Commission*, 39 Ill. 2d 396, 235 N.E. 2d 824 (1968).

b. With respect to Issue whether the Petitioner's current condition of ill-being is causally related to the incident of November 2011, the Arbitrator finds as follows:

Petitioner was transported by ambulance to St. Alexius hospital immediately after the incident. The St. Alexius Hospital records reflect that Petitioner suffered an abrasion or contusion, a head injury but not a concussion, and a neck strain. Petitioner was treated with a number of prescription medications. (PX #2)

Petitioner suffered no permanent orthopedic or mental injury in the November 2011 incident. The Arbitrator viewed the scar, and found that it is the size of a grain of rice. The scar is not visible from a distance of five feet, nor did it seem to be in the same location of the abrasion depicted in Police report. (PX #1 p.11)

The Arbitrator finds that Petitioner proved causation of a temporary mental injury as a result of the November 2011 incident.

The Arbitrator has reviewed Appellate Court and Commission decisions on the subject of physical-mental theories of recovery. The claimed trauma suffered by Petitioner,

from a physical perspective, does not seem rise to the level of that suffered by Petitioners wherein benefits were awarded for a physical-mental theory of recovery. However, in this case, the Arbitrator finds that Petitioner suffered a traumatic event, which caused a temporary mental condition that no longer currently exists.

The Arbitrator is persuaded that Petitioner suffered a mental incapacity injury as allegedly the result of the assault on November 19, 2011. Petitioner's description of her anxiety, and the cause of such anxiety, was established in her first visit with Dr. Robinson on December 16, 2005. Dr. Robinson's records state: "The core of Sherann's fear is the result of two factors: 1) she does not feel safe continuing to work on a forensic unit after twice calling a Code Green and having no staff respond, and 2) feeling that the hospital management failed to protect staff despite numerous assaults by this patient on Streamwood staff prior to November 19, 2011."

Nevertheless, the Arbitrator finds that the Petitioner did not prove that the incident caused a permanent disabling neurosis. No doctor has stated such and it seems that a large portion of the workers' compensation claim is based upon the Petitioner anger at her employer. Petitioner denied being angry at her employer at trial, but Delssanto's records state otherwise.

Dr. Delossantos' records are largely illegible, but is it clear that Petitioner's work status was never addressed and the Petitioner did not follow up with her monthly treatment. It bears repeating that no doctor stated that the Petitioner's mental condition was permanent. There is scant evidence of any lasting mental condition being diagnosed throughout the course of the Petitioner's treatment.

The Arbitrator relies on the opinion of Dr. Jeri Morris who examined Petitioner at the request of Respondent. Dr. Morris conducted objective testing, and concluded that Petitioner experienced anxiety after the attack. Petitioner was not clinically depressed and did not suffer Post-Traumatic Stress Disorder. Dr. Morris tested the Petitioner more thoroughly than the other mental health treaters and provided an extensive rational for her diagnosis. (RX #3, Ex. 2 p. 5)

The Arbitrator finds persuasive that Petitioner, in fact, returned to work as a registered nurse in a juvenile psychiatric setting. Petitioner failed to prove that her mental condition is permanent.

c. With respect to what temporary total disability benefits are due, the Arbitrator finds as follows:

Based on the foregoing decision and discussion on causal connection, the Arbitrator denies Petitioner's claim that she was incapable of work beyond December 17, 2011. There is no basis for payment of TTD beyond this date based on Petitioner's physical injury and/or mental injury. To wit, there are no off work slips. Petitioner continued to work at her part-time job. Additionally, Dr. Amy Robinson's assessment statement that, "Psychologically, she cannot do her job if she does not feel that the facility will provide for her safety. Therefore, it my opinion that should not return to work until this condition is met," is not a reasonable standard to determine whether the Petitioner is capable of returning to work. The Arbitrator notes that this rational is entirely subjective and there is no basis to monitor Respondent's ability to accommodate Petitioner's perceived level of safety. There is nothing in the record stating whether the assailant returned to unit at Streamwood.

d. With respect to nature and extent of the injury, the Arbitrator finds as follows:

Petitioner suffered an abrasion to the lip. The abrasion required little medical attention, no stitches and it is not clear to the Arbitrator that the "whitish rice grain" scar he observed is in the same location as the abrasion depicted in the police report. The Arbitrator viewed the scar. The scar cannot be seen from a distance of five feet away. The Arbitrator finds that Petitioner suffered a slight disfigurement, and awards 1 week pursuant to Section 8(c) of the Act.

No evidence supports the notion that Petitioner suffered a permanent orthopedic injury to her neck and low back.

No evidence supports the notion that Petitioner suffered a permanent psychological injury.

e. With respect to medical bills:

The Arbitrator finds that medical treatment at St. Alexius was reasonable, necessary and appropriate; therefore Respondent shall pay any unpaid bills for Petitioner's treatment at St. Alexius on November 19, 2011, according to the fee schedule. The Arbitrator awards all outstanding medical bills pursuant to the fee schedule. Dr. Morris stated that Petitioner would benefit from 4-12 more session of therapy following her Section 12 exam. Following

17IWCC0130

that exam, the Petitioner underwent fewer than 12 visits. As a result, all medical bills should be paid in accordance with the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

YVONNE BELL,

Petitioner,

vs. NO: 12 WC 35484

CITY OF CHICAGO - SANITATION,

Respondent.

ORDER

This matter comes before the Commission on Petitioner's Motion for 19(k) Penalties and Attorneys Fees, which was filed on May 4, 2016. A hearing was held before Commissioner DeVriendt on June 6, 2016. No record was made.

On September 2, 2015, Arbitrator Mason awarded Petitioner temporary total disability benefits, maintenance benefits and temporary partial disability benefits. Respondent took a review from Arbitrator Mason's award. On March 3, 2016, the Commission issued its decision, affirming and adopting the award of Arbitrator Mason, including the credit of $99,479.54. After subtracting the amount of the award, Respondent had a credit of $10,626.58.

On or about April 12, 2016, Respondent advised Petitioner's counsel that a balance of $5,076.44 of the credit remained, for which Respondent would temporarily cease paying benefits until the amount of the credit was exhausted. As Petitioner had been over paid, there were no unreasonable and vexatious delays in payment of the Arbitrator's Award affirmed by the Commission.

For the above stated reasons, the Commission denies Petitioner's Motion for 19(k) penalties and Attorneys' Fees.

DATED: MAR 2 2 2017

Charles J. DeVriendt

L. Elizabeth Coppoletti

Joshua D. Luskin

CJD/dmm
49

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Major,
Petitioner,

17IWCC0165

vs.

NO: 12 WC 14982

Thermo-Tech Windows,
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, jurisdiction, medical expenses, 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 May 2 2016, is hereby affirmed and adopted.

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

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

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

DATED: MAR 2 1 2017
o3/8/17
KWL/rm
046

Kevin W. Lamborn

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0165

MAJOR, JOHN
Employee/Petitioner

Case# 12WC014982

THERMO-TECH WINDOWS
Employer/Respondent

On 5/2/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.40% 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:

1836 RAYMOND M SIMARD PC
221 N LASALLE ST
SUITE 1410
CHICAGO, IL 60601

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

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

John Major
Employee/Petitioner

v.

Thermo-Tech Windows
Employer/Respondent

Case # **12** WC **14982**

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 **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Geneva**, on **March 14, 2016**. After reviewing all of the evidence presented, the undersigned Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☒ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the 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 **jurisdiction**

FINDINGS

On August 4, 2011, Respondent *was not* operating under and subject to the provisions of the Act conferring jurisdiction in Illinois as explained *infra*.

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

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

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

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

In the year preceding the injury, Petitioner earned $53,856.40; the average weekly wage was $1,035.78.

On the date of accident, Petitioner was 48 years of age, *single* with 2 dependent children.

Petitioner *has* received all reasonable and necessary medical services as explained *infra*.

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

Respondent shall be given a credit of $0 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits (i.e., mileage expenses), for a total credit of $0.

Respondent is entitled to a credit of $0 under Section 8(j) of the Act. AX1.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that jurisdiction is not proper in Illinois. Thus, all remaining issues are rendered moot and Petitioner's claim for benefits is denied.

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

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

Signature of Arbitrator

May 2, 2016
Date

MAY 2 - 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

John Major
Employee/Petitioner

v.

Thermo-Tech Windows
Employer/Respondent

Case # 12 WC 14982

Consolidated cases: N/A

FINDINGS OF FACT

The issues in dispute at this hearing include jurisdiction, accident, causal connection, Respondent's liability for certain unpaid medical bills, Petitioner's entitlement to periods of temporary total disability benefits commencing on May 30, 2012 through June 15, 2012, July 15, 2014 through July 24, 2015, March 31, 2015 through April 15, 2015 and April 13, 2015 through April 15, 2015 as well as the nature and extent of the injury. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Employment Relationship

Petitioner worked as a Territory Sales Representative for Respondent beginning in January 2009. His initial territory was Iowa and Illinois, and also depended on "what accounts were given to" him. By the time of the August 4, 2011 incident, Petitioner's sales territory expanded to include South Dakota and Nebraska. Petitioner believed the territory may have also included Indiana at that time. Petitioner's job responsibilities included introducing Respondent's window products to lumber-yards and builders by providing quotes, doing sales presentations and working contractor shows.

According to Petitioner, Respondent never had an office in Illinois other than his home office. See PX14 (Respondent's Verification of Coverage form indicating Petitioner's home address as its business location in Illinois). Petitioner initially traveled to Respondent's office, located in Minnesota, to be hired. He initially reported to a supervisor, Bob Brenneman, and later reported directly to Respondent's president, both of whom were located in Minnesota. Respondent would send Petitioner promotional apparel and paychecks from Minnesota to his home office in Illinois. Respondent also provided Petitioner with an automobile for his sales calls, which was registered in Minnesota, as well as a cell phone with a Minnesota area code phone number. Petitioner was required to stay in hotels overnight while on sales calls and he estimated he spent two or three nights per week in hotels, which may or may not have been located in Illinois.

Petitioner maintained his office at his residence in Elgin, Illinois. In a typical week, Petitioner estimated that he was in his home office 30% of the week ordering materials and promotional materials, processing paperwork and taking specifications on window drawings and turning those into e-quotes. He also estimated that 25-30% percent of his work-related expenses, for which Respondent reimbursed him, were generated in Illinois and 25-30% of the miles he traveled were in Illinois.

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party.

Prior 2011 Incident at Work

In late March or April of 2011, Petitioner testified that he had an incident at work while working in Manchester, Iowa at a ProBuild dealership. He explained that he was setting up a display when he felt twinge in his left elbow. Petitioner testified that he did not think much of it at the time, but as days and weeks passed he experienced tingling and a loss of muscle mass in the left hand and elbow as well as excruciating pain.

Petitioner then saw a chiropractor, Curt Buss, D.C. (Dr. Buss), on June 14, 2011. PX5. Petitioner reported "aching, burning tingling and numb discomfort in his cervical region, right upper thoracic area, left upper thoracic area, right shoulder, left shoulder, right arm, left arm, right elbow, right wrist and left wrist." *Id.* These symptoms reportedly had a gradual onset and had "been present for the past several years and are most noticeable the entire day." *Id.* Petitioner also reported that the "symptoms become aggravated by: almost any movement, walking, sitting, bending … standing, sleeping, lifting, running, climbing stairs, carrying, pushing, pulling, driving, reading, watching tv, household chares, gardening, exercising, working and dancing." *Id.* In addition, Petitioner provided a history that he "wrestled since he was [a] very small child and has 'beat his body up over the years.'" *Id.* Petitioner further reported that he engaged in weight training and that his work required him to sit 8-10 hours per day as well as light-to-moderate lifting. *Id.*

On physical examination, Dr. Buss noted that Petitioner was tender to touch at the cervical, cervical dorsal and thoracic regions with severe spasms of the neck and bilateral trapezius muscles. PX5. Digital thermography revealed imbalances at C2, C6, T1, T2, and L4; a surface EMG confirmed spasms at right atlas, left atlas, right C3, right C5, left C5, right C7, right T1, left T1, right T2, right L5 and left S1. *Id.* Loss of range of motion of the cervical spine was noted. *Id.* at 5. A cervical compression test was positive bilaterally, indicative of radicular pain. *Id.* X-rays further confirmed degenerative disc disease at C5, C6, and C7. *Id.*

Among other diagnoses, Dr. Buss diagnosed Petitioner with: (i) cervical/brachial syndrome; (ii) brachial neuritis or radiculitis; (iii) paresthesia; (iv) cervicalgia; (v) cervical segmental dysfunction or somatic dysfunction; and (vi) muscle weakness. *Id.* He recommended chiropractic treatment three times per week for the following four weeks. *Id.*

On June 14, 2011, Petitioner also saw his primary care physician, Dr. Neubauer reporting bilateral forearm pain and paresthesias as well as neck stiffness. RX6. Dr. Neubauer's records reflect that he performed a physical examination, which revealed tenderness in the neck, bilateral elbow tenderness and some distal paresthesias associated with palpation. *Id.* Dr. Neubauer diagnosed Petitioner with cervical radiculopathy and possible bilateral "nerve impingement vs elbow impingement." *Id.* He referred Petitioner for a consultation with a specialist noting that Petitioner would likely need an orthopedist as well as a neurologist and recommending a cervical spine MRI versus an orthopedic consultation. *Id.*

Petitioner testified that after undergoing chiropractic care he noticed that his left hand and elbow were a lot better. He explained that his muscle mass was back, his grip was back, he did not have as much tingling and his condition was improving.

August 4, 2011

On August 4, 2011, Petitioner testified that he was with a client, Mike Erickson, picking up damaged product from a work site in Iowa. They placed the damaged product in the back of a pickup truck and were leaving the work site when they noticed that the screens were blowing around. Petitioner explained that they decided to put these screens inside the pickup truck and pulled the truck over. It was at this time that Petitioner testified he

stepped off a ledge off the gravel road and fell about 20 feet into a ditch that he did not see because of grass and gravel. He explained that he tumbled hard and was grabbing for something and he finally caught himself about two-thirds of the way down, maybe on a tree. Petitioner testified that he knew immediately that he hurt his elbow and left hand again as well as his neck.

Petitioner also testified that he did not immediately seek medical attention after the incident on August 4, 2011. He explained that, between August 4, 2011 and August 31, 2011 he was icing and elevating his neck, left elbow and left hand. He then began elevating and icing his right elbow and wrist, which began to swell approximately five days to one week after the incident at work. Petitioner also testified that he felt sharp pain in the left elbow, wrist, thumb, and fingers. In his neck, he felt tightness, pain and experienced headaches. Petitioner testified that he thought he could take care of the problems himself and did not hear back from human resources so he was in "limbo" and sought medical care after he could not sleep anymore, etc.

Petitioner provided notice of the incident to Respondent alleging an injury to the left elbow and left hand only. RX5.

Medical Treatment

The medical records reflect that Petitioner sought medical care following the incident on August 31, 2011 at Delnor Express Care and saw Dr. Jonathan Parker (Dr. Parker). PX6. Dr. Parker noted the following chief complaint:

> ... Patient stated that four months ago he felt a twinge in left elbow. Patient hand went numb but came back. In left elbow. Patient stated that one month ago (Aug 5th) he fell again and is having trouble with grab[b]ing things in left hand. Also patient is having swelling on right hand. Patient said when he fell he felt a burning sensation in both forea[rm]s and hands. Patient has no feeling on medial side of forearms into fifth phalange.

Id. Dr. Parker further noted the following history of present illness in pertinent part:

> ... History as above, pt states he was pulling a large display off a truck above his head, during his job 4 months ago, and felt a twinge in left elbow with some numbness in hand developing a few days later, these symptoms persisted on/off for a few months, then got significantly better. However, the left hand numbness persisted, and he noticed a weakening and atrophy of his left hand near his thumb. On Aug 5, or there about per pt, he fell off a truck while working, landing on the ground, stiking his elbow, though he is not absolutely sure, he felt the same pain in the left elbow, but "100 times worse" along with numbness in left 4/5th pinkie. Also, he noticed since then, his right hand has been swollen and he has had numbness in the right thumb, 2nd and 3rd fingers of right hand. He came in today because he is worried about the right hand, that it will "end up like the left hand, and I want to nip this in the bud." He denies fevers, weight loss, headache, vision change, or neuro-muscular symptoms in places other than his UE. He does have a h/o a "bad neck" but denies recent trouble with it, and no pain of the neck after the falls as described above.

Id. Dr. Parker diagnosed bilateral neurologic symptoms with significant atrophy of the left hand, which he was "unsure if this is due to work injury or a progressive disease, given the bilateral nature." *Id.*

The following day, Petitioner saw Dr. Robert Swartz (Dr. Swartz) on September 1, 2011. PX7. Dr. Swartz noted the following history in pertinent part:

> ... He is here regarding left much greater than right upper extremity issues. Approximately four months ago, he had a shooting pain that went down into his fourth and fifth fingers. This would come and go at times. He would shake it out and it seemed to just go away. Then about a months ago, he fell and rolled a bit and had more pain and, since that time, constant numbness in the same distribution on the left. It comes and goes on the right. He has had an occasional neck ache but no shoulder symptoms and none in the elbow, wrist or fingers. He has noticed that the muscles are starting to disappear in the left hand, and he has trouble straightening out his fourth and fifth fingers. He does complain of some sleep symptoms.

Id. On examination, Dr. Swartz noted obvious atrophy in the muscles of the left hand with an extension lag in the ring and little fingers of the left hand, but concluded that his provocative examination did not indicate any specific symptoms. *Id.* Dr. Swartz referred Petitioner for a neurology consultation and EMG evaluations of the arms. *Id.* He diagnosed Petitioner with significant ulnar neuropathy with some degree of already permanent nerve injury demonstrated by his intrinsic atrophy. *Id.*

Petitioner testified that, following a denial of his workers' compensation claim, he considered pursuing further medical care through Blue Cross Blue Shield provided by his wife's employer, but he nevertheless delayed seeking further medical care. See also PX15 (October 27, 2011 workers' compensation claim denial letter).

On April 19, 2012, Petitioner saw Kishore Santwani, D.O. (Dr. Santwani) as Suburban Neurology Group as referred by Joseph Neubauer, M.D. (Dr. Neubauer) from Fox Valley Family Physicians. PX8. Dr. Santwani noted the following history in pertinent part:

> ... his symptoms began in May of 2011. He was working and moving a display when he noticed a sharp pain radiating from his left medial elbow to his left hand. Subsequent to that, he would notice that with left elbow flexion, he would notice pain and a "pinching" feeling in his left elbow which could be alleviated partially by pressing a specific spot near his left medial epicondyle. In August of last year, he fell down a hill and hit his neck and head without any loss of consciousness. He did not seek medical evaluation at that time. Subsequent to this fall, he notices a sharp increase in his left elbow pain and also notices pain radiating from his right elbow to his right second and third fingers as well as neck pain. He also started to notice decreased strength in his right hand and felt that he was clumsy with his right grip. Starting June or July of last year, he started to notice atrophy in the left hand intrinsic muscles. He states that he did see an orthopedic doctor who recommended what sounds like ulnar transposition surgery but patient deferred on getting any surgery at that point.
> ...

Id. Dr. Santwani diagnosed Petitioner with bilateral distal upper extremity dysesthesias with left hand intrinsic atrophy/weakness and differential diagnoses including a left cubital tunnel syndrome/ulnar neuropathy versus cervical radiculopathy versus less likely brachial plexopathy. *Id.*

Petitioner underwent an MRI of the cervical spine as ordered by Dr. Santwani on April 20, 2012 that revealed C5-6 diffuse bulging/osteophyte complex with moderate to severe central canal stenosis, moderate bilateral foraminal narrowing and C7-T1 disc bulging. PX8. The interpreting radiologist noted degenerative changes. *Id.* Petitioner also underwent bilateral upper extremity EMG/NCV studies on April 27, 2012. *Id.* The results were abnormal showing severe axonal, ulnar sensorimotor neuropathy on the left as well as evidence of moderate, predominantly axonal bilateral median neuropathies across the wrist (carpal tunnel syndrome), and mild acute C6 radiculopathy on the left. *Id.*

Petitioner then saw a neurosurgeon, John Brayton, M.D. (Dr. Brayton) on May 18, 2012 as referred by Dr. Santwani. PX9. Dr. Brayton noted a history from Petitioner including an "... initial onset of pain and aching in March 2011 after lifting, but primarily his symptoms occurred when he fell backward in August 2011 falling in a ditch and incurring injury to his neck and both upper extremities especially on the left." *Id.* After an examination, Dr. Brayton diagnosed Petitioner with a combination of C6 radiculopathy attributable to a C5-6 herniation, osteophyte and spondylosis as well as C7 and C8 radiculopathy association with neuroforaminal stenosis with superimposed severe ulnar entrapment neuropathy on the left. *Id.* Dr. Brayton also indicated that "[t]here is also the possibility of damage that occurred in the ulnar nerve concurrent with the fall, but it appears that his symptoms have been worsening consistent with progressive entrapment of the ulnar nerve." *Id.*

Dr. Brayton recommended surgery, which Petitioner subsequently underwent on May 30, 2012. PX9. Specifically, Dr. Brayton performed a C5-6 anterior cervical decompression and fusion with left C6-7, C7-T1 anterior microforaminotomy and left ulnar nerve decompression and transposition. *Id.* Post-operatively, Petitioner underwent physical therapy at West Physical Therapy beginning on July 24, 2012. PX10. Petitioner was discharged from physical therapy on December 28, 2012, at which time he was instructed to continue a home exercise program. *Id.*

In late November 2012 and into January 2013, Petitioner complained to Dr. Brayton's nurse of hand numbness. PX9. Petitioner was referred for an additional EMG, which he underwent on January 15, 2013. *Id.* As noted by Dr. Santwani, in comparison to Petitioner's prior EMG/NCV studies, this study showed similar findings, but the acute denervation in the left ulnar innervated muscles appeared to be mildly reduced with slightly worse right median sensory demyelination. PX8.

On February 28, 2013, Petitioner returned to Dr. Brayton who noted that Petitioner's neck pain and radicular symptoms resolved post-operatively, but he still had persistent severe ulnar neuropathy with paresis and atrophy in the left hand. PX9.

Records Review & Section 12 Examination – Dr. Butler

On July 9, 2013, Jesse Butler, M.D. (Dr. Butler) performed a review of Petitioner's treating medical records at Respondent's request. RX1; RX4 (Dep. Ex. 2). Dr. Butler issued a report in which he rendered opinions regarding the relatedness, if any, of Petitioner's physical condition with his alleged accident at work on August 4, 2011. *Id.*

Dr. Butler diagnosed Petitioner with cervical disc degeneration with multilevel stenosis at C5-6 through C7-T1 and severe ulnar entrapment neuropathy on the left. *Id.* He noted that Petitioner's upper extremity complaints began in March of 2011 and there was a recommendation for an ulnar transposition as early as June or July of 2011. *Id.* He attributed Petitioner's conditions to prior ulnar nerve issues dating back to March of 2011 as well as pre-existing degeneration in the cervical spine. *Id.*

Dr. Butler indicated that Petitioner's chiropractic note from June of 2011 clearly establishes pre-existing issues in the cervical spine and bilateral upper extremities before the claimed August of 2011 claimed accident. *Id.* He also noted that Dr. Parker's note from August 31, 2011 reflects Petitioner's denial of a history of a "bad neck" when he had seen a chiropractor for neck issues in June and that "[i]t would be unusual for someone to have a fall onto the left elbow and 26 days later have significant intrinsic atrophy of the hand. The ulnar atrophy speaks to a chronic issue that clearly preceded the August 5, 2011 incident. The atrophy develops over months and was likely a result of chronic ulnar nerve entrapment that may have begun in the patient through (sic) in

March of 2011. The bilateral neurologic symptoms are related to the chronic stenosis of the C5-6 level. The left sided complaints are related to the ulnar nerve entrapment and the left sided symptoms and the left sided degenerative foraminal stenosis of C6-7 and C7-T1. None of these conditions are work related." *Id.*

On January 8, 2014, Petitioner submitted to an evaluation with Dr. Butler at Respondent's request. RX2; RX4 (Dep. Ex. 3). After reviewing noting his prior review of Petitioner's treating medical records, taking a history from Petitioner and performing a physical examination, Dr. Butler rendered opinions regarding the relatedness, if any, of Petitioner's physical condition with his alleged accident at work on August 4, 2011. *Id.*

Dr. Butler diagnosed Petitioner with cervical spinal stenosis and ulnar neuropathy on the left as well as some possible ulnar neuropathy on the right. *Id.* He maintained his opinion that Petitioner's conditions were wholly unrelated to any accident at work. *Id.*

Continued Medical Treatment

Petitioner underwent another EMG/NCV study on March 25, 2014. PX8. Dr. Santwani noted that, when compared to the January 15, 2013 study, Petitioner's "median neuropathies appear to have progressed and the right ulnar sensory findings are new." *Id.*

Dr. Brayton recommended surgical intervention. PX9, PX12. On July 18, 2014, Dr. Brayton performed a right-sided carpal tunnel release with concurrent Guyon's canal decompression. *Id.*

Second Section 12 Examination – Dr. Butler

On January 8, 2015, Petitioner submitted to a second evaluation with Dr. Butler at Respondent's request. RX3; RX4 (Dep. Ex. 4). After reviewing noting his prior review of Petitioner's treating medical records and prior medical evaluation, as well as taking additional history and reviewing additional medical records, Dr. Butler rendered opinions regarding the relatedness, if any, of Petitioner's physical condition with his alleged accident at work on August 4, 2011. *Id.*

Dr. Butler updated Petitioner's diagnoses to ulnar neuropathy of both upper extremities and bilateral carpal tunnel syndrome. *Id.* He maintained his opinion that Petitioner's conditions were wholly unrelated to any accident at work. *Id.*

Continued Medical Treatment

Dr. Brayton later performed a left sided carpal tunnel release with concurrent Guyon's canal decompression on March 31, 2015. PX9, PX12. Dr. Brayton performed a final surgery on April 14, 2015 to decompress and transpose the ulnar nerve at the right elbow. *Id.* Dr. Brayton discharged Petitioner from care on May 14, 2015 with instructions to continue with a home exercise program. *Id.* Petitioner testified that he has had no further medical care and that he continues to work for Respondent.

Deposition Testimony – Dr. Brayton

On October 15, 2015, Dr. Brayton provided testimony at an evidence deposition taken by agreement of the parties. PX13. Dr. Brayton testified that he is board certified neurosurgeon. *Id.*, at 5-6. Dr. Brayton testified

generally about the medical treatment that he rendered to Petitioner and the relatedness, if any, of Petitioner's physical condition with an accident at work on August 4, 2011. See generally *Id.*

Dr. Brayton opined that there was a causal connection between the accident of August 4, 2011 and the need for surgery to the cervical spine. *Id.*, at 19. He testified that Petitioner had a pre-existing spondylosis of the cervical spine, but the injury caused severe nerve root compression. *Id.*

Dr. Brayton also opined that there was a causal connection between Petitioner's left ulnar nerve entrapment and the accident. *Id.*, at 19-21. Specifically, he testified that he was aware that there was some atrophy and paresis prior to August 4, 2011, but he opined that the accident caused these conditions to progress dramatically following the accident. *Id.* Dr. Brayton opined that the right sided symptoms were causally related to the accident for the same reasons as the left side. *Id.*, at 21.

Dr. Brayton explained that Petitioner's EMG findings were consistent with an acute progressive denervation which suggested that any pre-existing condition was made much worse by the accident. *Id.*, at 22.

On cross examination, Dr. Brayton acknowledged that Petitioner was previously a high level competitive wrestler who continued to be active with conditioning, weight lifting and wrestling. *Id.*, at 24. He testified that Petitioner's left ulnar nerve entrapment and deep scar tissue could be attributable to the accident of August 4, 2011 or be consistent with a chronic condition found in a competitive wrestler or weightlifter. *Id.*, at 26. However, he added that he could not definitively determine the cause of the deep scar tissue just by looking at it in surgery. *Id.*, at 27. Ultimately, Dr. Brayton testified that Petitioner's ulnar nerve pathology was not solely a chronic ongoing pathologic condition. *Id.*, at 29.

Deposition Testimony – Dr. Butler

On January 6, 2016, Dr. Butler provided testimony at an evidence deposition taken by agreement of the parties. RX4. Dr. Butler testified that he is board certified in orthopedics and independent medical examinations, and specializes in orthopedic spine surgery. *Id.*, at 5. He estimated that he performs 250 spinal surgeries per year. *Id.*, at 6.

Dr. Butler maintained the opinions contained in his three reports that Petitioner's cervical spine and bilateral upper extremity conditions were not causally related to the August 4, 2011 incident in question. *Id.*, at 14. In support of his determination, Dr. Butler cited to: (i) Petitioner's pre-existing symptomatology; (ii) abnormal findings of the cervical spine from the June 2011 evaluation with Dr. Buss; and (iii) the abnormal findings of the ulnar nerve following the August 4, 2011 incident, which are chronic and long-standing, and reflect months, if not years, of ulnar nerve compression. *Id.*, at 14. Rather than the result of trauma, Dr. Butler explained Petitioner's conditions were attributable to degenerative changes, exacerbated by Petitioner's outside activities:

> ... it's fairly well known that heavy weightlifting can lead to degenerative issues of the cervical spine and also degenerative changes in the shoulders, elbow, wrists.

Id., at 23.

Dr. Butler's testimony and reports further explain that, whereas Petitioner's alleged accident date was August 4, 2011, the medical records he reviewed reflect that Petitioner had "rather extensive" complaints as of June 14, 2011. *Id.*, at 7. He noted that the treating records of Dr. Swartz of September 1, 2011 from Midwest

Orthopaedic Institute also demonstrated Petitioner "had significant atrophy of the intrinsic muscles of the left hand and even an extension lag of the fourth and fifth fingers indicating that he was developing somewhat of a papal sign, which consists of a long-term compression and atrophy of the ulnar nerve". *Id.*, at 10. Dr. Butler described these as "end stage findings" and the function of the hand was unlikely to improve even with surgery. *Id.*, at 17. According to Dr. Butler, atrophy of the hand muscles takes quite some time to develop, unless there was a stab would or an acute laceration of the ulnar nerve – which was not present in this case. *Id.*, at 15.

Dr. Butler reviewed the operative report for the left elbow surgery performed by Dr. Brayton, and commented that the constricting band compressing the ulnar nerve:

> ... is something that based on chronic, repetitive stress of the upper extremity, from his wrestling, his weightlifting, activities of daily living, this band developed and led to severe compression and damage to his ulnar nerve.

Id., at 22.

Per Dr. Butler, the bilateral neurologic symptoms were related to the chronic stenosis at C5-6, and the left sided complaints were related to the ulnar nerve entrapment and the left-sided degenerative foraminal stenosis of C6-7 and C7-T1. *Id.*, at 14; RX1.

With regard to Petitioner's right upper extremity, Dr. Butler further specified that EMG studies, performed on January 15, 2013 and March 25, 2014, revealed a progressive deterioration of function of the peripheral nerves involving the median and ulnar nerve at the right wrist. *Id.*, at 24. The median neuropathy is not traumatically induced – these are related to underlying degenerative conditions not to a trauma. Moreover, such a progressive worsening of function could not be attributed to a traumatic incident three years prior, in Dr. Butler's opinion. *Id.*, at 24; RX3.

Additional Information

Regarding his current condition, Petitioner testified that is "beat up" and he has to make adjustments in his daily activities. He also testified that he continues to have pain in his neck, elbows and hands with good days and bad days. Petitioner testified that he has had a lifestyle change including how he dresses. He also experiences shooting pains in his neck radiating into his shoulders that can be bad or not so bad. Petitioner also experiences headaches and has difficulty sleeping. He explained that he has lost 90% of the grip in his hands and he drops things. Petitioner acknowledged that he was a college wrestler, but explained that he only wrestled for eight years. He continues to lift weights, but no longer uses free weights to maintain his shape and only uses machines now.

Petitioner acknowledged that he had prior workers' compensation claims or work-related injuries beginning on April 1, 1989, in an incident in which he fell through the second floor of a lumber-yard warehouse. RX6. The injuries for which Petitioner received workers' compensation recoveries included the following:

(i) April 1, 1989 (90 WC 38050; 20% right arm; 40% right leg);
(ii) June 28, 1991 (92 WC 48760; 20% right arm; 25% left leg; 25% right leg);
(iii) June 6, 1997 (97 WC 36796; 35% left arm; 5% left hand; 35% left leg; 24% 8(d)2);
(iv) April 10, 2002 (03 WC 17403; $20,000.00 compromise);
(v) January 20, 2004 (06 WC 31114; $1,000.00 compromise).

ISSUES AND CONCLUSIONS

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

In support of the Arbitrator's decision relating to Issues (A) and (O), whether Petitioner and Respondent were operating under, and subject to the jurisdiction of, the Illinois Workers' Compensation Act, the Arbitrator finds the following:

The threshold issue in this case is whether Petitioner's alleged accident of August 4, 2011 occurred under the jurisdiction of the Illinois Workers' Compensation Act (Act). Without admitting that Illinois has jurisdiction over the claim, Respondent stipulated that an employer-employee relationship existed between the parties on August 4, 2011. Petitioner stipulated that jurisdiction over the alleged August 4, 2011 incident does not exist based on Petitioner's contract for hire, which was made in Minnesota, or the situs of Petitioner's injury, Iowa. Rather, Petitioner alleges that Illinois has jurisdiction over his claim under the "principally localized" theory delineated in the Act.

Specifically, Section 1(b)2 of the IWCA states:

> Every person in the service of another under any contract of hire, express or implied, oral or written, including persons whose employment is outside of the State of Illinois where the contract of hire is made within the State of Illinois, persons whose employment results in fatal or non-fatal injuries within the State of Illinois where the contract of hire is made outside of the State of Illinois, and persons whose employment is principally localized within the State of Illinois, regardless of the place of the accident or the place where the contract of hire was made, and including aliens, and minors who, for the purpose of this Act are considered the same and have the same power to contract, receive payments and give quittances therefor, as adult employees.

820 ILCS 305/1(b)2 (LEXIS 2011). The phrase "principally localized" was first addressed in *Patton v. Industrial Commission*. 147 Ill. App. 3d 738 (5th Dist. 1986). In *Patton*, the Appellate Court noted the concession by Petitioner that jurisdiction did not arise from the contract for hire or situs of the injury, both in Missouri. *Id.*, at 741. The Court also analyzed the legislative intent behind drafting Section 1(b)2 of the Act. *Id.*, at 741-745.

Ultimately, the Court found that the claimant had failed to establish jurisdiction under the principally localized prong of Section 1(b)2 of the Act noting that, while the "quantity of time an employee spends in a single locale may be a factor in the determination of principal localization of employment, it is not controlling." *Patton*, 147 Ill. App. 3d at 745. The facility from which the claimant received assignments, to and from where he drove his over-the-road truck and from where he received his paychecks was located in Missouri. *Id.*, at 745-746. While the claimant "spent a good deal of his time making deliveries in Illinois, this activity still constituted less than half of his total mileage in the employ of the Respondent[, and a]lthough [claimant] is domiciled in Illinois, that, standing alone, is not sufficient to confer jurisdiction upon the Commission." *Id.*, at 746.

Petitioner makes the same concessions as the claimant in *Patton*. Specifically, that jurisdiction cannot be established due to the contract for hire or the location of the alleged accident, which occurred in Minnesota and Iowa, respectively. Similar to the facts in *Patton*, the evidence in this case does not establish that Petitioner's employment is principally localized within Illinois sufficient to establish proper jurisdiction as claimed.

The question of principal localization of employment was also addressed more recently in *Cowger v. Industrial Commission*, a case involving a truck driver who lived in Illinois and was injured in Texas. 313 Ill. App. 3d 364 (5th Dist. 2000). The Appellate Court affirmed the Commission's denial of jurisdiction in Illinois determining that a claimant's employment is "principally localized" in a state if (1) the "employer has a place of business in this or such other State and he regularly works at or from such place of business, or (2) if clause (1) foregoing is not applicable, he is domiciled and spends a substantial part of his working time in the service of his employer in this or such other State." *Id.*, at 372. The *Cowger* Court further specified that this "focuses first, and foremost, upon the situs where the employment relationship is centered,' and the alternative test involving domicile and working time is not to be considered unless the situs of the relationship cannot be determined." *Id.*, at 372-373 (internal citations omitted). "The factors relevant to the determination of the situs of the employment relationship include: '(1) where the employment relationship is centered, i.e., the center from which the employee works; (2) the source of remuneration to the employee; (3) where the employment contract was formed; (4) the existence of a facility from which the employee received his assignments and is otherwise controlled; and (5) the understanding that the employee will return to that facility after the out-of-State assignment is complete.'" *Id.*, at 372 (citing *Montgomery Tank Lines v. Industrial Commission*, 263 Ill. App. 3d 218, 222 (1st Dist. 1994)).

Moreover, certain jobs, including those in sales, are transitory in nature. *Id.*, at 374. The claimants in *Cowger* and *Patton* were both over-the-road truck drivers, which "constitute a unique class of employees whose activity, by its very nature, is transient. The fact that a truck driver may spend a significant amount of time in one State does not detract from the essentially transitory nature of the activity in which he engages." *Id.* (citing *Patton*, 147 Ill. App. 3d at 745). Similarly, citing *Larson*, the Appellate Court noted that "[i]n some kinds of employment, *like* trucking, flying, *selling*, or construction work, the employee may be constantly coming and going without spending any longer sustained periods in the local state than anywhere else; but a status rooted in the local state by the original creation of the employment relation there, is not lost merely on the strength of the relative amount of time spent in the local state as against foreign states. An employee loses this status only when his or her regular employment becomes centralized and fixed so clearly in another state that any return to the original state would itself be only casual, incidental and temporary by comparison. This transference will never happen as long as the employee's presence in any state, even including the original state, is by the nature of the employment brief and transitory." *Id.*, at 374 (citing 9 A. Larson & L. Larson, Workers' Compensation Law § 87.42(a), (b)(1998) (*emphasis* added).

The fact that Petitioner did not have to go to the office in Minnesota regularly after he was hired there does not confer jurisdiction in Illinois merely because the relative amount of time spent by Petitioner in Minnesota was minimal as compared to other states. While the evidence establishes that Petitioner did not have to work from Minnesota or return to Minnesota after his sales work was completed in any state, the evidence equally establishes that the employment contract was formed in Minnesota, Petitioner's paychecks were sent from Minnesota and Petitioner received his territorial assignments from Respondent's Minnesota facility when he was hired and at all times thereafter.

Based on the foregoing, the Arbitrator finds that Petitioner's employment is not principally localized in Illinois because the situs of the employment relationship is in Minnesota and, consequently, jurisdiction is not proper in Illinois. Notwithstanding, the evidence also establishes that Petitioner's employment is not principally localized in Illinois because, while he is domiciled in Illinois, he does not spend a substantial part of his working time in Respondent's service in Illinois.

Petitioner lived in Illinois at the time of his alleged accident. He also performed some of his work for Respondent from his home office in Illinois. However, Petitioner estimated that he was in his home office 30% of the week ordering materials and promotional materials, processing paperwork and taking specifications on window drawings and turning those into e-quotes. He also estimated that only 25-30% percent of his work-related expenses, for which Respondent reimbursed him or allowed him to use a company credit card, were generated in Illinois. Petitioner testified that the remainder of his work was dedicated to traveling in a car to states outside of Illinois in a car provided by Respondent with Minnesota plates. Respondent also provided Petitioner with a cell phone with a Minnesota area code for business use. Petitioner explained that only 25-30% of the miles that he traveled were in Illinois. Petitioner's paychecks, company car, company cell phone, travel expense reimbursements and sales materials all came from Respondent's office in Minnesota. Respondent's Minnesota office also assigned him to the territories in which he was to perform his sales duties.

Petitioner's activities in Illinois constituted less than half of his responsibilities for Respondent with his territorial assignments, resources and remuneration coming from Respondent's Minnesota facility. Petitioner's work in Illinois is only casual, incidental and temporary by comparison to his time spent working outside of Illinois. Based on the foregoing, the Arbitrator finds that Petitioner's employment is not principally localized in Illinois because he does not spend a substantial part of his working time in Respondent's service in Illinois and, consequently, jurisdiction is not proper in Illinois. Thus, all remaining issues are rendered moot and Petitioner's claim for benefits is denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Earby Brewer,
Petitioner,
vs.

NO: 12WC 18568

KC Builders and the Illinois State Treasurer as Ex-officio Custodian of the Injured Workers' Benefit Fund,
Respondent.

17IWCC0173

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 25, 2016, is hereby affirmed and adopted.

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

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

DATED: MAR 2 3 2017
MJB/bm
o-3/7/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BREWER, EARBY
Employee/Petitioner

Case# **12WC018568**

KC BUILDERS AND THE ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

17IWCC0173

On 4/25/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.35% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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

0000 KC BUILDERS
3 PLAINVIEW CT
BOLINGBROOK, IL 60440

5782 ASSISTANT ATTORNEY GENERAL
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CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Earby Brewer
Employee/Petitioner

v.

Case # 12 WC 18568

Consolidated cases:

17IWCC0173

KC Builders and the Illinois State Treasurer, as ex-officio custodian of the 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 **Carolyn Doherty**, Arbitrator of the Commission, in the city of **New Lenox**, on **March 2, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☒ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☒ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☒ What was Petitioner's age at the time of the accident?
I. ☒ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 20, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent.

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

No further findings were made.

ORDER

Based on the findings of no employment relationship and no 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.

Carolyn M. Doherty

Signature of Arbitrator

4/21/16
Date

ICArbDec p. 2

APR 25 2016

FINDINGS OF FACT

This action was pursued under the Workers' Compensation Act by Earby Brewer (hereinafter "Petitioner") and sought relief from the Respondent-Employer, KC Builders, (hereinafter "Respondent-Employer") and the Injured Workers' Benefit Fund (hereinafter "IWBF"). ARB EX 1. At trial, Petitioner was represented by counsel, Mr. Patrick Achebe represented KC Builders, and counsel from the Attorney General's Office represented the Illinois Workers' Benefit Fund. All issues were in dispute at trial. ARB EX 1.

Petitioner and Mr. Achebe both testified that they previously worked together at another company performing home preservation to foreclosed bank owned properties. Petitioner testified that late in 2011 Mr. Achebe wanted to start a new company, KC Builders, performing essentially the same duties and asked Petitioner to work for him. Petitioner agreed. Petitioner testified that he was told that he needed to use his own insured vehicle to drive to the job sites. Petitioner's job duties for KC Builders included performing pump outs, board ups, electrical work, lawn work and general home preservation work. Petitioner specifically testified that KC Builders was a home preservation company that performed various repairs to foreclosed properties owned by banks. (TX 9).

Petitioner testified that he was told Mr. Achebe would email or fax the job site addresses to Petitioner along with a work order and instructions on the work to be performed at the job site. Petitioner was free to accept or reject any job offer sent to him. (TX 73). Petitioner was free to set his own work schedule, as long as he completed the jobs he accepted by the deadline outlined in the job order. (TX 43). Petitioner did not wear a uniform. (TX 31). Petitioner did not punch in a time clock. (TX 45). Petitioner did not have to report to Mr. Achebe or anyone from KC Builders each day. Petitioner was free to work for others during this period. Petitioner testified that he performed various job duties based upon the job orders he received. Petitioner drove his own vehicle to each job site and used his own personal tools to complete each task. (TX 11). Petitioner would often also pay for materials to complete jobs. (TX 42). KC Builders reimbursed Petitioner for the materials purchased. KC Builders did not withdraw any taxes from Petitioner's paycheck. (TX 50). Petitioner reached out to Mr. Achebe to get information to fill out his 1099 tax return form. (TX 72).

Petitioner testified that they agreed on an average salary of $650 per week although the pay would vary depending on the assigned job. Petitioner was paid 60% of the job fee with 40% of the job fee going back to KC Builders. (TX 44). Under this fee structure, Petitioner earned an average of $650.00 a week. (TX 12). Petitioner alleges to work on average 65 to 70 hours a week. (TX 46).

On cross exam, Petitioner testified that Mr. Achebe asked Petitioner to join his new company. (TX 80). Petitioner did not fill out an application. He testified that he loaned Mr. Achebe $400 to start the company which Mr. Achebe paid back to Petitioner. Petitioner testified that he was told he had to have his own insured vehicle. He testified that both he and Mr. Achebe paid for the job materials and when they received payment for the job reimbursement for materials was "figured out." Petitioner agreed he set his own work schedule with only the job deadline in mind. Although he never refused a job, he was free to tell Mr. Achebe that he needed time away to take care of personal business. Petitioner testified that no deductions were taken from his paycheck which was a personal check from Mr. Achebe. PX 5 contains a few checks written to Petitioner by KC Builders, Inc.

Mr. Achebe also testified at trial. In his mind, the company was started by two friends, he and Mr. Brewer. All agreements were verbal and no application was completed. He testified that initially, Petitioner would meet Mr. Achebe to pick up the job orders in person but that later in 2012 Mr. Achebe was able to fax or email the orders

to Petitioner. With regard to the work orders, Mr. Achebe testified that KC Builders would receive work orders from a third party, ASON. ASON would send the work orders to Mr. Achebe who would then forward the orders to Petitioner. (TX 85). These documents contained all relevant information to complete the job, including the address of the work site, the task to be completed and the job's deadline. (TX 85). He testified that Petitioner was paid based upon the jobs he performed and was paid a different rate depending on the job.

Petitioner testified that on April 20, 2012 he was 59 years old, married, with no dependent children. Petitioner testified that on April 20, 2012, he was working at an assigned job site somewhere in Beach Park. He was there to perform a pump out. (TX 14). Petitioner testified that he was pumping out water from the basement when he slipped on the last step in the basement and fell on his left knee. (TX 15). He was carrying his tools and the sump pump at the time. He stated he fell backwards, dropped the sump pump and the pump fell on his knee. *Id.* The accident was not witnessed.

Petitioner testified that he used his personal cell phone to call Mr. Achebe about the accident around 2pm. (TX 17). Petitioner asked Mr. Achebe to come to the work site and pick him up. Mr. Achebe told Petitioner he would call him back. In the interim, Petitioner called his nephew to pick him up and drive him home. (TX 18-20). Petitioner called Mr. Achebe back and told him he was going either to the doctor or home. Mr. Achebe testified that Petitioner never called him on April 20, 2012 from the job site. If Petitioner had called him, Mr. Achebe would have driven over the work site to help him out. (TX 82). He testified that the first time Petitioner talked to Mr. Achebe after his April 2012 accident was two months later, in June. (TX 88-89).

Petitioner testified that he felt pain in his left knee and decided to go to the emergency room the next day. (TX 21). The ER record from Hines VA hospital is dated 4/25/12, 5 days after the accident. The history indicates "59 yo male presents after slipping on stairs 5 days ago and sustaining injury to L knee. HE was walking downstairs, slipped backwards, and during the fall the sump pump he was carrying fell on the superior aspect of his L knee." PX 3, p. 282. The Arbitrator notes that the accident date reported on 4/25/12 was five days earlier on 4/20/12. The ER records do no indicate a fall at work. An x-ray of the left knee on April 25, 2012 revealed osteroarthritis with patellofemoral compartment predominance, moderate suprapatellar effusion and mild prepatellar edema. (PX 3). In each of the histories contained in the VA Hines records, Petitioner reports a consistent history of a fall on stairs and injury to the left knee. These records do not mention that the fall took place while working or at a work site. PX 3. One record specifically mentions that Petitioner fell "in his basement." PX 3, p. 250. Petitioner was eventually diagnosed with a left quadriceps tear for which he underwent surgery on 5/14/12. PX 3.

Following his surgery, Petitioner underwent a course of physical therapy. He was prescribed a leg brace and finished up treatment for his left leg injury on March 18, 2013. (TX 24.) Petitioner testified that he was unable to put any pressure on his knee for four weeks. (TX 32). However, he was not given any work restrictions or an off work slip.

Petitioner did not return to work at KC Builders following his April 12, 2012 injury. (TX 25). He did receive unemployment benefits. Petitioner testified that he contacted Mr. Achebe after his surgery. He testified that he asked for a 1099 form but never received one from Mr. Achebe. Petitioner currently works for the Harvey Park District as a supervisor over maintenance and events. (TX 26). This position entails overseeing the cleaning and maintenance of four park buildings. Petitioner does not perform physical labor in this position. Petitioner experiences occasional pain in his left leg. (TX 27). His leg also occasionally swells up. Getting up out of a chair and walking upstairs also causes him left leg pain. Petitioner does not take any prescription pain medication, but does take ibuprofen occasionally.

CONCLUSIONS OF LAW

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

A. Was Respondent operating under and subject to the Workers' Compensation Act?

The Arbitrator finds that the evidence establishes that the Respondent was operating under and subject to the Illinois Workers Compensation Act. Section 3(1) of the Act provides automatic coverage applies to, "enterprises or businesses which are declared to be extra hazardous, namely, the erection, maintaining, removing, remodeling, altering or demolishing of any structure..." 820 Ill. Comp. Stat. Ann. 305/3. Petitioner testified that he performed various tasks in the area of property preservation, including, maintaining residences and electrical work.

B. Was there an employee-employer relationship?

The Arbitrator finds that based upon a preponderance of the credible evidence admitted at trial, the record does not support a finding of employee-employer relationship between Petitioner and KC Builders. In so finding, the Arbitrator notes that the evidence elicited at trial regarding the parties' relationship is too tenuous on which to characterize it as employee-employer for purposes of the Act. The Arbitrator notes that Petitioner was given job site information by Mr. Achebe, that he received two checks from KC Builders, and that on occasion he may have received reimbursement for materials purchased. The Arbitrator finds these facts outweighed by the casual nature of the business formation, Petitioner's use of his own tools and his own insured vehicle and Petitioner's total control over his work day, schedule, and manner of work, including his right to refuse the job. Petitioner testified that his work was not exclusive and that he could work for other parties if he wished. Petitioner did not report to Mr. Achebe each day, did not punch in or out, but rather completed each work order within the confines of the instructions issued by the client. Petitioner testified that the work order issued by a third party client dictated the location of the work site, the task to be completed, the deadline for completion and the pay for each job. Petitioner testified that no money was withheld from his pay for taxes. Lastly, the Arbitrator notes that the evidence surrounding how, how much and when Petitioner was paid is vague at best.

Based on the totality of the evidence at trial, the Arbitrator finds no employee-employer relationship existed for purposes of the Act. No benefits are awarded.

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

Because the Arbitrator finds there was no employee-employer relationship, the Petitioner's injury to his left leg on April 20, 2012 did not arise out of and in the course of Petitioner's employment. Further, the Arbitrator notes that even if an employment relationship existed, the record does not support a finding of a work related accident on April 20, 2012. In so finding, the Arbitrator notes that Petitioner's testimony regarding the location of the accident is not supported by any of the treating medical records documenting the history of injury. A review of those records indicates a fall down stairs occurring at home.

Based on the foregoing findings on the issue of employment and accident, the remaining issues are rendered moot and no further findings are made. No benefits are awarded.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Taylor,
Petitioner,

vs. NO: 12 WC 34332

State of Illinois/Vienna Correctional Center,
Respondent,

17IWCC0180

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, 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 8, 2016, is hereby affirmed and adopted.

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

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

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

DATED: MAR 24 2017
o030917
DLG/mw
045

David L. Gore

Stephen Mathis

Kevin W. Lamborn

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DAVID TAYLOR
Employee/Petitioner

v.

STATE OF ILLINOIS/VIENNA CORRECTIONAL CENTER
Employer/Respondent

Case # **12** WC **34332**

Consolidated cases: _____

17IWCC0180

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

DISPUTED ISSUES

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

17IWCC0180

FINDINGS

On **September 12, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$64,644.00**; the average weekly wage was **$$1,243.15.**.

On the date of accident, Petitioner was **56** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$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 **any and all medical payments** under Section 8(j) of the Act.

ORDER

Petitioner failed to prove by a preponderance of the evidence that he sustained an accident that arose out of and in the course of his employment on September 12, 2012. 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

February 3, 2016
Date

FEB 8 - 2016

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

17IWCC0180

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DAVID TAYLOR
Employee/Petitioner

v. Case #: 12 WC 34332

STATE OF ILLINOIS/VIENNA CORRECTIONAL CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On his date of accident Petitioner was 56 years old, married, with no dependents. He was employed by the State of Illinois Department of Corrections, Vienna Correctional Center as a correctional sergeant. He retired on November 30, 2012. As a correctional sergeant he supervised employees and inmates, performed searches, took care of the points of entry to the institution, and interacted with inmates and other staff daily. He was around inmates and other guards who he knew to have MRSA, and shared common areas with guards who he knew to have or previously have MRSA. His interaction with inmates included unit or wing shakedowns, in which he would go through the inmate's personal effects, clothing, et cetera. He also would escort inmates to segregation and search inmates. When transfers came into the facility he would take the restraints off and put them back on. All of these duties required him to physically come into contact with the inmates or their personal effects.

Petitioner testified that he worked 40 plus hours a week, including at least one to four overtime shifts per week. His assigned shift was 11 to 7, but he worked other shifts as well. Depending upon the shift he was on, his contact with inmates would become more or less.

Petitioner testified he was aware there were inmates at the facility that had MRSA. It was originally thought they had spider bites, but turned out to be MRSA. He testified this was common knowledge and was talked about among the staff. He worked around the health care unit quite a bit and there was talk regarding the spider bites. Petitioner was aware there were other guards he worked with, three in particular, that to his knowledge and understanding had contracted MRSA. He worked around some of them at the time of his accident.

Petitioner testified he became aware he had contracted MRSA on September 12, 2012, when he sought medical treatment at Alexander Family Practice for a place on the back of his scalp that never got better. Lab results confirmed MRSA. At that point he completed a worker's

compensation Notice of Injury form. Medical treatment consisted of oral medication, a topical salve, and lancing of the wound. He went to the doctor twice for treatment. He did not miss any work. During the period of time he had MRSA he was unable to have contact with his grandson, who he and his wife kept on a regular basis. He did his own laundry and stayed on his side of the bed so as to avoid his wife having contact with the infection.

On cross-examination Petitioner testified that at the time of the accident he was not aware of any family members or personal contacts outside of the facility who had MRSA. He did not recall visiting his doctor within two to four weeks prior to September 12, 2012. He testified he did not work out at a gym.

Petitioner testified that around the time of this accident he did not have personal knowledge of coming into contact with an inmate he knew to have MRSA. Under HIPAA laws, he was not supposed to know who was ill. He testified he wore gloves as much as possible. With regard to the three guards named during direct examination, Petitioner could not say whether any of them actually had an active case of MRSA around the time of his accident. He was not aware of the timeframe in which any of them had MRSA. He testified he shared common areas with them but did not have direct touching or physical contact with any of them. He was not aware of the incubation period for MRSA.

Petitioner testified he worked in the armory quite a bit in September 2012. This is an entry point for inmates, and the restraints came in and out of the area a lot. It was also a point of exit for inmates who had a medical run to the hospital. The ambulance would come through and the restraints would have to be handed out and then back to him.

Petitioner testified the armory is where inmates would come in and go out, and that's where the majority of restraints were kept and issued. Petitioner had to personally handle the restraints and keep track of them. He was in contact with restraints for new inmates that had just come into the facility, who had not yet been evaluated by the health care facility. He did not actually take the restraints on and off, but did handle the restraints.

Petitioner sought medical treatment at Alexander Family Practice and was seen by NP Loni Banks. PX1. On September 12, 2012, he presented with complaint of skin wound on his scalp which was painful and oozing. Examination revealed a 2 centimeter weeping wound which was warm, with carbuncles seen. Assessment was skin abscess. Treatment consisted of wound culture, wound debridement, and incision of soft tissue abscess. He was prescribed medication and told to follow up in one week. Petitioner returned to NP Banks on September 19, 2012. He reported the wound was no longer painful or oozing. Examination revealed the abscess was not warm or weeping. Assessment at that time was skin abscess and Methicillin resistant staphylococcus aureus infection (MRSA). He was to continue medication, wash all sheets and pillow cases and use Lysol or Clorox wipes on all surfaces. PX1.

On October 8, 2013, a letter was sent to Petitioner's counsel by Michelle Baggott, Business Manager at Illinois Department of Corrections, in response to a subpoena received. The letter states, in part: "Vienna Correctional Center is in receipt of your subpoena in the above referenced case for the number of reported MRSA incidents at Vienna Correctional Center from

9/12/2008 through present. Please be advised that as of the date of this letter, Vienna Correctional Center has had 244 reported cases of MRSA for the requested time frame." PX2.

On September 17, 2012, Petitioner completed an Employee's Notice of Injury, listing his date of accident as September 12, 2012. With regard to what duty he was performing at the time of the injury, Petitioner wrote: "This illness was a result of contact with large numbers of inmates—handling restraints—escorting inmates in restraints-contact with common quarters used by inmates—door handles, clothing, etc." With regard to how the injury occurred, Petitioner wrote: "This illness occurred as a result of direct contact with inmate restraints in the armory—actual cuffing and escorting inmates—handling common areas such as door handles used by inmates, as well as personal clothing and other items of inmates." PX3, RX1.

The Initial Workers' Compensation Medical Report completed by NP Banks confirms the history of abscess to the scalp and the diagnosis of MRSA. Prognosis was full recovery. The Report included lab results from Quest Diagnostics, Inc., showing MRSA from the culture taken from the scalp abscess. PX3, RX2.

A Supervisor's Report of Injury was completed by John Cox on September 17, 2012. The job description portion indicates Petitioner was "responsible for control and custody of incarcerated individuals". Regarding description of accident, Mr. Cox stated Petitioner "advised that he had a culture test conducted of an area on the back of his head. Test results confirmed the area was MRSA." Regarding cause of accident, Mr. Cox stated it was "unknown at this point what caused area on the back of the head". Mr. Cox also completed a "Demands of the Job" form. PX3, RX3, RX5.

Admitted into evidence were two color photographs of Petitioner's scalp wound, which depict an area with some blood and yellowish matter. PX4.

The Summary of Disability form indicates Petitioner missed no time from work as a result of his reported accident. It further lists Petitioner's earnings from September 1, 2011, through August 31, 2012, as $64,644.00, 12 months at $5387.00 per month. PX4.

MRSA Log Sheets were admitted into evidence, which cover the period of May 30, 2012, through November 21, 2012. The Arbitrator notes there was no facility name listed on any of the log sheets; however, in that there was no objection to the admission of the logs, they are presumed to be from the Vienna Correctional Center. The log sheets list, among other things, an onset date and culture result for each person listed. The culture results include not only those positive for MRSA, but also other results including Staph, Diptheroids, Morganella, Proteus Mirabillis, Gram Positive Cocci, Strep Group B, Pseudomomas, and No Growth result. There were six cases of confirmed MRSA in June 2012, one in July, six in August, two in September, two in October, and one in November. Petitioner's date of accident is September 12, 2012. In the 30 days prior to the date of accident, there were three confirmed cases of MRSA, on August 12, 22, and 26. There were also confirmed cases on September 13 and 18. None of the individuals were admitted into the facility in August or September 2012. PX6.

CONCLUSIONS OF LAW

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

In support of the Arbitrator's decision relating to issue (C), whether Petitioner sustained an accidental injury that arose out of in the course of her employment, the Arbitrator finds the following:

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he suffered a disabling injury arising out of and in the course of his employment. 802 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013 (1st Dist. 2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d, 52, 57 (1989). Liability cannot be premised upon imagination, speculation or conjecture, but must arise from the facts established by a preponderance of the evidence. *Illinois Bell Tel. Co. v. Industrial Comm'n*, 265 Ill. App. 3d 681, 685 (1st Dist. 1994).

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he sustained an accidental injury on September 12, 2012, that arose out of and in the course of his employment with Respondent. In so concluding, the Arbitrator finds significant the absence of any history of exposure to MRSA given by Petitioner to his treating physician's assistant, as well as the absence of any causation opinion by the treating PA. Further, the Arbitrator finds significant Petitioner did not testify that he had specific actual contact with MRSA at or through his employment with Respondent. He presented no evidence that he came into contact with anyone infected with MRSA at work at any time near the alleged date of accident. Although other guards were mentioned in testimony to have allegedly contracted MRSA, Petitioner presented no evidence that those cases were temporally close to his alleged date of accident. Further, although there were three documented cases of MRSA in the thirty days prior to his alleged date of accident, Petitioner presented no evidence that he came into contact with any of the individuals infected. A mere possibility of exposure does not satisfy the burden of proof.

Based upon the foregoing and the record in its entirety, the Arbitrator concludes that Petitioner failed to prove by a preponderance of the evidence that he sustained an accidental injury on September 12, 2012. All benefits are denied. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

☒ 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

Juana Alvarado,
Petitioner,

vs.

NO: 12 WC 35472

17IWCC0154

Pure 5 Cleaners and Il. State Treasurer,
as ex-officio Injured Workers' Benefit Fund,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of nature and extent of Petitoner's permanent partial disability and wages 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 23, 2015, 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.

17IWCC0154

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: MAR 10 2017

Joshua D. Luskin

o-03/08/17
jdl/wj
68

Charles J. DeVriendt

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ALVARADO, JUANA
Employee/Petitioner

Case# **12WC035472**

PURE 5 CLEANERS AND ILLINOIS STATE TREASURER AS EX-OFFICIO OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

17IWCC0154

On 9/23/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% 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:

0247 HANNIGAN & BOTHA LTD
PATRICK CZUPRYNSKI
505 E HAWLEY ST SUITE 240
MUNDELEIN, IL 60060

0000 PURE 5 CLEANERS INC
KWANG EN LEE
9314 N MASON
MORTON GROVE, IL 60053

5199 ASSISTANT ATTORNEY GENERAL
MELISSA HINTERHAUSER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

Juana Alvarado
Employee/Petitioner

v.

Pure 5 Cleaners and Illinois State Treasurer as ex-oficio custodian of the Injured Workers' Benefit Fund
Employer/Respondent

Case # **12** WC **35472**

Consolidated cases: _____

17IWCC0154

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **Waukegan**, on August 26, 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 **Adequate notice to employer?**

FINDINGS

On **October 8, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$0.00**; the average weekly wage was **$400.00**.

On the date of accident, Petitioner was **48** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$0.00** 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, related and necessary of medical services of $32,231.08, as provided in Section 8(a) of the Illinois Workers' Compensation Act ("Act").

Respondent shall pay Petitioner permanent partial disability benefits of $286.00/week for 71.75 weeks, because the injury sustained caused 35% loss of use of the left hand, as provided in Section 8(e)(9) of the Act. Respondent shall pay Petitioner permanent partial disability benefits of $286.00/week for 5.375 weeks because the injury sustained caused 2.5% loss of use of the leg under 8(d)(12) of the Act. This equates to 77.125 weeks or $22,057.75.

Respondent shall pay Petitioner temporary total disability benefits of $286.00/week for 17 weeks for the time period of October 9, 2012, through February 4, 2013. A total TTD benefit of $4,862.00

Respondent, Pure 5 Cleaners, shall pay Petitioner $18,546.54 in penalties pursuant to 19(k) of the Act, $10,000.00 Pursuant to 19(l) of the act and $5,709.31 pursuant to Section 16 of the Act.

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was names as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund aspermitted and allowed under Section 4(d) of this Act, except for the Penalties awarded against the Respondent, Pure 5 Cleaners, under section 19(k), 19(l) or 16(a) of the 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 to the Petitioner pursuant to Section 5(b) and 4(d) of the Act. Respondent/Employer/Officer/Owner shall reimburse the injured benefit fund for any compensation obligations Respondent/Employer/Officer/Owner 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.

#01 George J. Andros
Signature of Arbitrator

Sept 21, 2015
Date

SEP 23 2015

Juana Alvarado
Employee/Petitioner

Case #: 12WC35472

v.

17IWCC0154

Pure 5 Cleaners & Illinois State Treasurer
As ex-oficio custodian of the
Injured Workers' Benefit Fund
Employer/Respondent

Arbitrator's Findings of Facts and Conclusion of Law

I. Findings of Fact

This action was pursued under the Illinois Workers' Compensation Act by Petitioner, Juana Alvarado, and sought relief from Respondent-Employer, Pure 5 Cleaners. This action also sought relief from the Injured Workers' Benefit Fund because the employer did not maintain workers' compensation insurance. (Petitioner's Exhibit "Px." 7). An arbitration was held before Arbitrator Andros on August 26, 2015. Petitioner notified the employer of the hearing by mail. The employer did not appear for at the arbitration proceedings and was not represented by an attorney. The Illinois Attorney General's Office appeared on behalf of the Illinois State Treasurer, as *ex-officio* custodian of the Injured Workers' Benefit Fund, and participated in the arbitration proceedings.

Petitioner's unrebutted testimony and evidence establish the following: Petitioner was 48 years old, unmarried, had a third grade education in Mexico, and two dependent children on the date of the work accident, October 8, 2012. Petitioner worked for Pure 5 Cleaners for ten days prior to the accident. She was referred to the employer through a friend, and interviewed with the owner, before being hired. Petitioner worked as a shirt ironer, and her job duties included placing shirts on mannequins for cleaning/pressing and also ironing shirts with an industrial electric ironing machine. Petitioner was instructed by the owner to be at work from 7:00 AM to 4:00PM Monday through Friday. Petitioner used the company's tools to complete her tasks which included an industrial electric iron and there were a total of 5 employees of the company. Petitioner testified and provided corroborative photocopies of the cash she received from the employer demonstrating she was a salaried employee earning $400.00, paid in cash, per week.

Petitioner testified that around 2:00PM she was ironing a shirt using the industrial electric iron when it inadvertently closed onto her left hand causing immediate pain. Petitioner screamed, but no one came to help her. Petitioner eventually was able to release her hand after a few moments by pressing the emergency release button. Petitioner's employer took her to an immediate care facility who declined to provide treatment, but provided a topical cream. Petitioner was then taken to Advocate Condell Emergency Room. (Px. 1 pg. 342).

At the hospital on October 8, 2012, the records reveal claimant had a left hand burn while working with a hot cleaning press, when it fell onto her left dorsal part of the hand at about 2:00 in the afternoon. (Px. 1, pg. 342). Pain in the hand on the dorsum and bases of the second through fourth digits and tingling in the palm of the hand was reported. (Id). Dr. Talerico was consulted and the wound was covered, a splint and silver sulfadiazine were prescribed, Petitioner was to see the doctor later that week. (Px. 1, pg. 344). On October 12,

2012, Petitioner followed up with the Advocate Condell Emergency Department and the report by Dr. Ryabov provides a consistent description of the work accident . (Px. 1, pg. 151). Dr. Ryabov reports complaints of left hand: pain, swelling, radiation into the left arm , and blisters with epidermal lass due to second degree burns of the left hand. (Id). After diagnostics, the doctor diagnoses claimant with cellulitis of the left hand. (Id).

On October 13, 2012, Petitioner sees Dr. Aras Tijunelis at Advocate Condell Hospital (Px. 2, pg. 6). After examination, Dr. Tijunelis diagnosed Petitioner with full thickness burn dorsal left hand of 3cm x 6cm. (Px. 2, pg. 8). The Doctor continued Silvadene and prescribed debridement and skin grafting. (Id.).

On October 19, 2012, Dr. Tijunelis performed an excisional debridement of eschar on the dorsum of the left hand measuring 8x 5cm and a split split-thickness skin graft to the left hand and fingers measuring 8cm x 5cm squared using Petitioner's left thigh as a donor cite. (Px. 2, pg. 23).

Petitioner followed up with Dr. Tijunelis post operatively on October 22, 2012 and October 26, 2012. On October 26, 2012, the doctor notes the skin graft looks good, however, the donor site was leaking; occupational therapy is to begin the following week. (Px. 2, pg. 5).

On November 2, 2012, Dr. Tijunelis sees the Petitioner and removes stiches from the skin graft, discusses problems with occupational therapy due to workers' compensation problems and requests claimant to follow up in one month. (Px. 2, pg. 24). On November 14, 2012, Petitioner presents to the emergency room due to allergic reaction to silvadene; silvadene is discontinued. (Px. 4, pg. 17-18).

On November 23, Dr. Tijunelis notes that the petitioner has yet to completely heal and notes the importance of occupational therapy as range of motion has been decreased due to scarring. (Px. 2, pg. 24).

Petitioner undergoes physical therapy from December 12, 2012 through February 4, 2013, with Chicago Hand and Orthopedic (also known as Mid America Orthopedics. (Px. 3). On February 4, 2013, the therapist noted that claimant had skin grafts to the dorsum of the left hand, proximal phalanx of the index, middle and ring fingers. (Px. 3 at 4). The therapist reports demonstrate reduced range of motion of the thumb, index, middle, ring and small fingers, with occasional soreness and reduced grip strength (Px. 3, pg. 4, 5, 11, 13, 19). Petitioner testified that she has not treated for this injury since February 4, 2013, as she was told by the doctor she was discharged from care once she completed therapy.

Petitioner testified that he did not work from October 8, 2012 through February 4, 2013 while she was treating for her left hand injury. Petitioner testified that he did not receive compensation from the employer for the period of time she was off of work nor was there any payment of medical benefits by her employer. Petitioner was told by her employer that they would not pay for any benefits for the injury.

Petitioner's current employment is packing boxes at a warehouse. Petitioner has ongoing complaints of hand weakness and difficulty in making a fist with her hand. At certain times, Petitioner feels like ants are crawling on her hand, in the area where her burns are. Further, Petitioner has numbness, sun sensitivity, and for home treatment, she applies cream over the skin graft area. Petitioner is not actively seeking medical treatment for her left hand, nor is taking ongoing prescription medication.

II. Conclusions of Law

A. Was the respondent operating under and subject to the Illinois Workers' Compensation Act?

The unrebutted evidence establishes that, Pure 5 Cleaners' business was dry cleaning services in Kildeer, Lake County, Illinois. As a part of her employment, Petitioner used electric equipment provided by the employer; an industrial iron to iron clothes. The Arbitrator finds that Pure 5 Cleaners business and activities are sufficient to subject Pure 5 Cleaners to the automatic coverage provision of Section 3(15) of the Illinois Workers' Compensation Act.

B. Was there an employer employee relationship?

The unrebutted testimony and evidence provided by the Petitioner established an employee employer relationship between Pure 5 Cleaners and Petitioner at the time of the accident. Petitioner worked for 10 days prior to the October 8, 2012, accident. Petitioner was interviewed and hired by the owner of Pure 5 Cleaners; was told by the owner she would be paid a salary of $400.00 per week; was directed by the employer as to her job duties and working hours; the tools she used while performing her job duties were provided by Pure 5 Cleaners and Petitioner was paid 535.00 in cash for her work from September 9, 2012 through approximately 2pm on October 8, 2012. The Arbitrator finds that an employee and employer relationship existed between Petitioner and Pure 5 Cleaners on October 8, 2012.

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

The evidence establishes that the October 8, 2012, accident arose out of and in the course of Petitioner's employment with Pure 5 Cleaners. Petitioner testified that on October 8, 2012, she was operating a hot iron for her employer when the hot iron inadvertently closed onto her left hand causing immediate onset of pain. This is corroborated by the medical records. The Arbitrator finds that Petitioner suffered and accident that arose out of and in the course of her employment with Pure 5 Cleaners.

D. What was the date of accident?

Based upon the testimony of the petitioner and corroborating medical records, the evidence establishes a date of accident of October 8, 2012.

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

The unrebutted evidence established timely notice of the accident to the owner of Pure 5 Cleaners on October 8, 2012. Petitioner notified her employer on the date of the accident and was driven to various medical providers by the owner of Pure 5 Cleaners. The Arbitrator finds that the petitioner proved she gave notice of this injury to the Respondent within 45 days of the October 8, 2012, accident.

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

Petitioner has ongoing complaints of hand weakness and difficulty making a fist with her hand. At certain times, Petitioner feels like ants are crawling on her hand, in the area where her burns are. Further, Petitioner has numbness, sun sensitivity, and for home treatment, she applies cream over the skin graft area. Petitioner is not actively seeking medical treatment for her left hand, nor is taking ongoing prescription medication. The Arbitrator finds that the evidence establishes that his current condition of ill-being a described above is causally related to the October 8, 2012, accident.

G. What were petitioner's earnings?

The Petitioner testified she was 10 day employee of Pure 5 Cleaners, and at the time of the accident, she was earning a salary of $400.00 per week. The Arbitrator finds the Petitioner's testimony and evidence credible and unrebutted. Therefore, the Arbitrator finds an average weekly wage of $400.00.

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

The Petitioner testified that her date of birth is September 27, 1964, the Arbitrator finds Petitioner was 48 years old on the date of the accident.

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

Petitioner testified that she was unmarried at the time of the accident. Further, Petitioner testified he has two children, who were under the age of 18 at the time of the accident. This was stipulated by the Injured Workers' Benefit Fund. The Arbitrator finds the Petitioner was married with two dependent children at the time of the October 8, 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 Petitioner testified she sought treatment for his left hand and fingers between October 8, 2012 and February 4, 2013. Petitioner testified she was transported to Advocate Condell Emergency Room by her employer on October 8, 2012, had follow visits and surgery with Dr. Tijunelis and underwent occupational therapy. On February 4, 2013, Petitioner was discharged from care after completion of occupational therapy.

Petitioner received no payment of benefits from the Respondent, Pure 5 Cleaners and was told by the owner they would not pay any benefits. Petitioner presented the following medical bills and outstanding amounts, which were admitted into evidence as Plaintiff's Exhibit 25:

Advocate Condell Medical Center - $21,059.09
Libertyville Emergency Physicians - $1,216.00
Lake County Anesthesiologists - $1,152.00
Lake County Plastic Surgery - $5,575.00
Lake County Radiology - $94.00
Midwest Diagnostic Pathology - $226.00
Chicago Hand and Orthopedic/MidAmerica Orthopedics - $2,909.00

Based upon the unrebutted evidence of the Petitioner, the Arbitrator finds that the services rendered to the Petitioner for treatment between October 8, 2012 and February 4, 2013 was medically reasonable, necessary and related to Petitioner's work accident. Hence, the Arbitrator finds that the Respondent, Pure 5 cleaners and the Injured Workers' Benefit Fund shall pay the medical bills pursuant to the fee schedule or negotiated rate, whichever is less, pursuant to the Illinois Workers' Compensation Act.

K. Is the Petitioner entitled to temporary total disability benefits?

To show entitlement to TTD benefits, the Petitioner must prove not only he did not work, but that he was unable to work due to the injury in question. *Gallentine v. Industrial Commission*, 201 Ill. App. 3d 880, 559 N.E.2d 526 (2 Dist. 1990). Ultimately, the dispositive inquiry is whether the claimant's condition has stabilized. *Interstate Scaffolding Inc. v. Illinois Workers' Compensation Commission*, 236 Ill. 2d 132, 923

N.E.2d 466 (2010). Petitioner was unable to work from October 8, 2012 through February 4, 2013 because she was treating for her work injury and her condition had yet to stabilize until her last occupational therapy treatment of February 4, 2013. The Arbitrator finds that Petitioner was temporary and totally disabled due to the work injury from October 8, 2013, through her date of last treatment with occupational therapy of February 4, 2013. Petitioner is entitled to 17 weeks of TTD benefits.

Using the TTD state minimum rate of $286, the Arbitrator finds that the Respondent shall pay the Petitioner $4,862.00 in TTD benefits.

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

Workers' compensation accidents occurring on or after September 1, 2011 are governed by Section 8.1b of the Act:

> (a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.
>
> 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 record.
>
> No single enumerated factor shall be the sole determination 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

The physical therapist, on February 4, 2013, issued an AMA 5th edition impairment rating. (Px. 3, pg. 10). Although the impairment rating is not applicable in determining the level of impairment as such rating was not prepared by a physician nor was the 6th edition of the AMA Guidelines, the rating provided by the physical therapist does provide evidence of impairment to the to the left hand and fingers.

Petitioner at age 48, suffered a work injury to her left hand, thumb, index finger, middle finger, ring finger and small finger due to second degree burns after an industrial iron closed down on her hand on October 8, 2012. Petitioner underwent a 40cm squared skin debridement and split thickness skin graft with a donor site from her left leg. Days after the skin graft, the treating doctor noted some leakage from the graft site.

Petitioner is now working in a warehouse, packing boxes for her new employer. Petitioner has ongoing complaints of hand weakness and difficulty in making a fist with her hand. At certain times, Petitioner feels like ants are crawling on her hand, in the area where her burns are. Further, Petitioner has numbness, sun sensitivity, and for home treatment, she applies cream over the skin graft area. Petitioner is not actively seeking medical treatment for his left hand, nor is taking ongoing prescription medication.

Petitioner does not speak English, received a third grade education in Mexico and showed a partial inability to articulate her testimony at hearing. However, based upon the Petitioner's credible testimony, the medical exhibits that demonstrate debridement, skin graft with an donor cite from the Petitioner's left thigh, the Arbitrator awards 35% loss of use of the left hand pursuant to 8(e)(11) and 2.5% loss of use of the leg under 8(d)(12) of the Act. (See *Zarate-Martinez v. Torres' Son & Injured Workers' Benefit Fund*, 11WC35712, IWCC0491 (Commission modified Arbitrator's award of 2% person as a whole to 2.5% loss of use of the leg due to the "specific insult to the left leg itself"). Using PPD rate of $286.00, this equates to $22,057.75.

M. Should penalties or fees imposed upon Respondent?

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

"In case where there has been any unreasonable or vexatious delay of payment... the Commission may award compensation additional to that otherwise payable under this Act equal to 50% of that amount payable at the time of such award."

Section 19(l) of the Act states, in pertinent part:

"If the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing for the delay...In case the employer...shall without good and just cause fail , neglect, refuse or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or Commission shall allow the employee compensation in the sum of $30 per day ...not to exceed $10,000.00."

Section 16 of the Act states, in pertinent part:

"Whenever the Commission shall find that the employer, his or her agent, service company or insurance carrier has been guilty of...unreasonable or vexatious delay...within the purview of the provisions of paragraph (k) of Section 19 of this act, the Commission may assess all or any part of the attorney's fees and costs against such employer and his or her insurance carrier."

Petitioner was told by the employer that they would not pay for any benefits related to her work injury of October 8, 2012 with no explanation or documentation supporting the basis for their denial. The respondent was notified via certified mail that the Petitioner was adding the injured workers' benefit fund on January 29, 2013. (Px. 8). Petitioner issued through certified mail: demands for payment of benefits, requests for hearings, or trial notices that were received by Pure 5 Cleaners or its registered agent on March 21, 2014, April 28, 2014, August 6, 2014, September 4, 2014, September 24, 2014, December 15, 2014, December 19, 2014, February 26, 2015, April 2, 2015, July 22, 2015, August 5, 2015 and August 21, 2015 demonstrating Petitioner's pursuit of payment of benefits against Pure 5 Cleaners and the Injured Workers' Benefit Fund. (Px. 9, 10, 14, 16, 17, 18, 19, 20, 21, 22, 23). Additionally, Petitioner's petition for penalties filed on August 12, 2014, was received by the employer. (Px. 15).

The employer failed to appear before the Arbitrator after receiving proper notice of hearing dates and failed provide a reasonable explanation for non-payment of benefits to the Petitioner since the work-related accident of October 8, 2012. One-thousand and fifty-three days has passed since the date of accident and no payment of benefit or an explanation has been made.

This Arbitrator finds that there has been an unreasonable and vexatious delay of payment and awards penalties in the amount of $18,546.54 in penalties pursuant to 19(k) of the Act, $10,000.00 Pursuant to 19(l) of the act and $5,709.31 pursuant to Section 16 of the Act.

N. Is Respondent due any credit?

Respondent, Pure 5 Cleaners failed to appear at hearing and no evidence was admitted or provided which demonstrates Pure 5 Cleaners is due any credit. Thus, the Arbitrator finds that the Respondent is not due any credit pursuant to the Act.

O. Was sufficient notice sent to the Respondent/Employer?

Section 7030.20 of the "Rules Governing Practice Before the Workers' Compensation Commission," establish the practice for setting a case for trial:

> ...If any party fails without good cause to appear, the Arbitrator will hear the motion for trial date ex-parte and if the Arbitrator determines the matter ready for trial will set a trial date convenient to the Arbitrator and the party that appeared. The party that appeared shall notify opposing party of the trial date.

The Respondent, Pure 5 Cleaners and the Injured Workers' Benefit Fund were given adequate notice of this matter and trial occurring on August 26, 2015.

On July 22, 2015, thirty-one days before the status call, Petitioner sent a notice of motion and request for ex-parte trial date certain, a completed request for hearing form and a letter indicating a trial date would be requested at the status call of August 21, 2015, through certified mail. (Px. 22). This notice was received by Pure 5 Cleaners on July 29, 2015. (Id).

Further, a follow up letter sent on August 5, 2015, received by Pure 5 Cleaners on August 7, 2015, provided a notice of motion for ex-parte trial date certain, a completed request for hearing form and letter indicating a trial date would be requested at the status call. (Px. 23). Attorney for the Injured Workers' Benefit Fund was also provided notice of the hearing and trial dates above and is included as a part of Petitioner's exhibits. (Px. 22 and 23). Attorney for the Fund appeared on behalf of the Fund at all hearings.

Based on the above, the Arbitrator finds that Petitioner has provided adequate notice to Respondent/Employer.

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 permitted and allowed under Section 4(d) of this Act, except for the Penalties awarded against the Respondent, Pure 5 Cleaners, under section "M." 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 to the Petitioner pursuant to Section 5(b) and 4(d) of the Act. Respondent/Employer/Officer/Owner shall reimburse the injured benefit fund for any compensation obligations Respondent/Employer/Officer/Owner that are paid to the Petitioner from the Injured Workers' Benefit Fund.

Arbitrator George Andros **Date**

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Russell Allen,

Petitioner,

vs.

NO. 12WC036776

17IWCC0131

Jewel Food Stores,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 7, 2016 is hereby affirmed and adopted.

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

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

17IWCC0131

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

DATED: MAR 3 - 2017
SJM/sj
o-2/23/2017
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ALLEN, RUSSELL
Employee/Petitioner

Case# **12WC036776**

17IWCC0131

JEWEL FOOD STORES
Employer/Respondent

On 6/7/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

5074 QUINTAIROS PRIETO WOOD & BOYER
CAROL CESARETTI
233 S WACKER DR 70TH FL
CHICAGO, IL 60606

17IWCC0131

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

Russell Allen
Employee/Petitioner

v.

Jewel Food Stores
Employer/Respondent

Case # **12** WC **36776**

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 **May 12, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the 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 13, 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.

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner established causation only as to a bilateral shoulder condition and that Petitioner reached maximum medical improvement with respect to this condition in February 2014. Although Petitioner proceeded pursuant to Section 19(b), the parties agreed the Arbitrator could address permanency if she found the case compensable.

In the year preceding the injury, Petitioner earned **$44,908.20**; the average weekly wage was **$863.60**.

On the date of accident, Petitioner was **55** 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**. Arb Exh 1.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act. Arb Exh 1.

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $105, $3,800, $3,250 and $2,350 to Elmhurst Orthopaedics and $300 and $3,440 to Dr. Gurevich.

For the reasons set forth in the attached decision, the Arbitrator declines to award temporary total disability benefits.

For the reasons set forth in the attached decision, the Arbitrator views Petitioner as having reached maximum medical improvement in February 2014 with respect to the causally related bilateral shoulder condition. The Arbitrator awards permanency at the rate of $518.16 per week for 12.5 weeks, representing 2.5% loss of use of the person as a whole for the left shoulder and an additional 50 weeks, at the same rate, representing 10% loss of use of the person as a whole for the right shoulder.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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

6/7/16
Date

JUN 7 - 2016

Russell Allen v. Jewel Food Stores
12 WC 36776

Summary of Disputed Issues

Petitioner, a longtime Respondent employee with a complicated medical history, claims he slipped on a wet warehouse floor and fell backward while working alone on July 13, 2012. The disputed issues include accident, causal connection, medical expenses and temporary total disability, with Petitioner seeking benefits from January 13, 2013 through May 12, 2016, the date of hearing. Petitioner proceeded under Section 19(b) but the parties agreed that, if the Arbitrator found the case compensable, she could alternatively address permanency if she viewed Petitioner as having reached maximum medical improvement. Arb Exh 1. T. 7-8.

Arbitrator's Findings of Fact

Petitioner testified he worked for Respondent for 28 years. T. 13. He started out as an assembler but spent his last 17 years as a janitor, picking up debris, sweeping on a regular schedule and otherwise keeping the warehouse clean. T. 13-14.

On direct examination, Petitioner acknowledged a prior work injury involving his neck and back. Petitioner testified he underwent a cervical fusion at C5-C6 in 1988, in connection with that injury. T. 15-16. Petitioner indicated he settled a workers' compensation claim for that injury many years ago. T. 16. He continued performing his janitorial duties thereafter. T. 16.

Petitioner also acknowledged sustaining another work injury about five years before his claimed fall of July 13, 2012. T. 16-17.

Petitioner denied injuring his hips or shoulders before July 13, 2012. Petitioner testified he performed full duty at Respondent for about two to three years before that date. He even worked overtime during that period. He lifted a maximum of 30 pounds. T. 17.

Records in PX 2 reflect Petitioner saw Drs. Koutsky at Elmhurst Orthopaedics for bilateral knee problems in March 2006 and the doctor's partner, Dr. Nikoleit, on various dates thereafter. On January 26, 2007, Dr. Nikoleit noted that Petitioner complained of "a lot of achy pain throughout his body, shoulders, elbows, back and hips." He also noted that Petitioner complained of "radiating pain down both of his legs." He noted a "history of back problems" and stated: "it appears that he may have some stenotic problems." He prescribed a Medrol Dosepak "to decrease the inflammation throughout his knees and body." He continued seeing Petitioner for bilateral knee complaints and Hyalgan injections thereafter. On April 25, 2008, he noted that Petitioner reported "feeling better." He described Petitioner as "working and not complaining of any significant disabilities." He directed Petitioner to return to him as needed. [The next treatment note is dated September 19, 2012. See further below].

Petitioner acknowledged periodically seeing a pain physician, Dr. Gurevich, for a number of years before July 13, 2012. T. 17. During that time, he underwent injections and took pain medication for neck and back discomfort. The discomfort was "nothing [he] couldn't handle." T. 18. He took pain medication, initially Vicodin and then Oxycodone, during this period. He changed to Oxycodone because Vicodin was upsetting his stomach. T. 19. He recalled taking this medication two to three times per week, while he was at home. He denied taking this medication at work. T. 18-19.

Dr. Gurevich's records (Gurevich Dep Exh 2) reflect that the doctor saw Petitioner on five occasions in 2012 before the claimed work fall. On January 11, 2012, the doctor noted she was seeing Petitioner "for a follow-up visit" due to back and neck pain. She indicated Petitioner's medications included Vicodin. She described Petitioner as expressing concern about possibly losing his job "in few months." On examination, she noted neck pain with range of motion testing, a negative Spurling's sign, spasm in the SI joints, negative straight leg raising and no limp. She diagnosed various conditions, including arthritis. She recommended that Petitioner continue taking Vicodin and undergo lumbar spine X-rays. At the next visit, on March 7, 2012, she noted that Petitioner voiced neck and back complaints and also expressed concern about memory issues and being unable to afford his blood pressure medication. Her examination findings and diagnoses were unchanged. She recommended continued use of Vicodin for pain, blood work and an MRI of the SI joints. On April 18, 2012, she noted that Petitioner complained of increased neck and back pain. She also noted that Petitioner had recently "changed work" and begun performing more physically demanding tasks. She described Petitioner as taking Vicodin "more often than usual." She again recommended Vicodin, an MRI of the SI joints and blood work. On May 30, 2012, the doctor noted that Petitioner reported having to walk and climb stairs more frequently in his new job. She also noted that Petitioner complained of "more tiredness" in his back and difficulty sleeping due to constant back pain. She described Petitioner as "slightly worried" due to "most likely losing his job in the next months." She indicated Petitioner expressed concern about his financial status and losing his contract with his company. She switched Petitioner from Vicodin to Norco "due to financial status" and again recommended blood work and an MRI. On July 3, 2012, the doctor indicated that Petitioner was experiencing more pain than usual and could not tolerate the Norco due to cramping and constipation. She indicated that Petitioner primarily complained of pain in his lower back and sacroiliac area. She described Petitioner as "taking some days off during this month, up to three to four times." She noted that Petitioner complained of difficulty walking, sleeping and performing his job. She switched Petitioner from Norco to Oxycodone, to try to decrease the constipation. She recommended that Petitioner undergo MRIs of his lower back and "possible neck." She also recommended physical therapy. She indicated Petitioner "seem[ed] to understand" her recommendations but his "main concern [was] about the financial status." Gurevich Dep Exh 2.

Petitioner testified he felt "good" when he started his shift on the afternoon of July 13, 2012. T. 20. A "weather event" had occurred in the vicinity of Respondent's warehouse that morning. It had been rainy and windy. Petitioner testified it was raining horizontally "because

the wind was blowing so hard." T. 20. The "whole warehouse was flooded" because water had "blown under the dock doors." T. 20-21. There was "water everywhere." T. 21.

Petitioner testified he fell while lifting a load of plastic up into a bin. He slipped on water and fell backward, "land[ing] on the concrete on [his] back." He felt as if he had gotten hit by a linebacker. He experienced pain in "every part of [his] body" afterward. The pain was in his neck, back, hips and shoulders. He felt a "day and night" change in his condition, compared to how he had felt before the accident. T. 21, 24. He "always had" neck and back pain before the accident but he "could handle it." After he fell, the pain was sharp and he could not lift anything above shoulder level. T. 22.

Petitioner testified he reported the accident to his supervisor, Mark, and then completed a report. T. 22. Under cross-examination, Petitioner testified that Respondent wanted him to go to Concentra that day but the clinic was closed so he was unable to go until the following day. He described Concentra as the company clinic. He had gone to Concentra (albeit at a different location) for work-related problems in the past. T. 23.

The Concentra records of July 14, 2012 reflect that Petitioner complained of neck, upper trapezius, shoulder and back pain secondary to a fall occurring the previous day. The records set forth the following "patient statement": "My foot slipped on water when I was putting plastic into the plastic baler and I fell." A separate handwritten history reads as follows: "Pt states he fell yesterday and injured both shoulders, neck, lower back, middle back, both hips." This history goes on to state: "while putting plastic in baler slipped on wet floor or concrete, pain back of neck, shoulder, lower back."

The examining physician, Dr. Mohsin, noted that Petitioner complained of 6/10 pain with movement but denied any radicular symptoms. He also documented that Petitioner noted "immediate pain in shoulder with injury" and described his pain as "located at upper trapezius area and on both sides & radiating to the back of the neck."

Dr. Mohsin noted that Petitioner had a "history of multiple medical and surgical problems," including seven surgeries on his knees and elbows, a fusion, herniated discs in his cervical and lumbar spine and three myocardial infarctions requiring insertion of four stents. The doctor also noted a history of "chronic pain syndrome." He described Petitioner as taking Oxycontin "every nite for pain."

On bilateral shoulder examination, Dr. Mohsin noted a decreased range of motion in all planes and negative impingement, Apley and anterior apprehension signs. He also noted tenderness to palpation at the trapezius areas bilaterally and a decreased range of cervical spine motion. On lumbar spine examination, he noted positive straight leg raising bilaterally in the supine position, with the maneuver producing back but not sciatic pain, a decreased range of motion to all planes, normal sensation and a normal gait.

Dr. Mohsin assessed Petitioner as having a low back strain and a bilateral trapezius strain. He prescribed physical therapy, three times per week for two weeks, and directed Petitioner to continue taking Vicodin at night. He released Petitioner to regular duty, noting that "pt states he can perform regular duty." He directed Petitioner to return to Concentra on Monday, July 16, 2012. PX 1.

Petitioner testified that Concentra released him to full duty. T. 23. He resumed working but "was having a hard time." He was unable to adhere to his sweeping and debris collection schedule secondary to pain. T. 24. He experienced this pain "all over," in his hips, neck, back and shoulders. T. 24. About six weeks after his work fall, he started taking pain pills while he was at work. He was "basically hiding" at work rather than actually performing his assigned duties. T. 26.

On August 15, 2012, Petitioner returned to Dr. Gurevich and complained of low back and shoulder pain. The doctor recorded the following history:

> "The patient recently has fall at work a few days ago and she [sic] fell on the desk and due to fall the patient hurt his shoulder and lower back. Today, the patient presents more with the pain of his shoulder, difficulty on range of motion mostly on internal rotation and abduction."

Dr. Gurevich also noted that Petitioner reported having recently been diagnosed with diabetes.

On lumbar spine examination, Dr. Gurevich noted an antalgic gait, pain with range of motion testing and negative straight leg raising. On shoulder examination, she noted a positive abduction test. She administered bilateral shoulder injections and recommended that Petitioner continue the Oxycodone and return to her in four to six weeks. RX 6.

On September 19, 2012, Petitioner saw Dr. Koutsky at Elmhurst Orthopaedics. Under cross-examination, Petitioner denied seeing Dr. Koutsky at any prior time. He acknowledged seeing Dr. Nikoleits, Dr. Koutsky's partner. He testified he saw Dr. Koutsky's name on a list of Respondent-approved physicians.

Dr. Koutsky's note of September 19, 2012 reflects that Petitioner complained of "neck pain radiating into both shoulders as well as lower back pain radiating to bilateral buttocks and thighs," as well as "occasional numbness and tingling." The doctor recorded the following history:

> "He has had chronic neck and lower back issues since 1989. He underwent previous anterior cervical fusion and was doing well but was never 100% pain free. His symptoms would wax and wane on occasion up until a most recent work-related injury which occurred on June 13, 2012. He

was working as a janitor for Jewel Foods and there was stormy weather outside. There was water on the floor in the warehouse. He was taking large pieces of plastic and putting the plastic into a baler and, as he did so, he slipped on the water on the floor and landed backwards onto concrete. He did tell his supervisor about the injury and was sent to Concentra Medical Center. By history, he was given some medications. There were no X-rays ordered or therapy ordered. He has been working full duty."

Dr. Koutsky described Petitioner's surgical history as positive for carpal tunnel releases, knee surgery, elbow surgery and an anterior cervical decompression and fusion.

On neurological examination, Dr. Koutsky noted full strength in all extremities, a mildly positive Spurling's test, negative straight leg raising, some paracervical and paralumbar muscle tenderness and spasm to palpation, a limited range of cervical and lumbar motion and a well-healed cervical incision from the previous surgery.

Dr. Koutsky obtained cervical and lumbar spine X-rays. He described the cervical spine films as showing the previous fusion at C5-C6 as well as degenerative changes above and below this level. He described both sets of films as showing multiple-level spondylotic changes.

Dr. Koutsky described Petitioner as "present[ing] with an aggravation of his chronic neck and back pain after a work-related injury." He prescribed physical therapy for the neck and back as well as cervical and lumbar spine MRIs and medication. He indicated that Petitioner was performing full duty "and will continue to do so." He directed Petitioner to return in four weeks. PX 2.

Petitioner testified he wanted to undergo the prescribed therapy at Respondent's in-house therapy facility. He completed all of the paperwork and underwent an initial evaluation before being told by Chuck Grafton, a supervisor, that Respondent was denying the therapy. He testified he was "the first person to ever get turned down for therapy at Jewel." T. 26.

Petitioner continued working thereafter and returned to Dr. Koutsky on October 31, 2012. In his note of that date, the doctor indicated that Petitioner was awaiting authorization of the therapy and MRIs and was "still having a lot of significant pain in the neck and upper extremity as well as lower back and lower extremity." He also indicated Petitioner was "working full duty through his pain" and taking pain medication as needed. He again prescribed the therapy and MRIs. PX 2.

Petitioner underwent the recommended MRI scans on November 12, 2012. The lumbar spine MRI, performed without contrast, showed broad-based bulges extending unto boyh lateral recesses at L2-L3 and L3-L4 and a broad-based bulge at L4-L5. The cervical spine MRI, performed with and without contrast, showed the prior fusion at C5-C6 "with essentially

complete osseous coalition of these vertebral bodies" and flattening of the cord without cord signal change just above the fusion at C4-C5. The radiologist indicated this could be secondary to altered biomechanics. PX 2.

Petitioner returned to Dr. Koutsky on November 19, 2012. In his note of that date, the doctor indicated he was still awaiting authorization of the previously recommended therapy. He broached the idea of a pain clinic evaluation, noting Petitioner wanted to pursue a cervical injection followed by a lumbar injection. He directed Petitioner to return in one month. PX 2.

A Section 12 examination report offered by Respondent (RX 4) reflects that, on November 29, 2012, Dr. Koutsky made alternative recommendations, i.e., eight weeks of physical therapy followed by work conditioning versus a functional capacity evaluation and light duty work. The Arbitrator notes, however, that no note or prescription slip dated November 29, 2012 is in evidence and Dr. Koutsky did not testify to the existence of such a document.

Petitioner returned to Dr. Gurevich on December 12, 2012. In her note of that date, the doctor indicated Petitioner complained of pain in his neck, arms, lower back and legs. She also noted that Petitioner "is not able to work," had initiated a workers' compensation claim and had lost 35 pounds. She described Petitioner as "very anxious" and "thinking about to start disability" due to his pain and the "twisting, bending and heavy lifting" required in his job. She noted an "antalgic gait of the right lower extremity" and negative straight leg raising. She directed Petitioner to continue the Oxycodone and return to her after starting therapy and undergoing MRIs. Gurevich Dep Exh 3.

Petitioner next saw Dr. Koutsky on January 7, 2013, with the doctor recording the following interval history: "He had a flare-up of his cervical and lumbar spondylosis and stenosis. He has been working very hard over the holidays." He described Petitioner's neurological examination as unchanged. He noted that therapy had still not been authorized. He wrote out a new therapy prescription and took Petitioner off work, citing the "recent aggravation." He directed Petitioner to return to him in one month. PX 2.

Petitioner testified he has not worked anywhere since Dr. Koutsky took him off work on January 7, 2013. T. 27, 35. Dr. Koutsky has never released him to return to work. T. 29. He has received no workers' compensation benefits to date. T. 28.

Petitioner testified his condition worsened in 2013. His neck pain was initially in the back of his neck but in 2013 he began feeling a bulge on the right side of his neck. T. 30-31. He felt sharp pain in his neck, back, hips and shoulders every day. If he avoided all activity, "it was better." T. 32. Being off work helped "somewhat" but he still needed pain medication. T. 32.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Singh on January 14, 2013. T. 28. In his report of that date, Dr. Singh recorded the following history:

> "Mr. Allen is a 58-year-old male who was working as a

janitor for Super Value. On July 13, 2012, he was loading the plastic compactor when he slipped on the wet floor from rain entering in through the emergency exit door. he fell on his lower back."

Dr. Singh indicated he reviewed the Concentra records and Dr. Koutsky's notes of September 19 and November 29, 2012 in connection with his examination.

Dr. Singh noted that Petitioner complained of neck, upper back and lower back pain, rated 8-9/10. He also noted that Petitioner was not currently working and reported being able to sit, stand and work for 15 minutes at a time.

Dr. Singh described Petitioner's medical history as significant for three myocardial infarctions and carpal tunnel syndrome. He described Petitioner's surgical history as significant for a "non-specific" cervical spine surgery by Dr. Panchal in 1989 and a cardiac bypass.

Dr. Singh did not note any abnormalities on examination. He noted 5/5 Waddell's findings as negative. He indicated he had not been provided with any radiographic studies.

Dr. Singh diagnosed cervical and lumbar muscular strains. He requested that cervical and lumbar spine MRIs be obtained so that he could address causation and treatment needs for "this individual who gives forth a reasonable examination." RX 4.

Petitioner testified Dr. Singh examined his neck and back but did not look at his hips or shoulders. T. 28.

Petitioner underwent an initial physical therapy evaluation at Medchoice Medical Center on January 16, 2013. The evaluating therapist noted a history of low back, neck, bilateral hip and bilateral shoulder pain "off and on for many years – worse since 7/13/12 – slipped on water at work and landed on his back." Petitioner continued attending therapy thereafter until late June 2013, with the therapist documenting no improvement. PX 4.

Petitioner testified that the therapy at Medchoice consisted of E-stimulation and ultrasound. He further testified these measures did not really provide any relief.

Petitioner underwent an EMG and nerve conduction studies at Medchoice on January 22, 2013. The examiner, Dr. Park, found no evidence of cervical radiculopathy or peripheral neuropathy. He noted abnormally delayed left hand medial nerve motor distal latency and indicated this "could be a residual problem" from the bilateral carpal tunnel syndrome for which Petitioner underwent surgery in 2006. PX 4.

On January 28, 2013, Dr. Singh issued an addendum after reviewing the November 12, 2012 cervical and lumbar spine MRIs. He described the lumbar spine MRI as "normal appearing." He indicated the cervical spine MRI was also normal with the exception of the

findings relative to the prior surgery. He indicated the MRI showed a "solid arthrodesis at C5-C6 from a previous non-instrumented fusion." He opined that the work accident of July 13, 2012 caused cervical and lumbar muscular strains which had resolved. He further opined that the work accident did not aggravate any underlying spinal condition. He found Petitioner to be at maximum medical improvement and capable of unrestricted duty. RX 5

On February 4, 2013, Petitioner returned to Dr. Koutsky and reported he was attending therapy sometimes three hours per day. The doctor broached the subject of a pain clinic evaluation for injections but indicated Petitioner wanted to hold off on that. PX 2.

Petitioner saw Dr. Koutsky again on March 14, 2013 and reported increasing shoulder symptoms. The doctor refilled his prescriptions, recommended additional therapy and prescribed bilateral shoulder MRIs. PX 2.

Petitioner underwent bilateral shoulder MRI scans on March 19, 2013. The radiologist interpreted both scans as showing significant tendinosis of the distal supraspinatus and subscapularis tendons with "partial thickness intrinsic tear versus significant mucoid degeneration of the distal supraspinatus." In each report, he described the labrum as grossly intact. PX 2.

On April 26, 2013, Dr. Koutsky noted that Petitioner was awaiting authorization for shoulder therapy. He directed Petitioner to remain off work. PX 2.

At Respondent's request, Dr. Verma conducted a Section 12 examination of Petitioner on June 19, 2013. In his report of the same date, the doctor indicated he focused his examination on Petitioner's shoulders. He recorded a history of the alleged work fall and noted that Petitioner reported having arthritis "throughout his body . . . with the exception of his pinkies and toes." He also noted that Petitioner had been off work since January 2013.

Dr. Verma indicated he reviewed pre- and post-accident records in connection with his examination. He described the July 14, 2012 Concentra records as documenting upper trapezius rather than specific shoulder complaints.

On examination, Dr. Verma noted that Petitioner exhibited no shoulder deformity. He described Petitioner as "able to take his shirt on and off without difficulty." He noted a limited range of cervical spine motion and a full range of shoulder motion bilaterally, with full strength and no instability.

Dr. Verma obtained bilateral shoulder X-rays. He interpreted the films as showing AC joint arthropathy in both shoulders.

Dr. Verma diagnosed "mild bilateral shoulder impingement with axial neck pain and referred pain to the posterior shoulder blade." He viewed Petitioner's current symptoms as unrelated to the work injury. He requested that the shoulder MRI scans be sent to him for

review. He indicated Petitioner might require a trial of cortisone injections for his shoulder symptoms but he saw no need for shoulder surgery. He opined that the need for right shoulder treatment was unrelated to the work accident "based on the significant delay in onset of symptoms with initial diagnosis of cervical strain with posterior trapezial pain." He found Petitioner capable of full duty with respect to the shoulders. RX 2.

On September 4, 2013, Dr. Koutsky noted that Petitioner's neck, back and hips were "still bothering him significantly." He also noted Petitioner was awaiting authorization of bilateral hip MRI scans. He continued to keep Petitioner off work. PX 2.

On September 11, 2013, Dr. Koutsky described the hip MRIs as showing minimal degenerative changes and no evidence of any fracture or avascular necrosis. PX 2.

Dr. Koutsky testified by way of evidence deposition on September 26, 2013. PX 3. The doctor's CV reflects he underwent fellowship training in spine surgery at Northwestern University. He is board certified in orthopedic surgery, spine surgery and independent medical evaluation. Koutsky Dep Exh 1.

Dr. Koutsky's testimony concerning his interaction with Petitioner is largely consistent with his treatment records. He testified to an "interval change" in Petitioner's condition as of January 2013, with Petitioner describing worsening neck and low back pain secondary to "working a lot of extra hours around the holidays for Jewel." PX 3 at 8. He testified he took Petitioner off work at that point due to the "further aggravation" of his symptoms. PX 3 at 9. He testified that Petitioner's shoulder pain came "more to the forefront" in March 2013, at which point he recommended bilateral shoulder MRI scans. The MRIs revealed degenerative changes in both shoulders, with inflammation of the rotator cuff, a partial-thickness tear on the left and a questionable, small full-thickness tear on the right. PX 3 at 10-11. At that point, he continued to keep Petitioner off work and recommended additional therapy. PX 3 at 10-11. In July 2013, Petitioner's hips became "more of an issue." He again recommended therapy and was awaiting authorization for injections. He also recommended hip MRI scans. PX 3 at 12-13.

After being presented with a lengthy hypothetical which incorporated details concerning Petitioner slipping on water in Respondent's warehouse and falling on July 13, 2012, Dr. Koutsky testified that this fall aggravated Petitioner's arthritis and his neck, shoulder, lumbar and hip conditions. PX 3 at 14-15. He further testified that Petitioner's pre-existing neck, back and shoulder conditions "were stable" as of the fall and were "made worse" by the fall. PX 3 at 14-15.

Dr. Koutsky opined that, when he last saw Petitioner, in early September 2013, Petitioner was not capable of performing his janitorial job at Respondent. PX 3 at 15. He further opined that Petitioner requires a "complete rehabilitation program." Given the persistence of Petitioner's symptoms, it would be reasonable for him to undergo injections in his neck, back and/or shoulders. Petitioner might even be a candidate for an anterior cervical decompression and fusion at C3-C4 "because he does have some stenosis which was

aggravated by his fall." PX 3 at 15-16. If Petitioner has a small full-thickness tear of his right rotator cuff, he might also need surgery for that. PX 3 at 16.

Under cross-examination, Dr. Koutsky initially recalled first seeing Petitioner in 2012. After looking at his records, however, he recalled seeing Petitioner for bilateral knee pain in 2006, at which point he obtained a history of the previous cervical fusion. He also recalled referring Petitioner to his partner, who went on to operate on Petitioner's knees. PX 3 at 18. He acknowledged there is an arthritic component to Petitioner's bilateral knee condition. PX 3 at 18. When he saw Petitioner on September 19, 2012, he noted a history of various health problems, including significant diabetes, hypertension and coronary artery disease. PX 3 at 19. On that date, Petitioner told him he had experienced chronic neck and low back pain since 1989 and had never been pain free. PX 3 at 19-20.

Dr. Koutsky acknowledged that, with respect to the mechanism of Petitioner's claimed work fall, he knows only that Petitioner was putting large pieces of plastic into a baler when he slipped on a wet floor and fell backward. He does not know whether Petitioner caught himself with his arms. He also does not know exactly how Petitioner landed. He is aware that Petitioner continued performing full duty between the fall and the September 19, 2012 visit. PX 3 at 21, 24. He is also aware that Petitioner continued performing full duty after that visit, until he took Petitioner off work in January 2013. PX 3 at 22. It is his practice to make a thorough record of a patient's complaints. He does not instruct his patients to limit their focus to any particular body parts. PX 3 at 21-22. Petitioner was 56 years old as of September 2012. Petitioner's November 2012 spinal MRI scans showed degenerative changes. PX 3 at 23. In a patient with past arthritic complaints, it is typical for those complaints to progress. PX 3 at 23. The progress may be greater in a patient who is 56. PX 3 at 23-24. A patient such as Petitioner, who has a lot of degeneration, may experience a temporary aggravation of his underlying condition. Such an aggravation typically lasts six to eight weeks. PX 3 at 25. In Petitioner's case, it was not until January 2013 that he indicated his pain had worsened. Pain is subjective in nature. PX 3 at 25-26. Throughout the time he has seen Petitioner, his examination findings and diagnoses have stayed relatively consistent. PX 3 at 26. The only thing that changed was that he took Petitioner off work in January 2013. PX 3 at 27. Petitioner's shoulder MRIs showed degeneration and rotator cuff tearing. The tearing could be traumatic. PX 3 at 28. If a patient sustains a trauma causing a rotator cuff tear, he would typically develop pain immediately. PX 3 at 28. It would not be typical for the pain to start months later. PX 3 at 29. Petitioner has osteoarthritis, which is "wear and tear arthritis." PX 3 at 30. This condition "can affect almost any joint in the body and spine." PX 3 at 30. It would not be uncommon for a person with osteoarthritis to develop that condition in his hips. PX 3 at 30. Petitioner's symptoms were relatively constant. They did not wax and wane, allowing him to have any really good days. If an aggravation is temporary, the patient makes progress and feels better. PX 3 at 31-32. Petitioner did report improvement with therapy at the end of 2012. PX 3 at 32.

Dr. Koutsky testified that Norco is one of the stronger pain medications. Vicodin is similar to Norco. PX 3 at 33. Oxycodone is an "even stronger" pain medication. PX 3 at 32. If a person is on Norco for pain relief, he is probably experiencing relatively significant pain.

Hydrocodone is usually used by someone with even higher pain levels but it might be prescribed because it "prevents the roller coaster effect of some of the other narcotic pain medications." PX 3 at 32-33.

Dr. Koutsky testified that Petitioner never expressed financial concerns to him. If a patient expresses such concerns prior to an unwitnessed fall, "you'd always be suspect of secondary gain issues." PX 3 at 33-34.

Dr. Koutsky testified his opinions would not change if Petitioner was on Oxycodone ten days before his alleged fall. Nor would his opinions change if a doctor recommended MRIs and therapy at that point. PX 3 at 34.

Dr. Koutsky acknowledged that he did not review the records from Concentra or Dr. Gurevich. Nor did he review a job description or video. PX 3 at 35.

On redirect, Dr. Koutsky testified he has never questioned the veracity of Petitioner's complaints. PX 3 at 35. Petitioner never did well for any period of time. [The doctor then reviewed Dr. Gurevich's July 3, 2012 note.] The fact Petitioner was on Oxycodone as of July 3, 2012 does not prompt him to change his opinions. PX 3 at 37.

Under re-cross, Dr. Koutsky testified that Waddell's testing can determine the veracity of a patient's spinal complaints. He acknowledged he did not conduct any such testing. If he had done this testing, he would have noted it in his records. PX 3 at 38. Petitioner's initial pain complaints were significant. Between September 2012 and January 2013, his pain level lessened but he never reported he had very few symptoms. PX 3 at 39. Petitioner did not "decline" after the holidays. Petitioner had actually improved somewhat as of his last visit because he had undergone some rehabilitation. PX 3 at 40.

Dr. Verma testified by way of evidence deposition on January 22, 2014. The doctor testified he is board certified in orthopedic surgery. He sees about 140 patients per week. About half of these patients have shoulder problems. He performs all types of shoulder surgeries, including open replacements. RX 1 at 4-5. He performs about 250 shoulder surgeries per year. RX 1 at 5-6. He performs 5 to 7 IMEs per week. RX 1 at 6. About 80% of these IMEs are for respondents. RX 1 at 7.

Dr. Verma did not independently recall examining Petitioner. He relied on his report while testifying. RX 1 at 7. Petitioner told him he is right-handed. Petitioner also reported slipping on water at work on July 13, 2012, and falling directly onto his back. RX 1 at 8. Petitioner indicated he underwent therapy for his neck and back after the accident but did not undergo shoulder therapy. RX 1 at 8.

Dr. Verma testified that the shoulder complaints Petitioner voiced in March 2013 "were related to his neck and back." On examination, Petitioner's shoulder range of motion and

strength were normal. RX 1 at 10. He reviewed both the bilateral shoulder X-rays he took in his office and the bilateral shoulder MRI reports. RX 1 at 11.

Dr. Verma relied on his report [see summary above] while testifying as to his shoulder examination findings and treatment recommendations. He believes Petitioner could benefit from bilateral shoulder injections. He sees no relationship between Petitioner's mild shoulder impingement diagnosis and the work accident. Petitioner primarily complained of his neck and back after the accident. The shoulder MRI findings were primarily degenerative in nature. RX 1 at 14. A fall could be an appropriate mechanism for a shoulder injury but he sees no evidence that the fall Petitioner described could have caused or aggravated a bilateral shoulder condition. RX 1 at 14-15. He believes Petitioner is capable of full duty. RX 1 at 15.

Under cross-examination, Dr. Verma testified he examined Petitioner once, in June of 2013. RX 1 at 16. Most of the records he reviewed were authored by Dr. Koutsky. RX 1 at 17. It would be fair to say that Petitioner has a significant set of pre-existing conditions. RX 1 at 17. A 2008 shoulder MRI showed some degeneration but no condition requiring surgery. RX 1 at 17. He performed a cursory examination of Petitioner's neck. When he examined Petitioner's shoulders, the only abnormality he noted was some impingement. RX 1 at 17. He saw no indication that Petitioner magnified his symptoms, with respect to his shoulders. RX 1 at 18. He asked to see the MRI images but never reviewed them. RX 1 at 19. He is not sure whether Dr. Koutsky believes Petitioner has rotator cuff tears since the doctor referred to the tears as questionable. RX 1 at 19. He usually relies on MRI images when making a decision as to whether a patient needs surgery. RX 1 at 19. He has sometimes disagreed with a radiologist's MRI interpretation. RX 1 at 19. He did not review any description of Petitioner's job. With respect to his shoulders, Petitioner could work as a janitor. RX 1 at 20. The early post-accident records mention the shoulder but actually reflect complaints in the trapezial region. The first true shoulder complaints did not surface until March 2013. RX 1 at 20.

On February 12, 2014, Petitioner returned to Dr. Gurevich. The doctor described Petitioner as "doing very well." She indicated he denied any lower back pain and complained only of "very mild" shoulder and knee pain. She noted "normal movement of all extremities" and "no back pain" on examination. Gurevich Dep Exh 2.

Petitioner saw Dr. Gurevich again on April 9, 2014 and primarily complained of bilateral hip pain. The doctor administered sacroiliac joint and bilateral hip injections. At the next visit, on May 7, 2014, Petitioner complained of pain in his neck, back, hips and shoulders. The doctor administered shoulder injections and trapezius trigger point injections. On June 18, 2014, the doctor again injected both hips. Gurevich Dep Exh 2.

Petitioner testified he experienced a stroke in June 2014. He underwent therapy after the stroke and recovered. T. 33. He claims no connection between the work fall and the stroke. The stroke-related records are not in evidence.

Petitioner returned to Dr. Koutsky on August 13, 2014. The doctor noted that Petitioner had suffered a stroke "with residual left hemiparesis" since the last visit. He also noted that Petitioner was undergoing stroke-related therapy and was attempting to perform home exercises for his neck, back and shoulders. The doctor directed Petitioner to return in two to three months. PX 2.

Petitioner returned to Dr. Gurevich on September 10, 2014 and complained of 7/10 right shoulder pain. The doctor reviewed the previous right shoulder MRI. On right shoulder examination, she noted a limited range of motion and a positive impingement test. She administered a right shoulder injection and recommended therapy. PX 5.

Petitioner saw Dr. Gurevich again on September 17, 2014 and complained of 9/10 right shoulder pain. The doctor also noted that Petitioner had suffered a stroke a month earlier. On right shoulder examination, she noted a limited range of motion and positive impingement testing. She refilled the Oxycodone prescription and recommended a right shoulder MRI and therapy. PX 5.

Petitioner underwent the recommended repeat right shoulder MRI at Swedish American on September 26, 2014. The MRI report is not in evidence.

On October 8, 2014, Dr. Koutsky's assistant, Russell E. Wudel, P.A., noted that Petitioner reported having injured his right shoulder while undergoing stroke-related therapy. Wudel also noted that Petitioner reported having undergone two cortisone injections into the right shoulder thus far "with no relief of his pain." Wudel described Petitioner's neck and back examination as unchanged. He could perform only a "very limited exam of the right shoulder due to pain." He reviewed Petitioner's most recent September 26, 2014 right shoulder MRI with Dr. Bartucci and directed Petitioner to return in one to two months. Dr. Bartucci saw Petitioner the same day and interpreted the MRI as showing some anterior disruption or irritation of the subscapularis and a "50% thickness tear over 5 mm of the distal supraspinatus." He described Petitioner's right shoulder as very stiff. He administered another injection. He noted that Petitioner's therapy benefits had been "used up" due to his stroke. PX 2.

Petitioner also saw Dr. Gurevich on October 8, 2014. The doctor noted a complaint of worsening right shoulder pain, rated 9/10, with associated weakness. She also noted that Petitioner was no longer attending therapy due to "visit cap." Her examination findings were unchanged. She refilled the Oxycodone. PX 5.

Dr. Singh testified by way of evidence deposition on November 6, 2014. RX 3. Dr. Singh testified he is board certified in orthopedic surgery. He specializes in spine surgery and sees about 200 patients per week. RX 3 at 5. He performs 400 to 500 spinal surgeries annually. RX 3 at 6. He conducts 4 to 6 IMEs per week, about 65 to 70% of which are for respondents. RX 3 at 7. He stopped acting as an expert in civil cases in late 2012. RX 3 at 7.

Dr. Singh testified he has no independent recollection of Petitioner. RX 3 at 7. He examined Petitioner on January 14, 2013, according to his report. RX 3 at 8. He typically asks an examinee to complete a six-page intake form. He then reviews the form with the examinee and conducts a 5- to 7-minute examination. He then spends a few minutes reviewing records and the mechanism of injury with the examinee. His "total face time" is approximately 15 minutes. RX 3 at 8-9. He asks that records be sent to him two weeks before any examination. He reviews those records 48 hours before the examination. RX 3 at 9.

Dr. Singh testified to the contents of his initial report. He believed Petitioner "gave forth a reasonable examination with no component of symptom magnification." RX 3 at 12. Petitioner told him his janitorial job involved lifting. He placed Petitioner at a medium job level but did not obtain any more details as to the extent or frequency of lifting. RX 3 at 12.

Dr. Singh testified he provisionally diagnosed Petitioner with cervical and lumbar soft tissue strains. In his report, he indicated he could not address any other issues before reviewing the MRIs. Petitioner was "working in a light duty fashion" as of the examination and he kept Petitioner on a light duty restriction based on Petitioner's normal neurological examination. RX 3 at 13. He issued an addendum after reviewing the MRI images. The lumbar spine MRI was "essentially normal" and the cervical spine MRI showed a "non-instrumented fusion," meaning the fusion was performed without a plate, at C5-C6. RX 3 at 14-15. There was no evidence of any stenosis or nerve compression. RX 3 at 15. He diagnosed "status post anterior cervical discectomy and fusion, C5-C6, with solid arthrodesis." RX 3 at 15. He "could not objectify [Petitioner's] pain complaints as the MRIs were essentially normal" with the exception of the solidly healed cervical fusion. RX 3 at 15-16.

Dr. Singh found a relationship between the work fall and the diagnosis of cervical and lumbar strains, based on the mechanism of injury Petitioner described. RX 3 at 16. He did not believe the work fall was a possible cause for Petitioner's complaints of 8-9/10 pain six months out from the accident, given the appearance of the MRIs. RX 3 at 16. He felt there was no objective basis for precluding Petitioner from returning to his janitorial job. RX 3 at 17. He did not believe Petitioner required any additional care. RX 3 at 17. It would be reasonable for a patient to require therapy and light duty for four to six weeks following a Grade 0 or Grade 1 muscular strain. RX 3 at 17-18. In his opinion, Petitioner was at maximum medical improvement as of his January 2013 examination. RX 3 at 18.

Under cross-examination, Dr. Singh testified he examined Petitioner once. At that time, he recommended various restrictions, including no lifting/pushing/pulling over 10 pounds and minimal bending, kneeling, stooping and squatting. RX 3 at 19. He changed these recommendations after reviewing the MRIs, without re-examining Petitioner. RX 3 at 20. When he did examine Petitioner, he did not note malingering or inconsistencies. RX 3 at 20. The only degenerative change he saw on MRI was the fusion, which could be classified as a degenerative change that was "solidly healed." RX 3 at 20. He saw no stenosis or nerve root impairment at C4-C5. RX 3 at 20. He saw no degeneration in the lumbar spine. RX 3 at 20-21. In January 2013, Petitioner told him his condition was worsening. RX 3 at 21. If a person has a

structural strain, meaning "alteration of muscle integrity," the failure to undergo therapy could extend the recovery period. Petitioner's strains, however, were non-structural. RX 3 at 21-22. From a scientific standpoint, the data supporting improvement from therapy is minimal. Sometimes doctors prescribe therapy because "patients want something." RX 3 at 22.

On November 19, 2014, Dr. Gurevich again noted a complaint of right shoulder pain and limited motion. Her examination findings were unchanged. PX 5.

Petitioner returned to Dr. Gurevich on December 23, 2014 and complained of right shoulder and bilateral hip pain. Petitioner reported being unable to raise his right arm above shoulder level. He also reported intense pain when driving long distances and an inability to attend therapy "due to insurance limit." The doctor recommended home exercises, continued Oxycodone usage and formal therapy for the shoulder, neck and back. PX 5.

On January 28, 2015, Petitioner complained to Dr. Gurevich of right shoulder pain, an inability to lift his right arm above shoulder level, low back pain and neck pain. The doctor again recommended home exercises, Oxycodone and formal therapy. PX 5.

At Dr. Koutsky's recommendation, Petitioner underwent an upper extremity EMG and nerve conduction studies on March 5, 2015. Dr. Paly interpreted the studies as showing "no evidence of a cervical radiculopathy or neuropathy within the major motor and sensory nerves." PX 2.

A therapy note dated March 6, 2015 reflects Petitioner reported falling in his shower "earlier," striking the back of his head against the side of the tub. On March 9, 2015, the therapist reported that Petitioner reported improvement of his head pain. PX 6.

On February 25 and March 25, 2015, Petitioner complained to Dr. Gurevich of pain in his right shoulder, hips and lower back, as well as stroke-related memory, concentration and dexterity issues. The doctor again recommended Oxycodone, home exercises and formal therapy. On March 25, 2015, she described Petitioner's gait as slow and unsteady. PX 5.

Dr. Gurevich testified by way of evidence deposition on March 31, 2015. PX 5. The doctor's CV (Gurevich Dep Exh 1) shows she attended medical school and performed a pediatric residency in her native Moldava. She then came to the United States. She initially worked as a medical assistant from 1991 to 1997 and then did a residency in physical medicine and rehabilitation at Loyola University Medical School from 1998 to 2001. She is "board eligible" in physical medicine and rehabilitation.

Dr. Gurevich testified she first saw Petitioner in October 2008. Petitioner had previously seen a different physician for chronic pain. He began seeing her after his insurance coverage changed. He provided a history of prior neck surgery, bilateral carpal tunnel surgery, elbow surgery and testicle surgery. He reported working full-time plus a lot of overtime at Jewel. PX 5 at 6. He continued seeing her regularly, every six to eight weeks, thereafter. PX 5

at 6-7. Up until his claimed accident, her treatment consisted of adjusting his narcotic pain medications and administering acupuncture and injections. PX 5 at 7. On July 3, 2012, she switched his medication due to side effects. PX 5 at 7. On August 15, 2012, Petitioner reported being in more pain due to having fallen at work, landing on his right side on concrete flooring. Petitioner complained of right-sided shoulder, hip and lower back pain. PX 5 at 8. She recommended various measures, including therapy and MRIs, but Petitioner told her he had to see "the doctor from his company." PX 5 at 8-9. As of December 2012, Petitioner reported he was "seeing doctor from company." PX 5 at 10. Petitioner reported he had lost 35 pounds and was not working. When she last saw Petitioner in March 2015, he was having problems walking and with memory and comprehension. Petitioner had experienced a stroke in 2014. Before the stroke, but after the accident, Petitioner's condition had worsened. He was 60% worse than he was in 2008, when she first started seeing him. PX 5 at 15. He had tried to continue working but was not able to. Some other doctor had ordered MRIs, "which showed the condition get [sic] worse." PX 5 at 15-16.

Under cross-examination, Dr. Gurevich acknowledged that, on July 3, 2012, Petitioner told her he was taking days off of work due to pain. PX 5 at 18-19. On the same date, she switched Petitioner from Norco to Oxycodone. PX 5 at 19. She made the switch due to side effects from the Norco and due to Petitioner's reports of increased pain. PX 5 at 20. She had no reason to doubt Petitioner's December 12, 2012 report that he was not able to work. Her opinions would not change if she learned Petitioner was actually working full duty as of that date. PX 5 at 22. She never gave Petitioner any "off work" notes. PX 5 at 22. She is not aware that a Concentra physician diagnosed Petitioner with trapezius muscle strains after the work accident. PX 5 at 24. She did not review records from the other physicians who treated Petitioner. PX 5 at 24. As of January 2012, Petitioner was expressing financial concerns to her. PX 5 at 25-26. On May 30, 2012, Petitioner told her he was likely to lose his job in the next two months. PX 5 at 26. It is "possible" she ordered MRIs before the accident but Petitioner did not undergo those MRIs at that time. PX 5 at 27. It is possible she made a dictation mistake when she wrote on August 15, 2012 that Petitioner fell on a "desk." PX 5 at 28-29. She does not know how the fall occurred but Petitioner told her he landed on his right side. PX 5 at 29. When she later reviewed the bilateral shoulder MRI reports, the reports showed significant arthritis. She believes the work fall caused Petitioner's shoulder arthritis and tendonitis to worsen. PX 5 at 30. She bases this on Petitioner having fallen onto his right side. It is "very important how the person fell." PX 5 at 31. The fall could have also affected Petitioner's left shoulder if he tried to put his left arm out. She does not know if Petitioner twisted while falling. PX 5 at 33-34. She first ordered an MRI on May 30, 2012 but Petitioner "was not able to do MRI due to his financial status." PX 5 at 36.

On redirect, Dr. Gurevich testified she first injected Petitioner's shoulders on August 15, 2012. Before that date, she had never injected his shoulders. PX 5 at 38. She never had a reason to question Petitioner's pain complaints. PX 5 at 39. She has relied on her notes while testifying but she recalls 100% who Petitioner is. PX 5 at 40.

Petitioner continued seeing Dr. Koutsky on a regular basis in 2015 and the first part of 2016. During this time, the doctor recommended pain clinic management and repeat cervical and lumbar spine MRIs. He continued to keep Petitioner off work. PX 2.

Petitioner testified he has managed to pay his bills by using the funds in his profit sharing account. He started out with $230,000 in that account and is now down to $50,000. T. 35. He also receives Social Security disability benefits. The Social Security Administration awarded those benefits to him before his stroke. T. 36.

Petitioner testified it takes him two days to recuperate after mowing his lawn. He has a self-propelled mower. Before the accident, it took him half an hour to mow the lawn. It now takes him about two hours. He has to take a break every twenty minutes. After he finishes, he goes inside and takes a pain pill. He feels pain in his neck or back after mowing the lawn. T. 37. It "takes it out of [him]" to use a snow blower to move snow. T. 37. When he does this, he feels knee pain, back pain, neck pain and shoulder pain. He pays a price for any physical activity he engages in. T. 38. He continues to perform prescribed exercises at home but otherwise does nothing. T. 38. He gradually began increasing his intake of pain medication after the accident. He now takes three Oxycontins per day. T. 38-39.

Petitioner testified he attended school through the twelfth grade. He took a couple of college courses thereafter, while he was in the Marine Corp. He worked on a farm when he was a teenager but otherwise has held no jobs other than his assembler and janitor jobs at Respondent. T. 39.

Petitioner denied having any new injuries to his neck, low back, hips or shoulders. T. 39.

Under cross-examination, Petitioner testified he started working for Respondent in October 1985. T. 40.

Petitioner testified he has been honest with his medical providers. The histories he provided were accurate. T. 41.

Petitioner testified to settling various previous work injury claims. He injured his foot at work in 1987 and eventually settled that claim for 2.5% of the foot. T. 43. He settled his 1988 spine-related claim for 30% loss of use of the person and received about $41,000. T. 43. He also received a $135,000 settlement in connection with a 2003 slip and fall on grease that resulted in injuries to his hands, arms and knees. T. 44.

Petitioner acknowledged he has had arthritis for many years. This condition affects all of his joints. T. 46. He has experienced neck and back pain for many years. He has undergone arthroscopic surgery on both knees. T. 46-47. The stroke he suffered in June 2014 was not work-related. The stroke affected his overall function. T. 47.

Petitioner testified he started his shift at 2 PM on July 13, 2012. He believes it started raining at about 10 AM that day. T. 49. The wind was "blowing the rain horizontally" and water had come into the warehouse under forty doors located along the right side of the warehouse. T. 48-49. The roof of the warehouse also leaked. Water had come into the warehouse in a similar fashion one or one and a half years earlier. T. 53-54.

Petitioner recalled his fall occurring "before lunch" on July 13, 2012. Because he started his shift at 2 PM, he took his "lunch" at 6 PM. T. 50. He recalled cleaning water from his section before he fell. T. 53. The machine he worked on was about ten feet away from a door. The floor in his work area was made of concrete. T. 54. After he fell, his back was wet. T. 52.

Petitioner testified that no one was around when he fell but there were five cameras located in that area. T. 54-55. After the accident, he requested the video footage from Respondent but was told it had "disappeared." T. 55. When he fell, his feet flew up in front of him and he went straight backward. Both of his shoulders hit the floor at about the same time. T. 55-56. He did not strike any objects on the way down. T. 56. When he went to Concentra, on July ~~14, 2012,~~ he mentioned his prior cervical fusion and complained of his neck, back, shoulders and hips. T. 57. He was told to return on July 16th and begin physical therapy but he never went back to Concentra after July 14, 2012. He decided to see Dr. Koutsky instead. He did not see Dr. Koutsky until 68 days later. T. 57-58.

Petitioner acknowledged having "chronic pain syndrome" since 1989. T. 59. This problem waxed and waned over the years but never fully resolved. T. 59. He began seeing Dr. Gurevich for back and neck pain in 2008. T. 60. He also had some shoulder pain before the accident but it was "nothing major." T. 60. On July 3, 2012, he complained to Dr. Gurevich of more pain than usual. On that date, the doctor switched his medication from Vicodin to Oxycodone. T. 60-62. He acknowledged telling the doctor he had been taking days off work due to pain. T. 62. Before the accident, he was taking about a day off per week. T. 63. After the work accident, he continued working until Dr. Koutsky took him off work in January 2013. T. 64. On December 12, 2012, he told Dr. Gurevich he was not able to work. T. 64. He last worked for Respondent on January 7, 2013. He told Dr. Koutsky his pain had flared up due to the holidays but he actually experienced "progressive" pain over time. He had hoped to keep working but Respondent "stonewalled" his request to undergo therapy. T. 65. Respondent had changed his job before Dr. Koutsky took him off work. It was because of this job change that he wanted to be taken off work. T. 66. After January 7, 2013, he did not discuss the possibility of returning to restricted duty with Dr. Koutsky. Respondent mentioned this to him but wasn't letting him come back to work under any circumstances. T. 70. He is still seeing Dr. Koutsky and has an upcoming appointment. T. 71. He performs prescribed exercises at home. T. 71. He did not see Dr. Koutsky before the work accident but he did see the doctor's partner, Dr. Nikoleit for his knees. T. 72.

Petitioner testified his August 15, 2012 appointment with Dr. Gurevich was a regular, pre-scheduled visit. T. 74. He was experiencing a "little bit" of trapezius pain in January 2012. T. 75. At that time, he told Dr. Gurevich he was concerned about losing his job. T. 76.

Respondent kept switching him from one job assignment to another. T. 75. He does not recall telling Dr. Gurevich on May 30, 2012 that he was concerned about his finances and losing his job. T. 78. Dr. Gurevich recommended back and neck MRI scans on July 3, 2012. T. 81. He first complained of his shoulders to Dr. Koutsky in March 2013. T. 81. At two of his visits to Elmhurst Orthopaedics, he saw Dr. Koutsky's assistant rather than Dr. Koutsky. T. 82-83. His therapy at Medchoice and Swedish American was discontinued due to lack of progress. Therapy has never really helped him. T. 84-85. He has plateaued with his medication but he would "really have problems" if he did not take that medication. T. 84-85. The trigger point injections he underwent did not provide lasting relief. He "let" the doctors administer those injections. He does not really feel the effects of the injections. T. 85-86. Dr. Koutsky has recommended repeat MRIs but the MRIs have not been authorized. T. 86. His use of Oxycontin at work built up after the accident. T. 88. As of his July 3, 2012 visit to Dr. Gurevich, Respondent was "working [him] too much" and his pain was worsening. T. 89. He did not receive a copy of the accident report he completed. T. 89. He was diagnosed with a lumbar disc in 1988 but the surgery he underwent involved only his cervical spine. T. 89-90.

On redirect, Petitioner testified that, during the summer of 2012, he was not able to obtain authorization from Respondent to undergo physical therapy at work. T. 90. As of his July 3, 2012 visit to Dr. Gurevich, his job had worsened because Respondent had started hiring non-union janitors. "Every time someone went back to the floor, someone got fired." Respondent did not provide substitutes for the janitors who quit or called in sick, as they had in the past. Instead, Respondent expected the remaining janitors to pick up the slack. T. 91. For a while, he was performing work that was originally performed by three different people. This took a toll on him. T. 91-92. He continued working but took a few days off each month due to pain and the increased workload. T. 92. After the accident, he "couldn't really do the job anymore." He could no longer lift overhead. Instead of going through his assigned section four times per shift, as required, he would go through only once. T. 93. He was always looking for a place where he could sit and rest. T. 93. He did not recall complaining of his shoulder to Dr. Koutsky in March 2013. He complained of his shoulders when he first went to Concentra. As of January 2013, Dr. Koutsky was aware of what his job entailed. T. 94. Dr. Gurevich administered shoulder injections in August 2012. He did not recall undergoing any shoulder injections prior to that date. T. 94-95. His physical therapist ignored his shoulders and hips. Respondent never offered him light duty. His janitorial job was classified as light duty at Respondent. T. 95-96.

Under re-cross, Petitioner denied being angry about having to perform the work of three people. He was not happy about this but he did the work. T. 97. He is not claiming repetitive trauma. T. 95-96. Dr. Koutsky never released him to light duty. T. 98. He worked at Respondent's facility in Melrose Park. It rained in Melrose Park on the day of the accident. T. 99.

Respondent did not call any witnesses at the hearing. In addition to the exhibits previously discussed, Respondent offered into evidence weather-related data from the National Climatic Data Center for the Melrose Park, Illinois area for July 12 and 13, 2012. The records reflect 0.00 inches of precipitation for both dates. RX 7.

Petitioner was recalled in rebuttal. He remembered Respondent's warehouse being wet at the time of his accident. There was "water all over the receiving dock." T. 119. He assumed it had rained but he did not actually see it rain. The entire side of the warehouse, which extends 100 to 150 feet, was wet. T. 119-120.

Under cross-examination, Petitioner reiterated he did not see it rain on July 13, 2012. T. 120. Water had accumulated in the warehouse on a prior occasion. He acknowledged testifying earlier in the hearing that he had seen rain blowing sideways on the date of the accident. T. 121.

On redirect, Petitioner testified he lived in Rockford at the time of the accident. He started his day there and did not begin work at Respondent's Melrose Park facility until 2 PM. T. 122-123.

Under re-cross, Petitioner acknowledged driving from Rockford to Melrose Park on July 13, 2012. He would have seen the weather conditions while making this drive. T. 123-124.

Arbitrator's Credibility Assessment

The evidence bearing on Petitioner's credibility is mixed.

Petitioner's lengthy tenure with Respondent weighs in his favor, credibility-wise, but his very specific testimony on direct as to the wind, "horizontal rain" and flooding conditions on the morning of July 13, 2012 is in conflict with the documents offered by Respondent. Those documents show 0.00 inches of precipitation in Melrose Park (where Respondent's warehouse is located) on July 12 and 13, 2012. RX 7. After Petitioner was confronted with these documents, he resumed the stand, reversed himself and claimed he did not actually see it rain on July 12th. This reversal is of concern to the Arbitrator but it does not necessarily mean that Petitioner did not slip on a wet floor and fall backward while working, as he claimed. Most of the medical records in evidence document this fall. Dr. Gurevich's history of August 15, 2012 is somewhat inconsistent but the doctor is not a native speaker of English and acknowledged errors in dictation. PX 5 at 28.

Respondent did not offer any evidence contradicting Petitioner's testimony that he promptly reported the accident and completed an accident report. Respondent also did not contradict Petitioner's testimony that there were five cameras in the vicinity of his fall and that, when he requested the footage, he was told it had "disappeared."

Petitioner's testimony that the claimed work fall resulted in a "day and night" change in his symptoms and ability to work is at odds with Dr. Gurevich's pre-accident records. Only ten days before the fall, Dr. Gurevich documented significant symptoms, with Petitioner reporting he had taken three to four days off work that month due to those symptoms.

Neither Dr. Koutsky nor Dr. Gurevich noted symptom magnification. Dr. Singh, Respondent's spine examiner, noted no positive Waddell's signs. He described Petitioner as "putting forth a reasonable examination." Dr. Verma, Respondent's shoulder examiner, noted a complaint of arthritic pain in all body parts other than the pinkies and toes but acknowledged that Petitioner did not magnify his shoulder symptoms.

Petitioner denied re-injuring his neck, back, hips and shoulders after his claimed work fall but, on October 8, 2014, Dr. Koutsky's assistant noted that Petitioner reported having recently injured his right shoulder while undergoing stroke-related therapy. Petitioner underwent a repeat right shoulder MRI after this injury. PX 2

The Arbitrator accords Petitioner some deference, credibility-wise, based on the evidence that he sustained a stroke in mid-2014 and that therapists and other providers documented problems with his memory and concentration following this event.

Arbitrator's Conclusions of Law

Did Petitioner sustain an accident on July 13, 2012 arising out of and in the course of his employment?

The Arbitrator finds in Petitioner's favor on the issue of accident, despite the inconsistencies noted above. In so finding, the Arbitrator relies in part on Petitioner's testimony as to the prompt reporting of the accident. The Arbitrator also relies on Petitioner's testimony as to the presence of five cameras in the vicinity of the accident and Respondent's response to his request for the footage from these cameras. The Arbitrator further relies on the relatively consistent histories that appear in the initial post-accident records, i.e., those from Concentra and Dr. Koutsky.

While it would be easy enough to conclude that Petitioner "staged" the fall, due to his increased workload and the concerns he expressed to Dr. Gurevich on July 3, 2012, the Arbitrator declines to draw this conclusion. A person who "fakes" a work accident presumably seeks to benefit from the event. The only benefit Petitioner elected to receive from the initial reporting was one visit to Concentra. At that visit, Dr. Mohsin diagnosed strains and recommended some therapy, which Petitioner did not pursue. The doctor did not impose any restrictions, secondary to Petitioner "stating that he can perform regular duty." This statement would not be expected from a person whose goal was to use the reporting of an accident to secure time off from work.

Did Petitioner establish a causal connection between his work fall of July 13, 2012 and any claimed current condition of ill-being?

The Arbitrator initially addresses Petitioner's claimed bilateral shoulder condition of ill-being. The Arbitrator finds that the work fall of July 13, 2012 aggravated a pre-existing but largely asymptomatic bilateral shoulder condition and brought about the need for the

injections Dr. Gurevich performed in August 2012 and the bilateral shoulder MRI scans Petitioner underwent in 2013. With respect to the left shoulder, the Arbitrator finds the work fall aggravated and made symptomatic an impingement condition. With respect to the right shoulder, and in reliance on Dr. Koutsky, the Arbitrator finds the work fall resulted in a partial-thickness rotator cuff tear. In so finding, the Arbitrator relies on the following: 1) Petitioner's description of falling backward, landing on concrete; 2) the Concentra records, which show that Petitioner complained of his shoulders one day after the accident; 3) Dr. Gurevich's pre-accident 2012 records, which do not document any complaints specific to either shoulder; 4) Dr. Gurevich's note of August 15, 2012 and her testimony as to the shoulder abnormalities she documented on that date; and 5) Dr. Koutsky's testimony that the work fall aggravated an underlying bilateral shoulder condition and caused a right partial-thickness rotator cuff tear.

In analyzing causation as to the shoulders, the Arbitrator has considered the opinions voiced by Respondent's shoulder examiner, Dr. Verma. While Dr. Verma diagnosed a bilateral shoulder condition, i.e., mild impingement, for which he recommended injections, and conceded at his deposition that "a fall could be a causative mechanism for a shoulder injury in general," he did not believe that the work fall caused or aggravated the impingement. He based his opinion on what he perceived as a significant delay between the work fall and the shoulder complaints documented by Dr. Koutsky in March 2013. There is no indication he reviewed Dr. Gurevich's note of August 15, 2012, documenting a work fall and shoulder complaints. He also conceded he never saw the shoulder MRI images. RX 1 at 18-19. The Arbitrator concludes that Dr. Verma lacked vital causation-related information.

The Arbitrator finds that Petitioner did not establish causation as to the right shoulder complaints that resurfaced in the latter part of 2014, requiring a repeat MRI, therapy and additional injections. The Arbitrator attributes the need for that care to a right shoulder re-injury Petitioner sustained while undergoing stroke-related therapy. The Arbitrator also notes Dr. Gurevich's testimony that the stroke affected the right side of Petitioner's body. PX 5 at 13, 15.

The Arbitrator next considers the question of whether the work fall caused or aggravated a bilateral hip condition, as Petitioner claims. The Arbitrator finds that, while the fall may have resulted in bilateral hip pain, as documented in the initial Concentra records, Petitioner did not establish causation as to any specific hip condition. The bilateral hip MRI scans performed in 2013 showed only mild degenerative changes.

With respect to the spine, the Arbitrator finds that the work fall did not aggravate Petitioner's pre-existing cervical and lumbar spine conditions of ill-being or the chronic pain syndrome resulting from those conditions. Dr. Gurevich testified she took over treatment of that syndrome from another physician in 2008 and saw Petitioner on a regular basis thereafter. Dr. Gurevich's January – July 2012 records show that Petitioner complained of worsening neck and back pain and indicated he was having difficulty performing his job. When Dr. Gurevich saw Petitioner on July 3, 2012, only ten days before the work fall, she prescribed a new, stronger narcotic pain medication as well as a lumbar spine MRI and physical therapy. She also

indicated it was "possible" Petitioner would need a cervical spine MRI. In the Arbitrator's view, the doctor did not fully acknowledge the significance of her July 3, 2012 findings and recommendations when she addressed causation insofar as the spine is concerned.

The Arbitrator assigns little weight to Dr. Koutsky's spine-related causation opinions, primarily because the doctor did not thoroughly review Dr. Gurevich's pre-accident records prior to rendering those opinions. Instead, he relied on a hypothetical that did not incorporate all of the doctor's findings. He did review Dr. Gurevich's July 3, 2012 note during the deposition and testified this note did not prompt him to change his opinions, but the Arbitrator finds this testimony unpersuasive. Dr. Gurevich's pre-accident records paint a picture of a person with steadily worsening spinal complaints requiring a diagnostic work-up and therapy. Petitioner did not undergo the work-up and therapy until after the accident but that does not mean the accident was a contributing factor.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims a number of medical bills including, oddly, bills from the University of Illinois clinics that appear to relate to his 2014 stroke. PX 7.

Based on the foregoing causation analysis, the Arbitrator awards Petitioner the expenses associated with his August 15, 2012 visit to Dr. Gurevich, including the office visit charge of $300.00 and the $3,440.00 associated with the bilateral shoulder injections the doctor performed on that date. The Arbitrator acknowledges Petitioner's testimony that his August 15, 2012 visit was pre-scheduled and part of his regular protocol. However, as Dr. Gurevich explained at her deposition, the visit was different from others in that Petitioner voiced new shoulder complaints secondary to the work fall, with those complaints requiring evaluation and care. The Arbitrator also notes that Dr. Verma, Respondent's shoulder examiner, conceded the need for bilateral shoulder injections, although he did not link that need to the work fall. The Arbitrator also awards Petitioner Dr. Koutsky's charge of $105.00 for the office visit of March 14, 2013 and the charges of $3,800.00 for the bilateral shoulder MRI scans performed on March 19, 2013.

The Arbitrator declines to award the expenses associated with the right shoulder injections Dr. Gurevich administered later, in the fall of 2014, because it appears that the need for those injections stemmed from the June 2014 stroke and/or a right shoulder re-injury Petitioner sustained while undergoing therapy in connection with the stroke. Petitioner does not claim any relationship between the work fall and the stroke. When Petitioner saw Dr. Gurevich on February 12, 2014, about three months before the stroke, he complained of only "very mild" bilateral shoulder pain and the doctor noted "normal movement of all extremities." Gurevich Dep Exh 2. When Petitioner's shoulder complaints resurfaced, after the stroke, they were severe and unilateral.

The Arbitrator also awards the $3,250.00 and $2,350.00 expenses associated with the cervical and lumbar spine MRI scans performed on November 12, 2012. [See charges in

itemized bill from Elmhurst Orthopaedics, PX 8.] In awarding these expenses, the Arbitrator relies on Respondent's spine examiner, Dr. Singh, who indicated the MRIs needed to be performed to rule out accident-related interval changes, citing Petitioner's "reasonable examination." RX 4.

The Arbitrator awards the foregoing enumerated expenses subject to the fee schedule.

Is Petitioner entitled to temporary total disability benefits?

Petitioner acknowledged he continued performing his regular job after the accident until Dr. Koutsky took him off work in January 2013. He claims temporary total disability benefits from January 13, 2013 through the hearing of May 12, 2016. Arb Exh 1.

The Arbitrator has found causation only as to a bilateral shoulder condition that required injections in August 2012 and an office visit and MRI scans in March 2013. The Arbitrator views the causally related bilateral shoulder condition as stabilizing as of February 12, 2014. [See further below]. Dr. Koutsky took Petitioner off work in January 2013, two months before he noted any shoulder complaints. Dr. Koutsky continued to keep Petitioner off work after the shoulder complaints "came more to the forefront," to use his words, but he never indicated he was doing so because of the shoulder condition. He focused primarily on Petitioner's neck and back condition. The Arbitrator has previously found that the work fall did not bring about a change in that condition.

Based on the foregoing, the Arbitrator declines to award temporary total disability benefits in this case.

Has Petitioner reached maximum medical improvement with respect to any causally related condition of ill-being? If so, what is the nature and extent of injury?

The Arbitrator has previously found causation only as to a bilateral shoulder condition that brought about the need for the injections Dr. Gurevich administered in August 2012 and the MRIs performed in March 2013. Those MRIs showed tendinosis, arthritic changes and, according to Dr. Koutsky, a possible small right full-thickness rotator cuff tear. PX 3 at 16. At his deposition, Dr. Koutsky theorized Petitioner might require surgery to repair that tear but the doctor gave that deposition months before Petitioner's February 12, 2014 visit to Dr. Gurevich, at which time the doctor documented only "very mild" shoulder pain. The Arbitrator views Petitioner as reaching maximum medical improvement for his causally related bilateral shoulder condition as of February 12, 2014. For the reasons explained above, the Arbitrator does not view the subsequent right shoulder complaints and treatment as stemming from the work fall.

As noted at the outset, while Petitioner technically proceeded pursuant to Section 19(b), the parties agreed the Arbitrator could address permanency if she found the case compensable and found Petitioner to be at maximum medical improvement. With respect to the left

shoulder condition, the Arbitrator awards 2.5% loss of use of the person as a whole, equivalent to 12.5 weeks of compensation, pursuant to Section 8(d)2 of the Act. With respect to the right shoulder condition of ill-being, and based on Dr. Koutsky's diagnosis of a full-thickness rotator cuff tear (PX 3 at 16), the Arbitrator awards 10% loss of use of the person as a whole, equivalent to 50 weeks of compensation, pursuant to Section 8(d)2 of the Act. No other permanency is awarded, based on the Arbitrator's causation analysis.

STATE OF ILLINOIS)
) SS:
COUNTY OF KANE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dariusz Opadczuk,

Petitioner,

vs. NO: 13 WC 7843

Arrow Plastic,

Respondent.

ORDER

A "Motion to Countermand the Settlement" having been filed by Petitioner herein, due notice having been given, this cause came before Commissioner Thomas J. Tyrrell for hearing on January 11, 2017 in Geneva, Illinois. The Commission, having jurisdiction over the persons and subject matter, and after being advised in the premises, denies Petitioner's motion, for the reasons set forth below.

The record shows that settlement contracts were approved in this matter by Arbitator Granada on 12/8/16.

In his motion, Petitioner alleges that on 12/9/16 he asked his attorney to try to contact the Arbitrator in order to request that he refrain from approving the contract in question so that he could "... investigate whether he needed more medical treatment." (Petitioner's Motion to Countermand the Settlement, p.2). Counsel also represents that on that date he forwarded an email to the Arbitrator making such a request on behalf of his client, and that the Arbitrator subsequently replied later that same afternoon that the contracts had already been approved a day earlier. (Id.).

The Commission notes that approval of a settlement agreement constitutes a decision of the Commission and is, in legal effect, the equivalent of an award within the meaning of §19(g). *Ahlers v. Sears Roebuck, Co.*, 73 Ill.2d 259, 265, 383 N.E.2d 207, 210 (1978). Absent fraud or a clerical error, review of an approved lump sum settlement is specifically prohibited under §19(f) of the Act. See *Gillmore v. Ideal Industries, Inc.*, 74 Ill.App.3d 143, 392 N.E.2d 933 (4th Dist. 1979).

In the present case, Petitioner is alleging neither fraud nor a clerical error. Instead, Petitioner is essentially looking to void the contract in order to possibly pursue additional treatment for the accidental injuries which were the subject of the settlement. However, Petitioner has provided no statutory or case law precedent in support of his argument that the Commission has the authority to provide such relief. Indeed, the Workers' Compensation Act and Rules Governing Practice Before the Commission are noticeably silent on the matter.

Along these lines, it is important to remember that worker's compensation is a statutory remedy and the Workers' Compensation Commission, as an administrative agency, is without general or common law powers. *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission*, 236 Ill.2d 132, 145, 923 N.E.2d 266, 337 Ill.Dec. 707 (2010); See *Flynn v. Industrial Commission*, 211 Ill.2d 546, 553, 813 N.E.2d 119, 286 Ill.Dec. 62, (2004); *Cassens Transport Co. v. Industrial Commission*, 218 Ill.2d 519, 525, 844 N.E.2d 414, 300 Ill.Dec. 416 (2006).

Despite Petitioner's second thoughts, the contract in question was duly executed by Mr. Opadczuk, signed by both attorneys and properly approved by Arbitrator Granada. The Commission notes that the law is quite clear as to the finality of settlement agreements, and points to the obvious need for finality in such matters, else the system would be flooded by similar instances of "buyer's remorse", with no end to such appeals.

Based on the above, the Commission finds that it lacks the statutory authority to grant Petitioner's request to countermand the approved settlement contract in question, and Petitioner's request for said relief is hereby denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's "Motion to Countermand the Settlement" is hereby denied.

DATED: MAR 28 2017

Thomas J. Tyrrell

r-1/11/17
TJT/pmo
51

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

YVONNE BELL,

Petitioner,

vs. NO: 12 WC 35484

CITY OF CHICAGO - SANITATION,

Respondent.

ORDER

This matter comes before the Commission on Petitioner's Motion for 19(k) Penalties and Attorneys Fees, which was filed on May 4, 2016. A hearing was held before Commissioner DeVriendt on June 6, 2016. No record was made.

On September 2, 2015, Arbitrator Mason awarded Petitioner temporary total disability benefits, maintenance benefits and temporary partial disability benefits. Respondent took a review from Arbitrator Mason's award. On March 3, 2016, the Commission issued its decision, affirming and adopting the award of Arbitrator Mason, including the credit of $99,479.54. After subtracting the amount of the award, Respondent had a credit of $10,626.58.

On or about April 12, 2016, Respondent advised Petitioner's counsel that a balance of $5,076.44 of the credit remained, for which Respondent would temporarily cease paying benefits until the amount of the credit was exhausted. As Petitioner had been over paid, there were no unreasonable and vexatious delays in payment of the Arbitrator's Award affirmed by the Commission.

For the above stated reasons, the Commission denies Petitioner's Motion for 19(k) penalties and Attorneys' Fees.

DATED: MAR 2 2 2017

CJD/dmm
49

Charles J. DeVriendt

L. Elizabeth Coppoletti

Joshua D. Luskin

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Walter Bass,

Petitioner,

vs. NO: 13WC001473

Employee Solutions LLC d/b/a Chicago Mack Truck,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, temporary total disability, medical, 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 January 27, 2017 is hereby affirmed and adopted.

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

17IWCC0155

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

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

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

DATED: MAR 13 2017

Charles J. DeVriendt

Joshua D. Luskin

Kevin W. Lamborn

o030817
CJD/rlc
049

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

BASS, WALTER
Employee/Petitioner

Case# **13WC001473**

EMPLOYEE SOLUTIONS LLC D/B/A CHICAGO MACK TRUCK
Employer/Respondent

17IWCC0155

On 1/27/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0533 ROSS TYRRELL LTD
JAMES E TYRRELL
111 W WASHINGTON ST SUITE 1120
CHICAGO, IL 60602

1408 HEYL ROYSTER VOELKER & ALLEN
LYNSEY WELCH
PO BOX 1288
ROCKFORD, IL 61105-1288

17IWCC0155

W. Bass v. Employee Solutions, etc., 13 WC 01473

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)

WALTER BASS
Employee/Petitioner

v.

EMPLOYEE SOLUTIONS, LLC d/b/a CHICAGO MACK TRUCK
Employer/Respondent

Case # 13 WC 01473

An *Application for Adjustment 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 **2/3/2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 12/23/2011, Respondent ~~was~~ operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$58,572.80**; the average weekly wage was **$1,126.40**.

On the date of accident, Petitioner was **56** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $99,130.51 for TTD, $1,520.78 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $100,651.59.

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 $750.93/ week from 12/24/2011 through 2/3/2015, as provided in Section 8(b) of the Act. Respondent shall receive a credit for TTD and TPD payments made to Petitioner from 12/24/2011 to 10/28/2014 in the amount of $100,651.59. The Parties agreed that all lost time benefits have been paid through 10/28/2014 (132 weeks of TTD benefits and 4 weeks of TPD benefits). Thus, Respondent shall pay Petitioner **temporary total disability benefits of $750.93/week for 13-6/7 weeks, commencing 10/29/2014 thru 2/3/2015,** as provided in **Section 8(b) of the Act.**

Respondent shall authorize and pay for the right wrist re-fusion revision procedure with iliac crest bone graft and morphogenic protein recommended by Dr. Thomas Wiedrich,M.D. on 10/15/2014 and in his Evidence Deposition testimony, in accordance with **Sections 8(a) and 8.2 of the Act.**

Petitioner's claim for Penalties under Sections 19(l) and 19(k) and Attorney's Fees under Section 16 of the Act is denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of temporary total disability, medical benefits, or compensation for a permanent disability, if any.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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

1/27/2016
Date

JAN 27 2016

FINDINGS OF FACT

Petitioner was employed as a diesel mechanic by Respondent, Employee Solutions, LLC. Respondent was formerly known as Chicago Truck Sales and sold and serviced Mack and Volvo trucks out of an Alsip, Illinois location.

Petitioner has spent the majority of his life (38 years) working as a diesel truck mechanic or as a mechanic supervisor. He has some high school education and additional schooling in diesel engine maintenance.

Petitioner's work as a diesel mechanic for Respondent was very hands on, physical, work. He replaced brakes, did front end work, suspensions, differentials, axles, springs and clutch work. He used his hands in all of his duties, usually with tools such as screwdrivers, sockets, wrenches, pliers and side cutters. Some of the tools he used were quite heavy, such as torque wrenches and air drive impact guns. His work required hand/wrist movements such as flexion, extension, pronation and supination, almost always with tools and while applying force. Petitioner is left hand dominant.

Petitioner was in good health and asymptomatic regarding his right hand/wrist up until the morning of December 23, 2011. He had been diagnosed with bilateral carpal tunnel syndrome in 2005, which required surgical releases (2 in the right hand) performed in 2005 by hand surgeon Dr. Thomas Wiedrich. Petitioner last treated with Dr. Wiedrich in April of 2006 for the carpal tunnel syndrome, when he was released to full duty work as a diesel mechanic (with restrictions that he avoid use of the right hand on hot surfaces and for Petitioner to always maintain visual contact with his right hand). From the April, 2006 return to work until December 23, 2011, Petitioner did not receive any medical care or miss any time from work regarding his right hand. He had no right hand symptoms or problems until December 23, 2011, other than occasional wrist soreness, consistent with his hand intensive job duties.

Petitioner reported to work for Respondent at 7:00 AM on December 23, 2011, and was assigned to remove the chassis electrical harness on a late model White/Volvo truck. A chassis harness is a bundled mass of electrical wires running from the truck cab into the engine compartment providing power to the electrical components of the truck. In order to replace the chassis harness, Petitioner had to reach into the engine compartment to remove the chassis harness from the truck frame. The chassis harness was securely fastened to the truck frame with 30 to 35 plastic zip-ties.

Petitioner had removed about twenty to twenty five of the zip-ties when he attempted to cut a zip-tie securing the chassis harness to the crossmember of the truck frame. The crossmember was located at the bottom of the engine and Petitioner was not authorized to access it from underneath the truck. Due to the positioning of this zip-tie, Petitioner had to stand on a wooden crate, lean over the engine and, with his non-dominant hand, reach all the way into the engine compartment while grasping an industrial sized pair of side cutters. The zip-tie was about the width of a penny and about as thick. Petitioner was unable to get the side cutter blade between the zip-tie and the crossmember and had to cut the zip-tie width-wise. Petitioner had to hyperflex his wrist while applying force on the side cutters to grasp and then cut the zip-tie. The side cutter was a large commercial grade cutter (a Knipex, a little over 10" long in total, handle about 6 ½" long, cutting element 2" long and about 1 ½" wide). Petitioner applied as much force as he could to attempt to cut the zip-tie. As Petitioner was performing this task, he heard a "pop" which he later described as like cutting a chicken bone. He felt severe right wrist pain and noticed swelling. He pulled his hand out of the engine compartment and notified his supervisor of what had occurred. Petitioner was sent to Respondent's clinic for treatment.

Petitioner received initial medical attention at Southwest Industrial Care, where he was seen by a physician named Dr. Kang. Dr. Kang recorded Petitioner's history as "while at work he was working on a truck with chassis harness, had R hand in frame trying to cut zip ties when he squeezed the cutters he heard a snap in the R wrist. At that time felt sharp pain then a 'heavy' pain." (PetEx. 3) Dr. Kang provided Petitioner with a wrist support and medications. Petitioner followed up with another Southwest Industrial Care physician, Dr. R.

du Puis, on December 28, 2011. An MRI of the right wrist was ordered. The MRI revealed a full thickness tear of the scapholunate ligament with widening of the scapholunate joint space. Dr. du Puis recommended that Petitioner consult with a hand surgeon. Petitioner chose to receive treatment from Dr. Wiedrich. (PetEx. 3)

Petitioner saw Dr. Wiedrich on January 23, 2012, complaining of pain over the dorsal and radial side of the right wrist. Dr. Wiedrich noted that Petitioner was "working with a truck. His wrist was in a hyperflexed position and he had a pair of shears. As he went to cut a zip tie, he felt a 'pop' in his wrist. He had immediate pain and swelling." Dr. Wiedrich diagnosed sprain/strain wrist and concluded that Petitioner had at some point a scapholunate dissociation. Dr. Wiedrich recommended that Petitioner undergo a diagnostic wrist arthroscopy, which was performed on February 28, 2012. (PetEx. 2)

Dr. Wiedrich determined during the surgery that Petitioner had a complete tear of the scapholunate ligament. Dr. Wiedrich was unable to conclude whether the ligament completely tore during Petitioner's accident or whether there was then just an "extension" of the injury. Dr. Wiedrich explained that an extension of the injury meant that the ligament could have been in the process of stretching over time and the accident was a sudden event that caused it to tear the rest of the way. In either situation, Dr. Wiedrich opined that Petitioner had sustained a significant change, either an aggravation of Petitioner's arthritis or an extension of a probable pre-existing scapholunate ligament injury. Petitioner had an event, not a gradual degenerative problem. Furthermore, Petitioner did not sustain a temporary aggravation of a pre-existing arthritic condition because his symptoms did not clear up after the first surgery. (PetEx. 4)

Dr. Wiedrich scheduled Petitioner for a second surgery, a "four corner fusion" which Petitioner underwent on April 24, 2012. In this procedure, Dr. Wiedrich removed Petitioner's right wrist scaphoid bone and realigned and fused the carpal bones. Petitioner was suffering from "SLAC" wrist, scapholunate advanced collapse, which was a consequence of the scapholunate dissociation earlier diagnosed by the doctor. (PetEx. 4)

After having another surgery to remove surgical pins, Petitioner underwent several months of rehabilitation under Dr. Wiedrich's supervision. By December of 2014, Petitioner's wrist pain had returned and

a CT scan revealed that the previously fused wrist bones were separating. Dr. Wiedrich then recommended a total wrist fusion, which Petitioner eventually had on June 25, 2013. Dr. Wiedrich opined that the total wrist fusion was causally related to Petitioner's work accident. (PetEx. 4)

Petitioner made good progress after the total wrist fusion, although his recovery was delayed by tendonitis which cleared up with some cortisone injections. In May of 2014, Petitioner began a formal therapy program, which was initially beneficial. By July of 2014, he experienced a recurrence of hand pain, especially with activities around his house. Petitioner returned to Dr. Wiedrich, who determined after an x-ray that the surgical plate applied during the fusion had become separated from the metacarpal bones. A further CT scan demonstrated that the fused bones had not healed and, on October 14, 2014, Dr. Wiedrich recommended re-fusion revision of the right wrist using a bone graft from Petitioner's hip. (PetEx. 2) Respondent had provided all of Petitioner's medical care up until that point.

Respondent contested its liability for the revision surgery and TTD payments based on the opinion of its expert Dr. Michel Vender, who examined Petitioner on October 31, 2012 and September 17, 2014. Dr. Vender agreed with the necessity for the revision re-fusion recommended by Dr. Wiedrich, but did not feel that the surgery was causally related to the events of December 23, 2011. In Dr. Vender's opinion, Petitioner did not sustain an accident on December 23, 2011, but rather was on that date only doing normal activities at work and was experiencing the natural progression of a degenerative disease. Petitioner did not experience an "acute" injury, such as a fall. The was no specific injury that could be considered an exacerbating factor. Dr. Vender did not recall the exact history that Petitioner gave, but recorded "(h)e was reportedly replacing a harness when he heard a pop in his right wrist." (ResEx. 2) At his deposition, Dr. Vender did not recall the specific medical records that he reviewed. Dr. Vender agreed that all of Petitioner's medical treatment had been reasonable. (ResEx. 5)

Petitioner testified that the examination by Dr. Vender took about 15 minutes. Dr. Vender did not ask Petitioner how the injury happened. Dr. Vender did not ask Petitioner to demonstrate the position of his body and right hand at the time of the injury. He did not ask about the position of petitioner's right wrist at the time of the injury. Dr. Vender did not ask Petitioner about the amount of force that he was applying to the cutters at the time of the injury.

Respondent ceased paying TTD and medical benefits after October 28, 2014. No evidence of compliance with Rule 7110.70 was submitted into evidence.

Petitioner testified that he has not seen any medical professional since his last visit with Dr. Wiedrich on October 14, 2014 and has not been returned to work by any medical professional. He has not returned to work in any capacity. He described to the Arbitrator experiencing constant dull to sharp pain in the dorsal right wrist. He cannot lift more than one pound with his right hand. He helps his wife with household chores such as vacuuming and drying dishes using his left hand. He cuts his grass with a riding mower and has used only his left hand while helping with household projects such as building a dog fence with his grandson and with his wife replacing a toilet. Two to three times a week his right hand pain awakens him from sleep and on those nights he gets two to three hours of sleep. None of the complaints that Petitioner described to the Arbitrator were present before the accident of December 23, 2011.

Dr. Wiedrich, a board certified plastic surgeon with a subspecialty in hand surgery, testified by way of evidence deposition for Petitioner on December 4, 2014. (PetEx. 4) Dr. Vender, a board certified orthopedic surgeon with a subspecialty in hand surgery, testified by way of evidence deposition for Respondent on January 9, 2015. (ResEx. 5)

The Parties agreed that all medical bills and lost time compensation through October 28, 2014 had been paid by Respondent.

Petitioner testified that he wants to undergo the re-fusion revision procedure that has been offered by Dr. Wiedrich.

CONCLUSIONS OF LAW

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

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on December 23, 2011, based upon the unrebutted and credible testimony of Petitioner, the medical records and the credible testimony of Dr. Wiedrich.

Petitioner was performing a physically challenging task, leaning into the engine compartment with his wrist in a hyperflexed position, applying force to the side cutter (both by squeezing the handles and by pushing on the cutter) in order to cut a large and thick zip-tie so that he could remove the harness from the truck that he was working on. He heard a pop and felt sharp, then intense pain in his right wrist, either sustaining a scapholunate ligament tear, or suffering an extension (a sudden event causing a tear of the ligament, per Dr. Wiedrich) or an aggravation or exacerbation of a degenerative condition of the wrist. There was a definite time place and circumstance of the injury. There is a clear nexus between Petitioner's work activity and the injury.

The injury arose out of Petitioner's employment, as he was performing a work task involving obvious physical difficulty and risk of injury such that there is a causal connection between the employment and the injury. The injury obviously occurred in the course of Petitioner's employment, as he was at work, performing the duties of a diesel mechanic when the injury occurred. Sisbro, Inc. v. Industrial Comm'n, 207 Ill.2d 193 (2003)

Dr. Vender's testimony, that there was no acute event (such as a fall) and, therefore, there was no accidental injury is not believable and does not comport with the facts of this case. Dr. Vender analogized Petitioner's injury to where a patient would experience a pop or pain opening a car door, his door at home or shaking hands. As is noted above, Petitioner's wrist was injured performing a physically difficult work task. If Dr. Vender had taken a detailed history of accident from Petitioner and had reviewed the initial medical histories to Southwest and Dr. Wiedrich (we don't know if he did so, because he could not confirm exactly what records he reviewed), perhaps his opinion would have changed. In any event, Dr. Vender's opinion is not persuasive, given the remainder of the evidence adduced which clearly establishes a definite traumatic event involving Petitioner's right wrist caused by the stresses of cutting the zip-tie on the chassis harness.

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 current condition of ill-being regarding his right wrist (status post scapholunate tear, which was traumatically induced, aggravated or exacerbated by a work injury of 12/23/2011, status post 4 surgeries,with a pending re-fusion revision of a total wrist fusion) is causally related to the injury based upon the unrebutted and credible testimony of Petitioner, the medical records and the persuasive opinions of Dr. Wiedrich. Clearly Petitioner had preexisting osteoarthritis in his wrist, but the work injury caused Petitioner's wrist to become symptomatic, such that surgery was required to alleviate pain and disfunction.

Dr. Vender's opinions on causation are not persuasive for the reasons stated above regarding the Arbitrator's finding on the issue of accident.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Based upon the Arbitrator's findings above regarding accident and causation and the opinions of Drs. Wiedrich and Vender, Petitioner is entitled to prospective medical care in the form of the re-fusion, revision procedure that Dr. Wiedrich has offered Petitioner. Accordingly, Respondent shall authorize and pay for the proposed procedure, along with all related services, in accordance with §§8(a) and 8.2 of the Act.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

The Parties agreed that all TTD and TPD had been paid through October 28, 2014. Given the Arbitrator's findings above, Petitioner has not reached MMI and is entitled to TTD benefits beginning October 29, 2014 through February 3, 2015. See: Interstate Scaffolding v. Workers' Compensation Comm'n, 236 Ill.2d 132 (2010)

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES OR FEES BE IMPOSED UPON RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Considering the entire Record, the Arbitrator finds that Penalties should not be imposed on Respondent in this case. Respondent did pay benefits and authorize treatment for Petitioner through October 28, 2014. The Arbitrator finds this conduct to be in good faith. Respondent's disputes after October 28, 2014 are based upon Dr. Vender's opinions. While the Arbitrator has found that Dr. Vender's opinions on causation and accident are defective and not persuasive, Respondent's reliance upon a board certified orthopedic surgeon's opinion is not unreasonable and does not appear to be vexatious in this case. Thus, Petitioner's claim for Penalties and Attorney's Fees is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt	☐ 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

Roberto Ortiz

Petitioner,

17IWCC0149

vs.

NO: 13 WC 3470

Four Seasons Hotel,

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 benefit rate, temporary total disability, temporary partial disability, causal connection, reasonableness and necessity of medical treatment, and prospective medical and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary partial compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Petitioner appealed the May 3, 2016 19(b) Decision of Arbitrator Huebsch finding that Petitioner, a 49 year-old room server, sustained accidental injuries arising out of and in the course of his employment on August 22, 2012, that Petitioner provided timely notice of the accident, that Petitioner's current condition of ill-being is, *in part,* causally related to the accident, that Petitioner was temporarily partially disabled for a period of 6-5/7 weeks, from December 17, 2012 through February 1, 2013, that Respondent is entitled to credit of a total of $37,553.42 representing $7,566.21 for TTD paid plus $21,600.86 for TPD paid plus $8,386.35 that was advanced by Respondent for other benefits paid, and that Petitioner's request for an award of prospective medical in the form of a two level decompression and fusion is denied.

17IWCC0149

Based on a review of the record as a whole, the Commission modifies the Arbitrator's Decision to find that the Petitioner is entitled to temporary partial disability from the period December 17, 2012 through December 11, 2013, the date that Dr. Goldberg opined that the Petitioner reached maximum medical improvement.

The Commission affirms the Arbitrator's denial of all other lost time benefits and the denial of prospective medical. The Commission finds that the Petitioner is not credible based upon several discrepancies between his testimony, his actions and his alleged condition of ill-being. The Petitioner collected TTD while working at his second job and contrary to his doctor's order to stay off-work. The Petitioner testified that he worked only part-time while working at Ina's Restaurant; however, his wage stubs and the surveillance evidence confirm he worked substantially more than part-time. Furthermore, the surveillance evidence demonstrates the Petitioner walking, driving his car and working at Ina's Restaurant without apparent distress. Although the Petitioner underwent a second FCE, the Commission gives significant weight to the fact that the Petitioner's first FCE was considered to be inconclusive with regards to validity in determining Petitioner's full physical tolerances. The evaluator also reported that the Petitioner showed inorganic signs with Waddell's Questionnaire, Waddell's signs and Positive Placebo test. Dr. Goldberg documented that he did not find any evidence of the Petitioner's complaints of left leg numbness or tingling and that the Petitioner had inconsistencies upon exam with facial grimacing, contrary to what was seen in the video surveillance. Dr. Salehi opined that before the recommended fusion surgery, Petitioner would need to see a psychologist to rule out non-organic causes for his pain, a final testament to Petitioner's questionable veracity.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on May 3, 2016, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner, a sum, to be determined, per week, for a period of 51-3/7 weeks, that being the period of temporary partial disability as provided in § 8(a) of the Act. This award in no instance shall be a bar to a further hearing and determination of a further amount of temporary partial compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for prospective medical treatment in the form of lumbar surgery under §8(a) of the Act is denied.

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

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

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

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

DATED: MAR 8 - 2017
KWL:bsd
O: 1/10/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0149

ORTIZ, ROBERT
Employee/Petitioner

Case# **13WC003470**

FOUR SEASONS HOTEL
Employer/Respondent

On 5/3/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.39% 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:

2932 KUGIA & FORTE PC
MARTIN V KUGIA
711 W MAIN ST
WEST DUNDEE, IL 60118

2097 GRANT & FANNING
JUAN RODRIGUEZ-DEL MORAL
10 S RIVERSIDE PLZ SUITE 2050
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

17IWCC0149

Case # 13 WC 03470

Roberto Ortiz
Employee/Petitioner

v.

Four Seasons 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 Jeffrey Huebsch, Arbitrator of the Commission, in the city of Chicago, on June 1, 2015. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

R. Ortiz v. Four Seasons Hotel, 13 WC 03470

FINDINGS

On the date of accident, **August 22, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$82,654.52**; the average weekly wage was **$1,589.51**.

On the date of accident, Petitioner was **49** years of age, *Married* with **1** dependent children.

Respondent shall be given a credit of **$7,566.21** for TTD, **$21,600.86** for TPD, **$0** for maintenance, and **$8,386.35** (PPD ADVANCE) for other benefits, for a total credit of **$37,553.42**.

ORDER

Petitioner is entitled to TPD benefits from December 17, 2012 to February 1, 2013. All other lost time benefits are denied.

Petitioner's claim for prospective 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

May 3, 2016
Date

ICArbDec19(b)

MAY 3 - 2016

FINDINGS OF FACT

Petitioner was employed by Respondent as a room server. He began working for Respondent around June 17, 2000. In addition, Petitioner held a second job at Ina's restaurant, located in the West Loop, as a part time dining room server. Petitioner's job duties at Respondent involved room service server activities, including setting up tables, getting food ready for transport to rooms and bringing food to guests. He would also help with setting up banquet rooms and sometimes served from a martini cart or an ice cream cart. (PX1 (A) & (B)) At Ina's, Petitioner hand carried a maximum of 3 or 4 plates, or a tray of drinks. They did not use serving trays at Ina's.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on August 22, 2012. Petitioner testified that he slipped and fell due to a recently cleaned black marble floor, landing on his back. Petitioner testified that when he tried to get up from the ground he fell a second time, landing on the left side of his body with his left shoulder and hand making contact with the floor and injuring his left knee. Petitioner said that he noticed that his back felt weird, he had pain in his left leg and shoulder and numbness in the left leg. He finished the job that he was working on and reported the injury to his manager. He filled out an accident report at security and went home and to bed. The next day, he was in pain and was sent home by Respondent.

Petitioner testified that on August 24, 2012, he sought initial treatment with his primary care physician, Dr. Juan Zapata. The accident history documented by Dr. Zapata reflects that the petitioner "fell at work falling on left side shoulder, thumb, knee, and lower back." Dr. Zapata noted that Petitioner was able to ambulate with pain and sit comfortably on the examination table without difficulty or pain, adding that he did not have any radiation down the legs or numbness. The neurologic exam was normal and strength was 5/5. The physical examination of the left shoulder, hand, and knee revealed no swelling, deformity, joint asymmetry or atrophy. Dr. Zapata ordered x-rays of the left thumb, left shoulder, and left knee, each of which were within normal limits revealing no evidence of fractures or bony abnormality. Dr. Zapata released Petitioner to return to work with a 10 pound lifting restriction after being kept off work for two days. (PX4)

Thereafter, Petitioner returned to work for Respondent and Ina's. He worked at Ina's only during the weekends. Petitioner testified that his light duty work at Respondent included polishing glasses and folding napkins.

On August 30, 2012, Dr. Zapata prescribed physical therapy and placed Petitioner off work through September 11, 2012. (PX4) Petitioner testified that thereafter he stopped working at Respondent, but continued working at Ina's.

On September 17, 2012, Petitioner presented with continued complaints of pain in his lower back, left shoulder, and left knee since starting work on September 11, 2012. Dr. Zapata ordered an MRI of the lumbar spine, left shoulder, and left knee, which Petitioner underwent on September 24, 2012. (PX4)

On September 27, 2012, Dr. Zapata reviewed the MRI findings and opined that findings of the MRI of lumbar spine " are somehow unspecific unless for L4-5 annular tear and L5-S1 mild bilateral foram [sic] stenosis," adding that it "does not look like he is going to need a consult with a neurosurgeon or pain clinic for any of his traumas, will manage conservatively." Dr. Zapata found the MRI of the left knee was significant for tendinosis and muscle contusions, and the left shoulder MRI findings were significant for tendinosis and DJD. Dr. Zapata

took Petitioner off work, to return on October 1, 2012, with a 20 pound lifting restriction and no kneeling. Petitioner testified that he returned to work on October 1, 2012, at Respondent and at Ina's.
On December 17, 2012, Dr. Zapata evaluated Petitioner and stated that "patient's condition is not improving sufficiently...it is possible that his continued working activity, even with restrictions, is not allowing a steady recovery.". Dr. Zapata referred Petitioner to pain management and issued an off work slip from December 17, 2012, through January 18, 2013. (PX4) Petitioner testified that he stopped working at Respondent, but kept working for two days a week at Ina's. Petitioner collected full TTD benefits during this time.

On January 14, 2013, Dr. Maunak Rana evaluated Petitioner. The accident history documented by Dr. Rana reflects that the patient "fell on marble tile floor and landed on his lower back." Dr. Rana administered an LESI and released Petitioner to return to work on January 14, 2013, with no lifting greater than 40 pounds. (PX5)

Petitioner contacted Aja Bullingham at Respondent to come back to work. He was not allowed to return to work. Petitioner's employment was terminated by Respondent on February 1, 2013, due to his working at Ina's while being taken off work by Dr. Zapata and collecting TTD. Petitioner testified that he continued working at Ina's part time until December 31, 2013, when the business closed. Wage records from Ina's for the time period of 1/7/2013 through 12/30/2013 were submitted as Petitioner's Exhibit 13. It appears that Petitioner worked about 30 hours per week and made $42,051.85 during this time period. (PX13)

On February 19, 2013, Dr. Rana evaluated Petitioner and noted improvement following the January 14, 2013, LESI. Dr. Rana administered another LESI at this visit and on subsequent visits on May 6, 2013, June 17, 2013, July 29, 2013, and May 5, 2014. Petitioner testified that the injections provided relief from his back pain "only a little bit, for a short time." (PX5)

On April 10, 2013, Dr. Mark T. Nolden conducted a Section 12 examination of Petitioner at the request of Respondent. The accident history documented by Dr. Nolden reflects that Petitioner slipped on a marble floor falling directly onto his left side. Petitioner gave an additional history that he had originally injured himself on or about June 2012 after carrying a large number of chairs to different floors. Dr. Nolden documented that Petitioner stated that he could only tolerate approximately 20 hours of work per week currently because of pain. Dr. Nolden opined that Petitioner had degenerative disk disease at L4-L5 and L5-S1 with resulting discogenic low back pain. Dr. Nolden opined that Petitioner's lower extremity complaints and pain were not radiculopathic because at no level on the September 24, 2012, MRI of the lumbar spine is there "significant neurocompressive pathology." Moreover, he opined that Petitioner was not a surgical candidate and that there was no objective reason on imaging to strictly restrict Petitioner's work capabilities. Dr. Nolden recommended more therapy, additional epidural steroid injections if indicated, and an FCE if Petitioner's subjective complaints of pain did not improve. (RX1)

On May 6, 2013, Dr. Rana noted that Petitioner presented with no weakness or numbness in his lower extremities but complained of constant pain and discomfort along the left leg. Dr. Rana administered another LESI and issued the 40 pound lifting restriction for an additional 4 weeks. On October 28, 2013, Dr. Rana referred Petitioner for a surgical consultation with Dr. Muro and prescribed an FCE. (PX5)

On December 11, 2013, Dr. Edward Goldberg conducted a Section 12 examination on behalf of Respondent. Petitioner's history of accident was that "he slipped on a marble floor and fell on his left side." Petitioner informed Dr. Goldberg that he was working 4 hours a day at Ina's Restaurant. In addition, Dr. Goldberg reviewed video surveillance of Petitioner and noted that he was able to lean forward easily, was standing and walking with a brisk and normal gait without any appearance of being in distress. Following review of the medical records, video surveillance, and the physical examination, Dr. Goldberg opined that Petitioner suffered

a lumbar strain and had subjective lumbar radiculitis with the MRI revealing "no evidence of any nerve compression." Dr. Goldberg could not find any objective evidence of Petitioner's complaints of left leg numbness or tingling. Dr. Goldberg noted that during his examination, Petitioner sat comfortably in a chair and was able to ascend and descend off the exam table without difficulty. Based on the foregoing, Dr. Goldberg opined that Petitioner was at MMI with no further treatment required, and was capable of returning to work at full duty. (RX2)

On January 17, 2014, Petitioner participated (?) in an FCE at Athlectico. The FCE was inconclusive with regards to validity in determining Petitioner's full physical tolerances since he did not exert full physical effort during the examination. (PX7)

On January 27, 2014, Dr. Rana saw Petitioner, who presented with complaints of experiencing more pain over the past month since his position at work was terminated and increased low back pain with household chores. Dr. Rana released Petitioner to work consistent with the January 17, 2014, FCE results. On March 25, 2014, Dr. Deepti Agarwal saw Petitioner and the documented history of the accident was that the patient "fell on the ground." Dr. Agarawl referenced a surgical consultation with Dr. Muro who apparently opined that surgery was not indicated at that time. (PX5)

On June 10, 2014, Petitioner participated in a second FCE, at Best Practice Physical Therapy, which was ordered by Dr. Rana. The FCE did not reference review of Petitioner's job description. Petitioner was released with restrictions of maximum lifting of 15 pounds, carrying of 10 pounds, no pushing or pulling more than 60 pounds, and no crouching, stooping or crawling. (PX8)

On November 3, 2014, Dr. Hector Salcedo evaluated the petitioner for chief complaints of epigastric left sided abdominal pain, GERD, cervicalgia and lumbago. The listed medical problems included obesity, hypertension, gastritis, neck pain and lumbago with sciatica. Petitioner reported that he was not experiencing muscle aches or weakness, joint pain or back pain. On November 11, 2014, Dr. Salcedo evaluated Petitioner and noted slightly improved lumbago with sciatica. On December 8, 2014, Petitioner sought treatment by Dr. Salcedo for a chief complaint of high cholesterol, left chest and arm pain. Petitioner reported that he was not experiencing muscle aches or weakness, joint pain or back pain. (PX11)

On December 15, 2014, Petitioner's attorney retained Dr. Sean Salehi to conduct an examination on his behalf. Petitioner reported the mechanism of his accident to Dr. Salehi that he "slipped and landed on his back." He presented with complaints of pain in the low back down the left leg, which Petitioner stated "radiated up his back to his head." Non-organic pain responses were noted on examination. Dr. Salehi referenced Petitioner's inability to tolerate the lifting requirements of a job at Trump hotel. Dr. Salehi reviewed the September 24, 2012, Lumbar MRI and found a L4-L5 disc bulge and a disc herniation at L5-S1 without neural compression. Dr. Salehi opined that the mechanism of injury, as described, was consistent with having resulted in a lumbar annular tear and recommended a two level decompression and fusion. (PX9)

On January 5, 2015, Petitioner sought a follow up evaluation with Dr. Hector Salcedo for chief complaint of kidney stones and fatty liver. Petitioner reported that he was not experiencing muscle aches or weakness, joint pain or back pain. On May 5, 2015, Dr. Salcedo released Petitioner to return to work with a 20-30 pound weight limit and referred him to pain management and neurosurgery. (PX11)

Petitioner submitted wage records from Trump Hotel as Exhibit 14. It appears that Petitioner worked at Trump from 3/8/2014 through around 5/30/2014. Petitioner worked over 30 hours per week most weeks and appears to have made $6,545.86 for this time period. (PX14) Petitioner submitted wage records from Breakfast House

from 2014 and 2015 as Petitioner's Exhibit 15. These records show inconsistent hours worked and that Petitioner earned $60.00 per week in tips consistently for every week. (PX15)

Petitioner tendered job search records as Exhibits 2(a), 2(b), 3(a) and 3(b). He was not successful in finding full time employment.

The Parties both submitted evidence regarding Petitioner's job duties at Respondent and the weights of various objects that Petitioner would have to lift as a room server or when setting up banquets and working the martini cart or the ice cream cart.

Petitioner and his attorney rented a room at Respondent's hotel and weighed various objects using a bathroom scale that Petitioner brought to the hotel and also a scale from the room that was rented. Some of the items weighed more than 40 pounds. Further, there would be times when a cart might have to be lifted in order to go over a "lip" between carpet and tile flooring. Petitioner also presented the testimony of Eddie Sanchez and Baltezar Medina (two former employees of Respondent), who described the weights of the martini and ice cream carts, food carts, hot boxes and of serving dishes with and without ice and beverages. Sanchez and Medina supported Petitioner's testimony regarding the weights of various objects.

Respondent's witnesses, Aja Bullingham and Melissa Sims disputed the testimony of Petitioner and his witnesses as to the weights of various objects. Bullingham was the Assistant Manager of Room Service at the time of Petitioner's accident. In this position, she had performed the same job duties as Petitioner, occasionally.

Sims is Respondent's Director of Human Resources. Respondent has a light duty program that can accommodate any type of work restrictions, including sedentary work. Respondent wants to keep its injured employees engaged in the workforce and at Respondent. The room server position had a 30 pound maximum lifting rating. (RX4) Petitioner was not allowed to return to work because he was terminated, effective February 1, 2013. The reason that Petitioner was terminated was that he was working at another entity as a server while he was collecting TTD benefits from Respondent and had been taken completely off work by his doctor.

Respondent submitted video surveillance evidence, showing Petitioner walking, driving his car and working at Ina's. He is shown carrying food orders, walking at a rapid pace, bending at the waist and knees, crouching and walking and standing (not favoring either lower extremity) with no apparent difficulty. On a couple of occasions, Petitioner does exhibit an altered gait walking outside, but the gait does appear to be favoring the hip, as opposed to favoring the low back and left leg. (RX3)

Petitioner denied prior back injuries or treatment and no evidence of any prior back related complaints or treatment was submitted.

Petitioner testified that he has back pain. "A little pain." The pain increases after he has walked around for 3 or 4 hours. The pain goes down his leg down the left thigh to the calf. He gets a "pinch" if he stops suddenly while walking or if he bends down. Petitioner takes Ibuprofen, Hydrocodone, Gabapentin and Baclofen for his pain complaints. Petitioner would like to undergo the surgery that Dr. Salehi has recommended, so that he can do the things that he used to do.

The issue of incurred medical expenses was reserved. The Parties stipulated to the Average Weekly Wage of $1,589.51. There were no proofs on wages that Petitioner made at Respondent, or what he would make in the full performance of his duties working for Respondent.

CONCLUSIONS OF LAW

The Arbitrator hereby adopts the Findings of Fact set forth above in support of the Conclusions of Law set forth below. Petitioner's credibility is weakened by his working at Ina's while collecting TTD benefits and being authorized totally off work by Dr. Zapata.

In support of the Arbitrator's decision relating to Issue (F), whether Petitioner's current condition of ill-being is casually related to the injury, the Arbitrator finds the following:

The Arbitrator finds that Petitioner's current condition of ill-being (degenerative disc disease at L4-L5 and L5-S1, aggravated by a work related fall on August 22, 2012, with resulting low back pain) is causally related to the injury. Petitioner's left lower extremity complaints are not related to the injury. Petitioner's condition as it relates to the accident reached MMI as of the date of the examination by Dr. Goldberg (December 11, 2013).

The Arbitrator bases this finding on the medical records (no radicular type complaints until 1/14/2013, radicular complaints excluded by Dr. Zapata in his treatment notes beginning 8/24/2012; inconsistent findings and complaints; none of the initial treating doctors thought that Petitioner had a condition requiring surgery; the inconsistent FCE performance), the video surveillance evidence and the persuasive opinions of Dr. Nolden and Dr. Goldberg.

Dr. Nolden opines that Petitioner's lower extremity complaints are nor radiculopathic. Petitioner's injury resulted in an aggravation of his underlying DDD condition. Dr. Goldberg opines that Petitioner suffered a lumbar strain as a result of his fall, with subjective radiculitis that is not objectively confirmed.

Petitioner's testimony that he experience pain (originating from his back, down his leg) and numbness in his left leg is not supported by the medical records. Dr. Zapata documented that there was no radiculopathic pain on the first day of treatment after the accident.

The causal connection opinion offered by Dr. Salehi is not persuasive.

In support of the Arbitrator's decision relating to Issue (K), whether Petitioner is entitled to any prospective medical care, the Arbitrator finds the following:

Based upon the Arbitrator's finding regarding causal connection above, the medical records and the persuasive opinion of Dr. Goldberg, the Arbitrator finds that Petitioner is not entitled to prospective medical care.

Dr. Goldberg opines that Petitioner is at MMI as of December 11, 2013 and is not in need of future medical care related to the injury. Dr. Nolden and Dr. Goldberg do not believe that Petitioner is a surgical candidate. These opinions are given great weight, especially in light of what appears to be non-organic complaints of leg pain and disability made by Petitioner and the video evidence confirming a lack of disability.

Dr. Salehi's recommendation for surgery is not persuasive, given the above and the documented non-organic pain behavior that Dr. Salehi notes in his report.

In support of the Arbitrator's decision relating to Issue (L), is Petitioner entitled to TTD and TPD benefits, the Arbitrator finds the following:

§1.1(e) of the Act provides that "decisions of an arbitrator or a Commissioner shall be based exclusively on evidence in the record of the proceeding..." As noted above, there was no explanation of the calculation of the AWW (was it solely based upon wages earned at Respondent?; did it include wages from Ina's?). There was no evidence of what wages Petitioner would make in the full performance of his job duties. The wage records from Ina's do not document the wages that Petitioner earned from December 17, 2012 (the day that Dr. Zapata restricted Petitioner from all work, thus obligating Respondent to begin TTD payments) until January 7, 2013. Respondent submitted no evidence that it complied with Rule 7110.70 in terminating benefits. Petitioner testified that he continued to work at Ina's, collecting wages, while collecting TTD. Petitioner was terminated by Respondent for this wrongful conduct in collecting wages and TTD at the same time, effective February 1, 2013.

No award of TTD benefits is made. Petitioner was never temporarily and totally disabled from work as a result of the injury. Petitioner worked at Ina's until it closed on December 31, 2013. Clearly, no award for TTD can be made when Petitioner continued to work and collected wages. Dr. Goldberg's opinion that Petitioner was at MMI and capable of full duty work as of December 11, 2013 is persuasive and controlling on the issue of TTD. As Petitioner is at MMI as of December 11, 2013, Respondent has no obligation to pay TTD thereafter. Additionally, the Arbitrator believes the testimony of Ms. Sims,that Respondent would have worked with Petitioner when he returned to work to facilitate his return to full duty work. Respondent would have been able to accommodate restricted work for Petitioner (he may have been capable of full duty work, per the testimony of Respondent's witnesses), but for Petitioner's employment termination.

Petitioner is entitled to TPD benefits for the time period of December 17, 2012 through February 1, 2013. Given the proofs in this case, the Arbitrator cannot calculate the amount of the TTD award. The Parties are encouraged to determine the amount that Petitioner would make in the full performance of his job at Respondent and the amount that he made at Ina's for the above time period. It does appear that Petitioner made $469.60 at Ina's for the time worked in 2013 through February 3, 2013 (4-4/7 weeks). See: §8(a) regarding Maintenance/TPD.

The Arbitrator finds that Petitioner is not entitled to TPD benefits after his discharge for cause by Respondent on February 1, 2013. The Interstate Scaffolding case is controlling on the issue of TTD (an employer's obligation to pay TTD benefits to an injured employee does not cease because the employee has been discharged-whether or not the discharge was for "cause"), but it does not apply to TPD benefits. Interstate Scaffolding , Inc. v. The Illinois Workers' Compensation Commission , 236 Ill.2d 132 (2010) No award for TPD benefits after February 1, 2013 is made.

17IWCC0185

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

EUGENE BLACKMON,

Petitioner,

vs.

NO: 13 WC 4417
13 WC 17684

GILSTER-MARY LEE CORP.,

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 prospective medical care and nature and extent and being advised of the facts and law, affirms and adopts the Decisions of the Arbitrator, which are attached hereto and made a part hereof, but makes the following clarifications and explanation of its reasoning.

We initially note that the Petition for Review includes whether prospective medical care is necessary but that was not an issue at the arbitration hearing. We find that this issue is not appropriately before us on Review. On the issue of nature and extent, Petitioner does not dispute the awards of 10% loss of use of the left hand and 12.5% loss of use of the left arm. His only argument on Review is that the permanency award of 15% loss of use of the right hand is inadequate under the circumstances of his case. Section 8(e)9 of the Act limits the permanent partial disability for hand awards to:

> 190 weeks if the accidental injury occurs on or after June 28, 2011...and if the accidental injury involves carpal tunnel syndrome due to repetitive or cumulative trauma, in which case the permanent partial disability shall not exceed 15% loss of use of the hand, except for cause shown by clear and convincing evidence and in which case the award shall not exceed 30% loss of use of the hand.

Since Petitioner's right hand carpal tunnel injury is based on a repetitive trauma claim and occurred after June 28, 2011, the above section of the Act applies. Although we agree with the Arbitrator's analysis of the five factors in §8.1b of the Act, Petitioner argues that he has

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proven by clear and convincing evidence that he should be awarded 25% of the right hand and we address those arguments here.

Petitioner argues that he required two right hand carpal tunnel surgeries and that there is "objective evidence of CTS even after the second surgery." (Petitioner's brief at 5 – unnumbered, Emphasis in brief). Presumably, the objective evidence he is referring to is his last office visit with Dr. Young on October 9, 2014. Dr. Young noted that Petitioner stated that his numbness and tingling had improved since the second surgery but he still had *occasional* numbness and tingling throughout the day. On examination, Petitioner was able to form a full fist and extend the digits past neutral. He did have slight tenderness on palpation of the incision site but he demonstrated full range of motion of his wrist (flexion, extension, supination, pronation, ulnar and radial deviation). Dr. Young wrote, "I believe the patient is doing very well." He discharged Petitioner from formal care without restrictions but gave him some Voltaren gel to apply to the hand as needed for tenderness and swelling. He also instructed Petitioner to call his office if he had any issues or concerns.

Petitioner returned to work full duty for almost nine months until he retired in June 2015. He never returned to see Dr. Young but at the hearing, on February 11, 2016, he testified that he "hopes" he can go back at some point because it is bothering him. In his brief, Petitioner claims that he testified that he did "not have the funds" to return to Dr. Young. (P-brief at 6). However, we find that Petitioner never testified that this was a reason he didn't return.

Petitioner's brief also claims that, "He eventually decided to retire since he was eligible and his hand continued to be symptomatic." (Id.) However, we again find that he never testified that his decision to retire was related in any way to continued right hand symptoms. Petitioner also never testified that his right hand became increasingly symptomatic after he returned to work and, on cross-examination, he stated that he was able to do his job until he retired.

Petitioner's brief concludes by stating that increasing his award "will not open a flood-gate…unless it was a flood-gate full of people with positive EMG/NCV studies after multiple surgeries." (Id. at 7). It isn't clear if Petitioner is claiming that he actually had a positive EMG test after the second surgery but no EMG report following the second surgery was introduced as evidence.

Petitioner also seems to argue that the number of surgeries he underwent should play a significant role in determining his permanency award, but §8.1b does not specifically include that as one of the factors. Although Petitioner did need a revision right carpal tunnel surgery, the medical records after the second one indicate a successful outcome and do not corroborate Petitioner's testimony regarding his current condition.

The Decision of the Arbitrator contains a good summary of Petitioner's testimony regarding his current right hand condition and alleged symptoms so we will not repeat that here. However, other than the occasional numbness and tingling noted by Dr. Young and some tenderness/swelling at the incision site, the treating medical records do not corroborate Petitioner's testimony at all. Despite all of Petitioner's alleged symptoms, he testified that he no longer wears the splint on his hand because Dr. Young said he doesn't need them. He doesn't take any pain or other medication for his right hand and the only medication he takes is for his diabetes. There is simply no medical evidence to corroborate his claim that he experiences constant pain and numbness in his fingers, constantly drops items like cooking utensils, and that he has such reduced grip strength that he can't even lift up small objects like a penny. While Petitioner may be experiencing some increased symptoms since he last saw Dr. Young, it defies credulity that he would not have returned to him or another physician to address these concerns.

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Regardless, the fact of the matter is that under §8.1b(b)(v), Petitioner's testimony, unrebutted or not, regarding his symptoms and disability is not corroborated by the treating medical records to the extent that Petitioner claims. Therefore, we find that Petitioner has failed to prove by "clear and convincing evidence" that this should be an exception to the 15% limit for carpal tunnel injuries that is applicable in this case.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decisions of the Arbitrator filed March 2, 2016, are hereby affirmed and adopted with the clarifications and explanations noted above.

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 $17,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 8 2017

Charles J. DeVriendt

Joshua D. Luskin

SE/
O: 2/1/17
49

SPECIAL CONCURRING OPINION

This case was scheduled for Oral Arguments on February 1, 2017, before a three-member panel of the Commission including members Charles DeVriendt, Joshua Luskin, and Ruth White, at which time Oral Arguments were either heard, waived or denied. Subsequent to Oral Arguments and prior to the departure of Ruth White on March 3, 2017, a majority of the panel members had reached agreement as to the results set forth in this decision and opinion, as evidenced by the internal Decision worksheet initialed by the entire three member panel, but no formal written decision was signed and issued prior to Commissioner White's departure.

Although I was not a member of the panel in question at the time Oral Arguments were heard, waived or denied, and I did not participate in the agreement reached by the majority in this case, I have reviewed the Decision worksheet showing how Commissioner White voted in this case, as well as the provisions of the Supreme Court in Zeigler v. Industrial Commission, 51 Ill.2d 137, 281 N.E.2d 342 (1972), which authorizes signature of a Decision by a member of the Commission who did not participate in the Decision. Accordingly, I am signing this Decision in order that it may issue.

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0185

BLACKMON, EUGENE
Employee/Petitioner

Case# **13WC017684**

13WC004417

GILSTER MARY LEE CORPORATION
Employer/Respondent

On 3/2/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4888 LAW OFFICE KEITH SHORT
1355 N BLUFF RD
COLLINSVILLE, IL 62234

0693 FEIRICH MAGER GREEN & RYAN
PIETER N SCHMIDT
2001 W MAIN ST PO BOX 1570
CARBONDALE, IL 62903

17IWCC0185

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

Eugene Blackmon
Employee/Petitioner

v.

Gilster-Mary Lee Corporation
Employer/Respondent

Case # 13 WC 17684

Consolidated cases: 13 WC 4417

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **February 11, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 1, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* 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 28.5 weeks preceding the injury, Petitioner earned **$9,603.17**; the average weekly wage was **$336.95**.

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

The parties stipulated at the time of hearing that Petitioner was entitled to temporary total disability benefits for the timeframe of 10/4/13 to 10/8/13, a period of 5/7 weeks, and that Respondent paid $160.46 in TTD benefits.

The parties stipulated at the time of hearing that Respondent is entitled to a credit for **$20,544.51** for medical bills paid through its group medical plan under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner the sum of **$220.00/week** for a period of **79.125 weeks**, as provided in **Section 8(e)** of the Act, because the injuries sustained caused **10% loss of use of the left hand, 12.5% loss of use of the left arm and 15% loss of use of the right hand.**

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

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

Melinda M. Rowe-Sullivan
Signature of Arbitrator

3/1/16
Date

MAR 2 - 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0185

BLACKMON, EUGENE
Employee/Petitioner

Case# **13WC004417**

13WC017684

GLISTER MARY LEE CORPORATION
Employer/Respondent

On 3/2/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4888 LAW OFFICE KEITH SHORT
1355 N BLUFF RD
COLLINSVILLE, IL 62234

0693 FEIRICH MAGER GREEN RYAN
PIETER N SCHMIDT
2001 W MAIN ST PO BOX 1570
CARBONDALE, IL 62903

17IWCC0185

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

Eugene Blackmon
Employee/Petitioner

v.

Gilster-Mary Lee Corporation
Employer/Respondent

Case # 13 WC 4417

Consolidated cases: 13 WC 17684

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **February 11, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **June 1, 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 28.5 weeks preceding the injury, Petitioner earned **$9,603.17**; the average weekly wage was **$336.95**.

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

The parties stipulated at the time of hearing that Petitioner was entitled to temporary total disability benefits for the timeframe of 10/4/13 to 10/8/13, a period of 5/7 weeks, and that Respondent paid $160.46 in TTD benefits.

The parties stipulated at the time of hearing that Respondent is entitled to a credit for **$20,544.51** for medical bills paid through its group medical plan under Section 8(j) of the Act.

ORDER

With regard to the nature and extent of Petitioner's left hand, left arm and right hand injuries, the Petitioner has already been compensated as explained more fully in the decision of Petitioner's consolidated Case No. 13 WC 17684. In that case, Petitioner was compensated for permanent partial disability stemming from his injuries on both June 1, 2012 and February 1, 2013 as a result of a consolidated full trial on the merits of both cases. Thus, the Arbitrator denies any additional award for further compensation as a result of Petitioner's left hand, left arm and right hand injuries.

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

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

Melinda M. Rowe-Sullivan
Signature of Arbitrator

3/1/16
Date

MAR 2 - 2016

17IWCC0185

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Eugene Blackmon
Employee/Petitioner

Case # 13 WC 4417

v.

Consolidated cases: 13 WC 17684

Gilster-Mary Lee Corporation
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified at the time of arbitration that he is currently 66 years of age and resides in Carbondale. He testified that he began working for Respondent in the summer of 2010, and that he was hired as a forklift driver and then became a line stacker. He testified that his employment caused him to develop bilateral carpal tunnel syndrome as well as left cubital tunnel syndrome. He testified that his job as a line stacker was to stack product all day long, including boxes of cereal and pasta.

Petitioner testified that his family physician, Dr. Azam, referred him to Dr. Young. He testified that he saw Dr. Azam and had an EMG of his right hand done in June 2012. He agreed that Dr. Azam sent him with the EMG to Dr. Young on June 26th, at which time he was diagnosed with right carpal tunnel syndrome. He testified that he ultimately underwent a right carpal tunnel release on August 2, 2013, after which he underwent physical therapy. He agreed that Respondent accommodated his light duty restrictions during most of this time. He further agreed that after he returned to work, he developed problems with his left hand and left elbow.

Petitioner agreed that Dr. Young in September 2013 recommended that he undergo an additional EMG, and that he ultimately underwent a left carpal tunnel release and left cubital tunnel release on October 4, 2013. He agreed that after surgery, he underwent physical therapy on the left side. He agreed that he returned to work as a line stacker.

Petitioner testified that he continued to have problems with his right hand and returned to Dr. Young with complaints of numbness and tingling in the primary digits of his right hand, and that in May of 2014 he received an injection into his wrist. He testified that he used splints for a period of time as well. He testified that he underwent an additional EMG with Dr. Glennon, which showed moderate to severe right carpal tunnel syndrome. He testified that he had a second surgery on his right hand on August 22, 2014. He testified that after surgery had additional physical therapy, and that he returned to work until he retired. He testified that he retired effective June 30, 2015, and that he last saw Dr. Young on October 9, 2014.

Petitioner testified that he had one surgery on his left hand and left elbow. He testified that the left elbow was weak, that it got tired and that it was more uncomfortable rather than painful. He testified that he did not anticipate seeing a physician for further treatment on the left elbow. He also testified that the left hand was weak, and that the fingers affected were that of the index, long and ring fingers. He testified that he is right-handed. He testified that he has numbness and tingling periodically, and he agreed

that he is diabetic and has been so for a number of years. He denied having any issues with his left hand or left elbow prior to working for Respondent.

Petitioner testified that he underwent two surgeries on the right wrist, and he notices that when he is cooking he is constantly dropping utensils. He testified that when he goes to pick up a skillet, he uses the aid and assistance of his left hand to make sure that he does not drop it. He testified that he likes to do yard work, and that he notices that his hand gets tired and weak. He testified that all fingers on his right hand bother him with exception of the little finger. He testified that he is unable to pick up a penny off the floor because he does not have the grip strength. He testified that he can feel numbness. He denied using the splints that were provided to him by Dr. Young. He testified that he has difficulties shooting pool because his hand is weak and gets tired.

Petitioner denied taking any medications for his condition, but admitted to taking his diabetes-related medication. He agreed that he is not working and is retired. He denied having any appointments scheduled with Dr. Young, but he does hope to return to have his right hand examined.

On cross-examination, Petitioner agreed that the last time he went back to work was in the fall of 2014. He further agreed that he was able to do his stacking job until he retired in June 2015.

The medical records of the Orthopaedic Institute of Southern Illinois were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Petitioner was seen on October 9, 2014, at which time it was noted he was six weeks, six days out from a right carpal tunnel release revision. Petitioner stated that his numbness and tingling had improved, but occasionally he had numbness and tingling throughout the day. It was noted that Petitioner had been on light duty at work since the surgery, and he stated he was ready to return to full duties. He was given Voltaren gel to apply to the hand as needed for the tenderness and swelling. Petitioner was allowed to return to work without restrictions, and he was instructed to return on an as-needed basis. He was also given a work slip dated October 9, 2014, allowing him to return to work without restrictions. (PX1).

The records reflect that Petitioner was seen on September 5, 2014, at which time sutures were removed and it was noted the incision site was healing well. Petitioner was placed on restrictions of no lifting over 5 pounds with the right hand, and he was instructed to return in one month. A work slip was issued on September 5, 2014, issuing restrictions of no lifting over 5 pounds with the right upper extremity. (PX1).

The Discharge Summary for physical therapy dated September 5, 2014 noted that Petitioner felt better, he reported he was not tender and that he felt like it was improving. It was noted that Petitioner had minimal to no pain at that time, and that he had good grip strength, good range of motion and good strength. (PX1).

The Operative Report dated August 22, 2014 was included within the medical records. The pre- and post-operative diagnosis was that of recurrent right carpal tunnel syndrome. The procedure performed was a revision right carpal tunnel release. Also included within the records was a work slip dated August 22, 2014, allowing Petitioner to return to modified duty beginning August 25, 2014 with no use of the right hand. (PX1).

The records reflect that Petitioner was seen on July 17, 2014, at which time it was noted he was still having numbness and pain in the right hand. It was noted that Petitioner had had a steroid injection, worn splints and had gone to therapy, but still had numbness in the thumb, index and long fingers. It was noted that a second nerve conduction study was ordered after his surgery, which showed moderate to severe carpal tunnel syndrome with some slight improvement. It was recommended that Petitioner

undergo a carpal tunnel revision of the right hand. Petitioner was also issued a work slip on that date, allowing him to return to work without restrictions. (PX1).

The records reflect that Petitioner was seen on June 16, 2014, at which time he stated he continued to have numbness and pain. It was noted that Petitioner had worn a splint, and that he had a steroid injection in the right carpal tunnel. It was noted that the injection gave him some relief for approximately a week, but he still had numbness in the thumb, index and long fingers which he stated was constant. It was noted that a new nerve conduction study showed moderate to severe carpal tunnel syndrome, with slight improvement. A revision of the carpal tunnel release was recommended, but it was noted no promises could be made. Petitioner was given a work slip allowing him to return to work without restrictions. (PX1).

The records reflect that Petitioner was seen on May 8, 2014, at which time it was noted that on March 25, 2014 he had been given a steroid injection into the right carpal tunnel. Petitioner stated the injection provided relief for about a week. He stated that the thumb, index and long finger were always "dead," but it was noted that the ring and small finger did not seem to present any problems. It was noted that a nerve conduction study was a reasonable option, and that the repeat nerve study would not show a normal situation as Petitioner had a very severe carpal tunnel pre-operatively, which was a somewhat unusual scenario. Petitioner was also given a work slip on that date, allowing him to return to work without restrictions. (PX1).

The records reflect that Petitioner was seen on March 25, 2014, at which time it was noted he was several months out from surgical intervention of the right upper extremity. It was noted that Petitioner had left carpal tunnel release and ulnar nerve transposition. Petitioner stated that his symptoms had improved but began coming back about a week after he was discharged from the clinic. Petitioner stated he was doing the same work that he did before, that it seemed to exacerbate his symptoms and that he had numbness in all of his fingers at that point in time. Petitioner underwent an injection into the right carpal tunnel on that date, and it was noted that he could consider a repeat nerve conduction study. Petitioner was also given a work slip on that date, indicating he could return to work without restrictions. (PX1).

The records reflect that Petitioner was seen on January 30, 2014, at which time it was noted that he was 18 weeks, six days out from his bilateral upper extremity surgeries. It was noted that Petitioner had carpal tunnel releases and ulnar nerve transposition. Petitioner stated he was still having some numbness on the right side, and it was noted that he could expect changes for up to a year but that since it was so severe he could have some remaining symptoms. It was noted that as Petitioner was already working full duty, he was allowed to return as needed and it was noted that if the numbness became worse or he started to experience pain, he was to call the clinic for a follow-up appointment. A work slip was issued on that date as well, discharging Petitioner from care. (PX1).

The records reflect that Petitioner was seen on November 21, 2013, at which time he stated he was having some numbness around his left elbow but otherwise the hand felt good. On the right side, Petitioner stated that the hand was still numb. It was noted that he was back to work on light duty. A work slip was issued on that date allowing Petitioner to return to work without restrictions, and he was instructed to return for a follow-up appointment in two months. (PX1).

The records reflect that Petitioner was seen on October 18, 2013, at which time it was noted he was two weeks out from a left carpal tunnel release and left ulnar nerve transposition. The sutures were removed, and it was noted that the incision sites were healing well. Petitioner was instructed to return in one month. A work slip was issued on that date, noting that as of October 23, 2013 Petitioner could return to work with no use of the operative hand and no lifting, and that as of November 1, 2013 he could return to work light duty with no heavy lifting greater than 5 pounds, no pushing or pulling with the operative arm, and no repetitive activity or impact loading. (PX1).

The Operative Report dated October 4, 2013 referenced pre-and post-operative diagnoses of (1) left carpal tunnel syndrome; (2) left cubital tunnel syndrome. The procedures performed included that of a left carpal tunnel release and a left ulnar nerve transposition. Petitioner was also issued a work slip on that date, indicating that as of October 9, 2013 he could return to work with restrictions of no use of the operative hand, and that as of October 18, 2013 he could return to work with restrictions of no heavy lifting, pushing or pulling with the operative arm, no repetitive activity or impact loading, and a lifting limit of 2-3 pounds for operative extremity. (PX1).

The records reflect that Petitioner was seen on September 13, 2013, at which time it was noted he was six weeks out from a right carpal tunnel release. Petitioner stated he was still having numbness in the right thumb, index and long fingers. It was noted that Petitioner may have had the symptoms due to the severity of his carpal tunnel, and it was noted he was to be released from the right. It was further noted that he was having symptoms on the left, and that he had a nerve study that showed severe left carpal tunnel syndrome and mild ulnar nerve entrapment. It was noted that Petitioner was be placed on the surgical schedule for a left carpal tunnel release and ulnar nerve transposition. He was also given a work slip on that date, indicating that as of August 5, 2013 he could return to work with restrictions of no use of the operative hand, that as of August 16, 2013 he could return to work with a 2-3 pound lifting limit of the operative hand, and that he should avoid impact loading, heavy pushing/pulling and repetitive activity with the operative hand. The work slip further indicated that as of September 13, 2013, Petitioner could return to work without restrictions. (PX1).

The records reflect that Petitioner was seen on August 16, 2013, at which time he was two weeks out from the right carpal tunnel release. The sutures had been removed, and the incision site was healing well. It was noted that Petitioner was to follow-up in one month and re-evaluate, and to possibly release him from the right side and schedule the left. (PX1).

Included within the records was the Discharge Summary related to physical therapy dated August 14, 2013, which noted that Petitioner continued with unchanged numbness into the fingers, and that he had mild pain complaints at the incision site. At the time that the initial evaluation was performed on August 5, 2013, it was noted that Petitioner was at work on a light duty basis using the left hand only, and that he planned to have the left hand done when the right hand healed. (PX1).

The Operative Report dated August 2, 2013 was included within the records, and reflected that Petitioner underwent a right carpal tunnel release on that date. The pre-and post-operative diagnosis was that of right carpal tunnel syndrome. (PX1).

The records reflect that Petitioner was seen on July 11, 2013 for follow-up of his bilateral upper extremities. Petitioner stated that his numbness and tingling had worsened substantially, and that the right side was worse than the left. Petitioner stated that the right thumb, index, long and ring fingers went numb, but the small finger did not. It was further noted that on the left side, it was the entire hand. Petitioner had been wearing a cubital tunnel splint on the left, and it was noted he would like to have surgery on the right side. Petitioner was scheduled for a right carpal tunnel release, and it was further noted that there was potential treatment of the left upper extremity to include not only a left carpal tunnel release but also an ulnar nerve transposition. He was also given a work slip on that date, allowing him to return to work without restrictions. (PX1).

The records reflect that Petitioner was seen on June 11, 2013, at which time he presented for follow-up on his bilateral carpal tunnel syndrome and left cubital tunnel syndrome. It was noted that he had been given a prescription for carpal tunnel splints and cubital tunnel splints on the previous visit, which Petitioner stated he was unable to pay for so he was not using them. Petitioner stated he was having quite a bit of pain and numbness, and that it was keeping him up at night. It was noted that the nerve studies showed a severe right carpal tunnel syndrome and a severe left carpal tunnel syndrome as well as

a mild left ulnar neuropathy. Petitioner was given carpal tunnel splints and a left cubital tunnel splint to wear. He was also given a work slip on that date, allowing him to return to work without restrictions. (PX1).

The records reflect that Petitioner was seen on May 1, 2013 for evaluation of his bilateral upper extremities. Petitioner stated that he had had numbness and tingling in his bilateral upper extremities for quite some time, and that he worked in a factory setting in which he did multiple continuous stacking and repetitive use of his bilateral upper extremities. Petitioner stated that he had pain, numbness and tingling in all fingers of his left hand and in the thumb, index and long finger of his right hand. It was noted that he noticed some decrease in grip strength, but he had not tried any conservative treatment or bracing. The assessment was that of bilateral carpal tunnel syndrome and left ulnar nerve neuropathy. Bracing was recommended to see if it alleviated any of his symptoms. Petitioner was prescribed cubital tunnel and carpal tunnel splints, which he refused. He was also issued a work slip on that date, allowing him to return to work without restrictions. (PX1).

The records reflect the Petitioner was seen on June 26, 2012 at the referral of Dr. Azam for evaluation of his right upper extremity. It was noted that Petitioner had been having numbness and tingling for the last six months, and he stated that his thumb, index and long fingers were asleep most of the time at night and that he had occasional numbness into his right ring finger. It was noted that he had not tried any splints, but he did report having a history of diabetes. Petitioner was assessed with right carpal tunnel syndrome severe in nature, and surgery was recommended. It was noted that Petitioner already had some thenar atrophy, and it was felt that surgical intervention would be beneficial. (PX1).

The medical records of Center For Medical Arts/Dr. Azam were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen on January 24, 2013, at which time he reported numbness in the left hand that began eight months ago. The symptoms were reported as being moderate, and occurred constantly. It was noted that Petitioner was dropping things from his hand for the last few months as he could not feel them. It was further noted that Petitioner was diabetic, and that his symptoms were reported as being moderate. It was noted that a nerve conduction study would be performed, and that he would be referred to orthopedics as needed. (PX2).

The medical records of Rehab Physicians Services were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner underwent a nerve conduction study on June 10, 2014, which was interpreted as revealing evidence of a moderate to severe right median neuropathy at the wrist (carpal tunnel syndrome) affecting sensory and motor components, that axonal loss was noted with evidence of denervation/re-innervation on needle EMG, and that clinical correlation was advised regarding whether this represented chronic versus recurrent median neuropathy. (PX3).

The medical records of SI Neurology & Sleep Medicine, LLC were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner underwent an electromyography/nerve conduction study on June 1, 2012, which was interpreted as revealing (1) severe right carpal tunnel syndrome; (2) no evidence of ulnar neuropathy on the right; (3) no evidence of cervical radiculopathy on the right. The records further reflect that Petitioner underwent an electromyography/nerve conduction study on February 1, 2013, which was interpreted as revealing (1) moderately severe left carpal tunnel syndrome; (2) mild left ulnar neuropathy at the elbow; (3) no evidence of cervical radiculopathy on the left. (PX4).

The medical bills of the Orthopaedic Center of Southern Illinois were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The medical bills of Center For Medical Arts/Dr. Azam were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The medical bills of Rehab Physicians Services were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The

medical bills of SI Neurology & Sleep Medicine, LLC were entered into evidence at the time of arbitration as Petitioner's Exhibit 8.

The Medical Bill Recapitulation was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The TTD Recapitulation was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The wage statement was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The parties stipulated at the time of hearing, however, that in the 28.5 weeks preceding the injury Petitioner's earnings were $9,603.17, and the average weekly wage, calculated pursuant to Section 10 of the Act, was $336.95.

The medical records of Dr. Steven Young were entered into evidence at the time of arbitration as Respondent's Exhibit 4. A duplicate copy of the October 9, 2014 office note and corresponding work slip as contained in Petitioner's Exhibit 1 was included within the exhibit. (RX4).

CONCLUSIONS OF LAW

The parties stipulated that Petitioner sustained accidents on both June 1, 2012 and February 1, 2013 that arose out of and in the course of his employment with Respondent, and that Petitioner's condition of ill-being was causally connected to these injuries. (AX1).

With respect to the sole disputed issue at the time of hearing which was that of 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 in this matter. As a result thereof, the Arbitrator gives no weight to this factor.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner agreed that he was able to do his line stacker job until he retired in June 2015. The Arbitrator finds that, given his retirement, the nature and demands of his former position will no longer affect his permanent partial disability and, as such, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 62 and 63 years old, respectively, on his dates of accident. Given the age of Petitioner and the fact that his treating physician, Dr. Young, gave him a full duty/no restriction release, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that, following his work injury, Petitioner returned to his pre-accident employment with Respondent and, as such, there was no evidence proffered at arbitration to demonstrate that his work accidents have impaired or otherwise affected his future earnings capacity, particularly in light of his retirement. The Arbitrator places no 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 his left elbow was weak, that it got tired and that it was more uncomfortable rather than painful. He testified that his left hand was weak, and that the fingers affected were that of the index, long and ring

fingers. He also testified that he has numbness and tingling periodically in the left hand. With respect to his right hand, Petitioner testified that he notices that when he is cooking he is constantly dropping utensils, and that when he goes to pick up a skillet, he uses the aid and assistance of his left hand to make sure that he does not drop it. He testified that he likes to do yard work, and that he notices that his right hand gets tired and weak. He testified that all fingers on his right hand bother him with exception of the little finger. He testified that he is unable to pick up a penny off the floor because he does not have the grip strength. He testified that he can feel numbness. He further testified that he has difficulties shooting pool because his right hand is weak and gets tired. At his final office visit with Dr. Young on October 9, 2014, it was noted that Petitioner stated that his numbness and tingling had improved, but occasionally he had numbness and tingling throughout the day. He was given Voltaren gel to apply to the hand as needed for the tenderness and swelling. (PX1). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and limitations, were minimally corroborated by his treating records at the conclusion of his treatment with Dr. Young. The Arbitrator accordingly places greater weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant.

The Arbitrator further notes that the evidence presented at the consolidated hearing in these matters was insufficient to "delineate and apportion the nature and extent of permanency attributable to each accident." *See City of Chicago v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 258, 265 (1st App. Ct. Dist. 2011). As such, the permanency award in this case encompasses and compensates Petitioner for his injuries alleged in both of the above-captioned claims and no separate award is being made. *See Baumgardner v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 274, 279-80 (1st App. Ct. Dist. 2011) ("From a procedural and practical standpoint, where a claimant has sustained to separate and distinct injuries to the same body part in the claims are consolidated for hearing and decision, it is proper for the commission to consider all of the evidence presented to determine the nature and extent of his permanent disability as of the date of the hearing."). Based on the record as a whole, the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 10% loss of use of the left hand, 12.5% loss of use of the left arm, and 15% loss of use of the right hand under Section 8(e) of the Act for his injuries.

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

Lemuel Askew,
Petitioner,

vs.
City of Harvey,
Respondent,

NO: 13 WC 14889
17IWCC0143

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, causal connection; award for payent of medical bills directly to the providers instead of the petitioner, permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 18, 2016 is hereby affirmed and adopted.

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

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

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

DATED: MAR 3 - 2017

MB/mas
o: 2/23/17
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ASKEW, LEMUEL
Employee/Petitioner

Case# **13WC014889**

17IWCC0143

CITY OF HARVEY
Employer/Respondent

On 7/18/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.39% 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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17IWCC0143

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

Lemuel Askew
Employee/Petitioner

v.

City of Harvey
Employer/Respondent

Case # **13** WC **014889**

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 **5/16/2016 and 6/21/2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **10/28/2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current lumbar spine and right shoulder conditions of ill-being *are* causally related to the accident.

In the year preceding the injury, Petitioner earned **$65,258.96**; the average weekly wage was **$1,254.98**.

On the date of accident, Petitioner was **56** years of age, ***married,*** with **1** dependent child.

Petitioner ***has in part*** received reasonable and necessary medical services.

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

At the continued hearing, the parties presented the Arbitrator with a written stipulation agreeing that Petitioner is entitled to temporary total disability benefits from 10/29/2013 through 1/20/2014 representing 12 weeks at $836.66 per week or $10,039.92, that Respondent paid temporary total disability benefits in the total amount of $14,274.36 and that Respondent is entitled to credit towards permanency in the amount of $4,234.44 for the overpayment.

ORDER

Respondent shall pay Petitioner the following medical expenses, subject to the fee schedule and with Respondent receiving credit for any payments made toward said expenses: 1) Bud's Ambulance, 10/28/12, $619.00; 2) South Holland Injury Care, $10,165.00 (10/29/12 – 3/14/13) plus $3,400.00 (8/13/13 – 10/23/13); 3) Advantage MRI, 12/12/12, $1,300.00; 4) Dr. John Mazzarella, 7/13/13, $9,450.00; 5) Windy City Medical Specialists, all claimed expenses other than the duplicative charge of $1,400.00, with Respondent receiving a specific credit for its $5,331.04 payment; 6) RX Development, all charges other than the 8/26/13 charge of $7.10 for Soothing Pureway-C; 7) ISI, $411.21; and 8) Gold Coast Orthopedics (Dr. Fink), $600.00. [See the attached decision for further details].

Respondent shall pay Petitioner permanent partial disability benefits of $712.55/week for 70 weeks because the injuries sustained caused 14% permanent partial disability to the person as a whole [4% for the lumbar spine condition plus 10% for the right shoulder condition], as provided in Section 8(d)(2) of the Act. The Respondent is granted a credit in the amount of $4,234.44 towards the permanent partial disability award, per the parties' written stipulation.

Respondent shall pay Petitioner compensation that has accrued from **1/21/2014** through **6/21/2016**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Molly E Mason

Signature of Arbitrator

7/15/16
Date

JUL 18 2016

Summary of Disputed and Stipulated Issues

The parties agree Petitioner sustained a motor vehicle accident while working as a patrol officer for Respondent on October 28, 2012. Petitioner claims he injured his back and right shoulder in this accident. As of the initial hearing of May 16, 2016, the disputed issues included causal connection, medical, nature and extent and whether Respondent was entitled to credit for an alleged temporary total disability overpayment. Arb Exh 1. The case was continued to June 21, 2016 by agreement so that the parties could determine the extent of Respondent's medical payments. On that date, the parties presented a written stipulation (Arb Exh 2) stating: 1) Petitioner received full salary pursuant to PEDA from October 28, 2012 through October 28, 2013, and is not entitled to temporary total disability benefits during that period; 2) Petitioner is entitled to temporary total disability at a weekly rate of $836.66 from October 29, 2013 through January 20, 2014, a period of 14 weeks; 3) Respondent paid temporary total disability benefits at an incorrect rate of $1,189.53 during the foregoing 14-week period and, by virtue of this overpayment, is entitled to a credit in the amount of $4,234.44 as against permanency.

Arbitrator's Findings of Fact

Petitioner testified he has worked as a police officer for Respondent since 1983. He drives a patrol car every day.

Petitioner testified he was performing full duty as of his undisputed accident of October 28, 2012. He worked the night shift on that date. As he was driving eastbound on 147th, another driver rear-ended his patrol car. He testified he experienced pain in his back and right shoulder after being rear-ended. He was taken from the scene of the accident to the Emergency Room at Ingalls Memorial Hospital via ambulance.

The Emergency Room records reflect Petitioner was wearing a cervical collar and was strapped to a back board when he arrived at the hospital early on the morning of October 28, 2012. The records also reflect Petitioner reported being rear-ended and complained of neck and back pain. On examination, Dr. Stossel noted neck tenderness, no back tenderness and no abrasions or contusions. He ordered a cervical spine CT scan and lumbar spine X-rays. The CT scan showed degenerative changes at various levels and no fracture or dislocation. The X-rays showed no abnormalities. Dr. Stossel diagnosed cervical and lumbar strains. At discharge, he directed Petitioner to apply ice to the affected areas, take Ibuprofen and follow up with an occupational medicine clinic. He imposed restrictions of no lifting over 15 pounds and no overhead work. PX 1.

Petitioner testified he saw Dr. Camarrano, a chiropractor, at South Holland Injury Care on October 29, 2012. The doctor's note of that date reflects that Petitioner complained of 9/10

bilateral neck pain, 8/10 back pain radiating to the right leg and 9/10 right shoulder pain secondary to a work-related motor vehicle accident of October 28, 2012. On examination, Dr. Camarrano noted cervical and lumbosacral tenderness and a limited range of neck, back and right shoulder range of motion. He diagnosed sprains of the cervical spine, lumbar spine and right shoulder. He attributed these diagnoses to the accident and recommended a course of chiropractic care. PX 2.

Petitioner continued seeing Dr. Camarrano on a very regular basis thereafter (initially about three or four times per week), with the doctor performing electrical stimulation, soft tissue manipulation and chiropractic manipulation. PX 2.

On December 6, 2012, Dr. Cammarano prescribed a lumbar spine MRI. Petitioner underwent this MRI on December 12, 2012. According to Dr. Aikenhead, a chiropractic radiologist, the MRI demonstrated early facet arthrosis at L3-L4 and disc bulging with no evidence of focal herniation at L5-S1. PX 2.

Petitioner underwent a right shoulder MRI on January 20, 2013. The MRI report lists Dr. Cammarano as the prescribing physician. Dr. Aikenhead interpreted the MRI as showing a full-thickness partial tear of the supraspinatus, biceps tenosynovitis and acromioclavicular arthrosis with sub-deltoid edema. RX 3.

On February 1, 2013, Dr. Cammarano recommended an orthopedic consultation. He continued rendering chiropractic care, including manipulation, thereafter. PX 2.

At Respondent's request, Petitioner saw Dr. Kornblatt for purposes of a Section 12 examination and records review. In his report of March 14, 2013 (RX 1), the doctor noted that Petitioner was at a stop in his police vehicle on October 28, 2012 when he was rear-ended. He also noted that Petitioner experienced pain in his neck, back and right shoulder after this accident. He indicated Petitioner had been undergoing passive modality care, with no exercise, five days per week since the injury. He described Petitioner as right-handed. He noted that Petitioner had undergone lumbar spine and right shoulder MRIs but that he had not been provided with the MRI reports or images.

Dr. Kornblatt described Petitioner as complaining of constant right shoulder pain, right-sided neck pain, constant low back pain, aggravated with sitting, bending, twisting and lifting, and intermittent tingling in his right hand.

Dr. Kornblatt described Petitioner's past history as negative for any prior injury to the neck, back or right shoulder.

Dr. Kornblatt indicated he reviewed a First Report of Injury, the initial Emergency Room records and various records from South Holland Injury Care.

On examination, Dr. Kornblatt noted no cervical spine abnormalities, a limited and painful right shoulder range of motion, slight tenderness with palpation of the anterior deltoid and bicipital groove, no significant right shoulder atrophy, tenderness to palpation of the lumbosacral junction, a functional gait, a limited range of lumbar spine motion and negative straight leg raising to 90 degrees bilaterally.

Dr. Kornblatt opined that, by history, the work accident resulted in cervical, lumbar and right shoulder strains as well as a possible rotator cuff injury with resultant adhesive capsulitis. He attributed the right shoulder condition to the accident, noting that Petitioner denied any pre-existing shoulder symptoms. He indicated that his objective findings did support Petitioner's complaints.

Dr. Kornblatt described Petitioner as having undergone "minimal appropriate treatment" to date, noting that Petitioner had received "only passive modality" care. He did not believe Petitioner had reached maximum medical improvement with respect to any of his conditions. With respect to the cervical and lumbar spine, he recommended four weeks of aggressive rehabilitation, to include aerobic conditioning and strengthening exercises. He anticipated Petitioner would reach maximum medical improvement with respect to his neck and back after completing this therapy. As for the right shoulder, he recommended that Petitioner undergo an evaluation by a shoulder specialist "and appropriate treatment depending upon [the] results of the MRI." He indicated Petitioner would most likely require aggressive care, including injection therapy and possibly surgery. He stated he would be happy to review the shoulder MRI. He did not believe Petitioner required any additional diagnostic studies referable to his neck or back. He found Petitioner capable of sedentary duty with respect to all three diagnoses. RX 1.

On March 20, 2013, Petitioner saw Dr. Fink at Gold Coast Orthopaedic Spine and Hand Surgery. Petitioner testified that Dr. Cammarano referred him to Dr. Fink.

Dr. Fink's records (PX 3) include a history sheet that Petitioner apparently completed on March 20, 2013. On this sheet, Petitioner complained of low back and right shoulder pain secondary to being rear-ended while working as a police officer on October 28, 2012. Petitioner denied having any pain prior to this accident.

Dr. Fink's initial handwritten note sets forth a history of the October 28, 2012 accident and subsequent treatment. The doctor indicated he needed to review the MRIs and obtain authorization for a lumbar spine epidural injection. He took Petitioner off work. PX 3.

On April 8, 2013, Dr. Fink issued a report indicating he had reviewed the right shoulder MRI but still needed to review the lumbar spine MRI.

On May 22 and June 24, 2013, Dr. Fink noted that Petitioner was scheduled to undergo a right rotator cuff repair on July 18th. He directed Petitioner to remain off work. PX 3.

On July 18, 2013, Drs. Fink operated on Petitioner's right shoulder at Rogers Park One Day Surgery Center. Dr. Mazzarella acted as first assistant. In his operative report, Dr. Fink documented a large rotator cuff tear and labral fraying. He described the biceps tendon as intact. He performed an open repair of the rotator cuff tear, with Neer acromioplasty, an arthroscopic partial synovectomy and debridement of loose articular cartilage from the proximal humerus. PX 3.

On July 31, 2013, Dr. Fink recommended that Petitioner start physical therapy and remain off work. PX 3.

On August 13, 2013, Petitioner resumed chiropractic care with Dr. Cammarano, having last seen the doctor on July 15, 2013, three days prior to surgery.

On August 26, 2013, Dr. Fink recommended that Petitioner remain off work and continue therapy. PX 3.

On October 2, 2013, Dr. Fink administered a right shoulder injection. He prescribed Terocin patches and a Medrol Dose-Pak. He instructed Petitioner to remain off work. PX 3.

On October 25, 2013, Petitioner underwent an initial therapy evaluation at Flexeon Rehabilitation. The evaluating therapist noted a history of the rotator cuff repair. She also noted persistent complaints of pain in the right shoulder and the right side of the neck. PX 4.

Petitioner continued seeing Dr. Cammarano after beginning therapy at Flexeon Rehabilitation.

In a Flexeon Rehabilitation progress note dated November 5, 2013, Petitioner's therapist indicated Petitioner reported a little improvement and had set up a pulley system at home so as to allow him to perform home exercises. PX 4.

On November 25, 2013, Dr. Fink issued a report indicating Petitioner was still experiencing low back pain and tenderness in the facet joints. He interpreted the previous MRI as showing a herniated disc at L5-S1. He addressed causation as follows:

> "This is all related to patient's accident. He did not [sic] have some degeneration of the discs but he certainly had an accident that could have caused the protrusion or contributed to this protruding herniated lumbar disc at L5-S1. "

He indicated he planned to administer epidural steroid injections as soon as he received authorization from workers' compensation. PX 3.

On December 9, 2013, Dr. Fink recommended continued shoulder therapy and indicated he was still waiting for workers' compensation to authorize epidural steroid injections. PX 3.

A Flexeon Rehabilitation therapy note of January 15, 2014 reflects that Petitioner reported he was still experiencing right shoulder soreness and was scheduled to resume desk duty as of January 20th. PX 4.

On February 26, 2014, Dr. Fink noted that Petitioner had resumed light duty and was undergoing therapy and using a TENS unit. On lumbar spine examination, he noted positive straight leg raising at 45 degrees. He indicated he was still awaiting authorization of an epidural steroid injection. PX 3.

On March 19, 2014, Petitioner's therapist noted a gradually improving range of right shoulder motion but indicated Petitioner was still having difficulty reaching overhead. PX 4.

At Respondent's request, Dr. Kornblatt re-examined Petitioner on March 24, 2014. In his report of April 1, 2014, Dr. Kornblatt indicated he reviewed the MRIs as well as records from Dr. Fink and Flexeon Rehabilitation.

Dr. Kornblatt noted that Petitioner reported having resumed office work with Respondent as of January 20, 2014. He also noted that Petitioner reported 80% improvement of his right shoulder complaints, secondary to the surgery, and was still attending shoulder therapy. He indicated that Petitioner complained of diffuse pain in his right shoulder and the right side of his neck along with constant central low back pain "present with sitting, standing, walking, bending and twisting."

On right shoulder examination, Dr. Kornblatt noted a fairly long anterior scar with some keloid formation, 5/5 strength, active abduction to 120 degrees, internal rotation to L4, external rotation to 40 degrees, forward flexion to 140 degrees and extension to 50 degrees.

On lumbar spine examination, Dr. Kornblatt noted a slow but functional gait, a complaint of pain with palpation of the lower lumbar spinous processes, the ability to heel and toe walk, flexion to 30-40 degrees, extension to 10 degrees, lateral bending and rotation to 10 degrees bilaterally and negative straight leg raising to 90 degrees bilaterally.

Dr. Kornblatt found causation as to the need for the right shoulder surgery and Petitioner's post-operative condition. He further found that Petitioner's subjective back complaints were unrelated to the work accident. He described the accident as causing a "self-limiting lumbosacral strain, which has resolved." He viewed Petitioner as having reached maximum medical improvement for both his shoulder and his back. Based on his right shoulder examination, which showed "excellent strength . . . as well as functional range of motion," he found Petitioner capable of resuming full duty as a police officer. RX 2.

On April 9, 2014, Petitioner's therapist noted that Petitioner reported being unable to reach into higher cabinets at home due to right shoulder tightness and weakness. She also noted that Petitioner indicated he was no longer able to reach for his holstered gun in a quick, smooth manner. This is the last Flexeon Rehabilitation therapy note in evidence. PX 4.

On April 30, 2014, Dr. Fink released Petitioner to seated work, with that restriction continuing through May 26, 2014. He again indicated he was awaiting authorization of epidural steroid injections. PX 3.

Based on the records and bill in PX 2, it appears Petitioner last underwent care with Dr. Cammarano on May 5, 2014.

Petitioner testified he resumed full duty in May 2014.

Dr. Fink's records reflect he released Petitioner to seated work as of June 2, 2014. He noted he was awaiting authorization of epidural steroid injections. PX 3. There is no evidence indicating Petitioner ever underwent these injections.

On June 2, 2014, Flexeon Rehabilitation discharged Petitioner from therapy due to lack of authorization for additional care. PX 4.

Petitioner testified he is "not the same as before" the accident. He is right-handed. Due to his right shoulder injury, he has difficulty lifting a gallon of milk, emptying a mop bucket and playing with his grandchildren. His back injury has affected his ability to walk and engage in sex with his wife. He takes over the counter medications, such as Aleve and Ibuprofen. He no longer takes any prescription medication.

Under cross-examination, Petitioner testified his attorney sent him to Dr. Cammarano. Dr. Cammarano referred him to Dr. Fink. He underwent examinations by Drs. Kornblatt in March 2013 and March 2014. He received his full salary the first year he was off work. He has not seen Dr. Fink since June 2014. He belongs to a health club. Before the accident, he used to swim, lift weights and walk on the treadmill at this club. Now he simply uses the Jacuzzi and steam room. He is unable to rotate his right arm sufficiently to swim. He cannot lift more than 25 or 30 pounds. He experiences back pain "almost every day." He did not injure his right shoulder or low back at any point before or after the accident. He filed a personal injury claim against the driver who rear-ended him but he did not recover any money from this claim.

On redirect, Petitioner testified that the attorney who handled the personal injury claim told him the other driver was uninsured.

In addition to the exhibits previously discussed, Petitioner offered into evidence itemized bills from the following providers (PX 5 – bills listed in chronological order):

Bud's Ambulance		
10/28/12, ambulance service	$	619.00
South Holland Injury Care (Dr. Cammarano – PX 2)		
10/29/12 – 5/5/14, chiropractic care	$	25,165.00 [this amount includes a $200 balance for pre-accident care]
Advantage MRI		
12/12/12, lumbar spine MRI	$	1,300.00
Gold Coast Orthopedics (Dr. Fink)		
3/20/13 – 6/2/14	$	600.00 (balance)
Dr. John Mazzarella		
7/18/13, rotator cuff repair (Dr. Fink's assistant)	$	9,450.00
Windy City Medical Specialists		
11/6/13 – 12/31/13, vascutherm rental unit	$	2,245.00 (balance)
RX Development Associates		
6/24/13 – 10/2/13, medications	$	5,569.64 (balance)
12/9/13, medication	$	1,610.79
1/13/14, medication	$	2,402.90
3/26/14, medication	$	1,850.90
6/2/14, medication	$	861.02
(Drs. Fink and Mazzarella are the prescribing physicians)		
Infinite Strategic Innovations		
11/6/13, medication	$	411.21

No witnesses testified on behalf of Respondent. In addition to Dr. Kornblatt's reports, the lumbar spine MRI report (RX 3) and certain Flexeon Rehabilitation records, Respondent offered into evidence a print-out of the PEDA benefits Petitioner received from October 29, 2012 through October 29, 2013 (RX 5), a lengthy print-out of payments Respondent made to treatment providers, Petitioner, its counsel, its Section 12 examiner and IPMG, its medical case manager, and a document from Alpha Review Corporation showing a bill reduction of $1,400.00 for durable equipment supplied to Petitioner by Windy City Medical Specialists in November 2013. According to a "message" that appears at the bottom of the Alpha Review document, the reduction was made because "a charge was made for a duplicate procedure and/or supply." RX 7.

Arbitrator's Credibility Assessment

Petitioner's very lengthy tenure with Respondent weighs in his favor, credibility-wise, as does his position as a police officer.

Petitioner provided credible testimony concerning the rear-end collision, his subsequent treatment and his current complaints. The Arbitrator has no basis to question his denial of pre- and post-accident back or right shoulder injuries. The records in evidence refer to a left shoulder surgery that took place in 2006 but they contain no mention of prior or subsequent right shoulder or back injuries.

The initial Emergency Room records of October 28, 2012 do not mention right shoulder complaints but Dr. Cammarano noted such complaints the following day.

Overall, the Arbitrator found Petitioner very believable.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal connection between his undisputed rear-end collision of October 28, 2012 and his current claimed conditions of ill-being?

Initially, the Arbitrator finds that the undisputed accident caused a cervical strain which required conservative care and which has largely resolved. Petitioner did not testify to any lingering neck complaints.

The Arbitrator further finds that Petitioner established causation as to a lumbar strain and lumbar disc pathology which required conservative care and which remained symptomatic as of the hearing. The Arbitrator is not persuaded by Dr. Kornblatt's opinion that, as to the back, the accident caused merely a "self-limiting strain." RX 2. The Arbitrator assigns greater weight to Dr. Fink's opinion that the accident caused or contributed to the L5-S1 protrusion diagnosed via MRI. The Arbitrator finds Dr. Fink's recommendation of lumbar epidural steroid injections to be reasonable, although it appears no such injections were ever performed.

Finally, the Arbitrator finds that Petitioner established causation as to both the need for the right shoulder surgery performed on July 18, 2013 and as to his current, post-operative right shoulder condition of ill-being. In so finding, the Arbitrator relies in part on the treatment records and Petitioner's credible testimony concerning his ongoing right shoulder problems. The Arbitrator also notes that Respondent's examiner, Dr. Kornblatt, found causation as to the need for a right shoulder orthopedic consultation and care, up to and including surgery.

Is Petitioner entitled to reasonable and necessary medical expenses?

The Arbitrator has attempted to correlate the bills claimed by Petitioner (PX 5) with RX 6, a print-out of medical and other payments made by Respondent. There is, however, a

discrepancy between the names of the providers on Petitioner's itemized bills and some of the providers listed on the print-out.

The Arbitrator awards Petitioner the $619.00 bill from Bud's Ambulance for ambulance services provided on October 28, 2012, the date of accident, subject to the fee schedule. RX 6 does not list any payment for ambulance services provided on that date.

With respect to the claimed $25,165.00 bill from South Holland Injury Care/Dr. Cammarano, the Arbitrator awards the following, subject to the fee schedule: 1) the $10,165.00 in charges relating to the care Dr. Cammarano rendered from the initial visit of October 29, 2012 through March 14, 2013 plus the $3,400.00 in charges relating to the care Dr. Cammarano rendered following the right shoulder surgery, from August 13, 2013 through October 23, 2013. With respect to the first interval, the Arbitrator selects an end date of March 14, 2013 because this is the date on which Respondent's examiner, Dr. Kornblatt, described Dr. Cammarano's passive modalities as "minimally appropriate" and recommended a different, more active form of therapy for Petitioner's neck and back. The Arbitrator views this recommendation as reasonable. As for the second interval, the Arbitrator uses a cut-off date of October 23, 2013 because Petitioner's subsequent visits to Dr. Cammarano overlapped with his visits to Flexeon Rehabilitation. Petitioner began attending therapy at Flexeon on October 25, 2013. PX 4. The Arbitrator views the therapy rendered at Flexeon as more active and beneficial than the passive chiropractic modalities used by Dr. Cammarano.

The Arbitrator awards Petitioner the $1,300.00 bill from Advantage MRI for the lumbar spine MRI performed on December 12, 2012, subject to the fee schedule. RX 6 does not list any payment for any services provided on that date. The Arbitrator views Dr. Cammarano's recommendation of a lumbar spine MRI as reasonable in light of Petitioner's persistent complaints. Respondent's examiner, Dr. Kornblatt, did not view the MRI as unnecessary.

The Arbitrator awards Petitioner the $9,450.00 bill from Dr. Mazzarella for assistance he provided to Dr. Fink during Petitioner's right shoulder surgery of July 18, 2013, subject to the fee schedule. RX 6 lists various payments for services rendered in connection with this surgery but these payments were made to individuals and entities other than Dr. Mazzarella. Respondent's examiner, Dr. Kornblatt, viewed the right shoulder surgery as necessary and causally related to the accident. There is no evidence suggesting Dr. Mazzarella's surgical assistance was unwarranted.

Petitioner claims various bills/balances from RX Development for medication prescribed by Drs. Fink and Mazzarella. Respondent contends it paid for much of this medication, citing the corresponding treatment dates and amounts in RX 6. [RX 6 does document many prescription-related payments, albeit payments to an entity named "Catamaran RX."] Respondent also argues that one charge from August 26, 2013 (Soothing Pureway, $7.10) should be denied as no corresponding prescription appears in Dr. Fink's note of that date. The Arbitrator agrees with this argument and declines to award the claimed $7.10 expense. Respondent further maintains certain charges for medication prescribed on March 26, 2014

and June 2, 2014 should be denied based on Dr. Kornblatt's March 24, 2014 finding of maximum medical improvement. RX 2. The Arbitrator disagrees and awards these expenses based on the previous finding that Petitioner's lumbar spine and right shoulder conditions remained symptomatic as of the hearing. The Arbitrator also notes that, when Dr. Kornblatt re-examined Petitioner on March 24, 2014, he acknowledged Petitioner voiced complaints of mechanical low back pain. Dr. Kornblatt did not see the need for further diagnostics or active treatment but he did not specifically state that it was unreasonable for Petitioner to continue utilizing pain medication. In summary, the Arbitrator awards Petitioner all of the claimed RX Development charges other than the $7.10 charge of August 26, 2013, with Respondent receiving credit for the prescription payments reflected on RX 6.

Petitioner also claims expenses of $411.21 from Infinite Strategic Innovations (ISI) for Protonix, Mobic and Norco prescribed by Dr. Fink on November 6, 2013. RX 6 does not show any payments to Infinite Strategic Innovations. The Arbitrator awards Petitioner the claimed $411.21 charges.

The claimed bill from Windy City Medical Specialists lists charges of $12,045.00 (for durable equipment delivered to Petitioner's home following the shoulder surgery), insurance payments of $5,331.04, adjustments of $4,468.96 and a balance of $2,245.00. PX 5. RX 6 lists payments to Windy City Medical Specialists totaling $5,331.04. Neither party offered a fee schedule analysis and it appears the $1,400.00 charge of November 20, 2013 is duplicative. The Arbitrator awards Petitioner the Windy City Medical Specialists bill, other than the $1,400.00 charge of November 20, 2013, subject to the fee schedule and with Respondent receiving credit for the $5,331.04 payment.

The Arbitrator awards the Gold Coast Orthopedic/Dr. Fink bill of $600.00 (office visits of 3/26/14, 4/30/14 and 6/2/14), subject to the fee schedule. As indicated earlier in the decision, the Arbitrator finds Dr. Fink more persuasive than Dr. Kornblatt with respect to the issue of whether Petitioner required ongoing lumbar spine care.

What is the nature and extent of the injury?

This is a post-amendatory case, since Petitioner's undisputed accident occurred after September 1, 2011. Accordingly, the Arbitrator looks to Section 8.1b of the Act for guidance in determining nature and extent. That section sets forth several factors to be considered in establishing permanent partial disability. None of these factors is to be considered the sole determinant of disability. The Arbitrator also relies on the recent case of Corn Belt Energy Corp. v. IWCC, 2016 IL App (3d) 150311 WC.

With respect to the first enumerated factor, any AMA impairment rating, the Arbitrator notes that neither party offered such a rating into evidence. In Corn Belt, the Court clarified that the submission of such a report is voluntary.

As for the second factor, the occupation of the injured employee, the Arbitrator notes Petitioner is a police officer. The Arbitrator assigns weight to this factor. At any time, Petitioner can be called upon to protect the safety of citizens. The therapy note of April 9, 2014 reflects Petitioner reported being unable to reach quickly and smoothly for his holstered gun due to his right shoulder injury.

With respect to the third factor, the age of the employee at the time of the injury, the Arbitrator notes Petitioner was 56 years old as of the accident. The Arbitrator views Petitioner as an older worker.

As for the fourth factor, the employee's future earning capacity, the Arbitrator notes that Petitioner resumed full duty after the accident and claims no diminution of earnings. The Arbitrator thus does not view the fourth factor as relevant to this case.

With respect to the fifth factor, evidence of disability corroborated by the treating medical records, the Arbitrator notes the MRI reports as well as Dr. Fink's operative report, which documented a large, crescent-shaped rotator cuff tear. The Arbitrator also notes that Respondent's examiner, Dr. Kornblatt, documented a limited range of right shoulder motion in his re-examination report of April 1, 2014. RX 2,

The Arbitrator, having considered all of the foregoing along with Petitioner's credible testimony concerning his limitations, awards permanency equivalent to 4% loss of use of the person, equivalent to 20 weeks of benefits under Section 8(d)2, for the lumbar spine condition and an additional 10% loss of use of the person, equivalent to 50 weeks of benefits, for the right shoulder condition. The Arbitrator awards no permanency for the cervical spine condition.

STATE OF ILLINOIS)	☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF ROCK ISLAND)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☒ Modify down	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MELISSA SORRELLS,

Petitioner,

17IWCC0189

vs. NO: 13 WC 18284

JOHN DEERE PARTS DISTRIBUTION CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission modifies the Decision of the Arbitrator solely relating to the nature and extent of Petitioner's disability. The Commission considered the following criteria enumerated in §8.1b of the Workers' Compensation Act, (Act) with no single factor as the sole determinant: 1) the reported level of impairment pursuant to §8.1b(a); 2) the occupation of the injured employee; 3) the age of the employee at the time of the injury; 4) the employee's future earing capacity; and 5) evidence of disability corroborated by treating medical records.

Relative to impairment, the Commission finds both parties submitted impairment ratings pursuant to the American Medical Association's "Guides to the Evaluation of Permanent Impairment," the current, sixth edition, however, no testimony was elicited from the doctors to clarify the discrepancy in the impairment ratings. The discrepancy appears to be based upon the use of two different Tables referenced in Chapter 15 that were used for the initial impairment rating. Respondent's examining doctor, Dr. Deignan, assigned an impairment of 0% upper

17IWCC0189

extremity for both the right and left sides relying upon Table 15-23, page 449, entitled Entrapment Compression Neuropathy Impairment and Dr. Deignan noted this Table is to be used for rating carpal tunnel syndrome. Dr. Deignan identified the modifiers including: 1) the Test findings are a Grade 1 modifier; 2) History is a Grade modifier -0-; and 3) Physical findings are Grade modifier -0-. Dr. Deignan then averaged the three modifiers and the average was rounded to -0-. The QuickDASH score of -0- confirmed the appropriate final Grade is -0-. Petitioner's examining doctor, Dr. Milas, assigned an impairment of 4% of each upper extremity relying upon Table 15-21, page 438, for mild motor deficit secondary to the median nerve dysfunction below the mid forearm with no further explanation and he did not reference modifiers. Dr. Milas did not include a QuickDASH Score or make any reference to Petitioner's QuickDASH report. Therefore, the Commission finds Dr. Deignan's impairment rating is more credible than Dr. Milas' impairment rating. The Commission finds the reported level of impairment is a factor given moderate weight in determining the Petitioner's permanent partial disability.

With regard to the occupation of the injured employee, the Petitioner testified that she is a picker packer. Petitioner testified that in 2010 she was picking parts and packing them. She described picking washers in little poly bags out of a box, putting a designated quantity in a sack, taking them back to a pack bench and putting the picked parts into a box. Using a taper, she described taping the box and scanning it onto rollers, then stapling the ticket to the part "or to the sack or whatever." Petitioner testified she did that continuously. (T, pp. 8-9) Petitioner later testified that she drives a Taylor Dunn, noting "which is what we do." (T, p. 11). The Commission finds Petitioner's testimony regarding driving a Taylor Dunn contradicts her earlier testimony that she was continuously picking, packing, taping and stapling. Furthermore, Petitioner testified that in 2013 she went through a department change and that she picks "bulk stuff." (T, p.15) She testified the work was more hand intensive because there was more repetition, however, no further testimony was elicited regarding specifics of how picking and packing "bulk stuff" differed from picking washers in little poly bags out of box or created a more hand intensive function. The Commission also notes that the Petitioner's medical records are devoid of any evidence her condition is related to her job. The Commission finds that Petitioner's occupation is a factor given moderate weight in determining the Petitioner's permanent partial disability.

Petitioner was 50 years old at the time of the injury, more than the midpoint of anticipated work-life. The Commission finds the Petitioner's age is a factor given moderate weight in determining the amount of Petitioner's permanent partial disability.

The Commission finds that Petitioner's future earning capacity appears to be unaffected by the injury, therefore, her future earning capacity is given only a minor amount of weight in determining the amount of the Petitioner's permanent partial disability.

Regarding the Petitioner's evidence of disability corroborated by the treating medical records, the Petitioner testified that she continues to notice some weakness in her hands, a fact that is corroborated solely in Petitioner's examining doctor's records, not in her surgeon's records or by the Respondent's examining doctor. In ORA Orthopedics last office note, only seven weeks after the second carpal tunnel release, the physician assistant notes that Petitioner was doing well. Petitioner had some pain over the incisional area with direct pressure only. She

17IWCC0189

was to continue to work on strengthening exercises. There were no noted complaints of weakness and Petitioner was returned to work with no restrictions. Dr. Milas, Petitioner's examining doctor, documented that the Petitioner subjectively reported to him that she still had occasional discomfort and that she had less strength in her hands on repetitive use. In his opinion, she also had "done extremely well following her surgical treatment and there are no specific restrictions applicable to her." Respondent's examining doctor, Dr. Deignan, noted in her May 25, 2014 History that Petitioner was very pleased with the results of Dr. VonGillern's treatment and she has absolutely no numbness or tingling and "does not notice any weakness." Dr. Deignan noted Petitioner confirmed there are no activities that are precluded since her surgery, she is completely pain-free and does not require analgesic medications. Therefore, the Commission finds that the Petitioner's complaints are not wholly supported by the medical records. There is, however, evidence of disability. The evidence of Petitioner's disability is given significant consideration by the Commission.

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 permanent partial disability, consideration is not given to any single enumerated factor as the sole determinant. Having considered the factors enumerated in §8.1(b) of the Act, the Commission finds that as a result of her accidental injuries, Petitioner sustained 10% loss of use of her right hand and 10% loss of use of her left hand.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $495.55 per week for a period of 9-6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $445.99 per week for a period of 38 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 10% of the right hand and 10% of the left hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $35.00 for medical expenses under §8(a) and §8.2 of the Act.

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

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

17IWCC0189

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $7,100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 9 2017
KWL:bsd
O: 1/24/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

17IWCC0189

SORRELLS, MELISSA
Employee/Petitioner

Case# **13WC018284**

JOHN DEERE PARTS DISTRIBUTION CENTER
Employer/Respondent

On 12/7/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0568 WINSTEIN KAVENSKY & WALLACE
JOHN MALVIK
224 18TH ST 4TH FL
ROCK ISLAND, IL 61201

2119 CALIFF & HARPER PC
STEVE NELSON
506 15TH ST
MOLINE, IL 61285

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

17IWCC0189

Melissa Sorrells
Employee/Petitioner
v.

Case # **13** WC **18284**

John Deere Parts Distribution 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 **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Rock Island**, on **September 9, 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 **April 16, 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 $**38,652.64**; the average weekly wage was $**743.32**.

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 is entitled to a credit of $**10,917.00** under Section 8(j) of the Act for payments and write offs through its group health insurance plan, and $**3,907.20** in non-occupational indemnity disability benefits under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**495.55**/week for **9 6/7** weeks, commencing **June 4, 2013** through **August 12, 2013**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $**35.00**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $**445.99**/week for **57** weeks, because the injuries sustained caused the **15%** loss of the **right hand**, and the **15%** loss of the **left hand**, as provided in Section 8(e) of the Act.

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

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

Arbitrator Anthony C. Erbacci

October 22, 2015
Date

DEC 7 - 2015

FACTS:

On April 16, 2013 the Petitioner was employed by the Respondent as a "picker" and "packer" and she had been so employed for approximately 9 years. The Petitioner described that her job involves picking and packaging parts located at various places in the facility and she described how she performed her job. The Petitioner indicated that the job is very hand intensive and repetitive due to the number of parts she handles, the labeling and packaging of them, and how often she performs these tasks. The Petitioner testified that the job is very hand intensive and that she uses both of her hands repetitively to perform the job.

The Petitioner testified that she began experiencing symptoms of pain, numbness and tingling in her hands while working for Respondent in 2010, and while seeing her primary care physician for other issues at that time, she discussed her ongoing symptoms with her doctor. The Petitioner underwent EMG/NCV studies at that time and she was diagnosed with bilateral carpal tunnel syndrome. The Petitioner testified that the possibility of an eventual need for surgery was discussed but she declined to consider surgery at that time. The Petitioner was treated conservatively with medication and splints and she testified that her symptoms improved. The Petitioner testified that she was able to continue working her regular job without experiencing any significant problems with her hands and that she missed no time from work due to her carpal tunnel syndrome until June of 2013.

The Petitioner testified that in early 2013 she again began having problems with her hands and on April 16, 2013, while seeing Dr. Teresa Coon, her primary care physician, she again mentioned her worsening hand symptoms. The Petitioner testified that she reported her condition to the Respondent's nurse the next day. The Petitioner was then referred to ORA Orthopedics for surgical intervention due to her worsened symptoms. In June of 2013 she underwent two (2) separate carpal tunnel surgeries, one for each hand.

At the request of the Respondent, the Petitioner was examined by Dr. Christine Deignan, the Respondent's Workers Compensation Medical Director, on March 27, 2014. Dr. Deignan's May 25, 2014 report of that examination was admitted into the record as Respondent's Exhibit 1. Dr. Deignan opined that the Petitioner's work activities for the Respondent were not the cause of the Petitioner's bilateral carpal tunnel syndrome. Dr. Deignan opined that the Petitioner's impairment rating pursuant to the American Medical Association's Guides to the Evaluation of Permanent Impairment was 0% of each upper extremity.

At the request of her attorney, the Petitioner was examined by Dr. Robert Milas on January 27, 2015. Dr. Milas' report of that date was admitted into the record as Petitioner's Exhibit 4. Dr. Milas opined that the repetitive nature of the Petitioner's work activities for the Respondent was the direct cause of the Petitioner's bilateral carpal tunnel syndrome. Dr. Milas opined that the Petitioner's impairment rating pursuant to the American Medical Association's Guides to the Evaluation of Permanent Impairment was 8% of the upper extremities or 5% of the whole person.

The Petitioner testified that the surgeries she underwent resulted in improvement of her condition and that she currently has no pain in her hands but she continues to notice some weakness. The Petitioner testified that she has returned to the same job with the Respondent and that she is not under any work restrictions.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds and concludes as follows:

The Petitioner testified, and the medical records demonstrate, that she was first diagnosed with carpal tunnel syndrome in 2006 after visiting her primary care physician who arranged for EMG/NCV studies. The studies confirmed the diagnosis of bilateral carpal tunnel syndrome. Despite her diagnosis in 2006, the Petitioner continued to work for the Respondent with no lost time from work. She was prescribed medication and splints, which she wore at night. These conservative measures improved her symptoms and she continued to work with no lost time from her job due to her symptoms. It was not until April 16, 2013 when Petitioner again was seeing her primary care physician for unrelated matters, when the topic of her worsening bilateral carpal tunnel syndrome again was discussed between doctor and patient. At that time, a referral for surgery was made to ORA Orthopedics. It is only at this point in time that the Petitioner's condition worsened to the point that she lost time from work due to surgical intervention. Her condition had deteriorated to the point that it was now disabling.

As a general rule, the date of an accidental injury in a repetitive-trauma claim is the date on which the injury "manifests itself." While the "manifestation date" has been held to be 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, Illinois courts have held that the date the Petitioner could no longer perform the job without medical intervention is also an appropriate "manifestation date".

In the instant matter the Petitioner was first diagnosed with carpal tunnel syndrome in 2006 but, despite that diagnosis, the Petitioner continued to work for the Respondent with no lost time from work and no ongoing medical treatment. It was not until April 16, 2013 that the Petitioner's condition had deteriorated to the point that it was disabling and she was referred for surgery for her worsening bilateral carpal tunnel syndrome. The Arbitrator finds that April 16, 2013 is the date that the Petitioner's injury manifested itself because it is the date that her symptoms had worsened to the point where the condition had become so disabling that she was referred for surgery by her primary care physician. She then lost time from work and surgical intervention was necessary to alleviate her symptoms.

Based upon the foregoing and the principles of law set forth in Peoria County Belwood Nursing Home v. Industrial Commission (1987) 115 Ill2d 524, 106 Ill Dec 235, 505 NE2d 1026; Oscar Mayer & Co. v. Industrial Commission 176 IllApp3d 607, 531 NE2d 174 (4th Dist. 1988); and Durand v. Industrial Commission, 224 Ill2d 53, 862 NE2d 918, 308 Ill Dec 715 (2006) and applying those principles to the facts of this case, the Arbitrator finds that on April 16, 2013 the Petitioner suffered an accidental which arose out of and in the course of her employment with the Respondent.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

The Petitioner testified, and the medical records demonstrate, that she was first diagnosed with carpal tunnel syndrome in 2006. Despite the diagnosis in 2006, the Petitioner continued to work for the Respondent with no lost time from work. The Petitioner testified that conservative measures improved her symptoms and she was able to continue to work with no lost time and no significant symptoms. The Petitioner testified that her job activities increased in early 2013 and that her symptoms worsened and became more constant. In April 16, 2013 the Petitioner again sought treatment for her worsening bilateral carpal tunnel syndrome and she was referred for surgery.

The Petitioner described her job duties as very hand intensive and repetitive and she testified that her symptoms of numbness, pain, and tingling in the hands occurred with performing her work activities. Dr. Deignan, the Respondent's Workers Compensation Medical Director, opined that the Petitioner's work activities for the Respondent were not the cause of the Petitioner's bilateral carpal tunnel syndrome. Dr. Milas, the Petitioner's own examining doctor, opined that the repetitive nature of the Petitioner's work activities for the Respondent was the direct cause of the Petitioner's bilateral carpal tunnel syndrome.

While the Arbitrator notes the opinions of Dr. Deignan, the Arbitrator notes that the Petitioner's description of the actual work she performed differed from the job duties as described by, and relied upon by Dr. Deignan in rendering the opinions in her report. The Arbitrator also notes that Dr. Deignan is an employee of Respondent and it is therefore difficult to view her opinions as independent and unbiased. The Arbitrator finds that, in the instant matter, the opinions of Dr. Milas are more credible, reliable and persuasive than those of Dr. Deignan.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner's current condition of ill-being is causally related to her work injury on April 16, 2013.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

As a result of the accident of April 16, 2013, the Petitioner suffered an injury to her hands diagnosed as bilateral carpal tunnel syndrome. She commenced medical treatment for the injury on April 16, 2013 by going to Teresa Coon, her primary care physician. She was referred to ORA Orthopedics for surgical consult for her bilateral carpal tunnel syndrome and she underwent surgery on her hands as described in the medical records. The Petitioner submitted Petitioner's Exhibit 9 as evidence of the various physicians and providers who provided treatment for the symptoms related to her bilateral carpal tunnel syndrome and the charges for their services. An examination of the medical records reveals that the charges and services billed by the providers, as shown in Petitioner's Exhibit 9, correspond to treatment for her bilateral carpal tunnel syndrome. No evidence was offered to show that the treatment received was not reasonable and necessary. The charges for the services were not challenged.

Therefore, the Arbitrator finds that all of the bills incurred for medical services listed on Petitioner's Exhibit 9 were reasonable, necessary and causally related to the work injury of April 16, 2013, and are the responsibility of the Respondent. Accordingly, the Arbitrator finds that the Respondent is liable in the sum of $10,946.00 for medical bills incurred as a result of the Petitioner's accident of April 16, 2013. The Respondent is entitled to a credit of $4,615.55 in payments and $6,301.45 in PPO write-offs by providers pursuant to Section 138 (j) of the Act for group, non-occupational health benefits. A balance of $35.00 was paid by Petitioner, for a total of $35.00 awarded to Petitioner.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Respondent disputed it's liability for Temporary Total Disability benefits based upon the dispute as to the issues of accident and causation. The parties stipulated, however, that the Petitioner was temporarily totally disabled from June 4, 2013 through August 12, 2013, a period of 9 6/7 weeks. As the Arbitrator has found for the Petitioner with regard to the issues of accident and causation, the Arbitrator finds that the Petitioner was entitled to Temporary Total Disability benefits from June 4, 2013 through August 12, 2013, a period of 9 6/7 weeks.

The parties stipulated that the Respondent is entitled to a credit of $3,907.20 in non-occupational indemnity disability benefits pursuant to Section 138(j) of the Act.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

The Petitioner's accident occurred after September 1, 2011. Therefore, Section 8.1(b) of the Act requires consideration of the following criteria in determining the level of permanent partial disability:

* The reported level of impairment based upon the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment;
* the occupation of the injured employee;
* the age of the employee at the time of the injury;
* the employee's future earning capacity; and
* evidence of disability corroborated by the treating medical records.

Additionally, Section 8(e)9 of the Act provides that if the accidental injury involves carpal tunnel syndrome due to repetitive or cumulative trauma, the permanent partial disability shall not exceed 15% loss of use of the hand, except for cause shown by clear and convincing evidence and in which case the award shall not exceed 30% loss of use of the hand. No single enumerated factor shall be the sole determinant of disability but the relevance and the weight of any additional factors used must be explained.

In the instant case, the Petitioner suffered from bilateral carpal tunnel syndrome which ultimately required surgeries. She ultimately returned to her regular work for the Respondent without restrictions and she continues to work in that same capacity. The Petitioner testified that she currently continues to notice some weakness in her hands

With regard to the reported level of impairment pursuant to Section 8.1(b), the level of impairment reported by Dr. Deignan, the Respondent's examining doctor, pursuant to the American Medical Association's Guides to Evaluation of Permanent Impairment is 0% of each upper extremity. The level of impairment reported by Dr. Milas, the Petitioner's examining doctor, pursuant to the American Medical Association's Guides to Evaluation of Permanent Impairment is 8% of the upper extremities or 5% of the whole person. The Arbitrator notes that impairment does not equate to permanent partial disability under the Workers' Compensation Act. The Arbitrator also notes that Dr. Deignan is an employee of Respondent and it is therefore difficult to view her opinions as independent and unbiased. In the instant matter, the Arbitrator finds that the reported level of impairment is not a significant factor in determining the amount of the Petitioner's permanent partial disability.

With regard to the occupation of the injured employee, the Petitioner's occupation is that of a picker packer, which the Arbitrator notes is repetitive, hand intensive work. The Arbitrator concludes that the Petitioner's ability to perform the duties of his employment will be more adversely affected by his permanent partial disability than would the ability of an individual who performs lighter work. Thus, the Arbitrator concludes that the Petitioner's occupation is a significant factor in determining the amount of the Petitioner's permanent partial disability.

With regard to the age of the employee at the time of injury, the Petitioner's age at the time of injury was 50 years old. The Arbitrator finds that the Petitioner's age is not a significant factor in determining the amount of the Petitioner's permanent partial disability.

With regards to the employee's future earning capacity, the Arbitrator notes that the Petitioner's future earning capacity appears to be unaffected by the injury. The Arbitrator finds that the Petitioner's future earning capacity is not a factor in determining the amount of the Petitioner's permanent partial disability.

With regard to the evidence of disability corroborated by the treating medical records, the Petitioner credibly testified that he currently continues to notice some weakness in her hands. These complaints are corroborated in the medical records of Dr. Milas. The Petitioner's complaints as supported by the medical records, evidences a disability as indicated by Commission decisions regarded as precedent pursuant to Section 19(e).

The determination of permanent partial disability is not simply a calculation but an evaluation of all 5 factors as stated in the Act. In making this evaluation of permanent partial disability, consideration is not given to any single enumerated factor as the sole determinant. Therefore, having considered the factors enumerated in Section 8.1(b) of the Act, 820 ILCS 305/8.1(b), and having considered the provisions of Section 8(e)9, the Arbitrator finds that as a result of her accidental injuries the Petitioner has sustained 15% disability to her right hand and 15% disability to her left hand.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Peterson,
Petitioner,
vs.

NO: 13 WC 22038

University Of Chicago,
Respondent,

17IWCC0141

DECISION AND OPINION ON REVIEW

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

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

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

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

The party commencing 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: MAR 3 - 2017
o022317
DLG/mw
045

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PETERSON, MICHAEL
Employee/Petitioner

Case# 13WC022038

13WC026734

UNIVERSITY OF CHICAGO
Employer/Respondent

17IWCC0141

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

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

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

0758 KREITER BYCK & ASSOCIATES LLC
PAUL M BYCK
180 W WASHINGTON ST SUITE 800
CHICAGO, IL 60602

1401 SCOPELITIS GARVIN LIGHT ET AL
GREGORY E AHERN
30 W MONROE ST SUITE 600
CHICAGO, IL 60603

17IWCC0141

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

MICHAEL PETERSON
Employee/Petitioner

v.

UNIVERSITY OF CHICAGO
Employer/Respondent

Case # **13 WC 22038**

Consolidated cases: **13 WC 26734**

An *Application for Adjustment 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 **March 1, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS (13 WC 022038)

On **June 8, 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 **$99,248.76**; the average weekly wage was **$1,908.63**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **0** dependent children.

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

Respondent ***has*** 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 (13 WC 022038 - DATE OF ACCIDENT 6/8/2013)

Respondent shall pay Petitioner Permanent Partial Disability benefits of **$712.55**/week for **75** weeks, due to injuries sustained which caused a **15% loss of the person-as-a-whole**, as provided in **§8(d)(2)** of the Act.

Respondent shall pay Petitioner compensation that has accrued from **June 8, 2013** through **March 1, 2016** and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

June 3, 2016
Date

ICArbDec p. 2

JUN 6 - 2016

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

John R. Lawrence,

Petitioner,

vs.

NO: 13 WC 22507
13 WC 21922

Sam's Club,

Respondent.

17IWCC0176

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.

At the time of arbitration, Petitioner moved to voluntarily dismiss claim 13WC 21922, said motion being granted and the claim voluntarily dismissed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 7, 2016, is hereby affirmed and adopted.

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

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

17IWCC0176

The party commencing 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: MAR 2 3 2017
TJT:yl
o 3/14/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LAWRENCE, JOHN R
Employee/Petitioner

Case# **13WC022507**

13WC021922

SAM'S CLUB
Employer/Respondent

17IWCC0176

On 1/7/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.50% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0564 WILLIAMS & SWEE LTD
STEVEN R WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

2593 GANAN & SHAPIRO PC
BRET E TAYLOR
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

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

17IWCC0176

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

John R. Lawrence
Employee/Petitioner

v.

Sam's Club
Employer/Respondent

Case # **13WC 022507**

Consolidated cases: **13 WC 21922**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Bloomington, Illinois**, on **August 25, 2015 and November 20, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 17IWCC0176

On 4/15/2013, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$12,109.93**; the average weekly wage was **$378.43**.

On the date of accident, Petitioner was **27** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$822.89** for other benefits, for a total credit of **$822.89**.

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

ORDER

Petitioner having moved to voluntarily dismiss claim 13WC 021922, said motion being granted and the claim is hereby dismissed.

With respect 13 WC 22507, the Arbitrator having found that Petitioner failed to prove an accident occurred on April 15, 2013 which arose out of and in the course of his employment with Respondent, his claim for compensation is hereby denied.

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

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

Signature of Arbitrator

1/4/16
Date

JAN 7 - 2016

17IWCC0176

Summary of Facts

Petitioner initially filed two Applications for Adjustment of Claim alleging two separate injury dates, 13WC 021922 with an accident date of April 24, 2013, and 13WC 022507 with an accident date of April 15, 2013. At the time of arbitration, Petitioner moved to voluntarily dismiss claim 13WC 021922, said motion being granted and the claim voluntarily dismissed. Arbitration proceeded on claim number 13WC 022507.

Petitioner testified that on April 15, 2013, he was an employee of Sam's Club, working as the meat team lead. His job responsibilities included putting away loads of meat each day, stacking shelves and managing other people in the meat department. He would also assist customers with their orders of packaged meat. Petitioner provided that on April 15, 2013, he was loading a box of meat into a customer's grocery cart when he felt a pop in his abdomen. Petitioner testified the box weighed approximate 50 to 80 pounds. He testified he was coming from a squatting position into a raised position when he felt the pop. He testified there was one specific lifting incident when he felt the pop in his abdomen.

Petitioner testified he waited nine days to report the injury to Respondent, April 24, 2013, because he was afraid of losing his job. He testified he was confident of the date of the injury he reported, April 15, 2013. However, at the time of trial, he testified he was not sure what he was lifting at the time of the injury, stating it was over two years since the date of injury. Petitioner testified he was unsure whether his memory of what he was lifting would have been better 9 days after the injury, or over 2 years later at the time of arbitration.

Petitioner testified he initially sought treatment at Occupational Health at OSF St. Joseph Hospital on April 24, 2013. He provided a history that "[o]n April 15, 2013 lifting an 80 pound box to bending over to place on bottom of shopping cart, felt a pull in navel area..." He was diagnosed with umbilical hernia, right groin/testicle strain and referred to Dr. Naour for further treatment. (PX-3)

Petitioner was seen by Dr. Naour on May 14, 2013. Petitioner provided a history of noticing an umbilical hernia four weeks prior while lifting heavy boxes at work. He was again diagnosed with an umbilical hernia and surgery was recommended. (PX-4)

Petitioner underwent repair of an incarcerated umbilical hernia with placement of Ventralex ST mesh on June 3, 2013 with Dr. Naour. (PX-2) Dr. Naour placed a restriction of no lifting over 10 pounds for 4 weeks following surgery. (PX-1) Petitioner testified he only missed two weeks of work following the procedure and returned to work with no limitations thereafter. Post-operatively, Petitioner treated with Dr. Naour on two occasions. On June 25, 2013, he was released from care with the only limitation being no unnecessary strains and to advance activity as tolerated. (PX-4) Petitioner sought no additional treatment thereafter.

Petitioner testified he no longer works for Respondent and is currently employed as an insurance agent for insurance agency Petrov, Lawrence, Reed Insurance Services.

Mike Kraynak testified on behalf of Petitioner. Mr. Kraynak stated in April 2013 he was employed at Sam's Club in the deli as a deli processer. He testified to seeing Petitioner on April 15, 2013 and noticing he was in pain and having trouble lifting things. He did not witness the accident. Mr. Kraynak testified Petitioner requested assistance in lifting basic simple things. Mr. Kraynak further testified he left the employ of Respondent in September 2013, but has maintained his friendship with Petitioner in the years since.

Mr. Kraynak testified he and Petitioner socialize and keep in contact on a regular basis, hanging out and going to social events such as golf outings for fundraisers. He further testified they maintain contact at least once every couple of weeks.

Petitioner also presented his father, Williams Lawrence, as a witness on his behalf. Mr. Lawrence testified he saw Petitioner either the evening of April 15 or the next day, April 16, at which time he noticed Petitioner's naval was sticking out. He did not witness the accident.

Petitioner testified there were no witnesses to the injury in question. 17IWCC0173

Petitioner testified he reported the injury to his supervisor, Shelly Perry, on April 24, 2013. At that time, he was required to complete an Associate Incident Report documenting the injury. Petitioner testified Respondent's Exhibit 1 is an accurate copy of the handwritten Associate Incident Report he completed. Petitioner testified RX-1 is in his handwriting and contains his signature. The Associate Incident Report completed by Petitioner identifies the injury occurring on April 15, 2013 in the p.m. In the report, Petitioner provided that "I was loading a case of 80% grind for a member onto the bottom of their cart…While loading the case, I bent down and felt pain in my stomach area." (RX-1)

Petitioner also testified upon reporting the injury he was required to input the injury history into a computer system for Sam's Club. A copy of the information inputted into Respondent's computer system, introduced as Respondent's Exhibit 2, summarizes the claim information. The summary of claim information identifies the accident date as April 15, 2013, and the time of day was approximately 2:44 p.m. Petitioner testified the time of day was an estimate. Also documented was Petitioner "lifted a[n] 80% box of grind from the push cart. He then put it on the bottom of a member's cart. At that time he felt pain in his stomach." (RX-2) Petitioner testified that he was not certain who entered the information into the computer stating it could have been "himself or someone else."

Respondent's Exhibit 3 is the Manager Investigation Report completed by Petitioner's supervisor, Shelly Perry, on April 24, 2013. The Manager Investigation Report appears to confirm the information provided by Petitioner to his supervisor that on April 15, 2013, he was loading a case of 80% grind for a member onto the bottom of a cart. (RX-3)

Respondent's Exhibit 4 appears to be a claim identification summary which was completed by Petitioner's supervisor, Shelly Perry. The claim identification summary provides that the accident occurred on April 15, 2013 at 2:44 p.m. (RX-4)

Respondent presented the testimony of Mary Allen, Respondent's Asset Protection Manager responsible for compliance, safety and shrink for Respondent. Ms. Allen provided that as part of her job responsibilities, she is required to run and monitor a video surveillance system within the Sam's Club premises. If there is a claim for an injury by an associate while working, she is required to conduct an investigation including review of the video surveillance system. Ms. Allen testified she was advised Petitioner reported a lifting injury on April 15, 2013. Ms. Allen testified she conducted an investigation into the alleged injury. She indicated Petitioner had completed an incident report identifying he had lifted an 80% box of grind into a member's cart. She then reviewed the merchandise purchasing system to determine when 80% grind was purchased on that day. She testified only one box of 80% grind was purchased on April 15, 2013. The computer receipt for the one purchase of 80% ground chuck (grind) shows the purchase was made at 2:11 p.m. on April 15, 2013. (RX-5) After determining what time of day the purchase of 80% grind occurred, she then reviewed the video of the meat department to review the grind being brought out to the member (customer) and put into the customer's

cart. She testified she was able to observe the case of 80% grind being brought out to the customer and loaded into the customer's cart. The video surveillance showed it was the customer who actually loaded the box of 80% grind off of the employer's cart and into the customer's cart. Respondent's Exhibit 8 is a disc containing the video surveillance showing the box of 80% grind being brought out to the customer and loaded into the customer's cart by the customer. Respondent's Group Exhibit 6 are snapshot pictures of the video surveillance contained on Respondent's Exhibit 8. Ms. Allen testified Respondent's Group Exhibit 6-1 shows the case of 80% grind being brought out by a different meat associate, Dillon, to the customer at approximately 2:03 p.m. (RX-6-1) Ms. Allen testified Respondent's Exhibit 6-2 shows the customer carrying the case of meat over to their own shopping cart at 2:04 p.m. (RX-6-2) Ms. Allen testified Respondent's Exhibit 6-3 shows the customer putting the case of 80% grind underneath his own cart at 2:04 p.m. (RX-6-3) Ms. Allen then testified Respondent's Exhibit 6-4 shows Petitioner pushing a cart containing plastic meat racks out to a white rectangular cooler which they were cleaning at that time. (RX-6-4) Petitioner was bringing out the racks in a grocery cart at approximately 2:05 p.m. (RX-6-4)

With respect to (C.) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds as follows:

Petitioner testified at arbitration he could not remember what type of meat he was lifting at the time of the alleged injury. The Arbitrator thus refers to the history Petitioner provided not only to his manager, Shelly Perry, but also the history he provided to his employer in his own handwriting 9 days after the alleged date of injury. When Petitioner reported his injury to Respondent on April 24, 2013, he provided a detailed history of lifting a box of 80% grind off of a cart and placing it in the bottom of a customer's cart. He indicated the time of day was around 2:44 p.m., but this was only an estimate. The merchandise purchasing system for Respondent on April 15, 2013 showed only one box of 80% grind was purchased that day, at approximately 2:11 p.m. The video surveillance of the meat department minutes prior to the purchase of the 80% grind show another associate, not Petitioner, bringing the box of 80% grind out to the customer. The customer then unloaded the box from the co-worker's cart and into the bottom of the customer's cart. Petitioner did not bring the box of 80% grind out to the customer and did not load the box of 80% grind into the customer's cart. Petitioner's co-worker did not even load the box of 80% grind into the customer's cart. Of interest, one minute after the box of 80% grind was loaded into the customer's cart, the video surveillance shows Petitioner performing a completely unrelated activity. Based upon the injury histories provided by Petitioner to his supervisor, and documented by both Petitioner and Petitioner's supervisor at or near the time of injury, as well as the purchase receipt and video surveillance of the 80% grind being delivered to the customer, the Arbitrator finds Petitioner failed to prove by a preponderance of evidence that he sustained an accident that arose out of and in the course of his employment with Respondent on April 15, 2013.

All remaining issues are moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Peterson,
Petitioner,
vs.

NO: 13 WC 26734

17IWCC0142

University Of Chicago ,
Respondent,

DECISION AND OPINION ON REVIEW

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

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

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

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

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

MAR 3 - 2017

DATED:
o022317
DLG/mw
045

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PETERSON, MICHAEL
Employee/Petitioner

Case# 13WC026734
13WC022038

UNIVERSITY OF CHICAGO
Employer/Respondent

17IWCC0142

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

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

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

0758 KREITER BYCK & ASSOCIATE LLC
PAUL N BYCK
180 W WASHINGTON ST SUITE 800
CHICAGO, IL 60602

1401 SCOPELITIS GARVIN LIGHT ET AL
GREGORY E AHERN
30 W MONROE ST SUITE 600
CHICAGO, IL 60603

17IWCC0142

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

MICHAEL PETERSON
Employee/Petitioner

v.

UNIVERSITY OF CHICAGO
Employer/Respondent

Case # **13 WC 26734**

Consolidated cases: **13 WC 22038**

An *Application for Adjustment 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 **March 1, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 (13 WC 026734)

On **August 1, 2013** Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* 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 **$99,248.76**; the average weekly wage was **$1,908.63**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **0** dependent children.

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

Respondent ***has*** 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 (13 WC 026734 - DATE OF INJURY: 8/1/2013)

Respondent shall pay Petitioner Permanent Partial Disability benefits of **$721.66**/week for **25** weeks, due to injuries sustained which caused a **5% loss of the person-as-a-whole**, as provided in Section **8(d)(2)** of the Act.

Respondent shall pay Petitioner compensation that has accrued from **August 1, 2013** through **March 1, 2016** and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

June 3, 2016
Date

JUN 6 - 2016

MICHAEL PETERSON v. UNIVERSITY OF CHICAGO
13 WC 22038, consolidated with 13 WC 26734

INTRODUCTION

This matter proceeded to hearing on March 1, 2016 before Arbitrator Steven Fruth. The disputed issues were: ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***L:*** What is the nature and extent of the injury?

Petitioner was the only witness at trial.

FINDINGS OF FACT

Petitioner alleges that he suffered injuries from two accidents involving his right arm: the first on June 8, 2013 (13 WC 022038) and the second on August 1, 2013 (13 WC 026734).

Petitioner testified that he has worked for Respondent for almost 7 years. He is an engineering foreman in the Central Facility Plant. Prior to this position, he worked for LTV Steel for 29 ½ years as a pipefitter. Petitioner testified that he has been employed in jobs involving physical labor his entire adult life. He graduated high school and completed a four year pipefitting and welding apprenticeship program.

At the time of the June 8, 2013 accident, Petitioner held the position of "Acting Foreman". He was responsible for overseeing the steam and chilled water distribution system. He testified that the steam plants produce steam or chilled water used for heat, hot water and humidification which is distributed to approximately 156 buildings. The system is old and often needs repairs. Petitioner testified that his job involves replacing valves and steam traps as well as repairing pipes and pumps. All of these activities require the use of tools, including large pipe wrenches, end wrenches, hammers, and chisels. According to Petitioner, he performs the work in hard to reach places, such as crawl tunnels 4 ½ feet high. Much of his work is performed on his hands and knees and in awkward positions. He often has to crawl and reach with his arms. He also climbs ladders and scaffolds.

On June 8, 2013 (13 WC 22038), Petitioner testified he was changing a pressure control valve located in the steam room. The valve is made of cast steel and weighs between 125 and 150 pounds. In order to replace the valve Petitioner had to unscrew and retighten 16 bolts on a flange. Each bolt is four inches long and is secured by a 1 ¼ inch nut. Because the valve is holding a significant amount of pressure, the bolts are very tightly secured and often times require a hammer to loosen. Petitioner testified that he must exert a significant level of

force in order to tighten each of the 16 bolts in order to prevent leaking. The steam pipes are 350 to 400 degrees and all of the connecting metal is very hot.

While using two 18 inch end wrenches to tighten the bolts, he felt a pop in his right shoulder which caused immediate pain. He told his co-employee, Nate Marshall, that he thinks he hurt his shoulder. Mr. Marshall finished tightening the bolts and Petitioner completed his work day with minimal use of his right arm. He reported the incident to his Supervisor. An accident report was written and he was advised to go to Employee Health at University of Chicago Hospital.

Petitioner was first seen at the University of Chicago Occupational Medicine clinic (PX #3) on June 10. 2013. He testified that his right arm was painful. He followed up on June 14, 2013. He was diagnosed with shoulder strain and possible rotator cuff tear and was given a cortisone injection. The cortisone shot provided only one day of relief.

He was prescribed physical therapy at University of Chicago, which began on June 17, 2013. He complained that he was unable to sleep due to pain and had difficulty lifting his right arm or reaching behind his back. He was unable to pour a coffee pot due to weakness. He described his pain level at 8/10. He was given a sling by his physician and was working light duty. He continued therapy three times per week until July 2, 2013. At that time, the therapist noted little progress beyond passive range of motion and his pain level remained at 8/10. He was instructed to return to the doctor for re-evaluation. (PX #3)

On July 2, 2013, an MRI was ordered by Dr. Steven Lelyveki to rule out a rotator cuff tear. The MRI without contrast was performed on July 8, 2013. There was no full-thickness rotator cuff tear; there was supraspinatus tendinopathy with less than 50% partial thickness tear along the articular surface; there was degenerative labral tearing; and there was moderate to severe acromioclavicular joint degenerative changes and moderate joint effusion (PX #3).

Following the MRI, Petitioner made an appointment with an orthopedic surgeon, Dr. Sherwin Ho at the University of Chicago Medical Center. According to Petitioner, the earliest appointment date for Dr. Ho was on September 13, 2013, pending approval by the workers compensation adjuster.

Petitioner injured his right arm at work again on August 1, 2013 (13 WC 026734). Petitioner testified that he was searching for the source of a hot water leak on Ellis Avenue. He located a leaking pipe underneath the ground in a crawl tunnel. He entered the crawl tunnel through a manhole, approximately 30 inches wide. On his way back out of the tunnel, he climbed a short ladder that brought his body about chest level with the sidewalk. He placed his hands on each side of the manhole and lifted himself up. As he was lifting his body weight, he felt and heard a pop in his right arm. The pain was not severe and he continued to work. He did notify his Supervisor, Brandon Stone.

At the end of the day, while changing clothes in the company locker room, he noticed a sagging lump on his arm below his shoulder. There was a large bruise. He showed the deformity to his supervisor. The following day, he and his Supervisor each completed accident reports indicating the injury occurred while climbing out of a manhole (PX Group #1). Mr. Stone then took him to the emergency room of University of Chicago Hospital, since Employee Health was closed. Petitioner gave a history of an injury at work while pulling himself out of a manhole, consistent with Petitioner's testimony (PX #3). He had noticed a "knot" in his upper arm. He had bruising and mild soreness. He had been taking Aleve for the previous shoulder injury.

Petitioner was referred to Dr. Sherwin Ho for evaluation and treatment of his shoulder injury. Petitioner testified that he informed the medical staff that he would follow up with Dr. Ho, since he already scheduled an appointment with him as a result of the first injury.

Petitioner saw Dr. Ho on September 13, 2013 (PX #3). The chart note was dictated by Dr. Matthew Marcus and counter-signed by Dr. Ho. Petitioner did not recall Dr. Marcus, but testified there was usually a Resident in the room during his examinations with Dr. Ho.

Petitioner gave a history of injury in June, while performing a rolling motion while pulling on some equipment when he felt pop in right shoulder. A subacromial injection provided only one day of relief and physical therapy caused more pain than improvement. It was noted that the MRI showed right rotator cuff tear.

It was then noted that Petitioner reported that he was getting up from a chair in August and felt another pop in his shoulder. Petitioner testified that this never happened. Rather, Petitioner testified that he told Dr. Ho about the accident while getting out from the manhole and demonstrated for the doctor the position of his hands on the arms of a chair as he lifted himself.

Physical examination revealed a deformity in the right upper extremity, a negative Neer's sign, positive Hawkins, Speed's, Yergason's, and O'Brien's tests. Range of motion was reduced due to pain. Supraspinatus strength was 4+/5. The MRI showed fluid around the biceps tendon. A partial rotator cuff tear with a new long head biceps rupture were diagnosed. Surgery to repair the rotator cuff tear as well as a biceps tenodesis was discussed. However, it was noted that tenodesis may not be possible to repair the biceps rupture since it may have "retracted too far."

Petitioner returned to Dr. Ho on November 22, 2013. At this time, he was still symptomatic. Surgery was authorized and scheduled for December 3, 2013. On December 3 Dr. Ho performed arthroscopic rotator cuff repair, distal clavicle resection, distal clavicle excision, extensive debridement of torn biceps tendon, and injection of the shoulder with autologous platelet rich plasma (PX #3). Dr.

Ho noted that the biceps tendon was completely ruptured and having scarred into the bicipital groove. There was a stump left at the origin of the superior labrum. Since the biceps could not be removed or retracted, Dr. Ho decided to leave it alone.

Petitioner was taken off of work for two weeks following the surgery (PX #2). He followed up with Dr. Ho on December 13, 2013. Physical therapy was ordered. The initial therapy evaluation on December 16, 2013 indicated Petitioner was able to lift 100 pounds before his June injury, but has had pain, decreased motion and decreased strength since then (PX #3). Petitioner testified that he returned to work with restrictions on December 17, 2013. He wore a sling and took medication when his shoulder became irritated. By the time he saw Dr. Ho on January 24, 2014 he stopped taking medication, but still had some anterior shoulder pain and tightness into the biceps with difficulty reaching for objects (PX #3).

Petitioner continued with physical therapy. On January 28, 2014 the therapist noted that while his pain level was between one and two out of ten, his right arm was approximately 75% weaker than his left arm (PX #3). On March 3, 2014it was noted that Petitioner was slowly gaining strength, but that his greatest difficulty was reaching into flexion with a weighted object, especially a coffee pot. He was not able to attempt overhead lifting at that time. The therapist recommended continued focus on high level of strength and stability which are required for his job duties (PX #3).

Petitioner saw Dr. Ho on March 7, 2014. Dr. Ho wrote that he is doing very well with physical therapy and had no complaints. He returned Petitioner to work without restrictions.

Petitioner saw Dr. Ho for the last time on June 13, 2014. At that time, Petitioner complained of occasional twinges of pain in the anterior aspect of the shoulder. Dr. Ho noted the "Popeye deformity of the biceps". At trial Petitioner displayed his right arm and the deformity was described for the record as a smaller than baseball sized lump between the shoulder and the elbow but much closer to the elbow. For comparison purposes Petitioner displayed his left arm, which had no deformity. Petitioner testified that the Popeye deformity has been there since his August 1, 2013 accident.

Dr. Ho discharged Petitioner on June 13, 2014, but ordered six additional weeks of physical therapy, two to three times per week, for rotator cuff strengthening and range of motion. Petitioner returned to physical therapy on June 30, 2014 complaining of continued achiness and weakness in his right shoulder (PX #3). He complained of an increase in pain to 5/10 with hammering and heavy lifting which resolves the next day. Petitioner had pain with physical activity. On July 17, 2014, he complained of significant pain with hammering that week.

Petitioner was discharged from therapy on August 6, 2014. At that time, his pain level was recorded at 1/10. He had tenderness to palpation of the anterior bicipital groove and subacromial space. The therapist wrote that while he progressed very well, he still has weakness with hammering and lifting (PX #3). He continued to have fatigue with push-ups and simulated hammering activities at therapy. The therapist concluded that he did not achieve his goal of being pain free after 20 minutes of hammering.

Petitioner testified that he currently is unable to lift 100 pounds, as he was before his injuries. He stated that he continues to have weakness in his right arm with pain and discomfort after physical activities such as hammering or using tools at work. The pain is to the front and back of his shoulder. He ices it on occasion but does not take medication. He is right hand dominant, yet his left arm is much stronger. He testified that he now relies more on his left arm at work and at home such as lifting a case of soda at the grocery store. He is a foreman with three people working under him. He testified that he asks for assistance when needed. Although he does not do less work as a result of his condition, he testified that he is not able to perform his activities in the same manner and speed as before the accidents.

Petitioner testified that other than the accidents on June 8, 2013 and August 1, 2013, he never had any other accidents, injuries or treatment to his right shoulder. He testified that he never filed any other workers compensation claims. No other witnesses testified.

CONCLUSIONS OF LAW

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

(13 WC 022038; Date of Injury: 6/8/2013)

The Arbitrator finds that Petitioner's current condition of ill-being is causally related to his work accident on June 8, 2013. Petitioner testified that he never had any treatment or injuries to his right shoulder prior to the accident. The accident was competent to cause petitioner's shoulder injury. He was treated at the Employee Health Clinic for what was eventually diagnosed as rotator cuff tear and labrum tear. Dr. Sherwin Ho performed rotator cuff surgical repair at the University of Chicago Hospital. The Arbitrator finds the Petitioner testified credibly. There was no evidence rebutting the chain of events evidence presented by Petitioner which proved causation.

(13 WC 26734; Date of Injury: 8/1/2013)

The Arbitrator finds that there is causal connection between Petitioner's accident on August 1, 2013 and his current condition of ill being. Petitioner testified that he injured his right arm pushing himself out of a manhole. He notified his Supervisor that day. He observed a deformity in his right arm while changing out of his clothes at his work locker room and showed his Supervisor. They each completed accident reports consistent with the Petitioner's testimony and his Supervisor took him to the Emergency Room the following day. The history provided in the hospital records confirm Petitioner's version of the events. Bruising was observed in the upper arm. He told the emergency room physician that he had a previously scheduled appointment with Dr. Sherwin Ho due to the injury sustained on June 8, 2013 and was advised to follow up with Dr. Ho.

When he eventually saw Dr. Ho and his assistant on September 13, 2013, he demonstrated the mechanism of injury was similar to using both hands to push up from a chair. Petitioner testified that he never injured himself getting up from a chair. The Arbitrator finds that the chart note about a chair was an obvious mistake, as was the statement that Petitioner was 69 years old in the same note.

Since the Arbitrator finds the Petitioner's testimony credible, and since the emergency room record from August 2, 2013, Petitioner's accident report written on August 2, 2013 and the Supervisor's accident report on the same day are all consistent with Petitioner's testimony that he injured himself exiting a manhole, the Arbitrator concludes that this is the only logical explanation for the injury. Furthermore, Petitioner testified that he had not suffered any other injuries to his right arm between the June 8, 2013 and August 1, 2013 accidents, or any injuries since that time.

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

The Arbitrator evaluated the nature and extent of Petitioner' permanent partial disability in accord with §8.1b of the Act:

(i) No AMA impairment ratings were admitted in evidence. Therefore, the Arbitrator can give no weight to this factor.

(ii) The Petitioner's occupation is an engineering foreman in charge of replacing valves, steam traps and fixing leaking pipes and pumps. He described the strenuous nature of his work in detail. Aside from heavy use of his upper body and upper extremities Petitioner frequently climbs ladders and scaffolds and also works in hard to reach places, such as crawl tunnels 4 ½ feet high. It is heavy

physical labor. However, the Arbitrator notes that Petitioner's treating surgeon released him to full duty work. The Arbitrator therefore gives great weight to Petitioner's occupation and concludes that Petitioner's permanent partial disability will be greater than an individual who performs lighter work who has suffered a similar injury.

(iii) The Petitioner's age at the time of the injury was 59 years old. He has a statistical life expectancy of 22 years and a statistical worklife expectancy of 6.5 years. The nature of this injury is likely to affect the Petitioner more than it would a younger person, especially in light of the physical nature of his job. The Arbitrator gives moderate weight to this factor.

(iv) There was no evidence that Petitioner's earning capacity has been affected by his injury. Petitioner returned to his regular job, although he now works slower and more cautiously. There is no evidence on which any inference can be made that Petitioner's earning capacity has been, or will be, affected. Therefore, the Arbitrator gives this factor no weight.

(v) Petitioner has demonstrated evidence of disability corroborated by the treating medical records. Dr. Ho discharged Petitioner on June 13, 2014 indicating that Petitioner was back to full level of activity with occasional mild twinge of pain in his shoulder. He noted the "Popeye" deformity in the biceps. However, Dr. Ho did order additional physical therapy at that time for rotator cuff strengthening and range of motion. The physical therapy notes beginning June 30, 2014, document continued achiness and weakness in the right shoulder in addition to complaints of pain especially with hammering and heavy lifting. This is consistent with Petitioner's testimony. Even upon discharge from therapy on August 14, 2014, which was the last record of treatment, he had continued weakness and did not fully achieve his goals of being pain free after hammering for 20 minutes. Petitioner testified that he continues to have the same weakness and can no longer lift 100 pounds, as he did before his injuries. In addition, he continues to have pain with physical activity, though it will normally subside by the following day. Icing his shoulder does help his symptoms. Petitioner testified that he is right hand dominant but now has greater strength in his left arm, since he relies on it more for physical activities.

The surgical report outlines the repair to the rotator cuff, removal of his clavicle and debridement of the torn biceps tendon. However, Dr. Ho noted that the biceps tendon was completely ruptured and

scarred into the bicipital groove with a stump left at the origin of the superior labrum. The tendon could not be removed or retracted so it was left alone. Petitioner continues to have a Popeye like deformity, described as a smaller than baseball sized lump in his arm.

Based on all of the foregoing, and in consideration of the factors enumerated in Section 8.1b, the Arbitrator awards permanent partial disability to the extent of 15% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act for the occurrence on June 8, 2013 (13 WC 22038) and 5% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act for the occurrence on August 1, 2013 (13 WC 26734).

June 3, 2016

Steven J. Fruth, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Richard Henderson,

Petitioner,

vs. NO: 13 WC 26917

Vroom Vroom LLC.,

Respondent.

17IWCC0138

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 TTD, causal connection, medical benefits, prospective medical care, and credit 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 evidence adduced at the 19(b) arbitration hearing conducted on July 23, 2015 and April 8, 2016 showed that Petitioner was a motorcycle salesman for Respondent Vroom Vroom, LLC., when he sustained a work injury on May 11, 2013. The parties stipulated to the issue of accident and disputed causal connection. Petitioner had a long history of medical interventions for orthopedic injuries and chronic pain that preceded the May 11, 2013 work accident. Although he had not sought medical attention for almost a year preceding the accident, the records reveal that Petitioner had filled a prescription for Percocet on May 6, 2013, five days prior to the subject work accident.

On May 11, 2016 the Arbitrator issued a decision declining to make an award of TTD, medical expenses and future medical care having found that Petitioner waived these issues when he failed to make an argument for same in his brief. The Commission notes that in the request for hearing Petitioner sought TTD, payment of past medical expenses and an award of future medical treatment. The Commission finds therefore that there was no waiver of these issues.

On the merits the Commission notes that on September 10, 2013 Dr. Grear examined Petitioner at Respondent's request. Dr. Grear opined that Petitioner had reached MMI as of the date of his examination. The Commission adopts the opinions of Respondent's Section 12 examiner Dr. Grear and awards TTD commencing May 23, 2013 when Petitioner was taken off work by his long-time treating orthopedic surgeon, Dr.Waxman, through September 10, 2013 when Dr. Grear found Petitioner to be at MMI. Similarly, the Commission awards Petitioner medical expenses incurred from the time of the May 11, 2013 work accident through September 10, 2013.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $335.39 per week for a period of 15 and 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 $678.24 for medical expenses under §8(a) and 8.2 of the Act.

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

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

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

17IWCC0138

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

DATED: MAR 3 - 2017
SM/msb
o/1-26-17
44

Stephen Mathis

David L. Gore

Mario Basurto

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

HENDERSON, RICHARD
Employee/Petitioner

Case# **13WC026917**

VROOM VROOM LLC
Employer/Respondent

17IWCC0138

On 5/11/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1747 SEIDMAN MARGULIS & FAIRMAN LLP
KAREN C LEE
20 S CLARK ST SUITE 700
CHICAGO, IL 60603

0445 RODDY LAW LTD
PAUL W SCHUMACHER
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

17IWCC0138

STATE OF ILLINOIS)
)SS.
COUNTY OF Will)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION
19(b)

Richard Henderson
Employee/Petitioner

v.

Vroom Vroom LLC
Employer/Respondent

Case # **13** WC **26917**

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 **Robert Falcioni**, Arbitrator of the Commission, in the city of **Waukegan**, on **July 23, 2015** and the Village of New Lenox on **April 8, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **May 11, 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 **$26,168.48**; the average weekly wage was **$503.24**.

On the date of accident, Petitioner was **52** years of age, ***single*** with **3** dependent children.

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

Petitioner ***has not*** received all reasonable and necessary medical services.

Respondent shall be given a credit of **$6,613.95** for TTD, **$0** for TPD, **$0** for maintenance, and **$6,690.00 (advance on permanency)**for other benefits, for a total credit of **$13,303.95**.

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

ORDER

SEE ATTACHED FINDINGS

IN NO INSTANCE SHALL THIS AWARD BE A BAR TO SUBSEQUENT HEARING AND DETERMINATION OF AN ADDITIONAL AMOUNT OF MEDICAL BENEFITS OR COMPENSATION FOR A TEMPORARY OR PERMANENT DISABILITY, IF ANY.

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

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

Robert E Arbuckle

Signature of Arbitrator

5/11/16
Date

MAY 11 2016

17IWCC0138

Statement of Facts

On May 11, 2013, Richard Henderson (hereinafter "Petitioner") was a 52 year-old man employed as a parts and sales associate for Vroom Vroom LLC, doing business as Harley-Davidson (hereinafter "Respondent"). (T 12). Petitioner testified as follows. Prior to May 11, 2013, Petitioner had been working full duty, which entailed lifting batteries and heavy parts and frequent standing. (T 12). He had no restrictions on his job activities. (T 13). On May 11, 2013, Petitioner was working at Respondent's Woodstock location. (T 13). Suddenly, a motorcycle fell onto Petitioner and knocked him onto a row of other motorcycles and causing him to fall backwards onto those motorcycles. (T 13-14). The motorcycle that fell onto him struck Petitioner's knees. (T.14). His lower back, neck and shoulders struck the other motorcycles behind him. (T 14). Petitioner testified that he was pinned under the motorcycle that a co worker named John lifted the bike off of him and helped him to his feet. After the accident, Petitioner felt sore, but gradually felt fine. (T 15). He finished his shift and went home. (T 15). In the days following the accident, he felt pain in his lower back, neck, shoulders and knees. (T 15-16). He rented a motorcycle on the day of the accident, but was only able to drive it home from the dealership and back. (T 37). Even driving this short distance caused him more pain than ever. (T 38). The worst pain was in his neck, shoulders and knees. (T 19-20).

On May 15, 2013, Petitioner presented to the office of Dr. Julia Gorelik, his family physician. (PX 7). Petitioner complained of bilateral knee pain and back pain. (PX 7). He provided a history of trauma and indicated that a bike fell on his knee and he fell backwards onto more bikes. (PX 7). Dr. Gorelik ordered a series of x-rays of Petitioner's back and bilateral knees that he underwent on May 15, 2013. (PX 3). Dr. Gorelik referred Petitioner to Dr. Bryan Waxman, an orthopedic surgeon. (PX 7). Petitioner called the office as soon as the referral was given and was first able to see Dr. Waxman on May 23, 2013. (T 20).

On May 23, 2013, Petitioner presented to Dr. Waxman. (PX 6). At that visit, Dr. Waxman evaluated Petitioner for "several injuries." (PX 6). He provided a history of the accident and related multiple pain complaints. (PX 6). Dr. Waxman indicated that Petitioner could not return to work. (PX 6). Petitioner returned to Dr. Waxman on June 5, 2013, at which time Dr. Waxman noted that Petitioner "still" had pain in his neck, back, knees and shoulders, but now had radicular complaints. (PX 6). He recommended a lumbar MRI, which revealed disc bulges at L4-5 and L5-S1. (PX 6). He recommended a cervical MRI, which revealed neural foraminal and canal stenosis. (PX 6). Dr. Waxman recommended a course of physical therapy and referred Petitioner to Dr. Jonathan Erulkar to treat his neck injuries. (PX 6).

On June 25, 2013, Petitioner presented to Dr. Erulkar. (PX 6). Dr. Erulkar referred Petitioner to Dr. Richard Noren for cervical injections. (PX 6). Petitioner underwent multiple cervical and lumbar epidural steroid injections and continued under the consistent care of all three Illinois Bone and Joint physicians. (PX 6). On September 3, 2013, in light of the persistent neck pain, Dr. Erulkar and Petitioner discussed the necessity of a cervical fusion surgery, at which time Petitioner was sent for an evaluation pursuant to section 12 and his benefits were suspended. (PX 6; stipulation sheet). On January 30, 2014, Petitioner underwent an MRI of the cervical spine,

which revealed central disc protrusions at C2-C3, C3-C4 and C4-C5, progressed when compared to the prior study and leading to moderate central spinal stenosis, and disc bulging with mild bilateral foraminal stenosis at C5-C6. (PX 3). In light of his persistent radiating symptoms, Petitioner was sent for an EMG, which was conducted on July 24, 2014. (PX 4). The EMG revealed a mild generalized axonal sensorimotor polyneuropathy, a likely moderate to severe chronic left C5-C6 cervical radiculopathy with electrical features of ongoing denervation and possible mild left L5-S1 radiculopathy without ongoing denervation. (PX 4). Petitioner attended numerous physical therapy sessions from July 2014 through December 2014. (PX 11).

Meanwhile, Petitioner continued to follow up with Dr. Waxman, who administered multiple cortisone injections to Petitioners knees and shoulders. (PX 6). On December 3, 2013, Dr. Waxman noted that an MRI of Petitioner's right knee revealed a meniscal tear. (PX 6). He recommended surgical intervention. (PX 6). On January 30, 2014, Dr. Waxman noted that an MRI of Petitioner's right shoulder revealed acromioclavicular joint arthritis and a partial rotator cuff tear. (PX 6). He further noted that although the arthritis was likely present prior to the accident, clearly Petitioner sustained an aggravation that caused pain complaints and tendonitis. (PX 6). On September 18, 2014, Dr. Waxman noted that an MRI of Petitioner's left shoulder revealed a 50% partial-thickness tear of the supraspinatus tendon. (PX 6).

In light of the multiple surgical recommendations, Petitioner sought a second opinion from Dr. Juan Alzate, a neurosurgeon at The American Center for Spine & Neurosurgery. (PX 2). Dr. Alzate noted that Petitioner had a positive EMG and recommended updated MRIs of the cervical spine and shoulder. (PX 2).

Dr. Jonathan Erulkar testified on September 18, 2014 via evidence deposition. Dr. Erulkar is a board certified orthopedic surgeon and a fellow of the American Academy of Orthopedic Surgeons. (PX 9). He completed medical school and his orthopedic residency at Yale University and a spine fellowship at New England Baptist Hospital. (PX 9). 70-80% of his patients have orthopedic spine conditions. (PX 9). Dr. Erulkar confirmed that prior to the May 11, 2013 accident, Petitioner was last seen by the practice group on August 21, 2012, at which time he made no cervical spine complaints. (PX 9). Dr. Erulkar first saw the Petitioner on June 25, 2013, at which time he related a history of the accident. (PX 9). He complained of numbness and tingling into both arms and severe thoracic and cervical pain. (PX 9). Dr. Erulkar's impression was that Petitioner's complaints were consistent with the injury he reported. (PX 9). On or about September 6, 2013, Dr. Erulkar recommended an anterior cervical discectomy and fusion. (PX 9). He opined that the work accident was the cause of the need for the recommended surgery. (PX 9). There was no indication that the surgery would have been necessary in the absence of the work accident. (PX 9). The basis for his opinion was the progression of the Petitioner's symptoms, including pain and weakness, and Petitioner's history. (PX 9). Although there were clearly degenerative conditions present, they were exacerbated by the injury. (PX 9). He opined that the initial notes by Dr. Waxman indicated the Petitioner reported shoulder pain, which was likely referred from the neck and resulted in weakness and tingling in the upper extremities. (PX 9). Dr. Erulkar restricted Petitioner from returning to work pending the approval of the surgical procedure. (PX 9).

Dr. Bryan Waxman testified on November 14, 2014 via evidence deposition. Dr. Waxman is a board certified orthopedic surgeon. (PX 10). 60% of his practice involves the lower extremities and the other 40% involves the upper extremity. (PX 10). He defers any opinions regarding the cervical spine condition to Dr. Erulkar. (PX 10). Prior to the accident at issue, Dr. Waxman last saw Petitioner on August 21, 2012. (PX 10). At that time, Petitioner followed up for injuries sustained as a result of a fall on stairs and was back at his baseline. (PX 10). His impression was resolving sprains and contusions. (PX 10). He had no work restrictions. (PX 10). He had no treatment recommendations. (PX 10). Dr. Waxman next saw the Petitioner after the accident at issue. (PX 10). His impression was a thoracolumbar injury, left shoulder strain, bilateral knee injury and strain related to the accident. (PX 10). At the next visit on June 12, 2013, Petitioner complained of continuing neck, back and left shoulder pain. (PX 10). Dr. Waxman opined that Petitioner's bilateral knee injuries and pain complaints were caused by the accident. (PX 10). The basis for his opinion was that Petitioner had not had prior treatment for the right knee until after the accident, and the left knee had been asymptomatic for some time. (PX 10). He opined that based on his long history of treatment of the Petitioner, he tends to see a medical professional whenever necessary. (PX 10).

Dr. Waxman diagnosed Petitioner with a right medial meniscal tear, for which he recommends an arthroscopic surgery. (PX 10). He diagnosed Petitioner with an aggravation of left knee arthritis, for which he recommends cortisone injections, Visco supplementations and ultimately a knee replacement. (PX 10). He opined that the accident accelerated the need for the knee replacement. (PX 10). The basis for his opinion is that Petitioner had not had knee symptoms that required treatment prior to the accident for approximately ten years, and subsequent to the accident, he did. (PX 10). Furthermore, throughout his lengthy history of medical treatment, he frequently presented to Dr. Waxman, so based on the absence of any treatment records, clearly Petitioner did not have problems with his knees. (PX 10). He diagnosed Petitioner with a full thickness tear of the left shoulder, for which he recommends arthroscopic surgery. (PX 10). He opined that the accident was the cause of the left shoulder issues based on the chronology of the symptoms and complaints. (PX 10). He testified that Petitioner had exhausted all realistic conservative treatment options and his recovery had been derailed pending resolution of this claim. (PX 10).

Dr. Michael Grear testified on December 5, 2014 via evidence deposition. Dr. Grear practices general orthopedics. (RX 11). He stopped operating on spinal patients in 1981. (RX 11). He saw the Petitioner at the request of Respondent's insurance company on September 10, 2013, 7 days after the initial surgical recommendation of Dr. Erulkar. (RX 11). He testified that he probably spent around 30 minutes with the Petitioner. (RX 11). Petitioner recalled that he spent less than 10 minutes in Dr. Grear's office, including the examination. (T 28). Dr. Grear was unable to specify which records he reviewed. (RX 11). He did recall that he reviewed the records of Dr. Waxman that went back 12 years. (RX 11). He did not recall reviewing the records of Dr. Erulkar, Dr. Gorelik or any hospital records. (RX 11). The last medical record he reviewed was from December 23, 2013. (RX 11). He had no idea what treatment Petitioner was currently having or what treatment was being recommended for him. (RX 11). He testified that Petitioner was at maximum medical improvement at the time of his examination of him. (RX 11). However, when he examined Petitioner, he noted multiple positive findings. (RX 11). He found a positive compression test of the left patella. (RX 11). He found a positive impingement test of

the left shoulder. (RX 11). He testified that Petitioner displayed symptom magnification relative to his subjective complaints. (RX 11). However, he did not dispute or have any criticism of the objective findings, radiological interpretation or diagnoses of any treating doctor. (RX 11). He agreed an MRI is an objective test. (RX 11). He believes that Petitioner did sustain an aggravation of preexisting conditions, but it was only temporary. (RX 11). He had no disagreement with the treatment recommendations of Dr. Waxman or Dr. Erulkar. (RX 11). He gave the opinion that all of Petitioner's injuries were preexisting and none of the recommended treatment was related to the accident. (RX 11). However, he acknowledged that the last time the Petitioner had any orthopedic treatment was in August of 2012, at which time Petitioner was at a baseline and had sprains and contusions that had resolved. (RX 11). He could not identify any intervening trauma or accident that would explain Petitioner's multiple injuries. (RX 11).

At the July 23, 2015 hearing, Petitioner testified that he has severe muscle spasms and uncontrollable pain in his lower back, neck, shoulders and knees. (T 28). He had prescriptions for Percocet, Diazepam, and two muscle relaxants, which he described as so powerful it affects his ability to wake up in the morning. (T 29). He is unable to return to work. (T 30). He has pending surgical recommendations from Dr. Waxman and Dr. Erulkar. (T 30).

Petitioner has the following outstanding medical bills:

Illinois Bone & Joint Institute

		Charges	Fee Schedule
D/S:	10/1/13	$212.00	$101.84
	10/2/13	$141.00	$66.02
		$249.00	$140.30
		$249.00	$140.30
		$116.00	$12.42
	10/11/13	$141.00	$66.02
	10/17/13	$201.00	$43.37
	10/22/13	$134.00	$43.37
		$47.00	$30.21
	11/27/13	$78.00	$59.24
		$134.00	$44.15
		$47.00	$30.21
	12/3/13	$212.00	$101.84
	1/27/14	$229.00	$103.39
	1/29/14	$157.00	$67.02
	1/30/14	$157.00	$67.02
		$235.00	$142.43
		$8.00	$12.61
	3/14/14	$157.00	$67.02
	5/20/14	$157.00	$67.02
		$108.00	$152.01
	5/28/14	$229.00	$103.39
	6/6/14	$74.00	$67.02
		$120.00	$109.47

		~~$46.00~~	~~$44.03~~
		$34.00	$30.67
	6/11/14	$92.00	$44.03
		$48.00	$44.82
		$34.00	$30.67
	6/12/14	$48.00	$44.82
		$92.00	$44.03
		$34.00	$30.67
	6/17/14	$48.00	$44.82
		$92.00	$44.03
	6/23/14	$157.00	$67.02
		$235.00	$142.43
		$70.00	$104.31
		$8.00	$12.61
		$92.00	$44.03
	7/28/14	$229.00	$114.66
	8/4/14	$229.00	$114.66
		$107.00	$141.13
	9/11/14	$157.00	$77.34
	9/18/14	$157.00	$77.34
	9/24/14	$159.00	$109.47
	10/15/14	$78.00	$60.14
		$134.00	$44.82
		$46.00	$26.87
	10/17/14	$157.00	$77.34
	10/22/14	$70.00	$36.69
		$67.00	$44.82
		$63.00	$44.03
		$46.00	$26.87
	10/24/14	$134.00	$44.82
		$46.00	$26.87
	11/14/14	$229.00	$114.66

Highland Park Hospital/NorthShore University Healthsystem

D/S:	5/15/13	$1,361.00	$149.73	(Xrays lumbar spine)
		$123.00	$95.51	(Xray R knee)
				(Xray L knee)
	1/29/14	$3,189.00	$1,213.79	(MRI R shoulder)
		$224.00		
	1/30/14	$2,977.00	$1,253.37	(MRI cervical spine)
		$260.00		
	2/27/14	$1,052.00		(NCV/EMG)
	3/19/14	$533.00	$289.06	(Dr. Marcus)
	7/7/14	$83.00		(Dr. Marcus)
	7/24/14	$1,052.00	$279.30	(EMG)
		$783.00		

9/14/14	$3,189.00 $224.00	$1,213.79	(MRI shoulder)
11/10/14	$621.00 $53.00	$152.01	(Xray lumbar spine)

Consultants in Neurology
D/S: 9/4/13 $433.00

Many of Petitioner's bills could not be processed through the fee schedule due to coding modifications made by the providers to reflect that the bills were being submitted through Illinois Medicaid.

Respondent called three witnesses. None testified that he actually witnessed the accident.

On July 23, 2015, Respondent called Daniel Lange. He testified that he has been employed by Respondent for about 5 years. (T 78). He appeared for trial voluntarily. (T 82). He testified that he was involved in the interview process by which Petitioner became employed by Respondent. (T 79). At that interview, Petitioner was asked about his capabilities and previous job experience. He stated that he had previous health problems and would need frequent breaks and could not do overhead lifting.(T 80). After Petitioner's interview, Respondent decided to hire him. (T 83). Mr. Lange did not witness the accident. (T 81-82).

On July 23, 2015, Respondent called Ralph Sidorowicz. He appeared for trial voluntarily. (T 97). At the time of the trial, he had worked for Respondent for 3 years. (T 97). He testified that he was present the day of Petitioner's accident and recalls that a motorcycle fell or dropped. (T 89). He did not see the motorcycle fall or drop, he first heard it and then went over to the location. (T 90). He recalls seeing a motorcycle on its side on the floor. (T 90). He recalls Petitioner standing next to the motorcycle. (T 90-91). He testified that he did not lift the motorcycle off of Petitioner. (T 91). When he went over to where Petitioner was near the motorcycle, he asked Petitioner if he was okay. (T 91). He testified that the motorcycle was damaged on the gas tank and emblem and the mirror was scratched. (T 93-94). He testified that the gas tank, emblem and mirror must have struck the floor. (T 94-95). The motorcycle at issue goes by the trade name "Fat Boy" and weighed about 690 pounds. (T 98). Mr. Sidorowicz acknowledged that at the time the motorcycle fell down, he was not looking at Petitioner. (T 97).

On April 8, 2016, Respondent called John Bauer. At the time of the accident, Mr. Bauer worked as a sales representative. At the time of the arbitration hearing, he had been promoted to a position characterized as "business development," in which he was given better and more opportunities. He has been employed by Respondent for 6 years. At Respondent's request, he appeared multiple times for trial in the New Lenox venue and once when the case was set for hearing in Woodstock. He testified that on the date of the accident he heard a noise, voices, metal hitting metal, and someone requesting "a little help here." When he looked, he saw Ralph Sidorowicz next to an upright motorcycle. He testified that Ralph Sidorowicz lifted the bike. He was positive of that fact at the hearing. After the commotion he heard, he testified that he asked Petitioner if he was okay. He testified it is unlikely that a motorcycle hit the floor due to the setup and proximity to the other motorcycles. He testified it is likely that there are surveillance

cameras of the showroom where Petitioner's accident occurred. Lastly, he testified that he saw the Petitioner in a recent television news broadcast. The news clip was played at the arbitration. In a conversation with a reporter, the Petitioner essentially stated that he has had constant back pain for the last few years and was hopeful for an alternative to taking prescription narcotics. Petitioner attributed his pain to his service in the military(RX 12).

Conclusions of Law

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

In its Response to Petitioner's 19(b) Petition, Respondent stipulates that an accident occurred which arose out of and in the course of Petitioner's employment, and only disputes the causal relationship between said accident and Petitioner's current medical condition. Respondent appears to dispute the mechanism of the accident, but offers no testimony of any witness who actually saw it. In fact, all of Respondent's witnesses testified that they heard a racket, which called their attention to the Petitioner, but none claimed to have seen what happened that caused the noise. John Bauer testified that he heard a noise and heard someone say he needed help. Ralph Sidorowicz testified that he heard a noise and believed that a motorcycle had fallen on the floor. He described damage to the subject motorcycle that suggested that it had hit the floor. However, John Bauer testified that it is unlikely that a motorcycle would have fallen to the floor given the close configuration of motorcycles in the showroom, which would have been more like the dramatic domino effect of motorcycles falling over that one might see in a movie. In short, Respondent's witnesses could not agree on whether a motorcycle fell to the floor, who lifted it off the floor, or whether the motorcycle sustained any damage. However, although their testimony regarding the incident was inconsistent, each witness asked Petitioner if he was okay or if he needed medical attention. John Bauer testified that he asked Petitioner if he needed an ambulance. Logically, they asked if he needed medical attention because it appeared to them that he had been injured. Lastly, John Bauer testified that there were surveillance cameras in the showroom that would likely have recorded the accident. The fact that Respondent did not present the footage of the accident at the trial permits the inference that it contained evidence adverse to the Respondent and most likely was consistent with Petitioner's description of the accident. *Beery v. Breed*, 311 Ill. App. 469 (2nd Dist. 1941)("the failure of a party to produce testimony or physical evidence within his control creates a presumption that the evidence if produced would have been adverse to him.") In any event, the only logical description of the accident that was based on firsthand knowledge and is consistent with the medical evidence and ensuing injuries was provided by the Petitioner.

Respondent next disputes that Petitioner's current condition of ill being is related to his work injury. For this proposition, Respondent relies upon various exhibits.

Respondent's Exhibit 1 contains docket sheet printouts of three prior worker's compensation claims made by Petitioner in 1997, 1998 and 2002. The last of these claims was made 11 years prior to the accident at issue.

Respondent's Exhibit 3 is a catalog containing the motorcycle Respondent's witnesses identified as the one involved in the accident. The motorcycle is marketed under the name "Fat Boy" and weighs 690 pounds. Petitioner estimated the motorcycle weighed about 900 pounds.

Respondent's Exhibit 4 is a report of a cervical MRI conducted on August 20, 2003, ten years prior to the accident at issue. No accompanying records are attached.

Respondent's Exhibit 5 is a report of the cervical MRI conducted on June 17, 2013. Both MRIs appear to reveal some pathology at various levels.

Respondent's Exhibit 6 contains Dr. Waxman's pre-accident records.

Respondent's Exhibit 7 is the medical records of Petitioner's visits to his family physician on May 15, 2013 and May 17, 2013. These were also submitted by the Petitioner.

Respondent's Exhibit 10 contains records of Advocate Condell Hospital. These were submitted by Petitioner. Petitioner underwent several sessions of physical therapy throughout 2014. On February 6, 2015, Petitioner presented to the emergency room with right sided rib pain. He related that he had chronic back pain. Under "indication" of the chest x-rays, the radiologist's notes state "fell from motorcycle with right sided pain." This notation refers to the May 11, 2013 accident.

Lastly, Respondent's Exhibit 12 is a video of a news clip taken outside of a legal medical marijuana dispensary in Mundelein. The narrator indicates that Petitioner is a 20 year veteran of the U.S. Army. Petitioner indicates that he desires an alternative to taking narcotic medication that impairs his functioning.

At the hearing, Petitioner acknowledged that he has a long history of injuries and orthopedic treatment chronicled in the medical records. However, at the time of the accident at issue, he had last seen Dr. Waxman nearly a year ago concerning a fall down stairs. He essentially had bumps and bruises. He had one follow up visit, at which time Dr. Waxman noted that the bumps and bruises resolved. For nearly a year prior to the date of the accident, he received no orthopedic medical treatment and had been working and performing his normal activities. Dr. Waxman had treated the Petitioner for several years. Based on their long-standing patient-physician relationship, Dr. Waxman opined that Petitioner habitually seeks medical care when he experiences any problem. Based on this testimony and the absence of any medical records indicating any treatment from August 2012 to the date of the accident, the Arbitrator finds that Petitioner was not being treated for any orthopedic injury at the time of the accident.

Dr. Waxman's records from June 5, 2013, the second post-accident visit, indicate that Petitioner "still" presented with neck pain, indicating it was present prior to that visit. At the time, Petitioner was under the care of Dr. Waxman for other injuries to his knees, shoulders and back for which he was taking pain medication. The Arbitrator notes that all of these injuries individually were severe enough to warrant surgical recommendations. At his deposition, Dr. Erulkar indicated that it was likely that Petitioner's early complaints of shoulder pain were actually referred from his neck. Dr. Erulkar opined that the need for the neck surgery was precipitated by the accident. Dr. Grear's opinion attempts to rebut the testimony of Dr. Erulkar in either his reports or at his deposition. The Arbitrator however notes the following as significant in making his finding regarding the issue of causal connection to the cervical condition Petitioner

is seeking treatment for herein. First, Respondent stipulated that Petitioner had sustained an accident on the date indicated herein. Petitioner testified that this occurred when a large motorcycle fell and struck him, causing him to fall backwards and strike his head, cervical spine and shoulder on another motorcycle that was standing next to said motorcycle. One of Respondent's witnesses testified that the motorcycle apparently fell hard enough to have sustained damage to its gas tank, emblem and mirror. Petitioner sought medical care shortly after the accident which included immediate complaints of shoulder and knee pain. Within a short period of time, he was also complaining of cervical problems. Since the onset of these complaints, Petitioner has treated consistently and without interruption. It is noted that he had no orthopedic treatment of any kind for approximately one year prior to the date of accident alleged herein. Based on the record as a whole, and noting specifically the factors set forth above, the Arbitrator finds that Petitioner's conditions as related to his left knee, right knee, lumbar spine and cervical spine are causally related to the accident alleged herein and that they most likely aggravated or made symptomatic underlying pre existing conditions is said bodyparts. Based on this evidence, the Arbitrator further finds the opinions of Dr. Waxman and Dr. Erulkar regarding causal connection more persuasive than the opinions of Dr. Grear. Accordingly, the Arbitrator finds that Petitioner's current conditions, as alleged herein, are causally related to petitioner's industrial accident.

WITH REGARD TO THE ISSUES OF TTD, MEDICAL EXPENSES AND AWARD OF FUTURE MEDICAL, THE ARBITRATOR FINDS AS FOLLOWS:

While Petitioner noted on the request for hearing form that he was seeking TTD, payment of past medical expenses and an award of future medical treatment, no argument for same was made in Petitioner's brief, and the Arbitrator therefore deems these issues waived and declines to make any findings with regard to same.

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

Petra Delgado,

Petitioner,

vs.

NO: 13 WC 34498

17IWCC0169

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 15, 2015, 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.

17IWCC0169

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $21,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 22 2017
TJT:yl
o 3/7/17
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DELGADO, PETRA
Employee/Petitioner

Case# **13WC034498**

RICHELIEU FOODS
Employer/Respondent

17IWCC0169

On 9/15/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.26% 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:

1759 MARTAY LAW OFFICE
WILLIAM MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

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

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

17IWCC0169

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Petra Delgado
Employee/Petitioner
v.
Richelieu Foods
Employer/Respondent

Case # 13WC034498

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **June 26, 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 _____

17IWCC0169

FINDINGS

On **August 13, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$21,779.16**; the average weekly wage was **$418.83**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$00.00**.

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

ORDER

1. Respondent shall pay Petitioner the sum of $7,022.40 for the Hinsdale Orthopedics billing as per the Fee Schedule and Petitioner shall then be responsible to pay this medical provider. Respondent shall pay direct to Advocate Occupational Health $178.00 billing if currently unpaid, pursuant to Section 8(a) of the Act.

2. Respondent shall pay to Petitioner $279.22 per week for temporary total disability benefits from August 14, 2013 through November 14, 2013 or 14-1/7 weeks, pursuant to Section 8(b) of the Act.

3. Respondent shall pay to Petitioner the sum of $253.00 per week (the minimum PPD rate) for 40 weeks Petitioner suffered 8% loss of a person as a whole per 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.

FINDINGS OF FACT

The disputed issues in this matter are: 1) accident; 2) timely notice; 3) causal connection; 4) medical bills; 5) temporary total disability: and 6) the nature and extent of the injury. Mr. Cortez was sworn in as interpreter, with no objection.

Testimony of Jacqueline Galarza

Ms. Jacqueline Galarza, the live-in daughter-in-law of Petra Delgado ("Petitioner"), was called as a witness by Petitioner. She testified that she is familiar with Richelieu Foods ("Respondent"), where Petitioner works; as she has been out to the company on various occasions; and she is also familiar with the type of work Petitioner performs. During the spring and early summer of 2013, she observed Petitioner complaining about her left arm and noted that Petitioner could not sleep because of the pain in her left shoulder. She further testified that Petitioner only worked for Respondent, where Petitioner's work involved repetitive motion with her left arm. Tr. pp. 11-13.

Ms. Galarza attended a meeting at the respondent's company at approximately 1:00 p.m., on August 16, 2013. Prior to that meeting she had a phone conversation with Greg Dvorak; the person she thought was in charge of the company. This phone conversation took place approximately two hours before she and Petitioner were to arrive at the company. Ms. Galarza told Mr. Dvorak that Petitioner was going to show him paperwork of medical records, Petitioner had received from her doctor.

At the meeting on August 16th, Ms. Galarza was present with Petitioner as a translator; also present were Mr. Dvorak and subsequently, Mr. Bill Beadle. The meeting took place about 1:00 p.m., in Mr. Dvorak's office, where Petitioner showed him her doctor's reports, which included an MRI report, concerning the injury to her left shoulder. Ms. Galarza then testified that Petitioner asked for light duty work and Greg said he already had enough people on light duty, and asked Petitioner "if she wanted to go to work comp". Petitioner told Greg again that she wanted light duty work at which time, Mr. Dvorak called Bill. Ms. Galarza testified that Mr. Dvorak told the petitioner that "she was going to have therapy" and was told after she was good she could come back to work. "He then sent us right away to the office where she was able to get work comp". During the meeting, Mr. Dvorak asked the petitioner why she did not file a report of her being injured and Petitioner replied that she did not get injured at work; that she did not fall down or injure her finger of anything like that. The Arbitrator notes that this petitioner does not understand the concept of repetitive trauma, as she only equates an injury, with dramatic trauma.

Ms. Galarza testified that a second meeting was held October 2013, with the same parties plus Mr. Martin Gonzalez, and that an injury report was filed. The witness did not fill out any paperwork on behalf of Petitioner. She testified that she never told either Bill or Greg

specifically, that Petitioner wanted to file a work injury claim and she did not tell them that the injury occurred at work. Tr. pp. 15-28.

Independent Medical Examination by Dr. Charles Carroll

Ms. Galarza testified that on July 3, 2014, she went to the petitioner's medical examination by Dr. Charles Carroll, which was an examination requested by the respondent's insurance company. There was Dr. Carroll and an interpreter in the room, but she did not know her name. Petitioner testified as to having a conversation with the interpreter before the exam in the waiting room, explaining the condition of her shoulder. Ms. Galarza was not allowed to say anything during the exam with Dr. Carroll, as she was there to observe only. Dr. Carroll testified regarding his examination of the petitioner. RX10 & Tr. pp. 22-26.

Petitioner's testimony

Petitioner, through the interpreter, testified that she began to work for Respondent in August of 2005 and that she is right-handed. Prior to 2013, she never had an injury to her left arm or shoulder. In 2012 and into 2013, she worked on the line ten (10) hours per day, four (4) days per week. She has approximately three (3) different jobs at the company. She testified that she would open a box, turn it over and push the gallon bottles onto the conveyor, and that there were four (4) bottles per box. She testified that she would have to do overhead work on a line. The witness demonstrated the types of work she had to do, using both arms above her head. The Arbitrator notes that the petitioner was able to raise both arms overhead; without apparent difficulty. She had to do this job, every seven (7) minutes, to fill a pallet. Her height is approximately 5'1". Petitioner was shown a photograph of herself performing one of the jobs she described, reaching overhead. She had to do this job 2-1/2 hours and then they would put her on a different job, where she put lids on gallon bottles. She did some lifting however, it was not much weight, as the bottles were empty; but it was repetitive. In July, 2013 and into early August, 2013, she noticed that her left arm and shoulder would hurt and she would take a pain pill. Petitioner identified a photo of her working on the line. PX1; Tr. pp. 30-34.

In early August, she presented to Dr. Vishnu Madireddy, at Hermosa Medical Center, who performed an MRI of the left shoulder on August 9, 2013. She then went to the meeting on August 16, 2013 with her daughter-in-law, Bill and Greg. At hearing, she identified Petitioner's Exhibit 2 as a claim for lost time benefits, which she signed on August 23, 2013. There was also an attachment by Dr. Victor Romano dated August 22, 2013, indicating that the injury occurred at work. Petitioner gave the form to Greg on August 23, 2013. She was then referred by the doctor at Hermosa Medical Center, to Dr. Romano. Tr. pp. 35-38.

She presented to Dr. Romano on August 22, 2013 and continued to see him, from time to time, until November, 2013. She had therapy for her left arm and shoulder but no surgery. She was off work from August 14, 2013 through November 14, 2013, but received no temporary total disability benefits ("TTD"). She is asking for TTD for 14-1/7 weeks. She was released to return to work by Dr. Romano and did so mid-November, 2013. She is still working for Respondent,

doing the same type of work, but other work has changed. She still works ten (10) hours a day four (4) days per week. She is not currently under any active medical care however, she does take pain pills, and performs therapy. Petitioner was shown Petitioner's Exhibit 3, a medical bill from Hinsdale Orthopedics for $13,944.77, which she believes is unpaid. Petitioner was also sent to Advocate Occupational Health ("Advocate") by the Respondent, on November 4, 2013. She was shown a bill for $178.00 from Advocate, which is in collection. She testified she currently has no strength in her left arm and that her left shoulder hurts. When she drives it hurts; when it's cold or there is heavy humidity, it hurts and it hurts when she does any type of lifting. Tr. pp. 39-44.

On cross-examination, Petitioner was shown various photos of work stations where she worked between July and August, 2013. She performed some of the jobs on the barbecue bottle line two (2) to three (3) days, and then changed to a different line. She testified that she worked on that line, a couple of times a week. She would work 2-1/2 hours then would take a break, and they would switch her to a different job. Tr. pp. 44-46.

She was shown another photo where a machine cuts bags and she would stack them. She did that work before July, 2013, on an infrequent basis. She was shown a photo of line 3 where she assembled boxes. She was shown a photo of the barbecue line where the job was not overhead lifting, but was very rapid and repetitive. She testified that she had to dump the bottles and after the boxes are filled, she put them on top. The boxes contain empty plastic bottles, weighing less than five (5) pounds. Tr. pp. 47-51.

When Petitioner presented to her general practitioner at Hermosa, in August 2013, she had an MRI of the left shoulder. She testified that the doctor told her he thought it was due to work. The Arbitrator notes that this is not in the record. She asked the doctor for a note so she could give it to the supervisor, for light duty spot at her job. She further testified that she took that note to the meeting with Greg and Bill on August 16th and gave them all the documents that she had been given by the doctor. She stated that Bill and Greg told her to rest and go to therapy and go to work comp and recuperate. She testified that he explained workers' compensation to her.
Petitioner was shown Petitioner's Exhibit 2, a form that was filled out and signed on August 23, 2013. She testified that her daughter-in-law helped her with this form and Bill filled out the bottom part. She testified that it was her understanding that she had been given the form to apply for disability benefits and she did what Bill told her to do. Tr. pp. 52-57.

Respondent could not give her work within her restrictions however, she was told to go to therapy. She was not told by the Union that they were denying her disability benefits, but was told it was going to take a while to receive it. She did speak to a representative on or about August 31, 2013 and was given a report to fill out. She was shown Respondent's Exhibit 6, a report that she recognized because some of it was in Spanish. Part of it said "I was working in the Line #1 and I was feeling a lot of pain and I took pills for pain." My shoulder and elbow

hurt." She was asked to fill out a report in October because they had not made one out earlier. She further testified that at one point, she was told that she was working too slowly and that she had to produce more, but she told the supervisor she could not do more. Tr. pp. 58-65.

Respondent's witnesses

Respondent called William Beadle, who testified that he currently works at Horizons Window Fashions. Between August and November 2013, he worked with Respondent and was under subpoena to testify. He was the production manager for Respondent in 2013 and in charge of supervisors' reports, safety and quality. He was not involved in reporting work injuries. He is familiar with Petitioner as she worked on the second shift. He further testified that he had a meeting with Petitioner and her daughter-in-law August 16, 2013. Also present at the meeting was Greg Dvorak, the plant manager. The daughter-in-law was acting as a translator. Mr. Beadle testified that he also speaks Spanish.

According to this witness, the subject of the meeting was an injury that had occurred outside of work. Petitioner said her body hurt all over and she was asked if the injury occurred at work. During the conversation he spoke to Petitioner in Spanish and specifically asked her if the injury occurred at work and Petitioner answered "no." He stated that the company had procedures it had to follow when someone reported a work injury. Mr. Beadle was shown a contact log that he created on August 16, 2013 and testified that the log was prepared in the ordinary course of business, and kept in the controller's office. He further testified that Petitioner was advised to fill out forms for FMLA, which she should file through the Union, for her insurance benefits. He stated that if they had been told that this was a work injury, she would have been given different forms. Tr. pp. 67-74.

The witness was shown Respondent's exhibit 6, an incident report. He testified that Petitioner did ask for light duty work, however if the injury was not work related, the person could not come back to work until fully released. If it was a work injury, she could have been given light duty. The witness was shown Respondent's exhibit 5, another contact log for a conversation and meeting on October 31, 2013. He testified that at this meeting, Petitioner told them that she had been injured at work. She was told to fill out an accident investigation form and was sent to the company clinic. Tr. pp. 75-78.

On cross-examination, the witness testified that as a production manager, he was familiar with the various lines at the company. There are six lines in addition to packing machines. He is familiar with Petitioner and testified that she worked on a number of lines and on packing machines, in rotation; she worked on line 5 which is the barbecue line; line 1 which is a mayonnaise line, and line 3, another mayonnaise line. The witness was shown Petitioner's photo on line 1, where she was doing overhead work. He testified that she worked on that line and would produce approximately thirty (30) gallons a minute, and that it is repetitive work. Tr. pp. 79-82.

Mr. Greg Dvorak also testified for Respondent under subpoena. He was Respondent's plant manager in August, 2013 to November, 2013 and familiar with Petitioner. He testified that if a work-related injury happened, Petitioner would fill out an incident report and submit it to the insurance carrier. They then would manage the case with the doctors at the company clinic. He confirmed that he met with Petitioner, Bill Beadle and another person. During this meeting, Petitioner came in and told them that she wanted to work a light duty position. No one told him about a left shoulder injury and Petitioner asked for some sort of leave. He testified that he told Petitioner that since it was not a work injury, the Union had insurance for short term disability, and she should fill out paperwork. Once he found out it was a work injury, he testified that "we called her and told her to come in and fill out the paperwork."

On cross-examination, the witness testified that he had phone conversations with someone, but he was not sure who called, but it could have been Petitioner's daughter. He further testified that Petitioner worked on various lines in June, July and August 2013, some were waist high and a few lines were overhead. He stated that "it is repetitive to a point, but like I said, we have job rotations, so they don't do the same job. You rotate on the line depending on the production schedule. There are a couple of lines that move slower and there were a couple of lines that move fast depends on the line you were assigned that day". It was a ten (10) hour work day; four (4) days a week. Tr. pp. 98-99.

Bill Beadle was called for Respondent and shown Petitioner's Exhibit 2, of which he confirmed he completed the bottom part. Respondent also called Martin Gonzalez, who is still employed by Respondent, as an associate production manager. He testified that he is familiar with Petitioner and was Petitioner's supervisor in August 2013; as he was in charge of the second shift production. He stated that if an employee comes and informs him that he/she had an accident or incident, he would bring them to the office and document the accident or incident. She stated that Petitioner worked five different jobs in July and August 2013, and that none of the jobs involved any kind of lifting.

He was shown the photo of line 5 which is bottle dumping and involves overhead lifting. He explained that each box weighs about a pound and a half and the line runs at 28 bottles a minute. The employees are feeding a conveyor that runs into the filler, and then they put the empty box on the overhead conveyor to drive it to the packing area. The speed of the machine is approximately 36 cases every seven minutes; between 400 and 500 cases. They perform that job about 2-1/2 hours and then take a break. They would then be rotated to a different job. Tr. pp. 103-112.

He was shown Respondent's Exhibit 3, and testified that he does not agree with Petitioner's testimony that she did that type of work, two or three times a week. He estimated that she only worked on that job twice a month. The only job that would have been lifting over her shoulder was shown as Respondent Exhibit 5. He was shown a video which he made of line 1, i.e., dumping bottles. He testified that this was one of the jobs Petitioner performed in July and

August, 2013 and that the bottles were not heavy; probably weighing about 3 pounds between the two boxes. Tr. 113-118.

On cross-examination, Mr. Gonzalez looked at the various photos shown to him by the respondent's counsel, which depicted waist line work, nothing overhead. When asked "And is this work repetitive type work even on lines 1, 3 and 5", the answer was yes. According to the witness, on line 5, one would work 2-1/2 hours and do 36 cases in seven (7) minutes. And one would have to constantly put his/her arms overhead. When asked "Why didn't you do every job instead of just one? And who told you to do just one?" his answer was "That's the only job we were recording." He was told by the plant manager to record that job and not all the jobs that Petitioner performed. When asked "Other than this particular video, did you video anything else showing repetitive type work including overhead work that anyone did?" and the answer was "no." The witness further testified that "We do care about how fast people work as they do have standards to meet. "If they are not working fast enough we have a conversation with the people. There is no stacking on pallets". Tr. 121-126.

Jacqueline Galarza was again called as a witness as a rebuttal witness by Petitioner and reiterated that she was the interpreter at the meeting that took place August 16, 2013 and that her mother-in-law never asked for time off. She never stated she was hurt at home and she never stated she had done any repetitive work other than at Respondent.

CONCLUSIONS OF LAW

C. Did an accident occur that arose out of and in the course ofpetitioner employment by Respondent?

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin vs. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).

It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); see also *Hansel & Gretel Day Care Center v Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor vs. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d

740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal vs. Industrial Commission*, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances support the decision. *See generally, Gallentine v. Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), *see* also *Seiber v Industrial Commission*, 82 Ill.2d 87, 411 N.E.2d 249 (1980), *Caterpillar v Industrial Commission*, 73 Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v Workers' Compensation Commission*, 397 Ill.App. 3d 665, 674 (2009).

Petitioner testimony, regarding her job activities and the development of her left shoulder pain, was credible and unrebutted. Petitioner demonstrated at hearing, the repetitive movements, including overhead work, which she performed on the various lines. Respondent offered no contradictory evidence. In fact, the witnesses called by Respondent each testified that Petitioner's work was repetitive on certain lines and that line 5 did entail overhead repetitive motion.

Petitioner testified that she is right hand dominant and began employment with Respondent in 2005. She had no injury to her left shoulder prior to August, 2013 and worked on the lines ten (10) hours per day, four (4) days per week. Petitioner began to notice pain in her left shoulder which became worse and she finally saw her doctor in August, 2013, and an MRI was performed August 9, 2013. While Petitioner knew she was having left shoulder pain at work, it was not until she discussed this with her treating doctor that she was told it might be work related.

The Arbitrator finds that Petitioner has proven, by a preponderance of the evidence, that she suffered repetitive trauma injury to her shoulder that arose out of and in the course of her employment. The Arbitrator relies on the credible testimony of Petitioner; her description and demonstration of her job duties; the overhead work; rapid and fast work on the lines; the medical records of Dr. Romano and Respondent's witnesses, who testified that the line work that Petitioner performed, was repetitive in nature. *See, Durand v. Ind. Comm.*, 224 Ill. 2d 53, 862 N.E. 2nd 918 (2006).

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

Respondent argues that notice was untimely and therefore it is unduly prejudiced. The accident date is August 13, 2013 and the filed Application for Adjustment of Claim is dated October 22, 2013.

Testimony is not conflicting as to whether Respondent was informed of an "on the job injury" during a meeting on August 16, 2013. Respondent was told about an injury, but neither Petitioner nor her daughter-in-law informed the respondent that Petitioner was alleging that this was a work-related injury. Petitioner did execute a "Disability Notice" on August 23, 2013

which shows "at work." Petitioner testified that she gave this form to Greg Dvorak, which he denied.

Section 6(c) of the Illinois Workers' Compensation Act (the "Act") provides (c) "Notice of the accident shall be given to the employer as soon as practicable, but not later than 45 days after the accident, provided: No defect or inaccuracy of such notice shall be a bar to the maintenance of proceedings on arbitration or otherwise by the employee unless the employer proves that he is unduly prejudiced in such proceedings by such defect or inaccuracy."

Cases have held that this provision is to be liberally construed. *See, Republic Steel Corp. v. Ind. Comm.*, 26 Ill. 2nd 32, 185 N.E.22 877 (1962); *McLean Trucking co. v. Ind. Comm.*, 71 Ill. 2nd 350, 381 N.E. 22 245 (1978); and *City of Rockford v. Ind. Comm.*, 34 Ill. 2nd 142m 214 N.E. 2nd 763 (1966). *See also,* Commission decision 2012 IWC 1169 (10WC032788) and 2012 IWC1399 (08WC049922).
Respondent has not shown it was unduly prejudiced by Petitioner not strictly adhering to the 45 day notice provision, even if at the August 16, 2013 meeting Petitioner did not use the words, "at work." Respondent knew Petitioner performed repetitive work; and was given Petitioner's doctor notes and an MRI report. The Arbitrator concludes that Petitioner and her daughter-in-law are not knowledgeable about repetitive injuries at work and did not appear to attempt to conceal any information from Respondent.

The Arbitrator finds Respondent has failed to prove it was unduly prejudiced by notice given approximately ten (10) days beyond the 45 day statutory period and further finds notice was given within the meaning of the Act.

F. Is Petitioner's current condition of ill-being causally related to the injury?
Petitioner was performing repetitive work for Respondent and gave the doctor at Hermosa her complaints of left shoulder pain on August 12, 2013. The MRI of the left shoulder noted partial tearing of the distal supraspinatus tendon. Dr. Victor H. Romano noted this condition is "caused by her repetitive activity at work or at least aggravated by her work activities."

Dr. Charles Carroll requested, per his written report dated July 3, 2014, additional information concerning Petitioner's repetitive work activities. As Dr. Carroll testified he only received a two (2) minute video and nothing more.

As Mr. Gonzalez testified, he made a video which did not show Petitioner's overhead repetitive work. In addition, the video only showed slower moving box work and did not include the faster work, overhead, repetitive work that Petitioner performed.

When Dr. Carroll testified on cross-examination, he testified he only received a two (2) minute video with no date on it; received no formal job analysis; and that if Petitioner had other jobs at the company it may change his mind when he wrote a no causal connection opinion. If she were

lifting certain weight, that could cause him to change his mind on causality; and that if she was working at chest level and above the shoulder, that might change his opinion. After seeing a photo of Petitioner working overhead, he testified that he would possible consider a change concerning causality; and if he had been provided an actual job analysis and other videos as to other jobs Petitioner performed, his findings might be different concerning causality.

This Arbitrator notes Dr. Carroll specifically requested a complete, formal job activity report and videos showing the work actually performed by Petitioner, yet he was only provided a two (2) minute video. Respondent, whether intentional or not, withheld from their IME doctor, vital information he would have used to adequately determine causation. The opinion of Respondent's doctor, finding no causal connection, was not based on an accurate job description of Petitioner's work activities, and the video shown to Dr. Carroll was not a true depiction of the various repetitive job duties performed by Petitioner.

The Arbitrator finds that based on the totality of the evidence, Petitioner has proven, by a preponderance of the evidence, that her current condition of ill-being is causally related to repetitive trauma to the left shoulder.

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

Petitioner testified that a medical bill from Hinsdale Orthopedics for $13,944.77, she believes is currently unpaid. Petitioner has requested payment of this bill, in the amount of $7,022.40, in its proposed findings and that amount shall be awarded. Petitioner was also sent to Advocate Occupational Health ("Advocate") by the Respondent, on November 4, 2013. She was shown a bill for $178.00 from Advocate, which is in collection. Respondent shall pay to Petitioner, the amounts of these bills.

K. What temporary benefits are in dispute?

The testimony of Petitioner and the medical records support a finding of the temporary total disability benefits ("TTD") claim asserted by Petitioner. Petitioner was disabled from August 14, 2013 through November 13, 2013 or 14-1/7 weeks and Respondent shall pay to Petitioner 14-1/7 weeks of TTD at the rate of $279.22 per week.

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

Neither Petitioner nor Respondent offered an AMA rating exam, however this Arbitrator will still consider all factors set forth in Section 8.1b of the Act, and no single factor shall be the "sole determinant of disability."

(i) No AMA rating examination was offered by either party.

(ii) Petitioner works on several lines at Respondent and the work is repetitive in nature.

(iii) Petitioner is 60 years old which indicated the she is approaching the twilight of her employment life.

(iv) Petitioner still works ten (10) hours per day four (4) days per week at approximately the same wage she earned prior to the injury.

(v) The medical records and deposition of Dr. Carroll have been reviewed. The MRI shows tendinopathy/mild partial tearing of the distal supraspinatus tendon but no full thickness rotator cuff tear. Petitioner received therapy, scapular stabilization and conditioning. Petitioner has some weakness in the shoulder area. Dr. Carroll noted injections and surgery might be necessary, and also found the treatment given was reasonable and necessary. Further, Dr. Carroll was never given a formal job analysis or an accurate video showing Petitioner's repetitive work activities. However, the medical records and Petitioner's demonstrations at trial indicated that she has had a good recovery from her injury.

Based on all factors, the Arbitrator finds Petitioner suffered 8% loss person as a whole per Section 8(d-2) of the Act (15.81% left arm) and Respondent shall pay to Petitioner $253.00 per week for 40 weeks.

17IWCC0169

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
13WC34498
SIGNATURE PAGE

L Thompson Smith
Signature of Arbitrator

September 14, 2015
Date of Decision

SEP 15 2015

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt	☐ 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

BOTAO KOU,

Petitioner,

17IWCC0191

vs.

NO: 13 WC 35017

SOUTHWEST AIRLINES,

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 prospective medical expenses, permanent partial disability, penalties and fees and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission leaves the Decision of the Arbitrator undisturbed save for the benefits awarded under Section 8(e) of the Act. The Arbitrator's Section 8.1b(b) analysis of Petitioner's permanent partial disability gives proper weight to the enumerated factors. The Commission, however, differs with the Arbitrator as to where Petitioner's permanent partial disability lay.

The Arbitrator believed Petitioner's permanent partial disability was limited only to his right middle finger as evidenced by the benefit that was awarded under Section 8(e). The Commission notes Petitioner has testified to complaints of lingering fatigue and diminished grip strength in his right hand and concludes his permanent partial disability is to Petitioner's right hand as a whole and not specifically his right middle finger. The Commission, therefore, modifies the Decision of the Arbitrator to convert the awarded permanent partial disability benefit from a 20% loss of use of the right middle finger to a 7½ % loss of use of the right hand.

17IWCC0191

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $506.16 per week for a period of 15.375 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 7-1/2% loss of use of the right hand.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $7,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 9 2017
KWL/mav
O: 03/07/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0191

KOU, BOTAO
Employee/Petitioner

Case# **13WC035017**

14WC003974

SOUTHWEST AIRLINES
Employer/Respondent

On 3/18/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.51% 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:

1993 ROMANUCCI & BLANDIN LLC
FRANK SOMMARIO
321 N CLARK ST
CHICAGO, IL 60654

0766 HENNESSY & ROACH PC
NATALIE ROMO BAGLEY
140 S DEARBORN ST 7TH FL
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

Botao Kou
Employee/Petitioner
v.
Southwest Airlines
Employer/Respondent

Case # **13 WC 35017**

Consolidated case: **14 WC 3974**

17IWCC0191

An *Application for Adjustment 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 **July 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: Is Petitioner entitled to prospective medical care?

FINDINGS

On **January 3, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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 **$43,867.20**; the average weekly wage was **$843.60**.

On the date of accident, Petitioner was **34** 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 § 8(j) of the Act.

ORDER

Respondent shall pay Petitioner benefits for permanent partial disability sustained to the extent of **20%** loss of use of the right middle finger, **7.6 weeks**, pursuant to §8(e) of the Act.

Petitioner failed to prove that he is entitled to prospective medical care.

Petitioner failed to prove that his is entitled to penalties pursuant to §19(k) or §19(l) or attorneys' fees pursuant to §16 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

March 15, 2016
Date

MAR 18 2016

Botao Kuo v. Southwest Airlines
13 WC 35017, consolidate with 14 WC 3974

INTRODUCTION

This matter proceeded to hearing on July 15, 2015 before Arbitrator Steven Fruth. The disputed issues were: ***L:*** What is the nature and extent of the injury?; ***M:*** Should penalties be imposed upon Respondent?; ***O:*** Is Petitioner entitled to prospective medical care and services?

FINDINGS OF FACT

Petitioner is a 36-year-old male, hired by Respondent on August 19, 2002. Since then, he has been employed as a ramp agent and he is a member of TWU Local 555. According to the union agreement Petitioner is maxed at $25.97/hour.

The position of a ramp agent is considered to be in the heavy physical demand classification. Petitioner testified that his job duties as a Ramp Agent consisted of the following: heavy level labor job, which involves frequently lifting, pushing, pulling with his hands and arms, frequent overheard reaching and lifting, and occasionally operating machinery. Petitioner testified that the bags he lifted weighed between 2 and 99 lbs. and that on average he had to lift 150 to 200 bags per plane and 5-6 planes per day.

On January 3, 2013 Petitioner was inside an aircraft loading luggage. He grabbed a piece of luggage and felt pain in his right palm. He reported the accident and was sent to Concentra, the company clinic (PX #1). At Concentra he complained of pain in the right middle finger. Examination revealed right middle finger tenderness and reduced grip strength. The remainder of the exam of the right arm was normal. X-rays were negative for fracture. He was diagnosed with right middle finger metacarpophalangeal (MCP) joint strain. He was returned to modified duty.

Petitioner returned to work on January 4, 2013 with light duty. He returned to Concentra on January 7. He reported that his symptoms were no better. He also reported that he was taking hydrocodone which was prescribed for his back. Physical therapy for the hand was ordered with continued light duty with no lifting over 10 lbs.

Petitioner began a course of physical therapy on January 7, 2013. On January 15 Petitioner returned to Concentra. Petitioner's complaints and presentation were essentially the same. He was diagnosed with right hand pain. Due to persistent signs and symptoms without improvement Petitioner was referred to a hand surgeon for evaluation.

On January 22, 2013 Petitioner saw Dr. Nicholas Speziale of Midwest Hand Surgery at Concentra (PX #1 & PX #4). Petitioner complained of numbness in the long finger of his right hand but noted that he had this for w few weeks before his injury 2-3 weeks before. On exam Dr. Speziale noted tenderness over the A1 pulley and some

crepitance. There were limitations with petitioner making a complete fist. Petitioner Dr. Speziale suspected stenosing tenosynovitis of the right long finger and gave an injection at the level of the A1 pulley.

On February 12, 2013 Petitioner returned to Dr. Speziale. He had stenosing tenosynovitis in the trigger finger which was not helped by the injection. The doctor recommended an A1 pulley surgical release of the right long finger because of a trigger finger.

On March 26, 2013 Petitioner underwent a §12 examination with Dr. John Fernandez (RX #2) at the request of Respondent. Dr. Fernandez diagnosed a right middle finger A1 stenosing tenosynovitis. He opined that the stenosing tenosynovitis was caused by work activities. He further noted that exposure to repeated gripping and grasping, particularly of a more forceful nature, was a risk factor in the development or aggravation of the underlining condition of a trigger finger or A1 stenosing tenosynovitis and the condition was work related. He did not believe Petitioner was at MMI. He agreed with the recommendation for surgery.

On March 26, 2013 Dr. Fernandez issued an addendum report (RX #3). He reviewed Petitioner's treatment records from Dr. Graces and Dr. Speziale. He noted that Petitioner was off work on a non-related disability from December 30, 2010 through December 11, 2012 for 102 weeks. Petitioner then returned to work on December 12, 2012 and the claimed trigger finger injury which occurred on January 3, 2013. Dr. Fernandez noted that Petitioner sustained an isolated incident in which he experienced a sharp pain while loading luggage into an aircraft. The symptoms of the trigger finger were directly related to the January 3, 2013 injury and were to be treated as work related. He believed that the calluses involving Petitioner's palm, wrist, and hand were from work activities. He believed that loading luggage in an aircraft would cause a development of calluses across the hand.

On June 4, 2013 Dr. Speziale performed a release of the A1 pulley of the right long trigger finger (PX #2). The post-operative diagnosis was right long trigger finger. Petitioner continued to seek treatment with Dr. Speziale In June and July of 2013. He was noted to be progressing well with occasional sensitivity in the hand. On June 18, 2013 Dr. Speziale stated Petitioner could return to work with a 3 lb. lifting limitation. On July 9 Dr. Speziale increased the lifting limit to 15 lb. On July 23 Petitioner reported no pain except when he had maximum grip. He no longer noticed any triggering or clicking. He was doing quite well and he could return to regular duty without restrictions.

Petitioner returned to Dr. Speziale on August 20, 2013. He was working approximately 40 to 50 hours per week. His symptoms were better but he occasionally felt a clicking in the long finger when he made an extreme fist. It did bother him at times. He had full range of motion and had very good strength. He had normal sensation and when he made an extremely tight fist, the doctor could feel a small click intermittently. Dr. Speziale explained that it was unlikely that Petitioner had any

residual pulley present. He might have some scar tissue. If he did have persistent symptoms, the doctor would be willing to re-explore the hand. However, the doctor felt that it was unlikely that he had residual pulley proximally in the palm. For now, he would just be observed and he could work full duty. He was to return in one month.

On September 17, 2013 Petitioner returned to Dr. Speziale. He had full range of motion of the fist and was non-tender over the scar. Although with deep palpation he had some discomfort. Strength was good. There was no crepitance or clicking over the A1 pulley of the long finger. Petitioner at the end of the visit pointed out that if he made an extremely tight fist, he could hear a popping sound. Dr. Speziale believed that the popping sound had nothing to do with the A1 pulley of the long finger and he did not detect any triggering in any other digits. Dr. Speziale noted that Petitioner was improving and he was performing his regular duties without restrictions. The fatigue at the end of the day would hopefully improve with time. Petitioner also complained of some discomfort at the scar. Dr. Speziale recommended a silicone lined glove made to wear at work. Dr. Speziale reassured him that he did not anticipate that he would need any additional surgery or therapy and he felt that return to work was the best for Petitioner.

Petitioner testified that he injured his back at work on October 3, 2013. That injury is the subject of the consolidated case, 14 WC 3974.

On October 15, 2013 Petitioner saw Dr. Speziale and presented 2 issues (PX #1). He complained of significant sensitivity at the scar and at the middle of the right hand. Also, at the end of the day his hand was tired and sore over that area. On examination, the doctor did not detect any triggering. He noted that Petitioner could make a complete fist without triggering. When Petitioner made a super tight fist, the doctor could feel some pop but he was uncertain that the origin of the popping was near the right ring finger. The scar itself was well healed and it was smooth and flat. There was no sign of a neuroma. Petitioner could make a complete fist and had normal extension.

Dr. Speziale did not see any problems. He noted that the sensitivity might be normal given the demands of the job and that Petitioner should continue his scar massage. He was to wear a glove that was padded. Fatigue might be normal given the fact that he was off work for a period of time. Re-exploration of the finger was discussed but Petitioner did not wish to have the surgery. Dr. Speziale noted that it was unlikely that they would find the source of his discomfort and fatigue with additional surgery. He might seek a second opinion. Petitioner was returned to work without restrictions.

On November 1, 2013 Petitioner saw Dr. Brecher at Orthopedic Midwest (PX #3). He complained that he was still hurting after a trigger finger release. Dr. Brecher noted tenderness along the A1 pulley and some popping. Petitioner complained of pain at the MCP joint. He had residual symptoms of trigger finger and some unclear problems of the MCP joint. Dr. Brecher noted that Petitioner would benefit from an MRI and then probably a second operation to further release the A1 pulley.

Petitioner returned to Dr. Speziale on November 12, 2013 (PX #1 & PX #4). He

complained of pain in the fist and pain with motion and without motion. He felt very weak but denied numbness of the hand. Dr. Speziale felt some crepitance in the palm with no obvious clicking. The scar was tender. Another physician had recommended an MRI, which Dr. Speziale thought was reasonable and it might give some information about the scar tissue in the region of the palm. Petitioner also wanted the MRI to be certain that no other diagnosis was present. Dr. Speziale discussed another injection which was rejected by Petitioner.

On November 26, 2013, Petitioner saw Dr. Speziale. He stated that most of the time the pain usually 2-3/10 but occasionally it elevated to 7/10. He was allowed to return to regular duty without restriction. If the pain persisted Dr. Speziale would most likely recommend a re-exploration of the finger.

On December 6, 2013, Petitioner had an MRI of the right hand (PX #1), which revealed focal subchondral changes within the middle finger metacarpal head, suspicious for an old osteochondral injury. There was mild middle finger MCP joint osteoarthritis. There was mild irregularity of the middle finger MCP joint volar plate. This might be degenerative or might represent a partial tear. Focal tenosynovitis involving the right finger flexor tendons centered at the MCP joint and the flexor extensor tendons were otherwise intact and unremarkable.

Petitioner returned to Dr. Speziale on December 10, 2013. Petitioner had MRI findings consistent with a prior osteochondral injury. There was a question of a volar plate partial tear or degenerative changes. There was also focal articular cartilage, again consistent with a prior osteochondral injury. Ligaments and tendons were intact.

Dr. Speziale spoke with the radiologist. They agreed that the A1 pulley was completely released. He did not see any impact to the A1 pulley. He stated that the flexor tendon was noted to have been elevated off the bone. He did see some fluid in the right middle finger which was minimal to mild. Based on his conversation with the radiologist and review of the report, he believed that the A1 pulley had been completely released. The radiologist would add an addendum to that effect as he did not have it in the original report since he was unaware that Petitioner had a trigger finger release in the past and the resulting fluid could be post-operative change. It could also be a sign of some continued inflammation.

There was also some change in the right long finger MCP joint that was not acute. It was possible that those changes were causing Petitioner's pain leading the doctor to believe that he had a trigger finger. It was also possible that he had some triggering as Petitioner clearly had fluid along the tendon sheath. Petitioner might benefit from anti-inflammatory medication. Dr. Speziale did not believe that he would be re-operating on him. Some of the discomfort Petitioner had was likely due to prior osteochondral changes of the MCP joint which had nothing to do with the surgery itself. Petitioner could return to regular duty without restrictions. (PX #1 & PX #4)

On December 17, 2013, Petitioner returned to Dr. Speziale. He was still having pain in the hand and he did not have pain to palpation but did have pain with

movement. He stated that the pain he was experiencing was precluding him from doing his job. The MRI findings were. Dr. Speziale was not recommending surgery. He told Petitioner he did have some osteochondral changes at the MP joint in that he might even have a partial volar plate tear although the doctor did not know why he would have this. Petitioner was told there were no objective findings that would allow him from not returning to work. Petitioner stated that he could not return to work. He recommended that Petitioner have a second opinion and also ordered an FCE. Petitioner agreed to undergo the FCE. He could return to regular duty and was to return after the FCE.

Petitioner testified that he tried to return to Dr. Brecher but that consultation was not authorized.

On January 15, 2014 Petitioner returned to Dr. Speziale (PX #4). He had not obtained the FCE or the second opinion. He still had pain in his hand. He stated he had only about 30% of strength compared to normal. He did not feel he could grip as strongly due to pain. The clicking had resolved. On examination Petitioner had full range of motion. He was advised to try his regular duties and he should notify the doctor if he could not perform them. Then he would be put on restrictions. Dr. Speziale found that Petitioner might have pain but there was no objective reason why he could not attempt to return to regular duty. The MRI findings showed that the trigger finger had been released. He did have some signs of degenerative changes at the MTP joint. He was given ibuprofen. Dr. Speziale again recommended an FCE and a second opinion.

On April 17, 2014 Petitioner was seen for another §12 examination by Dr. Fernandez (RX #4). Dr. Fernandez reviewed additional medical records of Petitioner, including the June 4, 2013 operative report and the March 26, 2013 MRI. He diagnosed residual right middle finger pain at the metacarpal joint with likely osteochondral injury as seen on the MRI. Dr. Fernandez did not find any residual symptoms relating to the A1 pulley release itself. Petitioner could "watch it" and observe his conditions to see if there was further deterioration or worsening, particularly if he attempted to return back to his regular position. The other option was to proceed with further surgical intervention. Before that, he recommended a CT scan to further outline the size or nature of the defect. Surgical intervention would then consist of opening the joint to assess the osteochondral region to see if he was a candidate for reconstructive surgery including osteochondral transplant. Dr. Fernandez would only do that if Petitioner's continued residual symptoms limited his capacity to return back to regular work.

Dr. Fernandez found Petitioner was at MMI for his hand. He could return to full duty work, but he was then currently restricted because of his back injury. Once released from the back injury, they could then consider further treatment. If Petitioner still did not wish further treatment, and did not feel that he could return to his regular job, then consideration would be given to an FCE.

On April 7, 2015, Petitioner saw Dr. Fernandez for a third §12 examination (RX #7). Dr. Fernandez reviewed additional medical records. Petitioner reported that he

had been discharged from Dr. Speziale since February 2014. He also reported an FCE for his back in April 2014 had 40 lb. restriction. He reported that he was not working because of his back.

Petitioner rated his pain complaints as "0" for the right hand. Dr. Fernandez opined that Petitioner was still at MMI and had been so since the date of the last IME on April 17, 2014.

Dr. Fernandez also performed an AMA impairment rating on April 7, 2015. Dr. Fernandez again noted that Petitioner was at MMI. The AMA impairment rating for a triggered digit was "0." He noted that the osteochondral defect of abnormalities had not significant contributory residual impairment. Dr. Fernandez did not specify his methodology in arriving at his AMA impairment rating.

Petitioner underwent and FCE on June 19, 2014 for his back in his consolidated claim, 14 WC 3974.

Petitioner testified he takes Vicodin occasionally for the pain. He notices some clicking when he makes a fist and diminished grip strength.

Petitioner also testified that a follow-up consultation with Dr. Brecher or the FCE recommended by Dr. Speziale was never authorized. There was no evidence that Respondent notified Petitioner that the follow-up consultation with Dr. Brecher or the FCE had been denied.

Petitioner and Respondent participated in a union grievance process. Petitioner underwent an examination with a third-party physician, Dr. Avi Bernstein, who returned Petitioner to work full duty as a ramp agent on September 21, 2015. Respondent reinstated Petitioner full duty as a ramp agent on October 7, 2015. Petitioner was subsequently provided with his full salary from February 28, 2015 through October 6, 2015.

CONCLUSIONS OF LAW

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

The Arbitrator evaluated Petitioner's permanent partial disability in accord with §8.1b(b) of the Act:

(i) Dr. John Fernandez performed an AMA impairment rating on April 7, 2015. He came to an impairment rating of "0". However, Dr. Fernandez did not describe his methodology in his evaluation. Therefore, the Arbitrator gives Dr. Fernandez's impairment rating no weight.

(ii) Petitioner worked as a ramp agent for Respondent, which has been described as heavy work. Petitioner's treating physician, Dr. Speziale, found no objective reason why Petitioner's finger injury would prevent him from performing full duty work. Respondent's IME physician found Petitioner to be at MMI and able, as to the finger injury, to return to full duty work. Therefore, the Arbitrator places great weight on this factor.

(iii) Petitioner was age 33 at the time of his injury. He had a statistical life expectancy of approximately 47 years and a statistical worklife expectancy of 28 years. The Arbitrator gives this factor moderate weight.

(iv) Petitioner has returned to work with Respondent as a result of a successful grievance decision. There is no evidence that Petitioner's earning capacity has been impaired by his finger injury. Therefore, the Arbitrator gives this factor great weight.

(v) Petitioner's treating physician Dr. Nicholas Speziale diagnosed stenosing tenosynovitis of Petitioner's right middle finger. He administered a cortisone injection on January 22, 2013. Due to continuing complaints and symptoms Dr. Speziale performed a surgical release of the A1 pulley of the right long trigger finger on June 4, 2013. His post-operative diagnosis was right long trigger finger.

The evidence shows that Petitioner recovered to the point where his own physician found no objective reason to restrict Petitioner from full duty work. He reiterated that opinion on January 15, 2014. Dr. Fernandez found Petitioner at MMI for his hand on April 17, 2014, and further found that Petitioner could return to full duty work but for restrictions relating to his back injury.

Based on the evidence and analysis of §8.1b(b) factors the Arbitrator finds that Petitioner is entitled to 20% loss of use of a right middle finger, or 7.6 weeks of permanent partial disability pursuant to §8(e) of the Act.

M: Should penalties be imposed upon Respondent?

The Arbitrator finds that Petitioner failed to prove that he is entitled to assessment of penalties and attorneys' fees against Respondent.

Petitioner's claim for penalties and fees is based on Respondent not authorizing an FCE as recommended by Dr. Speziale. The subsequent fact that Petitioner returned to full duty work renders this point moot. However, the Arbitrator does note that the opinions of Petitioner's treating physician, Dr. Speziale, and of Respondent's IME doctor demonstrated that Petitioner was at MMI and able to return to full duty but for his back injury from the consolidated case. Taking all the evidence into account, there was no sound clinical basis for an FCE.

O: Is Petitioner entitled to prospective medical care and services?

The Arbitrator finds that Petitioner failed to prove that he is entitled to prospective medical care. For reasons stated above, in that Pettioner was found to be at MMI and that he has returned to full duty employment with Respondent, there was no credible evidence that an the FCE recommended by Dr. Speziale is warranted. The Arbitrator notes that in light of all the evidence in these consolidated matters Dr. Speziale' s recommendation was based on CYA rather than a clinical decision.

Steven J. Fruth, Arbitrator

March 15, 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF MCLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Penny Griffith,

Petitioner,

vs.

NO: 13 WC 36968

17IWCC0127

Kroger,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, causal connection, medical care, prospective medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 24, 2016, is hereby affirmed and adopted.

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

17IWCC0127

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

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

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

DATED:
o020917
DLG/mw
045

MAR 2 - 2017

David L. Gore

Stephen J. Mathis

Stephen Mathis

Mario Basurto

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

GRIFFITH, PENNY
Employee/Petitioner

Case# 13WC036968

KROGER
Employer/Respondent

17IWCC0127

On 5/24/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.37% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 . STRONG LAW OFFICES
TODD A STRONG
3100 N KNOXVILLE AVE
PEORIA, IL 61603

1739 STONE & JOHNSON CHARTERED
J MURRAY PINKSTON
111 W WASHINGTON ST SUITE 1800
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Penny Griffith
Employee/Petitioner

v.

Kroger
Employer/Respondent

Case # 13 WC 36968

Consolidated cases: n/a

17IWCC0127

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Bloomington , on March 30, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, August 8, 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 $26,590.20; the average weekly wage was $511.35.

On the date of accident, Petitioner was 53 years of age, married with 0 dependent child(ren).

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 13, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the fusion surgery recommended by Dr. Richard Kube.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

May 8, 2016
Date

MAY 24 2016

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment for Respondent on August 8, 2013. The Application alleged that a rack fell onto the Petitioner and that she sustained injuries to the right shoulder, neck and whole person (Petitioner's Exhibit 1). Respondent stipulated that Petitioner sustained a work-related accident on August 8, 2013, but denied that Petitioner sustained any injury to the cervical spine and disputed that Petitioner's current condition of ill-being in regard to the cervical spine was related to the accident of August 8, 2013. Based on the preceding, Respondent admitted liability for medical bills incurred for treatment to Petitioner's right shoulder, but disputed liability for bills incurred for treatment to Petitioner's cervical spine. This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills and prospective medical treatment, specifically, fusion surgery on Petitioner's cervical spine (Arbitrator's Exhibit 1).

Petitioner testified she began working for Respondent in 1997. At the time this case was tried, Petitioner was working for Respondent in a light duty position, cashier in the self-checkout lines.

Petitioner stated that on August 8, 2013, she was working in the bakery department. Petitioner was in the process of moving a bakery rack that was on wheels and one of the wheels got caught in a drain which caused the rack to fall on the Petitioner. Petitioner said the rack was approximately 6' tall and that she is 5'3" tall. Petitioner stated that when the rack struck her, she experienced pain in her right shoulder and neck.

Petitioner initially sought medical treatment from Dr. Daniel Hoffman, her family physician, on August 12, 2013. According to his record of that date, Petitioner was pushing a bakery cart on August 8, 2013, the cart fell and, when Petitioner attempted to grab the cart she sustained a twisting motion of the right shoulder. Petitioner complained of severe pain in the right shoulder. On examination, Petitioner had pain with movement of the right shoulder as well as "Tenderness of the paracervical musculature." Dr. Hoffman diagnosed Petitioner with a shoulder/arm and cervical strains. He ordered an MRI scan of the right shoulder (Petitioner's Exhibit 3).

Petitioner was subsequently seen by Dr. Hoffman on August 26, September 3, September 23, and October 24, 2013, because of pain in the right shoulder and cervical spine. When Dr. Hoffman saw Petitioner on October 24, 2013, he ordered an MRI of the cervical spine (Petitioner's Exhibit 3). The MRI of the cervical spine was performed on October 25, 2013. According to the radiologist, there was a small right central and posterolateral protrusion at C6-C7, mild canal stenosis, cord deformity and disc bulging at C5-C6 and a small left central disc protrusion at C4-C5 (Petitioner's Exhibit 4).

Dr. Hoffman referred Petitioner to Dr. Richard Kube, an orthopedic surgeon, who saw Petitioner on November 7, 2013. According to his record of that date, Petitioner sustained a "New accident at work" on August 8, 2013, to her neck and right arm. Dr. Kube's record also noted that he previously treated Petitioner for a work-related neck injury. The record also noted that Petitioner's neck was worse and different than what it was before. Dr. Kube's examination of

Petitioner's neck revealed radicular pain and symptoms. He recommended that Petitioner have an epidural injection (Petitioner's Exhibit 6).

On November 18, 2013, Dr. Kube gave Petitioner an epidural steroid injection at the C6-C7 level. This did give Petitioner some relief of her neck symptoms, but it was only temporary. Dr. Kube also ordered physical therapy but this also only gave Petitioner some temporary relief. When Dr. Kube saw Petitioner on November 27, 2013, he noted that Petitioner had a protrusion at C6-C7 which was new since 2010, and that the disc at C5-C6 had advanced as well (Petitioner's Exhibits 6 and 7).

At trial, Petitioner testified that she sustained a prior work-related injury to her neck in November, 2008. This case was tried before Arbitrator Peter Akemann on February 27, 2012. Arbitrator Akemann ruled that Petitioner's condition of ill-being in the cervical spine was not related to a work-related accident of November 9, 2008. Arbitrator Akemann's decision was subsequently appealed to and affirmed by the Commission, Circuit Court of Peoria County and the Appellate Court (Respondent's Exhibits A and B).

Arbitrator Akemann's decision, and its subsequent affirmations, were based to a large extent on the fact that Petitioner did not have any neck/cervical complaints when she was seen in the ER the same day as the accident. Petitioner did not have any neck/cervical symptoms until almost two months after the accident. Respondent's Section 12 examiner, Dr. Stephen Weiss, opined that because Petitioner did not have cervical spine symptoms within a 48 to 72 hours period following the accident, Petitioner's cervical spine conditions were not related to the accident. Arbitrator Akemann found the opinion of Dr. Weiss was more persuasive than that of Dr. Kube, Petitioner's treating physician (Respondent's Exhibit A).

In regard to the right shoulder condition, Dr. Hoffman referred Petitioner to Dr. Brent Johnson, an orthopedic surgeon, who initially saw Petitioner on September 18, 2013. While the primary focus of Dr. Johnson's examination was Petitioner's right shoulder, he noted a decreased range of motion of the cervical spine and opined that Petitioner had cervical spondylosis and C6 radiculopathy (Petitioner's Exhibit 9).

Petitioner was also treated by Dr. Blair Rhode, an orthopedic surgeon, for her right shoulder problem. Dr. Rhode saw Petitioner for the first time on November 23, 2013, and he also noted that Petitioner sustained a right shoulder and cervical injury on August 8, 2013. Dr. Rhode performed right rotator cuff surgery on February 11, 2014. As noted herein, Respondent did not dispute its liability for the right shoulder injury (Petitioner's Exhibits 10 and 11).

Dr. Kube ordered nerve conduction studies of Petitioner's upper extremities which were performed by Dr. Edward Trudeau on December 10, 2013. The studies were positive for moderately severe right C7 radiculopathy and mild to moderately severe right C6 radiculopathy (Petitioner's Exhibit 5).

Dr. Kube saw Petitioner on December 23, 2013, and reviewed the nerve conduction studies that had just been performed. At that time, Dr. Kube recommended that Petitioner have surgery consisting of a decompression and fusion at C5-C6 and C6-C7 (Petitioner's Exhibits 6).

Dr. Kube continued to periodically see Petitioner while she was being treated for her right shoulder condition. In his record of October 13, 2014, Dr. Kube noted that it was necessary for Petitioner to recover from the shoulder surgery prior to his performing neck surgery. He again made a surgical recommendation of performing a decompression and fusion at C5-C6 and C6-C7; however, he ordered another MRI because it had been over a year since one had been performed (Petitioner's Exhibit 6).

An MRI of the cervical spine was performed on April 8, 2015. Dr. Kube saw Petitioner on April 9, 2015, and reviewed the MRI findings. He opined that it did not show a substantial difference from the previous MRI and that Petitioner still had disc protrusions at C5-C6 and C6-C7. Dr. Kube again renewed his surgical recommendation (Petitioner's Exhibit 6).

Dr. Kube was deposed on August 17, 2015, and his deposition testimony was received into evidence at trial. Dr. Kube testified that he previously treated Petitioner for a work-related injury. When Dr. Kube saw Petitioner on August 30, 2011 (approximately two years prior to the accident of August 8, 2013), he opined that Petitioner had cervical stenosis with radiculopathy and he recommended Petitioner have surgery consisting of a decompression and fusion at C5-C6 (Petitioner's Exhibit 8; pp 8-9).

When Dr. Kube saw Petitioner on November 7, 2013, he noted that there were positive findings on examination of Petitioner's neck and right upper extremities that were not present prior. Specifically, Dr. Kube stated that there were dermatomal sensory deficits at C6 and C7, weakness in the right side with wrist extension and that reflexes were hyper. Further, Dr. Kube compared the MRIs performed in 2010 and 2013 and noted that there was additional narrowing and stenosis at C5-C6 and more disc bulging and protrusion at C6-C7 observed in the 2013 MRI than in the 2010 MRI (Petitioner's Exhibit 8; pp 9-16).

Dr. Kube also testified that his surgical recommendation was a two level decompression and fusion at C5-C6 and C6-C7. In regard to causality, Dr. Kube testified that there was a causal relationship between the accident of August 8, 2013, and Petitioner's cervical spine condition. This was based on the Petitioner's onset of symptoms at the time of the accident and the fact that there were differences in both the findings on examination and his review/comparison of the 2010 and 2013 MRIs (Petitioner's Exhibit 8; pp 19, 28-30).

At the direction of Respondent, Petitioner was examined by Dr. Stephen Pineda, an orthopedic surgeon, on April 14, 2014, and September 8, 2015. Dr. Pineda also reviewed the MRI of April 8, 2015. Dr. Pineda was deposed on November 4, 2015, and his deposition testimony was received into evidence at trial. Dr. Pineda testified that he did review medical records provided to him by Respondent in connection with his examination of Petitioner. He stated that Petitioner had cervical spinal stenosis, but did not have any radicular complaints at the time he examined her. He also opined that a two level fusion procedure was not medically indicated (Respondent's Exhibit 5; PP 13-20).

In explaining his opinion, Dr. Pineda stated that the spinal stenosis was congenital and degenerative. He stated that the congenital stenosis was a condition that Petitioner was born with

and the degenerative changes were just a natural progression. Further, he opined that neither of these conditions were related to the accident of August 8, 2013 (Respondent's Exhibit G; pp 23-26).

On cross-examination, Dr. Pineda testified that the primary reason he did not recommend fusion surgery was the lack of radiculopathy, probable instability at C4-C5 and the fact that Petitioner was a smoker. He indicated that a three level fusion might be a better surgical option for Petitioner (Respondent's Exhibit 5; pp 57-65).

At trial, Petitioner testified that she had neck problems as well as stiffness and pain in her right arm prior to August 8, 2013. However, Petitioner stated that the symptoms had intensified since the accident of August 8, 2013, the range of motion of her neck is less than it was before and that she now has "shock" type sensations in her neck as well as popping/cracking in her neck.

Conclusions of Law

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

The Arbitrator concludes that Petitioner's current condition of ill-being in regard to her right shoulder and cervical spine is causally related to the accident of August 8, 2013.

In support of this conclusion the Arbitrator notes the following:

Respondent stipulated that Petitioner's right shoulder condition was related to the accident of August 8, 2013.

Petitioner credibly testified that she injured her neck as a result of the accident of August 8, 2013. While Petitioner conceded that she had neck symptoms prior to August 8, 2013, her neck symptoms worsened considerably afterwards.

Petitioner informed all of her medical providers that she had neck symptoms immediately after the accident of August 8, 2013. Unlike the prior workers' compensation case, there was not a two month delay from the time of the accident to the onset of neck symptoms.

Petitioner's treating physician, Dr. Kube, clearly stated that this was a new injury and specifically noted differences in findings on examination and when he compared the MRIs of 2010 and 2013.

While Dr. Kube previously recommended that Petitioner undergo a one level decompression and fusion procedure at C5-C6, his current recommendation is a two level decompression and fusion procedure at both C5-C6 and C6-C7.

Respondent's Section 12 examiner, Dr. Pineda, based his opinion to a large extent, that there was not a causal relationship between the accident of August 8, 2013, because of a lack of radicular symptoms and findings. However, Dr. Kube consistently noted that Petitioner had radicular symptoms which were also observed when Petitioner underwent nerve conduction studies.

Based upon the preceding, the Arbitrator finds the opinion of Dr. Kube to be more persuasive than that of Dr. Pineda.

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

Arbitrator concludes that all the medical services provided to Petitioner were reasonable and necessary and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 13, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

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

The Arbitrator concludes that Petitioner is entitled to prospective medical treatment including, but not limited to, the fusion surgery recommended by Dr. Kube.

The Arbitrator notes that in his deposition, Dr. Pineda testified that a two level fusion was not medically indicated; however, in that same testimony he did indicate that a three level fusion might be a better surgical option.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Argenta,

Petitioner,

vs.

NO: 13WC 037560

Turner Industries,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, medical, credibility, nature and extent, whether the Arbitrator erred in questioning Petitioner, 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 25, 2016 is hereby affirmed and adopted.

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

17IWCC0156

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

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

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

DATED: MAR 13 2017

Charles J. DeVriendt

o030817
CJD/rlc
049

Joshua D. Luskin

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ARGENTA, DAVID
Employee/Petitioner

Case# 13WC037560

TURNER INDUSTRIES
Employer/Respondent

17IWCC0156

On 4/25/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.35% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1872 SPIEGEL & CAHILL PC
KATERINA D KYROS
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

4678 PARENTE & NOREM PC
PARAG BHOSALE
221 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

17IWCC0156

17IWCC0156

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DAVID ARGENTA
Employee/Petitioner

Case # **13** WC **037560**

v.

Consolidated cases: ____

TURNER INDUSTRIES
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 **JESSICA HEGARTY**, Arbitrator of the Commission, in the city of **Geneva**, on **1/14/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☐ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **prospective 8(a) medical; causal connection; TTD; MMI.**

17IWCC0156

FINDINGS

On **11/04/13**, 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 **$185,548.00**; the average weekly wage was **$3,549.00**.

On the date of accident, Petitioner was **54** years of age, ***married*** with **0** dependent children.

Petitioner ***has not*** 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 **$64,683.37** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$64,683.37**.

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

ORDER

RESPONDENT SHALL PAY PETITIONER TEMPORARY TOTAL DISABILITY BENEFITS OF **$1,331.20/WEEK** FOR **114 3/7THS WEEKS**, COMMENCING **11/04/13** THROUGH **1/14/16**, AS PROVIDED IN SECTION 8(B) OF THE ACT.

RESPONDENT SHALL BE GIVEN A CREDIT OF **$64,683.37** FOR TEMPORARY TOTAL DISABILITY BENEFITS THAT HAVE BEEN PAID.

RESPONDENT SHALL PAY REASONABLE AND NECESSARY MEDICAL SERVICES, PURSUANT TO THE MEDICAL FEE SCHEDULE, ASSOCIATED WITH A **LEFT CUBITAL TUNNEL RELEASE SURGERY WITH ANTERIOR NERVE TRANSFER AS RECOMMENDED BY DR. LEAH URBANOSKY ON 9/08/14**, AS PROVIDED IN SECTIONS 8(A) AND 8.2 OF THE ACT.

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

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

Signature of Arbitrator

APR 25 2016

3/8/16
Date

17IWCC0156

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DAVID ARGENTA, Petitioner,	)	
v.	)	**Case No: 13 WC 37560** Wheaton
TURNER INDUSTRIES, Respondent,	)	

ADDENDUM TO THE DECISION OF THE ARBITRATOR

This matter was before the Arbitrator on January 14, 2016 pursuant to sections 19(b) and 8(a) of the Illinois Workers' Compensation Act. The primary issues in dispute are whether Petitioner's elbow injury is causally related to his November 4, 2013 undisputed work accident and whether he is entitled to prospective surgery in the form of a cubital tunnel release with anterior nerve transfer.

FINDINGS OF FACT

Petitioner is a right-handed, 56-year-old union laborer who has been a member of Local 75 for 30 years. Prior to November 4, 2013, he had never injured his left shoulder, his left hip, his back, or his left elbow. As a former union steward, he is aware of the business practices and rules that Local 75 has in place. He is also familiar with the documents and records kept in the usual and ordinary course of business. He testified that Local 75 does not allow its members to work in any light or modified duty capacity because the union does not want its membership to put other workers at risk.

Petitioner began working for the Respondent about 2 weeks prior to his accident. The project involved the cleanup of a CITGO refinery in Lemont, IL, where a chemical fire had left a coating of sticky residue on the ground. It is uncontested that on November 4, 2013, while pushing a wheelbarrow loaded with heavy debris, Petitioner's leg got stuck in the residue and he fell on his left side. He felt pain immediately in his left shoulder, left hip, and the left side of his neck. He did not have any pain in his left elbow or left hand at that time.

He was taken to the ER at Adventist Bolingbrook Hospital. (PX.1:4). The history reflects left neck stiffness, left shoulder and left hip pain." He was given x-rays, a left arm sling, and medication for nausea. He was discharged with instructions to follow-up with a physician.

Petitioner followed-up with his primary care provider, Dr. Keyur Chauhan on November 6, 2013. (PX.2:8). Dr. Chauhan noted significant left shoulder and left hip pain with severe restriction of [range of motion] of neck and lower back. Dr. Chauhan prescribed Flexeril and Vicodin and referred Petitioner to Dr. Jason Hurbanek for orthopedic evaluation. He also took him off of work for at least "two and half weeks."

Petitioner saw Dr. Hurbanek on November 14, 2013 for initial consult. The doctor diagnosed a left shoulder rotator cuff strain with proximal biceps rupture. (PX.3:5). He referred Petitioner for an MRI and ordered him to remain off of work. On November 21, 2013, a left shoulder MRI revealed a full thickness rotator cuff tear, labral tear, a likely biceps tendon tear as well as moderate to severe acromioclavicular degenerative changes. (PX.3:13). After viewing this film on November 29, 2013, Dr. Hurbanek recommended surgery consisting of a left shoulder arthroscopy with rotator cuff repair, subacromial decompression, distal clavicle excision, debridement of the glenohumeral joint and proximal biceps exploration. (Id.)

On December 5, 2013, Dr. Anuj Puppala diagnosed Petitioner with a lumbar strain, radiculopathy and referred Petitioner for an MRI. (PX.3:24). The December 12, 2013 lumbar MRI revealed a "small lateral disc herniation at L3-4 which may contact the L3 nerve root" as well as "non-localizing spondylotic changes" and the "suggestion of mild congenital spinal stenosis" (PX.3:30).

The Petitioner saw orthopedic surgeon, Dr. Michael Grear, for the first of two Respondent-requested Section 12 examinations on December 17, 2013. Dr. Grear wrote in his report and testified at his deposition that the Petitioner suffered an acute biceps tendon tear, a torn rotator cuff, a trapezius muscle strain, and a lumbosacral strain, all as a result of his work accident. He agreed with Dr. Hurbanek that left shoulder surgery was necessary and causally related to Petitioner's work accident.

On February 14, 2014, Dr. Hurbanek performed arthroscopy with rotator cuff repair, a subacromial decompression, a distal clavicle excision, and exploration of the biceps tendon. (PX.3: 42).

The Petitioner testified that after surgery he was fitted for a rigid shoulder sling that prevented him from moving his left wrist, elbow, and shoulder. He could take it off for physical therapy, sleeping and showering, but had to keep it on at all other times.

After reviewing the lumbar MRI results on December 24, 2013, Dr. Puppala referred the Petitioner for lumbar injections noting that if conservative treatment fails he may ultimately follow-up with Dr. Cary Templin, a spine surgeon. (PX.3:40).

On December 25, 2014, the Petitioner consulted with Dr. Templin who noted the lumbar injection afforded Petitioner significant relief (PX.3:46). Dr. Templin recommended continuation of physical therapy for Petitioner's shoulder.

The Petitioner saw Dr. Hurbanek's physician's assistant Danielle Blair on February 27, 2014 for a follow-up on his shoulder. (PX.3:49). She noted, "[h]e will also wear his sling for a total of 6 weeks."

On March 27, 2014 the Petitioner returned to see Dr. Hurbanek who noted that the Petitioner could not sleep at night and that he was "very sore in his anterior shoulder and elbow." (PX.3:50). The doctor planned for to wean Petitioner from his sling.

The Petitioner testified that about 6 weeks after his surgery when he was allowed to stop wearing the shoulder sling, he noticed elbow pain and numbness in his left 4th and 5th fingers. He had not experienced these symptoms prior to his accident or prior to the removal of his sling.

On March 28, 2014, the Petitioner's physical therapist noted that he did not have to wear his arm sling any more. (PX.6). On April 2014, the physical therapist noted that more focus would be placed on "ulnar nerve glides." On April 4, 2014 the physical therapist noted that Petitioner been sleeping in a recliner because he can't sleep in bed without pain. He also noted intermittent tingling in the 4th/5th fingers. (PX.6).

On April 28, 2014 Dr. Hurbanek noted Petitioner's complaints of "excruciating" anterior shoulder pain that radiated to his distal biceps tendon as well as fourth and fifth finger numbness with cervical pain. On examination, Dr. Hurbanek noted negative Tinel's at the elbow although Petitioner did have altered sensation in his little and ring finger compared to the contralateral side. Dr. Hurbanek referred Petitioner for a cervical MRI to see if this was a neck issue or possibly something that would require another left shoulder arthroscopy. (PX.3:52). Dr. Hurbanek reviewed the cervical MRI on May 8, 2014 noting significant disc bulging at C5-6. He referred the Petitioner back to Dr. Templin to further evaluate.
(PX.3:55).

On May 31, 2014, Petitioner presented to Dr. Templin who noted a history of neck pain with left hand tingling and complaints of hand weakness and numbness since the removal of the sling. (PX.3:58). After reviewing the cervical MRI, Dr. Templin was not convinced that his hand symptoms were referred from his neck. An EMG study was ordered to confirm evidence of nerve entrapment. (PX 3: 57-59)

On June 5, 2014, Dr. Hurbanek noted that the Petitioner was showing improvement with regard to his left shoulder condition. (PX.3:61). He released him to return to work with a restriction to use his right hand only.

The Petitioner testified that the Respondent did not accommodate this restriction, and even if they did, he would not be allowed to do so by his union due to their membership rules. The Petitioner submitted a business record from Laborers' Local 75 reiterating the same policy. (PX.5).

On July 3, 2014 Dr. Hurbanek gave the Petitioner a subacromial injection in his left shoulder due to complaints of popping and clicking. (PX.3:63).

A left upper extremity EMG study was performed on July 10, 2014 by Dr. Nitin Nadkarni. (PX.3:64). The study was positive for mild left ulnar neuropathy and negative for carpal tunnel, radial neuropathy, brachial plexopathy or cervical radiculopathy. (Id.) Based on these results, Dr. Templin referred the Petitioner to Dr. Leah Urbanosky on July 29, 2014. (PX.3:66). Dr. Urbanosky's PA saw Petitioner on August 11, 2014 and diagnosed left cubical tunnel syndrome. He was kept off of work pending evaluation with Dr. Urbanosky. (PX.3:73).

On August 28, 2014 Dr. Hurbanek placed the Petitioner at MMI with regard to the left shoulder. The doctor noted that he was transferring his care over to Dr. Urbanosky for the left elbow. (PX.3:75).

On September 8, 2014 Dr. Urbanosky examined Petitioner's left elbow and confirmed her PA's diagnoses of left cubital tunnel syndrome. (PX.3:77). She recommended surgical intervention via "cubital tunnel release with anterior nerve transfer." She kept him off work pending surgical approval. (PX.3:80).

On October 17, 2014, Dr. Grear performed his second Section 12 examination. He did not feel there was a direct correlation between the ulnar nerve neuropathy and the work accident. Despite his feelings regarding causation, he did agree that the Petitioner's left elbow was in need of the surgical procedure recommended by Dr. Urbanosky. (PX.3: 89)

Over her next 11 office visits from October 13, 2014 through December 7, 2015, Dr. Urbanosky continued to recommend left elbow surgery and full duty restriction for the Petitioner. (PX.3:81-133). The Petitioner's symptoms remained the same during this time period.

EVIDENCE DEPOSITIONS

Dr. Leah Urbanosky

Dr. Urbanosky is a board certified orthopedic surgeon with a certificate in hand surgery. (PX.4:5-6). The doctor treated and diagnosed Petitioner with left sided cubital tunnel syndrome for which she recommended a cubital tunnel release with anterior transposition of the ulnar nerve. (PX4:12) The doctor explained ulnar neuropathy as

some abnormality along the distribution of the ulnar nerve which is comprised of 7th, 8th and part of the 6th cervical nerve roots. (PX4:13) Cubital tunnel syndrome is compression of the ulnar nerve with resulting ulnar neuropathy at the level of the elbow.

Dr. Urbanosky testified that following his shoulder surgery, Petitioner's left arm was immobilized in a sling. (PX4:17) The doctor explained that in this the postoperative period, while the arm is immobilized, the ulnar nerve is vulnerable to compression because swelling goes downwards. The swelling now sits at the elbow which, in a flexed position, puts strain on the ulnar nerve. (Id.). It was the doctor's opinion that while Petitioner did not have a direct injury to the elbow/ulnar nerve, there was an indirect injury, or association, with having had the shoulder injury followed by surgery with immobilization. (Id.) At the six week point, about the time that he was allowed out of his sling, he began to notice the ulnar nerve symptoms. (Id.) The doctor indicated that she was not stating that the accident of November 4, 2013 caused a cubital tunnel syndrome but that it was the postsurgical follow-up that caused the cubital tunnel syndrome. (PX4:18)

The doctor testified that left elbow condition had not improved since she began treating Petitioner, and it would not likely go away on its own. (PX.4:25-26). She though it unsafe for Petitioner to perform his job in his condition, so she kept him off of work. She did believe that if he was right-handed and there was a desk job available for him, he would probably be able to function. (PX.4:28).

She testified regarding the proposed surgical procedure, estimating Petitioner would require up to three months of physical therapy after surgery. (PX.4:24).

Dr. Urbanosky testified that non-traumatic causes of cubital tunnel syndrome can be chronic inflammatory disease like multiple sclerosis, rheumatoid arthritis, diabetes, alcoholism, and heavy smoking. The Petitioner, however, did not suffer from any of those factors. (PX.4:37).

Dr. Michael Grear

Dr. Michael Grear is an orthopedic surgeon who performs 75 to 125 surgeries per year, 20 percent of which are related to the shoulder and/or elbow. (RX1:6)

After his December 17, 2013 Independent Medical Exam ("IME"), he was of the opinion that Petitioner had sustained a torn rotator cuff and a torn left biceps tendon that were causally related to the work accident at issue. (RX.1:10). Petitioner presented to Dr. Grear again on October 3, 2014, when he diagnosed left ulnar nerve neuropathy at the elbow. (RX.1:14).

The Petitioner told Dr. Grear that two months following the surgical procedure, he had complaints of numbness and tingling in the left upper extremity in the fourth and fifth fingers. (RX1: 12) On examination, there was no significant swelling and the petitioner had excellent range of motion and good strength of the left upper extremity. There was some evidence of atrophy in the area of the biceps tendon. Restricted range of motion in the elbow was noted on exam. The doctor also noted a positive Tinel's at the medial aspect of the elbow and grip strength weakness but no atrophy of the intrinsic muscles. It was the doctor's opinion that the condition was unrelated to both the work accident and the arm sling. (RX.1:14,18).

The doctor testified that ulnar nerve neuropathies are usually due to either protracted repetitive injuries to the elbow or direct trauma to the elbow and it's usually several years before the ulnar nerve entrapment syndrome develops unless there is an acute injury with acute change in the nerve function. Dr. Grear went explained there was no evidence of any direct or medical event to the left elbow or to the ulnar nerve as result of a single independent fall. He also noted that there was no evidence of any pathology at the elbow when he first examined him.

Dr. Grear indicated that wearing of a sling would have no influence and had not caused or aggravated an underlying ulnar condition.

On cross-examination, Dr. Grear testified that when he does rotator cuff repairs that he keeps patients in a shoulder immobilizer for 2 to 4 weeks depending on the nature of the repair. After four weeks, he would ordinarily initiate pendulum exercises and passive range of motion activity.

He opined that while ulnar neuropathies can be either idiopathic or traumatic in nature that it was more often idiopathic where they have no history of a particular injury. He added that if Petitioner had ulnar neuropathy but wasn't experiencing symptoms, having his arm in a splint/sling would not have caused or aggravated the condition. Dr. Grear testified the Petitioner presented as a straightforward individual who didn't magnify his symptoms. (RX.1:28).

When asked if the Petitioner's left shoulder surgery was a contributing cause to his ulnar nerve condition, he testified, "[n]o significant contribution, correct." (RX.1:20 – emphasis added). When pressed on the wording of his answer, he later testified, "I guess my opinion is it had nothing to do with the accident or the treatment for the shoulder." (RX.1:22-23).

Dr. Grear conceded that it was possible that the Petitioner had the left elbow condition prior to his shoulder surgery but did not experience symptoms. (RX.1:23). He was in favor of the ulnar nerve transposition surgery recommended by Dr. Urbanosky, but also believed that the Petitioner could work fully duty without restrictions as a union

laborer. (RX.1:23-24). He made the exception that the Petitioner should not work with anything that would affect the temperature to his hand. (RX.1:24).

CONCLUSIONS OF LAW

F. Whether Petitioner's Current Condition of Ill-Being is Causally Related to his Work Injury

The Arbitrator concludes that the Petitioner's left elbow cubital tunnel syndrome and ulnar nerve neuropathy are causally related to the November 4, 2013 work accident. The Arbitrator is convinced that Dr. Urbanosky, who specializes in upper extremity micro-surgery, and has seen the Petitioner 12 times as opposed to Dr. Grear's two, better understands the nature of the condition and how it developed. Dr. Urbanosky testified that Petitioner's elbow symptoms came to light shortly after he was allowed to wean off of the rigid shoulder sling, and she was able to medically explain how the ulnar nerve entrapment became symptomatic. (RX1:6)

The Arbitrator is strongly persuaded by the timing of the onset of the left elbow symptoms and finger numbness. Dr. Grear's opinion that this was just a coincidence is not convincing. Both doctors agreed that even though cubital tunnel and ulnar neuropathy can be idiopathic, they can also be traumatic. Dr. Grear's opinion, however, is based solely on his "35 years of experience" of doing 2 or 3 ulnar transpositions per year as opposed to Dr. Urbanosky who has done "thousands" over her 20+ years of practice. The Petitioner's credibility was unchallenged, with Dr. Grear even agreeing that he was "straightforward" and did not "magnify his symptoms."

The Arbitrator also finds that if this was a pre-existing condition that was not aggravated by the left shoulder post-operative course, it is unsettling that the Petitioner never once complained about it to one of his several treating doctors (Drs. Chauhan, Hurbanek, Puppala, or Templin) prior to being in the rigid shoulder sling. The symptoms clearly came about after the shoulder sling was removed, which was necessitated by the work accident.

The Arbitrator is not persuaded otherwise by the Petitioner having previously worn a right shoulder sling for an unrelated injury and cubital tunnel not developing on that side. There was no medical evidence or testimony that cubital tunnel *must* occur after a shoulder sling is worn.

K. Petitioner is entitled to TTD

Having found a causal connection between the Petitioner's cubital tunnel syndrome and the work accident at issue, the Arbitrator notes that the Petitioner has not been released

by any treating doctor to return to work without restrictions except for Dr. Grear. Dr. Hurbanek released him back to work for the left shoulder only, noting that he was transferring care over to Dr. Urbanosky for the left elbow.

The Arbitrator finds that even if the Petitioner was able to work light or modified duty, there was no evidence presented at the hearing that the Respondent made light or modified duty available. Furthermore, the Petitioner's union prohibits its members from working light duty. The Arbitrator therefore concludes that the Petitioner is entitled to TTD payments from the date of loss, November 4, 2013, through the date of the hearing.

O. Other disputed issues.

The Arbitrator finds that the cubital tunnel release with anterior nerve transfer recommended by both Dr. Urbanosky and Dr. Grear is warranted. The costs associated with this procedure should be paid by the Respondent, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. The Arbitrator finds that the Petitioner will likely need additional physical therapy, pain management, and medications consistent with his treating surgeon's records and testimony. Respondent is ordered to satisfy the expenses associated with these treatments pursuant to the medical fee schedule.

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

Dennis Loew,
Petitioner,

vs.

Blankenship Construction/Ryan Inc. Central,
Respondent,

NO: 13WC 37859

17IWCC0172

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner, herein and notice given to all parties, the Commission, after considering the issues of medical expenses 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 18, 2016, is hereby affirmed and adopted.

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

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

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

DATED: MAR 2 3 2017
MJB/bm
o-3/14/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

LOEW, DENNIS
Employee/Petitioner

Case# 13WC037859

17IWCC0172

BLANKENSHIP CONSTRUCTION/RYAN INC CENTRAL
Employer/Respondent

On 5/18/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.37% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICES
DAVID M GALANTI
PO BOX 99
EAST ALTON, IL 62024

1296 CHILTON YAMBERT PORTER LLP
DANIEL T CROWE
303 W MADISON ST SUITE 2300
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Dennis Loew
Employee/Petitioner

v.

Blankenship Construction/Ryan Inc. Central
Employer/Respondent

Case # 13 WC 37859

Consolidated cases: N/A

17IWCC0172

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Collinsville**, on **August 27, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0172

FINDINGS

On the date of accident, **10/29/2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$70,856.76**; the average weekly wage was **$1,362.63**.

On the date of accident, Petitioner was **45** years of age, *married* with **1** dependent children.

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

Respondent shall be given a credit of **$84,787.36** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$84,787.36**.

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

ORDER

Because Petitioner has failed to prove a causal connection between his work accident of 10/29/2013 and the current condition of his cervical and lumbar spine. The Petitioner's petition under Section 8(a) for an order requiring the Respondent to authorize the surgery recommended by Dr. Gornet is denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Signature of Arbitrator

5/13/16
Date

ICArbDec19(b)

MAY 18 2016

FINDINGS OF FACT

The sole matter at issue in this case at this time is whether the need for the surgeries prescribed by Dr. Matthew F. Gornet was caused by the accident of 10/29/13.

On 10/29/13 the Petitioner was employed by Blankenship Construction/Ryan Inc. Central as a laborer. The Petitioner was 45 years of age. He was working at a landfill. At the time of the accident, the Petitioner was in position on a platform at the top of a hydro mulch truck. The Petitioner was going to spray grass seed on the ground with the use of a spray gun. The platform was approximately 12 to 15 feet off of the ground. At the time of the accident, the Petitioner had not started spraying. As the truck was getting into position it began to start down an incline toward a creek; the rear end of the truck was facing the creek. The Petitioner was situated on the platform near the front of the truck. When the truck came to the bottom of the incline, it came to an abrupt stop in the creek. At that point, the Petitioner went from the front of the platform to the rear. The Petitioner's body struck the guardrail located at the rear of the platform. When the Petitioner came to a rest, he was tangled up in the guardrail with his feet in the creek.

After the accident, the Petitioner was taken from the scene to Anderson Hospital in Maryville, IL. To the emergency room personnel, the Petitioner reported that he thought he struck his head on the metal guardrail, that he pulled himself out of a shallow waterway with a muddy bottom, that he felt dizzy but did not experience a syncopal episode. He also complained of pain in his neck, and the right side of his lower back. In addition, he had a puncture wound on his right hip and his left ankle was swollen. At Anderson Hospital, the Petitioner underwent several tests. A CT scan of his brain was normal. An x-ray of his chest was normal. X-rays of his left ankle revealed no acute fracture. A CT scan performed of the cervical spine revealed no fractures with mild cervical spondylosis. X-rays performed of the lumbar spine revealed chronic bilateral L4 pars defects and moderate lower lumbar spondylosis. X-rays of the pelvis were negative for fracture. The Petitioner was discharged from the emergency room and instructed to follow up with his personal physician.

The Petitioner followed up with Dr. Eavenson on 10/31/13.

X-rays that were taken of the Petitioner at Anderson Hospital did not reveal any fractures; however, they did reveal extensive degenerative changes in his lumbar spine and left ankle. Dr. Eavenson stated the following assessments: post-traumatic headaches, cervical disc protrusion, lumbar disc excision, contusion to the right hip with extensive ecchymosis as well as a laceration/open wound with the flap over the right buttock, left ankle sprain/strain with ligament tears, stress fracture of the right calcaneous, degenerative disc and joint disease in the lumbar spine, degenerative changes in the hip as well as the ankle and foot. Dr. Eavenson ordered MRIs of the Petitioner's cervical spine, lumbar spine and left ankle. He ordered a CT scan of the right foot. He authorized the Petitioner off work and instructed him not to weight bear, to use crutches. Further, he instructed the Petitioner to begin gentle physical therapy. As to the wound on his buttock, Dr. Eavenson said that it would close without sutures.

On 11/1/13 the Petitioner underwent MRIs of his left ankle, cervical spine, and lumbar spine at the MRI Partners of Chesterfield; the interpreting radiologist was Dr. David Wu.

With respect to the MRI of the left ankle Dr. Wu stated the following findings:

- Full thickness tear in the retinaculum of the posterior tibialis tendon associated with medial dislocation of the tendon from the retromalleolar groove in a partial thickness longitudinal tear extending from the myotendinous junction to the retromalleolar portion of the tendon; there is

no tendon retraction;

- A longitudinal split tear involving the retromalleolar and inframalleolar portions of the peroneus brevis tendon without tendon retraction;
- Small non-displaced fracture involving the plantar aspect of the talar head, anterior and lateral aspect of the calcaneous, and interior lip of the distal tibia;
- Small 3-4 mm. osteochondral defect in the lateral aspect of the talar dome;
- Full thickness tear in the anterior talofibular and calcaneal fibular ligaments associated with partial thickness tear in the deltoid ligaments;
- Two ossicles without significant marrow edema near the distal tip of the lateral malleolus, likely related to an old injury.

With respect to the MRI of the Petitioner's cervical spine Dr. Wu stated the following impression: broad based disc protrusion producing mild spinal canal stenosis at C3-4 and C5-6, associated with bilateral mild to moderate foraminal encroachment C3-4 and bilateral severe foraminal encroachment at C5-6.

With respect to the Petitioner's cervical spine, he sought treatment from a chiropractor, Dr. Mark Eavenson, on April 26, 2011. To Dr. Eavenson on April 26, 2011, the Petitioner complained of right sided neck pain that radiated down into his right thumb for a period of six months. On examination, Dr. Eavenson noted restricted rotation, lateral bending, and extension. He had a positive cervical compression test. Dr. Eavenson noted that the Petitioner's strength in his right arm was 4/5. Dr. Eavenson stated an impression of cervical disc protrusion and cervical radiculitis. Dr. Eavenson recommended a cervical MRI. Dr. Eavenson wrote that if the MRI were negative, he would recommend chiropractic adjustment, physical therapy, and a home exercise program. On the other hand, if positive, he would refer the Petitioner to a neurosurgeon.

The Petitioner underwent the MRI of the cervical spine at the MRI Partners of Chesterfield on April 27, 2011. The radiologist who interpreted the said MRI stated the following impressions:

- Circumferential disc bulges C3-4 and C5-6 resulting in bilateral foraminal stenosis at both levels and mild central canal stenosis at the C5-6 level, foraminal stenosis is worse on the right than the left at the C5-6 level;
- Intervertebral facet arthropathy bilaterally at C7-T1 resulting in mild bilateral foraminal stenosis.

The Petitioner followed up with Dr. Eavenson on April 28, 2011. Dr. Eavenson recommended physical therapy and chiropractic manipulation. Between May 2, 2011 and July 26, 2011, the Petitioner underwent 14 chiropractic manipulations with physical therapy. Dr. Eavenson noted on July 26, 2011 that the Petitioner's neck had improved, but that he was complaining of right shoulder pain. Dr. Eavenson stated an impression of right shoulder impingement and recommended a course of physical therapy for the shoulder. With respect to the cervical spine, Dr. Eavenson recommended that the Petitioner continue with chiropractic manipulations and physical therapy. The Petitioner did not seek further treatment from Dr. Eavenson after July 26, 2011 until after the accident of October 29, 2013.

As to the MRI of the Petitioner's lumbar spine, Dr. Wu stated the following impressions:

- Bilateral L4 pars interarticularis defects in 5 mm. anterolisthesis with broad based disc herniation producing moderate to severe stenosis of the spinal canal and left greater than right neural foramina at L4-5;
- Broad based disc herniation with facet hypertrophy producing moderate stenosis on both right and left lateral recesses and both neural foramina at L5-S1;
- Right lateral focal disc herniation producing right moderate foraminal encroachment at L3-4.

The Petitioner also underwent the CT scan of his right foot at CT Partners of Chesterfield on 11/1/13. Dr. Wu was the interpreting radiologist and stated the following impressions:

- A small non-displaced fracture involving the anterior process of the calcaneous, age indeterminate;
- Corticated ossicles near the distal tips of the medial and lateral malleoli, likely related to old injuries, correlate clinically;
- A 1-2 mm. bony fragment or osteochondral body in the anterior aspect of the tibiotalar joint.

The Petitioner returned to Dr. Eavenson on 11/4/13. Dr. Eavenson's note indicates that the Petitioner, over the weekend, went to the emergency room at the Gateway Regional Medical Center for right hip pain. The Petitioner advised Dr. Eavenson that the emergency room personnel suspected an infection in the right hip area. Dr. Eavenson had the results from the aforementioned diagnostic tests and referred him to Dr. Nathan Mall for the injuries to his extremities and to Dr. Gornet for the spinal injuries. Dr. Eavenson authorized the Petitioner off work.

The Petitioner was first seen by Dr. Nathan Mall of Regional Orthopedics on 11/4/13. The MRIs and CT scans the Petitioner underwent were available for Dr. Mall's review. Dr. Mall stated assessments as follows:

- Right hip Morel-Lavallee lesion;
- Significant left ankle injury with multiple torn structures;
- Right calcaneous contusion.

Dr. Mall instructed the Petitioner to continue wearing the left leg boot, to monitor the drainage from his right hip, and undergo an MRI of the right hip. He authorized the Petitioner off work. In addition, Dr. Mall referred the Petitioner to Dr. Gornet.

Between November 5, 2013 and November 12, 2013 the Petitioner underwent five chiropractic manipulations/physical therapy with Dr. Eavenson.

The Petitioner returned to Dr. Mall on 11/12/13. Dr. Mall stated in his history that the Petitioner's left ankle was improving in terms of swelling and that his right hip was becoming more painful and the swelling

was getting larger. His physical examination of the right hip revealed clear swelling and fluid in the area. He also noted pain of the right calcaneous and left ankle. The Petitioner had undergone an MRI of his right hip which Dr. Mall stated demonstrated a Morel-Lavallee lesion where subcutaneous fat and fascia have become disassociated. Dr. Mall stated that the fluid collection was 4 to 5 inches wide and 7 to 8 inches long. Dr. Mall stated assessments as follows:

- Right hip Morel-Lavallee lesion;
- Severe left ankle injury;
- Right calcaneous pain, possible stress fracture or severe bone bruise.

Dr. Mall recommended surgical decompression of the Morel-Lavallee lesion with an attempt to put the subcutaneous tissue and fascia back in continuity. He stated that this surgery should be performed ASAP. As to the right calcaneous, Dr. Mall stated that if there was no improvement within one week he would order an MRI. As to the left ankle, since it had improved, he would give it time in the boot. Dr. Mall stated the Petitioner could return to work, sedentary duty only, i.e. clerical.

The Petitioner underwent a presurgical screening with Dr. Kevin Bell on November 13, 2013. On that same date, he was seen by Dr. Eavenson for a chiropractic manipulation and performed physical therapy.

The Petitioner underwent the irrigation and debridement of the Morel-Lavallee lesion by Dr. Mall on 11/14/13.

The Petitioner followed-up with Dr. Mall on 11/19/13. Dr. Mall noted on physical examination that the fluid in the right hip had increased and that the wound VAC was not pulling much fluid off. Dr. Mall recommended a repeat procedure to irrigate and debride the lesion, this time potentially using fibrin glue. He authorized the Petitioner off work.

Dr. Mall performed the second right hip irrigation, debridement, and wound closure on November 20, 2013.

The Petitioner was next seen by Dr. Mall on 11/26/13. Dr. Mall's history indicates the Petitioner accidentally pulled out the drain in his right hip during the night. Dr. Mall did not note any fluid and some healing of tissue.

On November 27, 2013 the Petitioner sought treatment from Dr. Kevin Bell for stress. To Dr. Bell the Petitioner reported that he was having a difficult time with stress, that he was unable to sleep, and that he was experiencing nightmares. Dr. Bell prescribed Seroquel to be used by the Petitioner at bed time to help with post-traumatic stress.

The Petitioner followed-up with Dr. Mall on 12/3/13. He complained of significant pain in his left and right ankles. Dr. Mall's physical examination of him revealed a small amount of fluid accumulation in the right hip above the buttock. He noted good contact between the subcutaneous tissue and the underlying muscle fascia. The incision was well healed. The physical examination of the right foot revealed pain about the heel and in the plantar fascial insertion of the calcaneous. As to the left ankle, Dr. Mall noted pain over the medial malleolus. An MRI of the left ankle had been performed. Dr. Mall noted a tendon injury in the peroneal tendon and posterior tibialis tendon, the posterior tibialis tendon somewhat subluxed anteriorly onto the medial

malleolus. Dr. Mall stated the following assessments: morel-LaVallee lesion, right plantar fasciitis, and left ankle injury. Dr. Mall instructed the Petitioner to return to physical therapy for the left ankle and gave him a resting night splint for the right plantar fascitis.

On 12/4/13 the Petitioner underwent a second MRI of his left foot and ankle. The interpreting radiologist was Dr. Greg Cizek. Dr. Cizek stated the following impressions:

- Subluxation or dislocation of the posterior tibial tendon with intrasubstance partial tearing but no complete tear; this appearance is similar to previous peroneus brevis split or partial tear is similar to previous;
- Bone marrow changes with increased edema since previous seen within the talus, calcaneous, and distal tibia, particularly anteriorly without new fracture or displacement;
- Old vimalleolar avulsions, similar in extent to previous;
- Plantar fasciitis;
- Probable preexisting subtalar degenerative change.

Between December 4, 2013 and December 17, 2013 the Petitioner underwent seven chiropractic manipulations and physical therapy.

The next record we have was prepared by Dr. Mall on 12/17/13. Dr. Mall's history revealed that the right ankle had significantly improved with the brace and physical therapy. Dr. Mall noted that the left ankle was still painful on the medial side, the lateral side had improved. The right hip was improving. Dr. Mall stated the following assessments:

- Right ankle posterior tibial tendon tear and disruption of the sheath keeping the posterior tibia behind the medial malleolus. Dr. Mall recommended surgical intervention in the left ankle. He reiterated his work restriction of sedentary work, clerical work only.

Between December 18, 2013 and January 2, 2014 the Petitioner underwent seven chiropractic manipulations with Dr. Eavenson and physical therapy.

On January 2, 2014, the Petitioner underwent the surgery on his left ankle. The preoperative diagnosis was left ankle injury with posterior tibialis tendon dislocation. The post-operative diagnosis was left ankle injury with posterior tibialis and tendon dislocation and left ankle synovitis. Dr. Mall performed the following surgical procedures;

- Left ankle posterior tibial tendon sheath reconstruction/flexor retinaculum reconstruction;
- Left ankle posterior tibial tendon debridement;
- Left ankle arthroscopy and debridement.

On January 6 and 7, 2014 the Petitioner underwent chiropractic manipulation with Dr. Eavenson.

On January 7, 2014 the Petitioner returned to Dr. Mall. The Petitioner reported that he was sleeping better and that his blood pressure had improved since the surgery.

Between January 8, 2014 and January 15, 2014 the Petitioner underwent five chiropractic manipulations with Dr. Eavenson and performed physical therapy.

The Petitioner returned to Dr. Mall on January 15, 2014. This was for follow-up of his right hip and left foot. Dr. Mall injected the Petitioner's greater trochanteric with a solution of lidocaine and depo-medrol.

Between January 20, 2014 and January 28, 2014, the Petitioner underwent five chiropractic manipulations by Dr. Eavenson and attended physical therapy. In his note dated January 28, 2014, Dr. Eavenson noted, with respect to the cervical spine, "ongoing neck pain"; as to the lumbar spine, Dr. Eavenson noted the same.

The Petitioner returned to Dr. Mall on January 28, 2014. This was a follow up for the right hip debridement and left ankle reconstruction. Dr. Mall reported that the Petitioner wasn't doing well. Dr. Mall recommended physical therapy for the left ankle. Further, Dr. Mall authorized the Petitioner off work.

Between January 29, 2014 and February 5, 2014, the Petitioner underwent 11 chiropractic manipulations by Dr. Eavenson and performed physical therapy. It should be noted that throughout this period of time, Dr. Eavenson had been providing chiropractic care for the Petitioner's cervical spine, lumbar spine, right hip, right foot, and left ankle and foot.

On February 25, 2014 the Petitioner returned to Dr. Mall. This was a follow-up for the tibial tendon debridement and relocation. The Petitioner complained that his left ankle continued to bother him with weight bearing, mostly along the medial side. With respect to the Petitioner's cervical and lumbar spine, Dr. Mall referred the Petitioner to Dr. Matthew Gornet. Further, Dr. Mall released the Petitioner to return to work, clerical or sedentary work only.

Between February 26, 2014 and March 17, 2014, the Petitioner underwent eight chiropractic manipulations by Dr. Eavenson and performed physical therapy. In his March 17, 2014 note, Dr. Eavenson stated that Petitioner had ongoing neck pain, ongoing low back pain, ongoing right hip pain with some improvement, left ankle improvement, and no problem with the right foot. Dr. Eavenson recommended further manipulation and physical therapy for the Petitioner's cervical spine, lumbar spine, right hip, and left ankle.

The Petitioner was first seen by Dr. Matthew Gornet on March 17, 2014. Petitioner reported low back pain on the right side, particularly in the area of the right hip and posterior thigh. He also complained of neck pain to the right trapezius, right shoulder with numbness and tingling in his hand. The Petitioner reported his prior problems with his cervical spine but denied any prior problems with his low back. In his report of March 17, 2014, Dr. Gornet stated a belief that the Petitioner aggravated his underlying spondylolisthesis at L4-5 as well as causing a disc herniation at L4-5 and L5-S1. With respect to the cervical spine, Dr. Gornet stated a belief that the Petitioner had a new disc injury on top of chronic protrusion at C3-4. He also stated a belief that the Petitioner aggravated his disc herniation and foraminal stenosis at C5-6. Dr. Gornet recommended aggressive physical therapy and work hardening. Further, Dr. Gornet stated that if the Petitioner failed the aggressive treatment and the work hardening, the next stop would be injections in his neck and low back, and potential surgery. The surgery would include disc replacements at C3-4 and C5-6, and a fusion at L4-5 and L5-S1.

Between March 18, 2014 and April 23, 2014 the Petitioner underwent 17 chiropractic manipulations to his cervical and lumbar spines and performed physical therapy.

On May 8, 2014, he returned to Dr. Gornet. He continued to complain of neck and back problems. The neck problems were in the right trapezius and right shoulder with numbness and tingling in the hand. Dr. Gornet prescribed injections at C3-4 and C5-6 and referred the Petitioner to Dr. Boutwell. Dr. Gornet authorized Petitioner off work.

The Petitioner underwent an epidural steroid injection on the right at C3-4 on June 2, 2014; Dr. Boutwell administered the injection.

The Petitioner underwent a second epidural steroid injection on the right at C5-6 on June 16, 2014.

On 7/10/14, Dr. Gornet noted that the Petitioner had undergone two injections; however, they did not provide him with a sustained relief. Dr. Gornet stated that the Petitioner had failed conservative measures and recommended disc replacement surgery at C3-4 and C5-6. In his report, he stated that if the cervical surgery went well, it would be followed with treatments for the low back.

At the request of the Respondent, the Petitioner was examined by Dr. Chabot on 8/29/14. Dr. Chabot has been licensed to practice medicine in the state of Missouri since 1994. He is an orthopedic surgeon specializing in the treatment of the spine. He has been board certified since 1996. Dr. Chabot reviewed all of the Petitioner's medical records going back to April of 2011. He also reviewed the films of the MRIs that were performed on the Petitioner's cervical spine on 4/27/11 and 11/1/13, and the MRI that was performed on the Petitioner's lumbar spine on 11/1/13. Dr. Chabot met with the Petitioner, took an extensive history from him, and performed a physical examination.

With respect to his review of the MRI that was performed on the Petitioner's cervical spine on 4/27/11, Dr. Chabot testified that it revealed evidence of advanced degenerative changes primarily at the C3-4 and C5-6 levels. He also noted evidence of disc spur and disc bulges at C3-4 resulting in right greater that left foraminal narrowing.

The physical examination that was performed on the Petitioner's cervical spine in April of 2011 revealed a mild loss of lordosis, a decrease in the Petitioner's range of motion by 30 degrees, and decreased sensation involving the right lateral arm and the right extensor forearm. Dr. Chabot stated the diagnosis of the Petitioner's cervical spine in April of 2011 was cervical radiculitis. Dr. Chabot stated the cause of the Petitioner's cervical spine condition in April of 2011 was chronic and degenerative primarily on a genetic basis. Dr. Chabot compared he films from the April 2011 cervical MRI to the 11/1/13 cervical MRI and testified that the condition of the Petitioner's cervical spine was essentially unchanged. When Dr. Gornet gave his evidence deposition, he testified that the MRI that was performed on the Petitioner's cervical spine on 11/1/13 revealed an increased signal at C3-4. Dr. Gornet testified that this reported finding revealed the presence of fluid at the C3-4 level, which indicates a recent traumatic injury. Dr. Chabot testified that in his review of the 11/1/13 cervical MRI there was no increased signal at C3-4, nor was there any fluid present at the C3-4 level. Dr. Chabot testified that the evidence on both studies revealed a very profound degeneration of the disc/spur complexes which produces narrowing in the central portion of the canal as well as the neural foramen. Dr. Chabot testified that the cervical MRI performed on 11/1/13 did not reveal any evidence of a recent trauma; the study showed a chronic and degenerative condition, there was no acute component. The radiologist who interpreted the MRI that was performed on the Petitioner's cervical spine on 11/1/13, Dr. David Wu, did not note a high signal at C3-4, nor the presence of any fluid at C3-4.

Dr. Chabot's physical examination of the Petitioner's cervical spine on 8/29/14 revealed a mild loss of lordosis, diminished range of motion, and decreased sensation in the right lateral arm and extensor forearm. The Petitioner's motor and reflexes were normal.

With respect to the Petitioner's cervical spine, Dr. Chabot opined that in the accident of 10/29/13 the Petitioner sustained a contusion. Dr. Chabot testified that the accident of 10/29/13 did not cause any structural damage to the Petitioner's cervical spine. He testified that the Petitioner had a pre-existing degenerative disease which is genetic in origin. As to the cervical disc replacement surgery recommended by Dr. Gornet, Dr. Chabot testified that his physical examination did not reveal any active radiculopathy, and, therefore, the said surgery was not warranted. Dr. Chabot did state that the Petitioner may need this surgery in the future, but that the accident of 10/29/13 was not a causative factor. Dr. Chabot testified that the sensory loss that he noted in the Petitioner's right arm on physical examination would originate at the C6-7 level and that there was no evidence of any neural compression at C6-7.

As to his evaluation of the Petitioner's lumbar spine, Dr. Chabot's physical examination revealed that he was neurologically normal with some diminished range of motion, i.e. side bending. Dr. Chabot testified that the MRI that was performed on the Petitioner's lumbar spine on 11/1/13 revealed the following:

- Left sided disc protrusion at L1-2;
- Facet degeneration at L2-3;
- Mild stenosis at L3-4;
- Anterolisthesis at L4-5 with severe disc degeneration;
- Lipomatosis;
- Fatty infiltration of the spine with compression of the narrow tissue at L5-S1.

Relative to the Petitioner's lumbar spine, Dr. Chabot testified that the diagnoses were contusion, bilateral L4 pars defect for L4 pars intraarticularis degeneration, and grade 1 spondylolisthesis at L4-5. Dr. Chabot stated that the accident caused the contusion, but the remaining diagnoses were preexisting and degenerative. Dr. Chabot testified that the accident of 10/29/13 did not cause any structural damage to the Petitioner's lumbar spine. Dr. Chabot stated that the Petitioner did not need the surgery recommended by Dr. Gornet. The basis for this opinion is that the Petitioner has no active radiculopathy and he was not using any prescribed pain medication. Further, Dr. Chabot testified that the accident of 10/29/13 did not cause the need for any surgical procedure to the Petitioner's lumbar spine. Dr. Chabot opined, relative to the lumbar spine, that the Petitioner had reached MMI by 8/29/14 from the contusion injury he sustained on 10/29/13.

CONCLUSIONS

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 Arbitrator finds the testimony of Dr. Chabot more persuasive than the testimony of Dr. Gornet. It is clear from the medical records, the diagnostic films, and the testimony of the physicians that the Petitioner's

cervical and lumbar spine were in a degenerative condition long before 10/29/13. Further, it is clear that the accident of 10/29/13 did not cause any structural injury to the cervical or the lumbar spine.

As to the cervical spine, the only physician who stated that there was evidence of an acute or traumatic injury was Dr. Gornet. Dr. Gornet viewed and compared the films from the MRIs of the Petitioner's cervical spine that were performed on 4/27/11 and 11/1/13. He testified that the only difference between the two was a high intense signal at C3-4 which was caused by the presence of fluid at that level. Further, Dr. Gornet testified that the presence of the fluid was indicative of an acute or traumatic injury. Dr. Chabot reviewed and compared each of these films and stated that the 11/1/13 MRI was substantially the same as the MRI from 4/27/11 and that the 11/1/13 MRI did not demonstrate a finding of a high intense signal at C3-4 and that there was no indication of the presence of fluid at that level. In this case there is another interpretation of the 11/1/13 cervical MRI, i.e. that of the radiologist with MRI Partners of Chesterfield, Dr. David Wu. Dr. Wu reviewed the film and provided his interpretation in the initial MRI report. Dr. Wu did not report a high intensity signal at C3-4, nor did he state a finding of any fluid being present at that site. The Arbitrator finds that the Petitioner did not sustain any structural damage to his cervical spine as a result of the accident of 10/29/13.

As to the lumbar spine, Dr. Chabot opined that the condition of the Petitioner's lumbar spine was caused by degeneration which is genetic in nature, that the accident of 10/29/13 only caused a contusion injury to the soft tissue in the region of the Petitioner's lumbar spine, that the Petitioner's lumbar spine was neurologically normal, that the Petitioner had achieved MMI from this condition, and that surgery is not indicated as the Petitioner had no active signs of radiculopathy.

Therefore, the Petitioner's petition for order requiring the Respondent to authorize the surgeries recommended by Dr. Gornet under Section 8(a) is denied.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that the accident of 10/29/13 did not cause the need for the surgical procedures prescribed by Dr. Gornet and, therefore, denies Petitioner's request for an order requiring the Respondent to authorize the surgeries recommended by Dr. Gornet.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
CHAMPAIGN

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAFAYE LILLARD,

Petitioner,

vs.

NO: 13 WC 40805

17IWCC0174

WORLD ACCEPTANCE CORPORATION,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of nature and extent, and payment of medical bills, and being advised of the facts and applicable law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Respondent argues they stipulated and agreed to pay the outstanding medical bills. Their position is that since there is no dispute as to liability of the outstanding medical bills, Respondent can issue payment directly to the provider, not the Petitioner.

According to the Request for Hearing form, Respondent checked the "disputes" box relative to the unpaid medical bills and noted that "Respondent received bills noted on date of trial 2/10/16 for 1st time. Resp will satisfy related bills incurred prior to 7/24/14." Then, prior to the hearing, and on the record, Respondent indicated that medical bills after July 24, 2014 were in dispute. No other testimony was offered relative to the medical bills.

The Commission notes that the Respondent did not indicate what bills prior to July 24, 2014 were related to the accident. Therefore, the Arbitrator was tasked with determining which

17IWCC0174

medical bills were related to the accident. The Arbitrator provided a detailed analysis identifying which medical bills were related and which were not.

Therefore, the Commission finds that the issue of related medical expenses was in dispute. Accordingly, Respondent is to pay all related medical expenses to the Petitioner directly, pursuant to Section 8(a) and Section 8.2 of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 7, 2016 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $27,100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 3 2017

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
O: 2/7/16
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LILLARD, JaFAYE
Employee/Petitioner

Case# 13WC040805

WORLD ACCEPTANCE CORP
Employer/Respondent

17IWCC0174

On 3/7/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JAFAYE LILLARD
Employee/Petitioner

v.

WORLD ACCEPTANCE CORP.
Employer/Respondent

Case # **13** WC **40805**

Consolidated cases: _____

17IWCC0174

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Urbana**, on **February 10, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **10/22/2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$21,760.44**; the average weekly wage was **$418.74**.

On the date of accident, Petitioner was **43** years of age, ***single*** with **1** dependent children.

Respondent shall be given a credit of **$10,122.99** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of **$10,122.99**.

ORDER

Respondent shall pay reasonable and necessary medical services contained in the Petitioner's exhibits 19 through 27, except for those not related to the accident referred to in the accompanying Conclusions Of Law, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $279.16/week for 39 2/7 weeks, commencing 10/23/2013 through 7/24/2014, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $253.00/week for 20 weeks, because the injuries caused a 4 % loss to the Person As A Whole, pursuant to Section 8 (d) (2) of the Act.

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

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

D. Dyan McCarty

Signature of Arbitrator

03/01/2016
Date

ICArbDec19(b)

MAR 7 - 2016

RE: JaFaye S. Lillard vs. World Acceptance Corporation
Case No. 13 WC 40805

17IWCC0174

STATEMENT OF FACTS

The Petitioner testified that on October 22, 2013, she was employed by the Respondent as a branch manager. The Respondent is an installment loan company. Part of her job duties was to travel out in the field for collections.

On October 22, 2013, the Petitioner was driving her personal vehicle on a business matter. She was rear-ended at a stoplight. After the collision she noted severe pain in her neck and low back.

Prior to the accident, medical records show the Petitioner receiving regular medical care for her cervical and lumbar spine dating back to 2007. Records from the Danville Chiropractic Clinic show a visit on September 4, 2013. At that time, the Petitioner reported that she was doing pretty well, and her examination showed mild restriction of motion with pain in the cervical, thoracic and lumbar spinal regions. (PX 1)

She was initially seen in the emergency department of Carle Hospital on the date of the accident. The emergency room notes indicate she complained of head, neck and back pain after being rear ended while being stopped at a stop light. She was diagnosed with a cervical strain. (Petitioner's Exhibit # 11).

She received follow up care at the Carle Clinic Occupational Medicine Department. She was seen there from October 23, 2013 through December 12, 2013. (PX 13) The history at the Occupational Medicine Clinic indicated that she had a motor vehicle accident and was complaining of achy pain in the neck and upper back as well as the lumbar region which radiated into the right leg to the foot. She also had radiation of pain into her left arm. Findings included tenderness in both trapezius areas, upper thoracic

pain and lower lumbar pain. She was diagnosed with a cervical and lumbar strain with a history of a motor vehicle accident. She was taken off work. She was prescribed physical therapy which she attended at Professional Physical Therapy on November 12, 2013 and for six further visits. She was subsequently prescribed a MRI scan of the cervical and lumbar spines which was performed on November 21, 2013. The scan of the cervical spine demonstrated multilevel degenerative findings and mild to moderate thecal sac narrowing at C5-C6 and C6-C7 with a Grade I retro-listhesis at C3-C4. Examination of the lumbar spine revealed a mild broad based disc bulge at L4-L5 with mild/moderate bilateral foraminal narrowing at L4-L5 and a mild broad based disc bulge with probable mild thecal sac narrowing at T11 and T12. She was prescribed further physical therapy and was kept off work. The last exam note of December 12 indicates the petitioner had low back symptoms with radicular symptoms into the legs, along with neck discomfort. She was referred to the Pain Clinic for possible epidural injections and advised to continue physical therapy.

She was referred to Dr. Shabina Rauther, who administered an epidural steroid injection in the neck. When she returned to Dr. Rauther on February 27, 2014, it was noted that the steroid injection did not really help. (Petitioner's Exhibit # 11 and Respondent's Exhibit # 13).

On March 31, 2014, the Petitioner saw Dr. Victoria Johnson of the Carle Spine Institute. She was seen for consultation for back and neck pain. She complained of numbness in the arms that radiated to the fingers with some shoulder pain with bilateral leg pain, left side greater than the right. The leg pain went to the feet. The pain was noted to be an 8 on a 10 point scale. Dr. Johnson reviewed her MRI films and found the Petitioner had multilevel degenerative disc disease and small disc osteophyte complexes

and small posterior disc bulges at C3-C4, C4-C5, C5-C6 and C6-C7. In her lumbar spine, films demonstrate a loss of disc height and mild disc bulging at L4-L5. The examination of the cervical spine demonstrated revealed diffuse tenderness in the lower cervical paraspinals, a moderately restricted range of motion and a Spurling sign that produced pain but no radicular symptoms. Evaluation of the lumbar spine demonstrated decreased sensation to light touch to the left lower extremity compared to the right. Dr. Johnson diagnosed preexisting cervical and lumbar spondylosis which she suspected was exacerbated by the work related motor vehicle accident in October of 2013. Dr. Johnson felt chiropractic treatment may be beneficial but would be palliative and probably denied by workers' compensation. She also noted medication may be helpful but she felt the Petitioner was in a chronic pain situation. She found the Petitioner was at maximum medical improvement, and recommended the Petitioner undergo an FCE. (Petitioner's Exhibit # 13 and Respondent's Exhibit # 11).

Petitioner also received treatment at Christie Clinic from her primary care physician, Dr. Rahat Sheikh. (PX 14) She was under his care for her cervical and lumbar symptoms from November 18, 2013 to March 23, 2015. At the November 18, 2013 visit, the doctor noted the Petitioner was involved in a motor vehicle accident when she was hit from the back. It was reported that ever since the accident she had pain in her back which radiated to the gluteal area into her legs. She denied any weakness but reported sometimes she gets numbness and tingling. On physical examination, the doctor documented left side minimal tenderness, on the right side slightly impaired eversion, pain in the joint, ankle and foot, unspecified myalgia and myositis with anxiety. On December 9, 2013, Dr. Sheikh noted the Petitioner's pain had resolved and that she was doing much better. Her X-rays and MRI scan were unremarkable. The Petitioner saw the doctor on

January 8 and 23, 2014, for problems which appear to be unrelated to her accident. She again returned to him on May 7, 2014 complaining of neck and back pain. The doctor concluded her back pain was because of her fibromyalgia and that she needs to see a medicine specialist. She was seen on June 13, 2014, complaining of a pain exacerbation related to the FCE. She was told to use ice. On August 29, 2014, she was again seen with complaints that she could not perform her job, which she had been returned to three weeks prior. Her physical examination was negative. The diagnosis was lumbago. She also asked to be taken off work. She was given a work excuse and told to see her occupational medicine doctor, with the nurse practitioner explaining to the petitioner that she was not such a provider. (PX 14) She was not seen again at Dr. Sheikh"s facility until November 11, 2014, when she presented with low back pain after hearing a "pop" while getting out of bed. (Id) Her next two visits to the doctor in December 2014 and January 2015 were for problems not related to her accident. In March of 2015, after being seen in the emergency room, the Petitioner was sent for an MRI scan for her cervical spine at United Samaritans Medical Center. It was performed on March 18, 2015 and demonstrated a straightening of the cervical spine due to muscle spasm. The CT of her lumbar spine demonstrated disc bulges at L2-S1. (Petitioner's Exhibit # 14).

Petitioner also received treatment at McAskill' Chiropractic from January 29, 2014 to May 23, 2014. She was diagnosed with lumbar and cervical disc bulges with attendant intermittent lumbar and cervical radiculitis. (Petitioner's Exhibit # 15).

Petitioner was seen in the emergency room at Presence United Samaritan's Medical Center on June 11, 2014 because of exacerbation of back pain which the Petitioner attributed to the FCE performed the day before. (PX 16) It was recommended that she return to her primary care physician, Dr. Sheikh for follow up care.

On June 18, 2014, Petitioner was seen at the Danville Pain Management by Dr. S. Raju. At the initial visit she complained of chronic neck and low back pain since October 22, 2013, following a car accident at work. She was diagnosed with chronic neck and low back pain following a car accident with headaches. She was prescribed Norco and was offered physical therapy.

At the arbitration hearing, the Petitioner testified that she was off work from October 22, 2013 to August 21, 2014. She continues to have pain in her back going into her feet with numbness in her thighs. She also has numbness in her hands and severe pain in her neck that travels into both hands. She also drops things.

Respondent offered into evidence the report of Dr. Lawrence Li who examined the Petitioner on July 24, 2014. Included in the doctor's findings was decreased 2 point discrimination from C5 to T1. Dr. Li felt the Petitioner suffered from a lumbar strain and cervical strain as a result of her work related accident. He felt her underlying degenerative disc disease and lumbar spondylosis could not explain her current symptoms. He further indicated the accident that occurred on October 22, 2013 did not aggravate any of her pre-existing conditions beyond the natural progression. (Respondent's Exhibit # 1).

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (F) THE ARBITRATOR FINDS THE FOLLOWING FACTS:

The Arbitrator finds that a causal connection exists between the Petitioner's condition of ill-being of the cervical and lumbar spine and the accident of October 22, 2013.

This conclusion is in part based upon the testimony of the Petitioner that on October 22, 2013 she noticed the onset of severe neck and back pain after her vehicle was rear ended.

She was seen in the emergency room of Carle Clinic on the day of the accident and reported the history of head and neck pain after being rear ended.

Subsequently, she was treated at Carle Clinic, Christie Clinic and Danville Pain Management where she consistently attributed her present neck and lumbar symptoms to the accident at work in October of 2013.

The vehicle collision as described by the Petitioners is a competent mechanism for exacerbating degenerative disc with accompanying radicular pain.

Although the Petitioner did have pain problems with her low back and cervical spine before October 22, 2011, the record establishes that her condition of ill-being was aggravated by the accident. The Arbitrator notes that on March 31, 2014, the Petitioner was evaluated by Dr. Victoria Johnson of the Carle Spine Institute. She concluded that the Petitioner had preexisting cervical and lumbar spondylosis which she suspected was exacerbated by a "work related motor vehicle accident of October 13, 2011."

Considering all of the above the Arbitrator concludes that the record establishes a causal connection exists between the Petitioner's condition of ill-being and low back and neck and the accident of October 22, 2013.

RE: JaFaye S. Lillard vs. World Acceptance Corporation
Case No. 13 WC 40805

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (J) THE ARBITRATOR FINDS THE FOLLOWING FACTS:

After the accident the Petitioner developed a symptom complex of cervical and lumbar pain with a radicular component that was prolonged and largely unresponsive to treatment. It was reasonable for the Petitioner's treating physicians to administer different modalities of treatment and perform diagnostic testing and evaluation to monitor her progress.

After reviewing the medical records and bills in evidence, the Arbitrator concludes that some of the medical expenses offered into evidence as Pet. Exhibits 19 through 27 were reasonably required to cure or relieve the Petitioner from her injuries. Several bills were not related, and are not the Respondent's responsibility. They are as follows:

Hoopeston Community Hospital-5/9/14-urine pregnancy test

Christie Clinic-12/4/13-urinary frequency and menstration issues

Christie Clinic-1/8/14-smoking cessation

Christie Clinic-1/23/14-left shin pain

Presence United-3/18/15-no corresponding records admitted into evidence

Presence United-5/8/15-Petitioner testified the treatment not related.

With the exception of the bills listed above, the Respondent is responsible to pay the remainder, subject to the Fee Schedule.

17IWCC0174

RE: JaFaye S. Lillard vs. World Acceptance Corporation

Case No. 13 WC 40805

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (K) THE ARBITRATOR FINDS THE FOLLOWING FACTS:

The Arbitrator that the Petitioner was temporarily and totally disabled for 39 and 2/7ths weeks from October 22, 2013 to July 24, 2014.

This conclusion is based upon the stipulation of the parties.

Temporary total disability benefits after July 24, 2014 are denied. There is no opinion from a physician after that date that the Petitioner remained disabled or incapable of working.

RE: JaFaye S. Lillard vs. World Acceptance Corporation
Case No. 13 WC 40805

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (L) THE ARBITRATOR FINDS THE FOLLOWING FACTS:

The Arbitrator finds the Petitioner was involved in a motor vehicle accident on October 22, 2013 that resulted in aggravation of a pre-existing degenerative changes in the cervical spine and lumbar spine with radicular symptoms, in addition to myalgias affecting the soft tissues of the neck and low back.

During the course of her treatment, the Petitioner complained of neck and low back pain with intermittent radiation and tingling to the lower extremities. These symptoms have been prolonged and largely not responsive to treatment, although she has returned to work for the employer.

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.

With regard to Subsection (ii) of Section 8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that the Petitioner was employed as a branch manager of an installment loan company at the time of the accident and is able to return to work in her prior capacity as a result of said injury. The Arbitrator notes this is not a physically demanding type of employment. Because of the Petitioner's return to regular work activities, the Arbitrator gives lesser weight to this factor.

With regard to Subsection (iii) of Section 8.1b(b), the Arbitrator notes that the Petitioner was 43 years old at the time of the accident. Because of the relatively young

age and likelihood of distant retirement of the Petitioner the Arbitrator gives greater weight to this factor.

With regard to Subsection (iv) of Section 8.1b(b), the Petitioner's future earnings capacity, the Arbitrator notes that the Petitioner has no limitations that would affect her ability to perform her usual and customary employment. The Arbitrator therefore gives lesser 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 the Petitioner underwent a number of diagnostic studies and evaluations that demonstrated bulging discs at L4-L5 and T11-T12, thecal sac narrowing at C5-C6, Grade I retro-listhesis at C3-C4, decreased sensation to light touch in the left lower extremity and straightening of the cervical spine due to muscle spasm. When seen by Dr. Johnson on March 31, 2014, the only positive exam findings were moderate restrictions in cervical range of motion, diffuse pain and a slight decrease in sensation in the left leg. She was found to be at MMI and said date. Dr. Li, who saw the petitioner on June 10, 2014, agreed with Dr. Johnson's finding of MMI. He said the Petitioner's examination was clouded by her inconsistent effort. He said that her lumbar exam showed normal strength and reflexes.

Because of these objective findings the Arbitrator gives greater weight to this factor.

Based upon the above these factors and the record taken as a whole, the Arbitrator finds that the Petitioner sustained permanent partial disability to the extent of a 4% loss of use of the whole person pursuant to Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Celeste Thomas, nka Celeste Roberts,

Petitioner,

vs.

NO: 13 WC 41966

17IWCC0136

State of Illinois/Pontiac Correctional Center,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, medical, evidentiary issues, causal connection, this is a cross review on date of accident only if the Commission finds date of accident other than 12-18-13 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 20, 2016 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired

17IWCC0136

without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

No bond or summons is required for State of Illinois cases.

DATED: MAR 3 - 2017

Mario Basurto

David L. Gore

Stephen Mathis

MB/mas
o:2/9/17
43

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

THOMAS, CELESTE NKA ROBERTS, CELESTE
Employee/Petitioner

Case# **13WC041966**

17IWCC0136

STATE OF ILLINOIS/PONTIAC CORRECTIONAL CENTER
Employer/Respondent

On 6/20/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.40% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

0564 WILLIAMS & SWEE LTD
JEAN A SWEE
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

4138 ASSISTANT ATTORNEY GENERAL
WARREN WILKE
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9208

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

JUN 20 2016

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

17IWCC0136

STATE OF ILLINOIS)
)SS.
COUNTY OF Peoria)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Celeste Thomas, nka Celeste Roberts
Employee/Petitioner

v.

State of Illinois/Pontiac Correctional Center
Employer/Respondent

Case # **13** WC **41966**

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 K. Nowak**, Arbitrator of the Commission, in the city of **Peoria**, on **3/17/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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, **12/18/13**, 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 **$67,704.00**; the average weekly wage was **$1302.00**.

On the date of accident, Petitioner was **37** 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 **$ANY** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $2,525.00, as set forth in PX 11, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall authorize and pay for prospective medical care as recommended by Dr. Lombardi, as provided in Sections 8(a) and 8.2 of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Michael K. Nowak, Arbitrator

6/14/16
Date

JUN 20 2016

ICArbDec19(b)

FINDINGS OF FACT

Petitioner began working for Respondent as a juvenile correctional officer at its youth facility in Joliet Illinois in June of 2009. She indicated that while working at this facility she would use her hands for various kinds of operations and occasionally to restrain combative juvenile offenders. In 2010 she began experiencing tingling in her hands for which she saw her primary care physician, Dr. Martin. Dr. Martin provided Petitioner with a supportive brace and instructed her on exercise using foam or tennis balls. Petitioner testified that the symptoms had gone away completely by 2011 and she had stopped using the brace and the exercises. She indicated that at this point she did not know what had caused the tingling.

In February of 2013 she transferred to the Pontiac Correctional Center (CC) as a lead worker. She indicated that a lead worker does various tasks on the outer perimeter of the facility. In the cooler months they performed tasks such as snow and ice removal by shovel or plowing. When there was no snow they worked in the greenhouse, which was attached to the facility, preparing plants for the springtime. In the early springtime the various plants and flowers would be planted. Petitioner indicated that in March of 2013, she and the inmates participated in planting and replanting approximately 15,000 plants. The work involved moving soil, carrying flats with plants, watering, fertilizing, and transferring the seedling plants from the flats to plant elsewhere.

They were also in charge of preparing the equipment which would be necessary in the summertime to take care of the landscaping duties. During the warmer months she would be in charge of the mowing and general landscape maintenance of the Pontiac facility which totaled approximately 70 to 80 acres. Approximately half of that area was covered with buildings and the remainder of the area required either mowing or other landscaping.

Petitioner was a working supervisor who generally worked with inmates. She would be given instructions by her supervisor, Michael Melvin. She would then meet with whatever inmate workers she was supervising on a given day and advise them of the tasks to be performed. Petitioner testified that she worked side-by-side with the inmates while also supervising their movements. Petitioner testified she would generally be assigned 2 to 3 inmate workers. There were times when she had as many as 5. There were also times when there were no inmate workers to assist her.

During the mowing and landscaping season Petitioner and her inmate workers would operate large tractors, zero turn lawnmowers, smaller push mowers, gas powered string trimmers (weed whackers), gas powered hedge trimmers, manually operated hedge trimmers, hoes, rakes, and various gardening tools. Petitioner testified that the majority of these tools cause the operator to experience vibrations and or strenuous use of the arms and hands. Petitioner testified that during the mowing season, due to the size of the facility, the operation was performed nonstop. Petitioner indicated that when they were mowing they would literally mow all day long with the exception of the lunch break.

In approximately July 2013 Petitioner was assigned to work at the Dwight CC. Dwight had closed sometime earlier and the citizens in the area were complaining that the grounds had gone unmaintained. Workers from Pontiac were therefore dispatched to Dwight in order to eliminate the overgrown plants and get the facility into presentable shape. Petitioner indicated that when she was transferred to Dwight the facility was in such disrepair that they had to knock down grass which was 3 to 4 feet tall using string trimmers. She indicated that while at Dwight she would use string trimmers at least 30 hours per week. Petitioner testified that

Respondent had a three week lock down during the period when Petitioner was working at Dwight, meaning there were no inmates available to her for the grounds keeping work. Petitioner also indicated that there were no inmates available to her on at least eleven other days in August and early September of 2013. On those days, Petitioner performed all of the grounds work at either Pontiac correctional Center or Dwight Correctional Center by herself. Petitioner indicated that while working in Dwight she began to notice her hands tingling all of the time and experienced problems with her grip as well.

Petitioner's supervisor at the Pontiac facility, Michael Melvin, testified on behalf of Respondent. Mr. Melvin corroborated the vast majority of the Petitioner's testimony. He confirmed that she and a coworker referred to as a "double identical," Mr. Shaw, along with their inmate workers were responsible for the mowing and landscaping of the entire Pontiac facility. He also confirmed that during the period in the summer of 2013 an escape had occurred at another facility within the state resulting in the use of inmate workers being suspended. He also confirmed that during periods of lock down inmate workers could not be used. He testified that during these periods of time Petitioner and Mr. Shaw would be responsible for performing all of the mowing and landscaping duties. Mr. Melvin's testimony only differed from that of Petitioner in that he indicated the actual prison employees, Petitioner and Mr. Shaw, were more supervisory than hands-on workers. It was his testimony that the Petitioner would only be required to perform hands-on landscaping or mowing on rare occasions when inmate workers were unavailable. The Arbitrator noted, however that Mr. Melvin also indicated that his own supervisors were very particular about the way the grounds at the Pontiac facility were maintained. He stated on more than one occasion that whether or not there were inmate workers the work had to be done.

Petitioner called Mr. Richard Runyon as a rebuttal witness pursuant to subpoena. Mr. Runyon was also one of Petitioner's supervisors working out of the Pontiac facility in 2013. His title was public service administrator. He indicated that when it became the responsibility of the Pontiac employees to maintain the Dwight facility it was he who was charged with overseeing that task. He indicated that initially Petitioner's coworker, Mr. Shaw was the employees sent to perform the cleanup at Dwight. Mr. Runyon indicated that Mr. Shaw and his group were not getting the job done so he requested Petitioner be assigned to the task. Mr. Runyon testified that during the time he was supervising Petitioner whenever he would be present at the Dwight worksite Petitioner would always be working side-by-side with the inmate workers, if not by herself. Both Mr. Runyon and Mr. Melvin agreed that Petitioner was a hard worker who was eager to get the job done.

Petitioner testified that by September 18, 2013 her symptoms had progressed to the point that they were disrupting her ability to perform her daily activities. It was on that date she contacted her primary care physician, Dr. Martin and was given an appointment for September 23, 2013. Petitioner testified that after making the appointment she contacted Mr. Melvin's office and advised the secretary she was going to see her doctor on September 23, 2013. She stated she did not recall whether she told the secretary which body part required evaluation by the physician. Petitioner further testified that she obtained a "WORKERS' COMPENSATION EMPLOYEE'S NOTICE OF INJURY" form in September of 2013.(PX 5, RX 6) She indicated that she filled the form out and turned it in to Elaine Rentz, Respondent's Personnel Supervisor. Petitioner could not recall the date on which she submitted the form. At the time of hearing a discussion was had regarding RX6 which contained what at the time of hearing was thought to be two copies of the same document, one of which had been stamped "RECEIVED" by Pontiac Correctional Center Personnel Department on November 27, 2013. (T.

68-69) Upon review of the documents, they are not two copies of the same document. The sections reflecting the duties being performed at the time of injury, the location where the injury occurred, the description of how the injury occurred, and the description of the injury on both forms are identical. One of the forms comprising RX 6, and PX 5 do appear to be identical and reflect that the name of supervisor is "Supt. Melvin, Michael" and the date and time reported shows 4:00 p.m. on 09/18/2013. The form in RX 6 which is stamped "RECEIVED" reflects that the name of supervisor is "Supt. Melvin, Michael secretary - Paula" and the date and time reported shows 1:45 p.m. on 09/18/2013. Both forms are signed by Petitioner and undated. The Arbitrator notes that although both forms describe the injury/ body parts affected as "arms and hands," and the date of injury as "09/23/2013" (the date Petitioner was first seen by Dr. Martin), but neither form contains the words "carpal tunnel syndrome."

On September 23, 2013, Petitioner was evaluated by her primary care physician, Dr. Alicia Martin. Dr. Martin's records reflect that Petitioner had bilateral hand numbness/tingling, worse at night. Dr. Martin noted that Petitioner "needs forms filled out for work, disability papers, and also notes from the last time she was seen for carpal tunnel." (PX 8, p. 7) Dr. Martin further noted:

> Patient with on and off hand numbness for 3 years. Was doing really well for a few years. Over the past 6 weeks noting worsening of hand tingling numbness and pain. Pain is at the base of the right thumb. Notes at the tips of fingers that there is the numbness. She has been wearing the wrist splint with minimal improvement.... Has been doing more manual maintenance work at work. *Id.*

Dr. Martin referred Petitioner to Dr. Lombardi whom she saw on November 20, 2013. Dr. Lombardi noted a history that Petitioner:

> [P]resents with a complaint of numbness and tingling in the hands bilaterally, which has been going on for approximately 2-3 years with progressive worsening. Her right dominant is worse than the left. She has been operating machinery and with gripping has exacerbation of numbness and tingling as well as intermittent discomfort. She has been wearing night splints which initially did help, but now it is no longer providing relief....(PX 9, p. 6)

Dr. Lombardi's impression was "bilateral carpal tunnel syndrome, right more symptomatic than the left." *Id.*, at 7. Dr. Lombardi ordered an EMG and indicated "[m]ost likely, she will require a right carpal tunnel relase." *Id.*

On December 17, 2013, Petitioner underwent an EMG with Dr. Shahbandar. Dr. Shahbandar stated that Petitioner had evidence of moderate bilateral carpal tunnel syndrome (PX 7). She returned to Dr. Lombardi on December 18, 2013. Dr. Lombardi noted Petitioner had "bilateral carpal tunnel syndrome, right much more symptomatic than left." He further noted "[t]his was something that came on at work and has been accepted as a workers' compensation injury." (PX 9, p.3) Dr. Lombardi recommended a right carpal tunnel release, and noted "[w]e will seek approval for the procedure as it is a work related injury." *Id.*, at 4. Dr. Lombardi placed Petitioner on a 30 pound weight restriction with no use of power tools due to the vibration of the tools. Dr. Lombardi restricted Petitioner from repetitive use of the hands. (PX 12). On November 12, 2014, Dr. Lombardi again saw Petitioner. Dr. Lombardi noted that Petitioner was waiting for approval to proceed with the carpal tunnel release. Dr. Lombardi stated that the longer Petitioner waits to have the nerve decompressed, the higher risk she has of not making a full recovery. (PX1, p. 10-11)

Petitioner was examined by Dr. Li, pursuant to section 12 of the Act on July 16, 2015. Dr. Li's report reflects a history that Petitioner became a lead industrial grounds worker in February of 2013. Dr. Li stated that Petitioner worked approximately 6 hours a day mowing and weed whacking. Dr. Li stated that Petitioner spent 60 to 70% of the time riding a mower. She used a push mower up to 10% of the time and she used a weed whacker 5 to 10% of the time. Dr. Li stated that Petitioner used a leaf blower up to an hour a day when there were leaves to be blown. Dr. Li took a history that Petitioner had shoveled snow and had planted and gardened. Dr. Li reviewed Petitioner's medical records and performed an exam. Dr. Li diagnosed Petitioner with bilateral carpal tunnel syndrome. Dr. Li opined that, based on her history, Petitioner had carpal tunnel since 2011 which got worse with her job as a lead industry worker when she had to use machines that caused vibratory stress such as a weed whacker, push mower, leaf blower or a hedge trimmer. Dr. Li opined that Petitioner's job duties as a lead industry worker permanently aggravated her carpal tunnel syndrome to the point where it required further care. Dr. Li recommended that Petitioner undergo staged bilateral carpal tunnel releases with 2 to 3 weeks of therapy after each carpal tunnel release (RX 3)

Dr. Lombardi testified by deposition taken May 11, 2015. Dr. Lombardi stated that he first treated Petitioner for carpal tunnel on November 20, 2013 and that she gave a history of progressive worsening of numbness and tingling in her hands (PX 1, p. 6). Dr. Lombardi stated that he ordered an EMG on 12-17-13 which confirmed his diagnosis of bilateral carpal tunnel. Dr. Lombardi recommended that Petitioner proceed with her right carpal tunnel release *Id.*, at 8-9. Dr. Lombardi reviewed Dr. Martin's note of September 23, 2013 and stated that the history of Petitioner's increase in manual work with increased carpal tunnel symptoms was consistent with his understanding of Petitioner's history. Dr. Lombardi reviewed Petitioner's narrative job description of April 6, 2014 setting forth her work activities.[1] Dr. Lombardi stated that this description of Petitioner's work was consistent with his understanding of her work activities (PX 1, p. 12-13). Dr. Lombardi opined that Petitioner's work duties, which changed in February of 2013 to include ground work, snow removal, planting, and use of grounds keeping tools, contributed to the underlying carpal tunnel syndrome requiring surgery. Dr. Lombardi stated that mechanical overuse is a known cause of carpal tunnel syndrome. Dr. Lombardi stated that using power tools, such as weed whackers and lawnmowers contributed to the worsening of Petitioner's carpal tunnel. Dr. Lombardi stated that gripping activities can contribute to the development of carpal tunnel syndrome. *Id.*, at 17 Dr. Lombardi stated that all of Petitioner's work activities after February of 2013 could likely have a cumulative affect causing a progression of her carpal tunnel syndrome. *Id.*, at 18

[1] At the deposition of Dr. Lombardi Petitioner offered the exhibit as deposition Exhibit 4. Respondent indicated no objection to the exhibit at that time. At the time of trial Petitioner sought to offer the same document as PX 6. Respondent then, for the first time, objected to the document as hearsay. After Petitioner established that she had prepared the document and that it accurately reflected her duties it was admitted over objection as a past recollection recorded only to the extent that it listed the duties performed by Petitioner and the tools used to accomplish those duties, and subject to cross examination. Petitioner did not read through the document in its entirety at that time, but simply established the foundation for its admission. The document was not referred to further at that point and Petitioner then went on for approximately 20 pages of trial testimony to describe the job duties and tools from her independent recollection. It was only after Respondent renewed its objection to the document going into evidence as a separate exhibit that Petitioner was allowed to review the document to determine whether there were any other duties or tools which she had forgotten before the renewed objection to the document being admitted as a trial exhibit was ruled upon. Petitioner's testimony in that regard appears at pages 44-49 of the transcript. Following Petitioner's testimony the exhibit was withdrawn before the renewed objection was ruled upon. The Arbitrator did not rely upon Petitioner's testimony recorded on pages 44-49 in the formulation of this decision. Any matters discussed in those pages of the record were considered and or relied upon only to the extent that they were cumulative of matters elucidated in Petitioner's testimony from her independent recollection, the testimony of other witnesses, or the exhibits admitted at trial, with the exception of PX 6.

On cross examination, Dr. Lombardi stated that Petitioner's job description was consistent with the progression of her carpal tunnel syndrome. Dr. Lombardi stated that, although he could not quantify it, any power tool could aggravate the carpal tunnel, both by the grasping and the vibration, as these things are known to cause or aggravate carpal tunnel. *Id.*, at 19-20

Dr. Li testified by deposition taken October 19, 2015. Dr. Li stated that Petitioner's use of the weed whacker and the push mower likely contributed to the development of her carpal tunnel syndrome (RX 1, p.p. 14-15). Dr. Li testified that, although he does not mow his own grass and has not ridden a riding lawnmower, he did not consider a riding mower to be an aggravating factor. *Id.* Dr. Li testified that if Petitioner used a weed whacker less than two hours a week, it could affect his opinion that Petitioner's work contributed to the development of her carpal tunnel. *Id.*, at 16-18 Dr. Li stated that if Petitioner used the weed whacker less than 2 hours a week, he may classify her neuropathies as idiopathic. *Id.*, at 19 The Arbitrator declines to find Petitioner used a weed whacker less than two hours per week during the grass mowing season.

On cross examination, Dr. Li testified that he thought the weed whacker was the biggest contributor to the carpal tunnel, that the push mower was the second biggest one, and that the leaf blower was the third. *Id.*, at 22 On cross examination, Dr. Li stated that using hedge trimmers could be a contributing factor to carpal tunnel. Dr. Li stated that if Petitioner gripped with her hands flexed, this could be a contributor to carpal tunnel. *Id.*, at 23-24 On cross, Dr. Li stated that if the riding mower had vibration in the handles or the steering wheel, then the vibration could contribute to the development of carpal tunnel. *Id.*, at 25 Dr. Li testified that he took quite a bit of time getting Petitioner's history. Dr. Li stated that after he took Petitioner's history, he formulated an opinion within a reasonable degree of medical certainty that her work activities contributed to the development of the carpal tunnel syndrome. *Id.*, at 26)

Petitioner has continued to experience pain, numbness and tingling in both of her hands. The symptoms affect her ability to sleep. Petitioner would like to undergo the surgery as recommended by Dr. Li and Dr. Lombardi.

CONCLUSIONS

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

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

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

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

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

In this case, the evidence shows that Petitioner used her hands and arms extensively during the performance of her job duties for Respondent. The Arbitrator found Petitioner's testimony to be both credible and forthright. In addition, Petitioner's testimony was largely corroborated by Respondent's witness, Mr. Melvin. Mr. Runyon, who testified pursuant to subpoena, not only confirmed Petitioner's testimony, but refuted the testimony of Mr. Melvin indicating that Petitioner's duties are more supervisory with little hands-on work. Mr. Runyon had a much better opportunity to observe Petitioner's duties while at the Dwight correctional facility. In addition Mr. Melvin readily admitted that he would only see Petitioner a time or two per day outside of his meetings with her in his office at the beginning and end of the workday. To the extent the testimony of Petitioner, Mr. Melvin, and Mr. Runyon are at odds with one another, the Arbitrator finds the testimony of Petitioner and Mr. Runyon more credible and persuasive.

Both Petitioner's treating orthopedic surgeon and Respondent's section 12 examiner agreed that Petitioner suffered from carpal tunnel syndrome bilaterally and that the condition was causally related to her employment with Respondent. They also agreed that Petitioner requires bilateral carpal tunnel releases. There is no evidence in the record to contradict the opinions and recommendations of Dr. Lombardi and Dr. Li.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met her burden of establishing she sustained accidental injuries which arose out of and in the course of her employment with Respondent and that her current condition of ill being is causally related to the accident.

Issue (D): What was the date of the accident?
Issue (E): Was timely notice of the accident given to Respondent?

The Workers' Compensation Act is a humane law of a remedial nature that should be liberally construed to achieve its purpose. *Hagene v. Derek Polling Const.*, 388 Ill. App. 3d 380, 902 N.E.2d 1269 (2009). Hence, the Supreme Court has established a flexible but fair standard for determining manifestation dates in repetitive trauma claims. *Durand v. Industrial Commission*, 224 Ill.2d 53, 862 N.E.2d 918 (Ill. 2007). Although the date on which the employee becomes aware that he has a condition related to work was the first method for determining a manifestation date, it is not the only permissible means for alleging or proving manifestation. The

manifestation date can be set as: (a) the date the employee actually became aware of the physical condition and its relation to work through medical consultation; (b) the date the employee requires medical treatment; (c) the date on which the employee can no longer perform work activities; or (d) when a reasonable person would have plainly recognized the injury and its relation to work. *Durand v. Industrial Commission*, 224 Ill.2d 53, 862 N.E.2d 918 (Ill. 2007), *see also Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill.2d 524, 505 N.E.2d 1026 (Ill. 1987); *Oscar Mayer & Co. v. Industrial Commission*, 176 Ill.App.3d 607, 531 N.E.2d 174 (3rd Dist. 1988); *Three "D" Discount Store v. Industrial Commission*, 198 Ill.App.3d 43, 556 N.E.2d 261 (4th Dist. 1989).

Section 6(c) of the Act Provides "(c) Notice of the accident shall be given to the employer as soon as practicable, but not later than 45 days after the accident....No defect or inaccuracy of such notice shall be a bar to the maintenance of proceedings on arbitration or otherwise by the employee unless the employer proves that he is unduly prejudiced in such proceedings by such defect or inaccuracy. Notice of the accident shall give the approximate date and place of the accident, if known, and may be given orally or in writing." 820 ILCS 305/6(c). This notice requirement applies to employees who suffer repetitive trauma injuries.

The date of such an accident, from which notice must be given, is the date when the injury "manifests itself." *Peoria County Belwood Nursing Home, supra* 115 Ill. 2d at 531. The purpose of the notice requirement is to enable the employer to investigate the employee's alleged industrial accident. *Seiber v. Industrial Comm'n*, 82 Ill. 2d 87, 411 N.E.2d 249, 44 Ill. Dec. 280 (1980). In *White v. Workers' Comp. Comm'n*, 374 Ill. App. 3d 907, 873 N.E.2d 388, 313 Ill. Dec. 764 (2007), the Court was considering the application of the notice requirement. In discussing the Commission decision the Court wrote: "[t]he Commission could have reasonably concluded that Freeman United did not receive notice of his alleged accidental injuries **before** or within 45 days after that date." *Id.*, at 911. (emphasis added)

Although a claimant is aware of symptoms and carries a suspicion that these are work-related, the Supreme Court has stated, "The 'fact of injury' is not synonymous with the 'fact of discovery'" *Durand,* N.E.2d at 927. Claimants are not charged with filing a claim as soon as they believe they may have a work-related condition, nor are they penalized for failing to realize a condition is work-related when the employer feels that he or she should have. The Supreme Court stated that to rely solely on a claimant's testimony concerning symptoms, without accurate knowledge of the cause of those symptoms, would essentially be asking them to "rely on 'expert' medical testimony from a layperson." *Id.* at 929. The Court also recognized that claimants would have had difficulty proving injury with a sketchy and equivocal understanding of the cause of their symptoms. *Id.* at 930. The standard that "the 'fact of injury' is not synonymous with the 'fact of discovery'" has since become a safety measure employed by all Courts to ensure that the employers do "penalize an employee who diligently worked through" his or her symptoms. *Durand v. Indus. Comm'n*, 862 N.E.2d at 927, 930. In *Durand*, the claimant was not sure her pain was from carpal tunnel syndrome, but "she believed it was work-related" in 1997, some 3 years before her injuries manifested in 2000. *Durand v. Indus. Comm'n*, 862 N.E.2d at 929-30.

In *Oscar Mayer*, the Court embraced the "date of collapse" method of determination, setting the manifestation date on the date of surgery, or the date the employee could no longer work. Compensation was awarded to a claimant, despite his full knowledge that his condition was work-related well before he filed a claim, because the claimant diligently served his employer until he could no longer do so without intervention

for his repetitive injuries. *Oscar Mayer, supra.* The Court noted that no prejudice can occur in employing such a method, since it is not until the employee actually misses work for his injuries that the employer becomes adversely affected; and the notice provisions were not impugned as this flexible and fair provision in no way interfered with an employer's ability to effectively investigate the claim.

In *Three "D" Discount*, the Court held the manifestation date of claimant's injury was the date "petitioner first learned that his condition of ill-being was work related." (*Id.*, 556 N.E.2d at 265) The Court went on to caution "[a]lthough our finding that the injury in this case 'manifested itself' on July 10, rather than August 10, does not affect the Commission's ruling in petitioner's favor, we emphasize that the peculiar facts of each case must be closely analyzed in repetitive-trauma cases to be fair to the faithful employee and his employer as well as to the employer's compensation insurance carrier." (*Id.*)

The Supreme Court in *Durand* noted that the manifestation date is typically set on the date the employee requires medical treatment or the date on which the employee can no longer perform work activities. *Durand,* 862 N.E.2d at 929. The law also allows Petitioner to select a manifestation date that coincides with discovery of injury and its relation to work after medical consultation. See *Steven Beal v. Town of Normal,* 06 IL.W.C. 25261, 10 I.W.C.C. 0380 (2010); *see also White v Worker's Compensation Commissio*n, 374 Ill.App.3d 907, 873 N.E.2d 388, 392-393 (4th Dist. 2007) (holding Petitioner could select accident date); *A.C. & S. v. Industrial Commission*, 304 Ill.App.3d 875, 710 N.E.2d 837, 841-842 (1st Dist. 1999).

In *Linda Peters v. Village of Caseyville*, the Commission gave the most weight to when the claimant possessed a "confirmed diagnosis" of her condition in setting the manifestation date. *Linda Peters v. Village of Caseyville*, 14 I.W.C.C. 0796 (2014). The Commission stated:

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

In *Three "D" Discount Store v. Industrial Commission*, 198 Ill.App.3d 43, 556 N.E.2d 261 (4th Dist. 1989), the Appellate Court held that even though the claimant had previously sought treatment and received a diagnosis for his condition, his injuries manifested on the date that he was advised by a physician that his condition was work-related. In *Three "D" Discount*, the claimant sought treatment with his family physician, Dr. Johnson, who referred him to a Dr. Block for evaluation. Dr. Block performed an EMG study and a physical examination of the claimant, and sent the EMG results to Dr. Johnson. Dr. Block's report stated that his examination suggested bilateral carpal tunnel syndrome. Dr. Johnson discussed the results of the EMG with the claimant and referred him to a Dr. McKechnie. Claimant reported to Dr. McKechnie and gave a history of his symptoms, but did not state that his condition was work-related or that Dr. Johnson had so informed him.

Dr. MeKechnie scheduled the claimant for surgery, and the claimant notified his employer that he required surgery and that it was his physician's opinion that that the condition was related to work. The Appellate Court found that Petitioner's manifestation date was the day he met with Dr. McKechnie and stated the following:

> The evidence in this case establishes that Dr. Carl Johnson discussed Dr. Block's report of the EMG results with petitioner. The report was dated June 27, 1984; and it was in May and June that petitioner's condition had deteriorated to the point that his family doctor referred him to a medical specialist. No direct evidence was presented regarding whether Dr. Johnson ever told the petitioner that his injury was work related. It is clear that the condition was at least tentatively diagnosed as carpal tunnel syndrome on June 27, and that petitioner learned that the condition was work related prior to petitioner's conversation with Tom Underwood in late July or early August 1984. It is not clear, however, that the tentative diagnosis and its relationship to petitioner's employment were discussed at any time prior to or during petitioner's visit to Dr. Johnson following Dr. Block's examination. It was not until July 10, when petitioner met with Dr. McKechnie, that it became clear that petitioner's condition necessitated surgery.... Based on the evidence of record, it could be reasonably inferred that petitioner first learned that his condition of ill-being was work related at some point between July 10 and the first of August 1984. Applying the reasonable person test to these facts, we find that although petitioner persisted in his employment until August 10, a reasonable person in these circumstances would have been on notice that his condition was both work related and medically disabling on July 10, 1984. *Id.*, at 47-48.

The Arbitrator finds *Three "D" Discount Store* strikingly similar to the case at bar. Petitioner had sought treatment for her symptoms in the past and possibly received a tentative diagnosis of carpal tunnel syndrome. Although Petitioner alleged September 23, 2013, the date she saw Dr. Martin, as her date of accident it is clear that Petitioner did not have a clear understanding of her condition and its relation to work. Significantly, Petitioner was seeing a primary care physician rather than a hand specialist. On November 20, 2013 Petitioner was seen by Dr. Lombardi, a hand surgeon on the referral of Dr. Martin. Dr. Martin formulated a tentative diagnosis of bilateral carpal tunnel syndrome and commented that Petitioner may require right carpal tunnel release in the future. He ordered an EMG to confirm the diagnosis. The note of that visit notes Petitioner's recent work activities, but does not directly address the causal relationship between the suspected condition and the employment duties. Petitioner returned to Dr. Lombardi on December 18, 2013. Dr. Lombardi noted his preliminary diagnosis was confirmed. At point he noted "[t]his was something that came on at work and has been accepted as a workers' compensation injury." He recommended a right carpal tunnel release and, for the first time, placed Petitioner on a 30 pound weight restriction; no use of power tools due to the vibration; and no repetitive use of the hands.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds December 18, 2013 is the appropriate manifestation date in this case. Although Petitioner alleged her accident date was September 23, 2013, it is within the Arbitrator's discretion to modify the accident date to conform-to the evidence. *See Beal v. Town of Normal*, 10 IWCC 380 (2010). This was the first date there was a confirmed diagnosis. It was also the first date that a clear connection between the condition and the work duties was indicated. Further, and significantly, this is the first date on which restrictions were placed, preventing Petitioner from fully performing all of her job duties. It is not lost on the Arbitrator that Dr. Lombardi, a hand surgeon, diagnosed Petitioner's

condition on November 20, 2013. However the diagnosis was thereafter confirmed by EMG and the causal link between the condition and employment was discussed.

With regard to notice, Petitioner testified she phoned Respondent on September 18, 2013 after scheduling an appointment with her primary care physician for September 23, 2013. Her testimony was that she told her supervisor's secretary that she needed to see her doctor. She did not recall whether she told the secretary which body part required evaluation by the physician. Petitioner further testified that she obtained a "WORKERS' COMPENSATION EMPLOYEE'S NOTICE OF INJURY" form in September of 2013. She indicated she filled the form out and turned it in to Elaine Rentz, Respondent's Personnel Supervisor. Petitioner could not recall the date on which she submitted the form. RX6 contains two Employee's notice of injury forms, one of which had been stamped "RECEIVED" by Pontiac Correctional Center Personnel Department on November 27, 2013. Both documents contain sufficient information to satisfy the notice requirement of the Act. The sections reflecting the duties being performed at the time of injury, the location where the injury occurred, the description of how the injury occurred, and the description of the injury on both forms are identical. Both forms are signed by Petitioner and undated. It is obvious that the form stamped "RECEIVED" was provided to Respondent on or before November 27, 2013. While it is uncertain when Respondent received the other form it has in its file, notice was provided at least by November 27. This was one week following Petitioner's evaluation by a hand specialist and prior to the hand specialist's diagnosis being confirmed by EMG, his clear statement indicating the causal relationship between the condition and the employment, his recommendation for surgery, and his imposition of restrictions on Petitioner.

Having previously found the manifestation date of Petitioner's injury to be December 18, 2013, the notice provided on or before November 27, 2013 was received "**before** or within 45 days after" the date of accident. *White v. Workers' Comp. Comm'n*, 374 Ill. App. 3d at 911. (emphasis added).

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

Issue (K): Is Petitioner entitled to any prospective medical care?

Respondent did not dispute the reasonableness and necessity of the medical treatment provided to Petitioner. Respondent's only dispute with respect to the medical treatment was its liability for the payment of medical expenses based upon the issues of accident, notice, and causation. Having ruled in favor of Petitioner on said issues above, the Arbitrator finds the medical treatment provided to Petitioner up to the date of hearing was both reasonable and necessary. Dr. Li and Dr. Lombardi both agree that Petitioner requires bilateral carpal tunnel releases.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Respondent shall pay reasonable and necessary medical services of $2,525.00, as set forth in PX 11, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for any medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for prospective medical care as recommended by Dr. Lombardi, as provided in Sections 8(a) and 8.2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JERRY R. NEWQUIST,

Petitioner,

vs.

NO: 13 WC 42661
13 WC 42622

MBM CORPORATION,

17IWCC0137

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 causal connection, medical expenses, temporary disability and permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator in case No. 13 WC 42661 as stated below and otherwise affirms and adopts the Decisions of the Arbitrator, which are attached hereto and made a part hereof.

The evidence adduced at the arbitration hearing on April 21, 2016 showed that Petitioner was a 42 year old truck driver for Respondent MBM Corporation on December 17, 2013 when he sustained an injury to his right knee. Petitioner underwent an extremely complicated medical and surgical course of treatment that preceded the right knee replacement surgery. The total knee replacement surgery performed by Dr. Anderson followed injections, arthroscopic surgery and unicompartmental knee replacement surgery. The anatomy of the knee, and supporting structures have been subjected to repetitive medical trauma. Petitioner is currently only 45 years of age with a long working life expectancy and a job that involves manual labor. For the foregoing reasons the Commission increases the PPD award of 35% loss of the use of Petitioner's right leg to 45% loss of the use of the right leg.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $862.14 per week for a period of 64 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $721.66 per week for a period of 96.75 weeks, as provided in Section §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 45% of the right leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $106,759.28 for medical expenses under §8(a) and 8.2 of the Act, subject to Section 8(j) credit and corresponding hold harmless.

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

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

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

DATED: MAR 3 - 2017
SM/msb
o-2/9/17
44

Stephen Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NEWQUIST, JERRY R
Employee/Petitioner

Case# **13WC042661**

MBM CORPORATION
Employer/Respondent

17IWCC0137

On 6/16/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.40% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2934 BOSHARDY LAW OFFICE PC
JOHN V BOSHARDY
1610 S 6TH ST
SPRINGFIELD, IL 62703

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

17IWCC0137

STATE OF ILLINOIS)
)
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jerry R. Newquist
Employee/Petitioner
v.
MBM Corporation
Employer/Respondent

Case # **13** WC **42661**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **April 21, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 17, 2013** , Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* 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 $ **67,247.22** ; the average weekly wage was $ **1,293.22** .

On the date of accident, Petitioner was **42** 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 for $**10,646.88** for TTD, $**0** for TPD, $**0** for maintenance, and $**23,265.08** for other benefits, for a total credit of $**33,911.96**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $ **862.14**/week for **64** weeks, commencing **January 30, 2014 to May 1, 2014 and again from December 16, 2014** through **November 23, 2015**, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $ **721.66**/week for 75.25 weeks, because the injuries sustained caused 35 % loss of the right leg as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **December 17, 2013** through **April 21, 2016** , and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay $ **106,759.28** for medical services, as provided in Section 8(a) of the Act. Respondent is entitled to credit for any actual related medical expenses paid by any group 8(j) health provider and Respondent is to hold Petitioner harmless for any claims for reimbursement from said group health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

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

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

D. Glenn McCarty 6/13/2016

Signature of arbitrator Date

JUN 16 2016

Findings of Fact

Petitioner testified credibly. Petitioner was employed by Respondent on December 17, 2013 as a truck driver for Respondent delivering boxes of frozen, refrigerated foods and dry goods to fast food restaurants.

Respondent stipulated that Petitioner sustained an accident on December 17, 2013 while on a delivery in Missouri. On that date as Petitioner was lifting and moving some boxes at his first delivery location and was in a confined area in the refrigerated portion of the trailer. The Petitioner placed his right foot between two pallets to move a box and twisted. Petitioner felt a pop in his right knee and noticed that as he continued with his delivery he developed swelling and pain in his right knee.

Petitioner stated that prior to the accident of December 17, 2013 he had never sought any treatment or sought any medical treatment for his right leg. Petitioner notified his supervisor but finished his deliveries for that day. The following day, December 18, 2013 as he was walking in the trailer he had another event in which he stepped on a strap hanging from the side of the trailer and noticed that it aggravated his symptoms further. Petitioner acknowledged that the accident of December 17, 2013 was the accident for which he sought treatment.

Petitioner was sent by Respondent to Midwest Occupational Health Associates (MOHA) on April 18, 2013. Petitioner informed Donna Duncan ANP to Dr. Gregory Clem of the work accident of December 17, 2013 and that he had very intense pain in the knee. (PX 2) Examination of the knee revealed peripatellar and medial collateral tenderness with palpation and moderate swelling but no crepitus or clicking. (PX 2) Petitioner was diagnosed with a right knee strain and x-rays were ordered. Petitioner was advised to wrap and elevate the knee and prescribed pain medications including nabumetone and Tramadol. (PX 2) Petitioner was issued light duty restrictions of no lifting over ten pounds, no climbing, kneeling and sit down work only. Petitioner was scheduled off the next had the next day. Petitioner was told to return to on December 20, 2013. (PX 2)

X-rays of the right knee taken at MOHA showed joint effusion but no other abnormality. The joint spaces were well maintained. (PX 2)

Petitioner sought treatment from his primary care physician, Dr. Bryan Albracht on December 19, 2013. Petitioner described the work accident of December 17, 2013 to Dr. Albracht. (PX 11) On examination Dr. Albracht noted moderate joint effusion, tenderness over the medial collateral ligament, pain with valgus stressing and diagnosed the Petitioner with a torn medial collateral ligament and possible medial meniscus tear. (PX 11)

Petitioner returned to MOHA on December 20, 2013 and informed the staff of Dr. Albracht's opinions. Petitioner requested referral to Dr. Romanelli. (PX 2) Petitioner was advised to stop the nabumetone and begin a tapered dose of prednisone. Petitioner was advised that an MRI would be ordered and referrals would be discussed pending the findings. (PX 2)

An MRI of the right knee was performed at Memorial Medical Center on January 8, 2014. The MRI showed a complex tear of the anterior and posterior horn and body of the medial meniscus with probable radial and oblique components. A small Baker's cyst and joint effusion were also present but no osteoarthritis was noted. (PX 3)

Petitioner was seen by Dr. Ronald Romanelli on January 17, 2014. Dr. Romanelli was advised of the facts of the work accident of December 17, 2013 and the treatment and testing Petitioner had received to that point. (PX 4) On examination, Dr. Romanelli noted Petitioner walked with a mild antalgic gait, pain with palpation along the medial joint line and a positive MacMurray's test. (PX 4) Dr. Romanelli reviewed the MRI and diagnosed a right complex anterior and posterior horn medial meniscal tear. Dr. Romanelli also noted the Petitioner had joint spacing and there were no arthritic changes present. (PX 4) Dr. Romanelli recommended arthroscopic repair of the medical meniscus in light of Petitioner's continued pain and difficulty in performing daily activities. (PX 4) Dr. Romanelli expected the Petitioner to heal without any problem and be returned to work three to six weeks postoperatively. (PX 4)

Respondent authorized Petitioner's surgery under its workers' compensation coverage and paid Petitioner temporary total disability benefits beginning January 30, 2014 the day of surgery.

Petitioner underwent an arthroscopic repair of a right medial meniscus tear on January 30, 2014. Dr. Romanelli noted no findings consistent with osteoarthritis. (PX 4)

Dr. Romanelli saw Petitioner on February 7, 2014 and noted that he was walking without assistance but did have swelling and tightness in the right knee but no calf tenderness. Dr. Romanelli prescribed physical therapy. (PX 4)

Petitioner received physical therapy from Midwest Rehabilitation beginning February 12, 2014. (PX 5) At the initial visit Petitioner complained of soreness and occasional sharp pains in his right knee following surgery. (PX 5) Examination revealed negative varus and valgus testing. (PX 5)

On March 7, 2014 Petitioner returned to Dr. Romanelli noting continued swelling in his right knee and he could not extend the knee. (PX 4) Dr. Romanelli ordered work hardening. (PX 4) Physical therapy notes from March 7, 2014 note continued soreness, edema and weakness in the right knee. (PX 5) Dr. Romanelli continued to remove Petitioner from work. (PX 4)

Petitioner's last work hardening evaluation was on April 1, 2014. (PX 5) Petitioner stated that he was doing well, other than "The MCL when I bend or put weight on it". (PX 5 p. 2) Petitioner discussed getting additional therapy. (PX 5, April 1, 2014 note p. 2) The therapist noted Petitioner's chief concern was the right medial pain which Petitioner located to the MCL and anterior tibia. (PX 5, April 1, 2014 note, p. 3-4)

On April 4, 2014 Dr. Romanelli recorded that the Petitioner told him he had no pain in the right knee except for climbing. (PX 4) Examination of the right knee noted continued swelling, tenderness over the medial past tendon region and a stable knee. (PX 4) Dr. Romanelli indicated that Petitioner might be at maximum medical improvement at "four months post-op" and could return to driving as of April 7, 2014 with no unloading and then full duty. (PX 4)

Petitioner returned to regular driving after the initial two week period of no unloading began normal duties two weeks later on April 21, 2014. Petitioner testified that his right knee pain continued and increased with activities. Petitioner also noticed an unstable feeling in the knee.

Petitioner was examined by Respondent's Section 12 examiner Dr. Richard C. Lehman on one occasion on April 24, 2014. (RX 1, p. 5) Dr. Lehman diagnosed Petitioner as having post arthroscopic scarring in his right knee. (RX 1, p. 8) X-rays obtained by Dr. Lehman on April 24, 2014 also showed mild joint space narrowing on the right. (RX 1, p. 9) Dr. Lehman did not feel any further treatment was necessary as of April 24, 2014. (RX 1, p. 9) Dr. Lehman did not

believe Petitioner's need for surgery was related to the work accidents of December 17, 2013 or December 18, 2013. (RX 1, p. 9-10) Dr. Lehman was of the opinion that the MRI showed a complete shredding of the meniscus anteriorly, posteriorly, and in the whole meniscus, which he felt showed a degenerative tear. (RX 1, p. 10) Dr. Lehman felt the Petitioner's knee just wore out, the Petitioner had gout and had a BMI of 42.3 which accelerated his arthritis. (RX 1, p. 11-12) Dr. Lehman did not believe that as of April 24, 2014 the Petitioner was symptomatic for post-arthroscopic medial compartment arthritis. (RX 1, p. 12) Dr. Lehman stated that Petitioner had risk factors for knee arthritis including his age and body mass index. (RX 1, p. 14)

Dr. Lehman admitted that he has examined numerous claimants for Respondent's counsel over many years. (RX 1, p. 17) Dr. Lehman admitted that he was told that the Petitioner started working for the Respondent in 2009, four years before the accidents at issue here. (RX 1, p. 18) A job description was provided to Dr. Lehman and was admitted as Deposition Exhibit 6. (RX1, p. 18) Dr. Lehman admitted that Petitioner told him that prior to his work accidents he had never experienced and problems with his right knee. (RX 1, p. 19) Dr. Lehman also admitted that up to the date of his deposition testimony he had never been provided with any medical records that documented the Petitioner ever sought treatment for a right knee condition. (RX 1, p. 19)

Dr. Romanelli did not place Petitioner at maximum medical improvement. (PX 4)

Petitioner returned to Dr. Romanelli on April 30, 2014, approximately nine days after resuming full duty, noting that he had sharp right knee pain which he rated as an eight out of ten. (PX 4) On examination, Dr. Romanelli noted mild swelling and tenderness along the medial joint line. X-rays of Petitioner's right knee were obtained which showed mild joint space narrowing of the medial compartment, slightly decreased compared to the left knee. (PX 4) Dr. Romanelli diagnosed Petitioner with localized osteoarthritis for the first time and administered a corticoid steroid injection. (PX 4) Dr. Romanelli advised Petitioner to lose weight and recommended Petitioner use Mobic for a short duration of time. Dr. Romanelli asked the Petitioner to return in four weeks. Petitioner continued working without restrictions. (PX 4) Again, Dr. Romanelli did not place Petitioner at maximum medical improvement. (PX 4)

On April 30, 2014 Petitioner was also seen by his primary care physician, Dr. Bryan Albracht where it was noted that the month prior Petitioner had been started on sertraline for

anxiety. (PX 11) Petitioner testified that he had not had problems with anxiety before the work accident and felt stress from the injury and trying to pay his bills as his income was reduced. Dr. Albracht also noted the Petitioner was noticing pain after surgery even at rest, with extending the leg and whenever he lied in bed. (PX 11) Petitioner described it as severe throbbing in the knee. (PX 11) Dr. Albracht examined the knee and noted Petitioner's knee was bandaged from having the injection and swollen and that Dr. Romanelli had advised that he lose weight. (PX 11) Dr. Albracht noted Petitioner drove a truck and is on the road most of the day making it difficult for Petitioner to find health options. Dr. Albracht noted the Petitioner had tried to exercise but was limited due to pain. (PX 11)

Petitioner stated that he noticed his knee was not as stable and going up and down a ramp at work caused pain. Petitioner stated that Dr. Romanelli never released him from his care.

On May 28, 2014 Petitioner returned to Dr. Romanelli complaining of continued right knee pain of a seven out of ten, a giving way sensation and stiffness. (PX 4) Dr. Romanelli noted the Petitioner had lost 17 pounds. On examination, Dr. Romanelli noted an antalgic gait, swelling and that the right knee hyperextended. (PX 4) Petitioner continued to complain of pain and discomfort and he reviewed the intraoperative pictures noting the meniscal tear and a little chondromalacia of the medial femoral condyle but no other abnormality. (PX 4) Dr. Romanelli stated that he was concerned the Petitioner was having medial femoral condyle edema and "spontaneous osteonecrosis were a persistent meniscal tear on resected" [sic]. (PX 4) Dr. Romanelli was worried about Petitioner's lack of extension and persistent pain and discomfort. (PX 4) Petitioner was told to return in four weeks for possible re-x-ray and MRI of his right knee. (PX 4)

Petitioner continued to work, performing his normal work activities. Petitioner noted that his symptoms increased the more he worked. Petitioner did not sustain any other accidental injuries to his knee.

Petitioner returned to Dr. Romanelli on July 2, 2014 with continued right medial knee pain which ranged from a low of four out of ten to ten out of ten when he stepped wrong. (PX 4) Repeat x-rays showed moderate joint space narrowing of the medial compartment and normal joint space in the lateral compartment with a complete bone on bone deformity on the medial

joint. (PX 4) Dr. Romanelli discussed placing Petitioner in an off-loading brace, weight loss and visco-supplemenation (Synvisc). (PX 4)

Dr. Romanelli stated on July 2, 2014 that Petitioner would require a unicompartmental knee arthroplasty in the future and his current condition was due to his injury at work which resulted in a medial meniscus tear that necessitated an arthroscopy which accelerated the progression of his medial compartment arthritis. (PX 4)

Dr. Romanelli contacted the workers' compensation insurance carrier requesting authorization for Synvisc injections but was advised that workers' compensation was no longer paying for the right knee. (PX 4) Petitioner used is health insurance for further care. (PX 4)

Petitioner had a Synvisc injection on July 9, 2014. (PX 4) On July 16, 2014 Petitioner saw Dr. Romanelli complaining of right knee pain and difficulty working noting increased pain and discomfort with working. (PX 4) On examination, Dr. Romanelli noted grade 1 effusion, crepitus on range of motion testing and pain with palpation of right medial joint line. (PX 4)

On July 16, 2014 Dr. Romanelli noted that pre-operatively the Petitioner had standing x-rays which revealed normal medial clear space with no evidence of arthritis in his knees. (PX 4) Dr. Romanelli obtained x-rays on July 16, 2014 and compared them to x-rays taken in April and concluded the Petitioner had moderately to nearly severe medial joint space narrowing which he felt was compatible with "progressive posttraumatic arthritis of the medial compartment". (PX 4) Dr. Romanelli noted the lateral compartment was normal and Petitioner now carried a diagnosis of primary osteoarthritis of the right knee. (PX 4) Dr. Romanelli reiterated that the Petitioner would require a unicompartmental knee replacement in the future and it was his opinion that was work related since Petitioner did not have any such problem until his meniscus tear from the accident of December 17, 2013. (PX 4) Dr. Romanelli administered a second Synvisc injection on July 16, 2014. (PX 4) Petitioner continued working.

On September 19, 2014 Petitioner returned to Dr. Romanelli noting the Synvisc injections did not help. (PX 4) Petitioner continued to complain of right knee pain and on examination the Petitioner had a grade 2 effusion and a Varus deformity, pain with palpation of the right medial joint line and a Varus deformity with a "lateral France" when ambulates. (PX 4) Dr. Romanelli's

diagnosis remained the same and he ordered an MRI. (PX 4) Dr. Romanelli stated that he preferred to hold off on a unicompartmental joint arthritis due to Petitioner's young age. Dr. Romanelli injected Petitioner's right knee with a corticosteroid for pain. (PX 4)

An MRI of the right knee taken on October 8, 2014 which revealed the previous meniscectomy of the medial meniscus with the body and horn being truncated and full thickness cartilage loss of the medial femoral condyle. (PX 4)

On October 15, 2014 Petitioner returned to Dr. Romanelli complaining of continued right medial knee pain and Dr. Romanelli and Petitioner discussed proceeding with the unicompartmental knee replacement. Petitioner wished to proceed. (PX 4)

On December 12, 2014 Petitioner was seen by Dr. Romanelli for a pre-operative physical where Dr. Romanelli noted the Petitioner would proceed with the unicompartmental knee replacement but that he might need a total knee replacement. (PX 4)

Dr. Romanelli performed a right unicompartmental knee replacement at St. John's Hospital on December 16, 2014. (PX 7) Intraoperatively the medial compartment was noted to be bone on bone but the lateral compartment, ACL and PCL were all "pristine". (PX 7) Petitioner was removed from work again. (PX 4)

Petitioner stated that he had no pain at his first post-op visit of January 7, 2015. (PX 4) Dr. Romanelli ordered physical therapy and this was started at Midwest Rehabilitation on January 7, 2015. (PX 12) The intake notes indicate Petitioner was using a cane, had decreased right knee extension and stiffness with standing. (PX 12) On January 27, 2015 the therapist noted Petitioner complained of pain of 3.4 cm on a ten centimeter line scale on January 7, 2015. On January 27, 2015 the Petitioner's pain complaints increased to 3.9 cm, his functional limitations had improved but were still severe on a Lower Extremity Functional Scale. (PX 12)

On January 30, 2015 Petitioner returned to Dr. Romanelli complaining of swelling with activity, sand achy pain in the right knee which he stated was a four out of ten. Petitioner told Dr. Romanelli that he had been doing better but now felt his knee was still bothering him and was swelling more than post-operatively. (PX 4) Petitioner was concerned about his ability to go up and down ramps in the future. Petitioner was advised to begin physical therapy, lose weight and placed on Celebrex. (PX 4)

Petitioner stated that the unicompartmental joint replacement removed the pain from what was replaced but he had other pain which was not relieved. Petitioner noticed that after physical therapy caused knee pain which progressively worsened during therapy. Petitioner was advised to lose some weight and an appointment for weight loss was set up for Petitioner at Memorial Medical Center. Petitioner went for a consultation but the cost of the program was too much for Petitioner even with insurance. Petitioner attempted to exercise but pain would prevent him from continuing. Petitioner also changed his eating habits.

On February 12, 2015, a little more than two months after his unicompartmental medial knee replacement Petitioner returned to Dr. Romanelli and that he was noticing more pain than what he experienced before surgery. (PX 4) Petitioner reported his pain was a nine out of ten and that he had sharp pain was anterior from the back of the knee down his to his foot. (PX 4) Dr. Romanelli noted there was no calf pain. Dr. Romanelli diagnosed Petitioner with primary osteoarthritis of one knee and acute meniscal tear. (PX 4) Dr. Romanelli felt the Petitioner's recovery was proceeding and the symptoms he was experiencing were not uncommon. (PX 4) Dr. Romanelli had the Petitioner continue physical therapy. (PX 4)

Petitioner saw Dr. Romanelli in follow-up on March 13, 2015 with continued pain and was advised to look into weight loss programs to take pressure off of his knee. (PX 4) Dr. Romanelli's treatment plan included the need for a total knee arthroplasty. (PX 4)

On April 24, 2015 Petitioner returned to Dr. Romanelli where it was noted Petitioner complained of calf pain and right knee pain. On examination Dr. Romanelli noted clicking and popping of the patella/femoral joint space with flexion and extension of the knee. (PX 4) Dr. Romanelli noted there was possible loosening of the tibial component and that Petitioner would continued to be kept off of work. (PX 4) Dr. Romanelli diagnosed Petitioner with an acute medial meniscus tear, BMI of 40.0 to 44.9, knee joint pain, primary osteoarthritis of one knee and total knee arthroplasty. (PX 4)

Petitioner saw Dr. Romanelli on June 5, 2015 reporting excessive pain anytime he was on his leg, and popping and clicking when walking. On examination Dr. Romanelli noted full range of motion of the knee, pain at the medial joint line, popping in the joint, and inability to bend the knee to 90 degrees. X-rays revealed a little radiolucency and good position alignment of the

partial knee replacement. Dr. Romanelli continued to keep Petitioner off of work and advised Petitioner to follow up in two months. (PX 4)

Petitioner sought a second opinion from Dr. Danial Adair at the Springfield Clinic on referral from his primary care doctor. Petitioner was seen by Dr. Adair on June 9, 2015. (PX 11) Dr. Adair was provided with a history of Petitioner's work accident and prior treatment and that he continued to have pain of around a five and funny feeling when he flexes or extends the leg. (PX 11) On examination Dr. Adair noted Petitioner was fairly obese, had a mild antalgic gait, peripheral edema was present, mild tenderness on the femur, more tenderness along the tibia, no tenderness laterally, mild crepitus of the patellofemoral joint but no instability. (PX 11) X-rays were read as showing some "questionable loosening of the tibial component" in the right knee. (PX 11) Dr. Adair did not believe that the Petitioner required any more surgical treatment. (PX 11)

Petitioner spoke with an aunt who had worked for another orthopedic surgeon and obtained a third opinion from Dr. Peter Anderson, also on referral from his primary care physician. (PX 8)

Petitioner advised Dr. Anderson on the patient questionnaire of his work accident of December 17, 2013 and that he currently had pain, instability and swelling in his right knee. (PX 8) Petitioner stated that his pain was aggravated by activity, walking, squatting. Petitioner reported he had a catch in his knee and a give way sensation. (PX 8) Petitioner was examined by Dr. Anderson on June 25, 2015. Dr. Anderson noted Petitioner was a little obese, had no gross abnormality in his right knee. (PX 8)

Dr. Anderson concluded Petitioner had an injury, a scope and developed progressive arthritis requiring a unicompartmental knee replacement which was done in December of 2014 but continued to have moderately severe localized pain which was worse with activity. (PX 8) Dr. Anderson reviewed x-rays which he felt showed a little lucency. (PX 8) Dr. Anderson noted that since Petitioner had un-remitting pain six months after a knee replacement it would be reasonable to change it to a total knee. Dr. Anderson recommended to Petitioner that he could either have a revision of his knee or live with it. (PX 8) Petitioner decided to proceed with a right total knee replacement. Dr. Anderson advised Petitioner to remain off of work from June 25, 2015 through approximately November 16, 2015. (PX 8)

Petitioner underwent a revision to a total knee replacement on September 9, 2015. (PX 9) Petitioner reported 90% improvement with his total knee replacement as of October 22, 2015. (PX 8) Dr. Anderson recommended he resume activity slowly. Petitioner was released from Dr. Anderson's care on November 19, 2015 with 90% improvement and told to follow up as needed. (PX 8) Petitioner stated the total knee replacement helped him as it relieved the pain in his knee.

Conclusions of Law

The Arbitrator notes Dr. Lehman's testimony and opinions that Petitioner's right knee condition preexisted the work accident of December 17, 2013 and his knee condition was caused by his weight and gout. The Arbitrator is not persuaded by Dr. Lehman's opinions as they are not supported by the evidence. Further, if the opinions were true then it would follow the condition would be present in Petitioner's opposite leg. This was not the case. Further, it is axiomatic that the employer takes the employee as it finds him. *Killian v. Indus'l Comm'n 148 Ill.App.3 975, 977 (1986)*

A causal connection between an accident and a claimant's condition may be established by a chain of events including the claimant's ability to perform manual duties before an accident, a subsequent injury or a decreased ability to perform those same activities immediately after the accident and other circumstantial evidence. *Pulliam Masonry v. Indus'l Comm'n 77 Il.2d 469, 471 (1979), Kawa v. Ill. Workers' Comp. Comm'n, 2012 Il App 120469WC (2013)*

Respondent offered no evidence which suggested the Petitioner ever sought treatment for any condition related to his right knee and Petitioner was able to carry out the physically demanding duties required of his employment before December 17, 2013 without incident. The Arbitrator notes Petitioner credibly testified he did not have any prior accidents to his right knee and never sought any medical treatment for any right knee condition before the work accident of December 17, 2013. Dr. Romanelli's treatment records indicate that Dr. Romanelli felt the meniscal tear was an acute rather than a chronic injury. The Arbitrator finds that Petitioner carried his burden of proving through a chain of events and with reference to Dr. Romanelli's opinions, that the right knee meniscal tear was causally related to the work accident of December 17, 2013.

Whether Petitioner's weight or work activities after returning to work may have exacerbated or contributed to Petitioner's right knee osteoarthritis symptoms is not relevant. The law is well settled that every natural consequence which flows from an injury that arose out of and in the course of employment is compensable under the Act absent the occurrence of an intervening accident that breaks the chain of causation between the work-related injury and the ensuing disability or injury. *Dunteman v. Ill. Workers' Comp. Comm'n 2016 IL App (4th) 4-15-0543WC, Para. 42.* It has been recognized repeatedly that when the claimant's condition is weakened by a work related accident, even subsequent accidents which aggravate the work related condition do not act to break the causal chain. *Vogel v. Ill. Workers' Comp. Comm'n, 354 Ill.App.3d 780, 787 (2005)* For an employer to be relieved of liability by virtue of an intervening cause, the intervening cause must completely break the causal chain between the original work related injury and the ensuing disability. *Dunteman at para. 43.* Respondent offered no evidence of an intervening accident nor did Respondent offer any medical opinion tending to suggest that the work Petitioner performed after returning to work in April of 2014, or his weight, were the sole cause of the Petitioner's knee osteoarthritis. The medical evidence indicates that the rapid acceleration of Petitioner's degenerative knee would not have occurred but for the original injury to Petitioner's meniscus and the arthroscopic surgery that was performed. As long as there is a 'but-for' relationship between the work related injury and the subsequent condition of ill-being, the employer remains liable. *Dunteman at para. 44.*

Unfortunately, the Petitioner received no improvement from the unicompartmental joint replacement, even though he was held off of work after the surgery. Petitioner finally sought treatment from Dr. Peter Anderson who performed a right total knee replacement as a revision. Regarding the need for the unicompartmental and total knee replacements, the Arbitrator notes Dr. Romanelli's opinion as stated on July 2, 2014 that Petitioner would require a unicompartmental knee arthroplasty in the future and his current condition was due to his injury at work which resulted in a medial meniscus tear that necessitated an arthroscopy which accelerated the progression of his medial compartment arthritis. (PX 4) Dr. Romanelli later clarified his opinion to be that as a consequence of the arthroscopic surgery to repair the

work related meniscus tear Petitioner developed a spontaneous "progressive posttraumatic arthritis of the medial compartment". (PX 4) Dr. Romanelli's medical records document Petitioner's right knee did not have any signs of degeneration before the arthroscopic meniscal repair necessitated by the work accident of December 17, 2013. Additionally, Dr. Romanelli never concluded Petitioner had reached maximum medical improvement after the arthroscopic meniscal repair and the records show the condition never stabilized. The work hardening discharge note of April 1, 2014, recorded before Petitioner resumed his work activities documented that Petitioner continued to complain of medial joint pain and increased pain when standing on his knee. By April 30, 2014 after having been returned to work for one full week Dr. Romanelli documented the Petitioner was having sharp pains in his knee and injected the knee. Moreover, the evidence establishes that immediately after increasing his activities by returning to work Petitioner experienced a rapid increase in his symptoms and an accelerated progression of osteoarthritis in the right knee which was not present prior to the work accident.

The unicompartmental joint replacement did not relieve the Petitioner's symptoms and ultimately both Dr. Romanelli and Dr. Anderson felt a total knee replacement was necessary. The chain of events and medical records support this opinion.

The Arbitrator finds the Petitioner has carried his burden of proving a causal relationship between his work accident of December 17, 2013 and his right knee meniscus tear, as well his progressive osteoarthritic right knee condition necessitating his unicompartmental joint replacement and his total knee replacement.

In support of the Arbitrator's findings on the issue of **(J) Were the medical services that were provided to the petitioner reasonable and necessary?** the Arbitrator finds the following facts:

The findings of fact stated in other parts of this decision are adopted and incorporated by reference here.

The Arbitrator finds the medical expenses related to treatment of the right knee were causally related to the accident and should be paid as follows:

Orthopedic Center of IL, 7/1/14-6/5/15	$ 19,634.00
Associated Anesthesiologists, 1/30/14	$ 816.00
St. John's Hospital, 12/16/14-12/17/14	$ 36,303.08
St. John's Hospital, 9/28/15-9/30/15	$ 1,026.00

St. John's Hospital, 10/5/15-10/29/15	$ 3,888.00
IL Southwest Orthopedics, 6/25/15-10/22/15	$ 6,205.00
Anderson Hospital, 9/9/15-9/12/15	$ 36,029.20
Springfield Clinic, 12/19/13-8/26/15	$ 2,858.00
Total:	**$106,759.28**

Respondent is entitled to credit for any actual related medical expenses paid by any group 8(j) health provider and Respondent is to hold Petitioner harmless for any claims for reimbursement from said group health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

In support of the Arbitrator's findings on the issue of **(L). What is the nature and extent of the injury?** the Arbitrator finds the following facts:

The findings of fact stated in other parts of this decision are adopted and incorporated by reference here.

Under the amended Illinois Workers' Compensation Act the Arbitrator notes that the Commission shall base its Decision on five enumerated factors.

(i) the reported level of impairment;
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of injury;
(i) the employee's future earning capacity;
(ii) Evidence of disability corroborated by medical records.

:

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

Neither party offered an Impairment rating report pursuant to the Guides for the Evaluation of Permanent Impairment Sixth Edition. The Arbitrator does not consider this factor.

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

Petitioner has been a truck drive since he was 21 years old. Petitioner attempted to return to work for the Respondent after being released to return to work without restrictions but he was not called back. Petitioner found is a truck driver and his current position requires that he unload freight. He has stated that he is asking to be transferred to a position that does not require lifting. The Petitioner has difficulty in his new position driving a truck getting up and down from the trailer. Sometimes he is required to jump down a foot or two and this causes pain.

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

The Petitioner was 42 years old at the time of injury. Petitioner is currently 45 years old. The Arbitrator notes that the Petitioner has remaining work life.

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

The Arbitrator concludes Petitioner's earning capacity has not been permanently impacted by his injury.

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

Petitioner testified that he continues to numbness on the outside of his right knee. When Petitioner walks he has pain in his knee joint and especially in the back of his knee. Petitioner has pain getting into and out of his truck. Bending his knee causes occasional pain down the back of his leg. It depends on how he steps. Petitioner notices that after driving his truck for five or six hours and gets out he has to stand for a minute because his knee does not feel sturdy. Petitioner has difficulty getting up from a lower seated position and needs assistance because he is not strong enough to raise himself up. He has difficulties in getting into and out of a car or a sofa. He cannot take prescription pain medications because he drives for a living so Petitioner takes two Bayer Back and Body pills in the morning and two in the afternoon for pain.

When last seen by Dr. Anderson on November 19, 2015 and when last evaluated by his physical therapist at St. John's Hospital, the Petitioner exhibited a right knee range of motion of 0 to 110 degrees. Dr. Anderson commented that he would need to work a little bit on his range of

motion. The therapy records note that the range of motion for his unaffected left knee was plus 10-130 degrees. Both records indicate that the Petitioner's pain had basically resolved.

Considering the five factors listed in the statute, the Arbitrator finds the Petitioner to have sustained a 35 % loss of use of his right leg as a result of his accident.

In support of the Arbitrator's findings on the issue of **(K) What amount of compensation is due for Temporary Total Disability?**, the Arbitrator finds the following facts:

The findings of fact stated in other parts of this decision are adopted and incorporated by reference here.

The parties stipulated to the period Petitioner was temporarily and totally disabled as being from January 30, 2014 through May 1, 2014 and then again from December 16, 2014 through November 23, 2015, a period of 64 weeks. The parties further stipulated that Respondent paid temporary total disability benefits totaling $10,646.88 and $23,265.08 for other benefits including short and long term disability payments. Respondent has a total credit of $33,911.96 ($10,646.88 +$23,265.08= $33,911.96).

Respondent disputed liability for all temporary total disability benefits on the basis of causal connection. Having found that Petitioner carried his burden of proof on the issue of causation, the Arbitrator finds that Petitioner was temporarily and totally disabled for the aforementioned period.

The Arbitrator finds that Respondent is to be given credit for the temporary total disability benefits paid, as well as the short and long term disability benefits paid. Petitioner was due a total of $55,176.96 in temporary total disability benefits (64 x $864.14=$55,176.96). Deducting the credit due Respondent from the TTD owed yields a TTD underpayment in the amount of $21,265.00 ($55,176.96-$33,911.96=$21,265.00).

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NEWQUIST, JERRY R
Employee/Petitioner

Case# **13WC042662**

17IWCC0137

MBM CORPORATION
Employer/Respondent

On 6/16/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.40% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2934 BOSHARDY LAW OFFICE PC
JOHN V BOSHARDY
1610 S 6TH FL
SPRINGFIELD, IL 62703

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

17IWCC0137

STATE OF ILLINOIS)
)
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jerry R. Newquist
Employee/Petitioner

v.

MBM Corporation
Employer/Respondent

Case # 13 WC 42662

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Douglas McCarthy, Arbitrator of the Commission, in the city of Springfield, on April 21, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On **December 18, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $ **67,247.22** ; the average weekly wage was $ **1,293.22** .

On the date of accident, Petitioner was **42** 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 for $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

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

ORDER

This claim was consolidated for arbitration with case number 13 WC 42661. All benefits due Petitioner and credits due Respondent for this injury are addressed in the Arbitrator's Decision in case number 13 WC 42661.

Respondent shall pay Petitioner compensation that has accrued from **December 18, 2013** through **April 21, 2016** , and shall pay the remainder of the award, if any, in weekly payments.

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

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

D. Dyan McCarty

6/13/2016

Signature of arbitrator

Date

JUN 16 2016

ATTACHMENT F

In support of the Arbitrator's findings on the issue of **(F) Is the petitioner's present condition of ill-being causally related to the injury?,** the Arbitrator finds the following facts:

The findings of fact stated in other parts of this decision are adopted and incorporated by reference here.

Petitioner testified credibly. Petitioner was employed by Respondent on December 17, 2013 as a truck driver for Respondent delivering boxes of frozen, refrigerated foods and dry goods to fast food restaurants. Respondent stipulated that Petitioner sustained an accident on December 17, 2013 while on a delivery in Missouri. On that date as Petitioner was lifting and moving some boxes at his first delivery location and was in a confined area in the refrigerated portion of the trailer, the Petitioner placed his right foot between two pallets to move a box and twisted. Petitioner felt a pop in his right knee and noticed that as he continued with his delivery he developed swelling and pain in his right knee.

Petitioner stated that prior to the accident of December 17, 2013 he had never sought any treatment or sought any medical treatment for his right leg. Petitioner notified his supervisor but finished his deliveries for that day. The following day, December 18, 2013 as he was walking in the trailer he had another event in which he stepped on a strap hanging from the side of the trailer and noticed that it aggravated his symptoms further. Petitioner acknowledged that the accident of December 17, 2013 was the accident for which he sought treatment.

The Arbitrator finds the accident of December 18, 2013 to be a temporary exacerbation of right knee meniscal injury resulting from a work accident on December 17, 2013.
The Arbitrator has found that Petitioner's right knee meniscal tear, as well as the need for his unicompartmental and total joint knee replacement were causally related to the accident of December 17, 2013 addressed in a separate Decision in case number 13 WC 42661.

As the Arbitrator has made an award of benefits in case number 13 WC 42661, all further findings are rendered moot.

STATE OF ILLINOIS	)	☒ Affirm and adopt	☐ 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

Botao Kou,
Petitioner,
vs.

17IWCC0192

NO: 14 WC 3974

Southwest Airlines,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 18, 2016 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $20,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 29 2017
KWL/mav
O-3/7/17
42

Kevin W. Lamboth

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0192

KOU, BOTAO
Employee/Petitioner

Case# **14WC003974**

13WC035017

SOUTHWEST AIRLINES
Employer/Respondent

On 3/18/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.51% 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:

1993 ROMANUCCI & BLANDIN
FRANK SOMMARIO
321 N CLARK ST
CHICAGO, IL 60654

0766 HENNESSY & ROACH PC
NATALIE ROMO BAGLEY
140 S DEARBORN ST 7TH FL
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

17IWCC0192

Botao Kou
Employee/Petitioner
v.

Case # **14** WC **03974**

Consolidated cases: **13 WC 35017**

Southwest Airlines
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 **July 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 **October 13, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 **$43,867.20**; the average weekly wage was **$843.60**.

On the date of accident, Petitioner was **34** years of age, ***married*** with **2** dependent children.

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

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

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

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

ORDER

Petitioner's claim for additional maintenance benefits is denied

Respondent shall pay permanent partial disability benefits of 8% of a person-as-a-whole, 40 weeks, pursuant to §8(d)2 of the Act.

Petitioner's Petition for Penalties pursuant to §19(k) and §19(l) and for attorneys' fees pursuant §16 of the Act is denied.

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

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

Signature of Arbitrator

March 15, 2016
Date

MAR 18 2016

Botao Kuo v. Southwest Airlines
14 WC 3974, consolidated with 13 WC 35017

INTRODUCTION

This matter proceeded to hearing on July 15, 2015 before Arbitrator Steven Fruth. The disputed issues were: ***J:*** Were the 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? Maintenance; ***L:*** What is the nature and extent of the injury?; and ***M:*** Should penalties be imposed upon Respondent?

Proofs were closed on July 15, 2015. On October 21, 2015, an agreed stipulation was filed by the parties which provided new information affecting the Arbitrator's decision.

STATEMENT OF FACTS

Petitioner is a 36-year-old male, hired by Respondent on August 19, 2002. Since then he has been employed full time as a ramp agent. He is a member of TWU Local #555. He has "topped out" at $23.97/hour in accord with the union agreement. He testified that he intended to work to age 67.

The ramp agent position is classified in the heavy physical demand category. Petitioner testified that his job duties as a ramp agent consisted of the following: heavy level labor job, which involves frequently lifting, pushing, pulling with upper extremities, frequent overheard reaching and lifting, and occasionally operating machinery. Petitioner testified that the bags he would have to lift weighed between 2 and 99lbs and that on average he would have to lift 150 to 200 bags per plane and 5-6 planes per day.

On October 3, 2013, Petitioner, age 34, was offloading a flight and felt pain in his lower back. He reported the injury to his supervisor Nick Latronica. He was sent to Concentra/Occupational health Centers of Illinois (PX #1). Petitioner gave a history of low back pain going back about 8 years. He had received physical therapy, cortisone shots, and a specialist consultation. An MRI at that time showed a bulging disc.

Petitioner testified that he had injured his back at work on December 29, 2010. He further testified that he received physical therapy, an MRI, and an injection for that injury. He eventually returned to full duty work. Petitioner testified to other back strain injuries in 2004, 2005, and 2006. Petitioner also had a history of other prior injuries affecting different parts of his body, including his right hand which is subject of the consolidated case 13 WC 35017.

No x-rays were taken on October 3, 2013. On examination lumbar range of motion was limited and was tender. Spasm over L4-5 was also noted. Petitioner was diagnosed with lumbar strain. He was prescribed Tramadol and ibuprofen for pain and

cyclobenzaprine as a muscle relaxant. He was also advised to apply heat. Physical therapy was ordered and Petitioner was discharged with light duty restrictions.

Petitioner continued with Concentra for physical therapy on October 7. Petitioner saw Dr. Charlotte Albinson at Concentra on October 8, 2013. He reported that he was slightly better but that Flexeril was not working. Petitioner noted that his back pain switched sides – it was sharp on the right and dull on the left, when now it was sharp on the left and dull on the right with radiation down the left leg. The clinical exam was as before. Petitioner saw Dr. Albinson again on October 15. He reported he was pain free 30% of the time. Range of motion was markedly improves and no spasm was noted. The diagnosis remained as lumbar strain.

On October 22, 2013, Petitioner reported that physical therapy was not helping and he was not ready to return to full duty. He reported that light duty work was not available. Physical therapy was put on hold. On October 29 Dr. Albinson noted that Petitioner had had an IME scheduled for December 3, 2013 and an MRI in 3 days.

On November 1, 2013, Petitioner underwent an MRI of the lumbar spine, which revealed annular fissures at L2-3, L4-5, and L5-S1 and a possible left extraforaminal disc protrusion at L4-5 contacting the exiting left L4 nerve root with no significant lumbar spinal canal/neuroforaminal stenosis. (PX 1)

On November 15, 2013, Petitioner saw orthopedic surgeon Charles Mercier, M.D. at Concentra (PX #1). Petitioner gave a history of multiple low back injuries over his 11 years of working for Respondent. He felt that this was just a continuance of his first injury that occurred on the job. Petitioner noted that he really wanted to change the type of work he did. Dr. Mercier reviewed the MRI, which showed a small extraforaminal disc protrusion at L4-5, with annular fissures at L2-3, L4-5, and L5-S1. Range of motion was somewhat limited. There were no objective neurological abnormalities on exam. No spasm was noted. Petitioner stated he did not want surgery. Follow-up was scheduled for after Petitioner's IME.

On December 8, 2013 Petitioner was examined by orthopedic surgeon Kevin Walsh, M.D. pursuant to §12 of the Act at the request of Respondent (RX #15). Dr. Walsh also reviewed Petitioner's Concentra medical records.

Petitioner gave a history of injuring his low back 2 ½ years before. He had an MRI, physical therapy, and 3 epidural steroid injections. He also reported that he had leg pain at that time. At the point when his Workers' Compensation carrier denied his claim he returned to work in December 2012.

Petitioner also gave a history of previous Workers' Compensation claims and a pending lawsuit.

Petitioner gave a history of his October 3, 2013 back injury. He reported that he developed right lower back pain, which within 2 hours radiated into his right leg to the great toe. He also reported that he had left thigh pain at that time. Petitioner rated his back pain at 9.5/10 at its worst and 6/10 at best; his leg pain was 8/10 at its worst and 4/10 art best. On examination Petitioner was observed to move about with ease. His

lumbar range of motion was limited by pain. Petitioner reported numbness in the left leg but the remainder of the clinical exam was essentially normal.

Dr. Walsh diagnosed a left herniated disc at L4-5. He opined more likely than not, Petitioner's current symptoms were related to his pre-existing condition and, more likely than not, were a temporary aggravation of the pre-existing condition. Petitioner might require future intervention including epidural steroid injections for the pre-existing condition. Dr. Walsh noted that most people with sciatica get better without surgery. He was doubtful that Petitioner presented with a new problem. Work restrictions due to the pre-existing condition were appropriate. Petitioner would be able to return to full duty work and be at MMI once his symptoms resolve.

On January 17, 2014 Petitioner followed up with Dr. Mercier. He felt the same as before. Petitioner was still unclear as to what the IME doctor said.

Petitioner testified that Dr. Mercier gave him an injection in his back on March 10, 2014.

On March 18, 2014, Petitioner presented to Dr. Mercier and indicated that he had been discharged from medical care by his hand surgeon from another injury. He now had persistent low back pain as before. The first epidural had not helped him at all. Straight leg testing was negative. He would return in another week to see if he was a candidate for a second epidural injection. He would also seek a second opinion from Dr. Salehi.

On March 28, 2014, Petitioner saw Dr. Mercier. He reported that his lawyer had sent him to another doctor which he continued to follow at that time. He was to continue with modified duty and he was to return to Dr. Mercier as needed.

On March 28, 2014, Petitioner saw neurosurgeon Dr. Sean Salehi (PX #1). Petitioner gave a history of low back injury on October 3, 2013 when he was moving bags at work. He had pain and tingling in the left leg but that had since resolved. He typically has pain of 6-7/10. He did 8 weeks of physical therapy and 3 injections but still has complaints. Petitioner reported 2 prior injuries: one involving shoulder surgery and a low back injury for which he had physical therapy and 2 injections. He returned to work after the low back injury and had pain of 1/10 until the recent injury.

On examination Petitioner's lumbar range of motion was limited. The remainder of the exam was normal. The November 1, 2013 MRI report showed annular fissures at L2-3 and L5-S1 and a possible left extraforaminal protrusion at L4-5 contacting with the left L4 nerve root. Dr. Salehi diagnosed low back pain. He noted that Petitioner had persistent mechanical low back pain nearly 6 months from his work injury. Petitioner was to return in 2 weeks with the MRI for Dr. Salehi's review. Petitioner was to continue with 20 lb. lifting restrictions.

On April 11, 2014 Petitioner returned to Dr. Salehi (PX #2). He continued to have pain in the left side of his low back radiating into the left buttock and sometimes in to the left thigh. Petitioner rated his pain 7/10, 5/10 with medication. On examination Petitioner was neurologically intact. His lumbar range of motion was limited. In

reviewing the November 1 MRI Dr. Salehi found normal lumbar alignment, normal disc height at all levels, slight T2 signal alteration at L3-4 down to L5-S1, and small bilateral disc herniation at L4-5 without significant neural compression. No other focal herniation or neural compression was noted. He was diagnosed with a herniated lumbar disc at L4-5. The plan was to do one to two left L4-5 transforaminal epidural steroid injections and he was returned to work with previous restrictions. Petitioner might ultimately require an FCE if he remained symptomatic.

On April 22, 2014 Barbara Heller, D.O. gave Petitioner a left L4 transforaminal epidural injection for L4 radiculitis (PX #10).

On May 5, 2014, Petitioner returned Dr. Salehi. He had an injection 2 weeks before and he was unchanged. The day before he had tingling down the entire left leg, with 10/10 pain. On exam Petitioner was again neurologically intact, including a negative sitting straight leg raise. His range of motion was again limited. He found Petitioner was not a good surgical candidate due to the diffuse nature of the disc disease. Petitioner was to undergo work conditioning program 5 times a week for 2 weeks followed by an FCE and then would be released to work based on those restrictions.

On May 19, 2014, Petitioner began work conditioning at Concentra. Petitioner testified that work conditioning increased his low back pain.

On June 19, 2014 Laura Heckman, MPT, conducted an FCE of Petitioner (PX #2). The FCE was at 74% validity, suggestive of fair effort only. The evaluator noted symptom exaggeration. He complained of 9-10/10 pain during the evaluation but had low heart rate and was observed to sit comfortably and laughing during conversation. Petitioner had 2/5 Waddell signs and 2/21 positive Korbon indicators. His complaints of pain were disproportionate to objective measures. Petitioner was found able to work at the MEDIUM Physical Demand level, being capable of regularly lifting 30-40 lbs. to the waist and safe to lift 20 lbs. overhead.

On June 20, 2014, Petitioner saw Dr. Salehi again. Petitioner reported that he had completed only one week of work conditioning and then had intense pain. Petitioner complained of back pain radiating into his left leg with numbness in both the left and right legs. Petitioner again had limited range of motion but was otherwise normal on examination.

Dr. Salehi reviewed the FCE. He again diagnosed a herniated L4-5 without neural compression. Dr. Salehi found Petitioner at MMI with permanent restrictions per the FCE.

Petitioner testified that at that time, he demanded that maintenance be paid and that vocational rehabilitation counselling be provided. Respondent did pay maintenance benefits beginning June 21, 2014. Petitioner testified that on September 22, 2014 he began conducting a self-directed job search because Respondent threatened to cut off his maintenance benefits.

On September 25, 2014, Petitioner was examined by orthopedic surgeon Barak Lami, M.D. for Respondent pursuant to §12 of the Act (RX #5). Dr. Lami also reviewed

Petitioner's medical records from Concentra, the November 1, 2013 MRI, and Dr. Walsh's IME report. Petitioner complained of a low back injury when lifting luggage at work. His initial pain was 10/10 and was 9/10 at the exam. He also complained of numbness and tingling in the left leg. Petitioner reported having physical therapy and 2 injections, which did not provide relief. Petitioner also gave a history of a low back injury 2 years before (presumably the 2010 injury).

On clinical examination Petitioner had range of motion limited. Straight leg on the left reproduced back pain. Faber was positive bilaterally. Petitioner was observed to transition from supine to upright without difficulty. Dr. Lami opined that Petitioner had a pre-existing condition. He did not relate Petitioner's current symptoms to October 3, 2013. Dr. Lami noted that the subsequent MRI did not demonstrate acute findings. Dr. Lami further opined that Petitioner was at MMI and that, objectively, he could return to work full duty. However, Dr. Lami did note Petitioner may not have been able to return to work as a ramp agent due to his long history of back problems.

Petitioner testified that was informed of Dr. Lami's opinions and that, nonetheless, Respondent was accepting his permanent restrictions and that vocational counselling would be authorized according to his prior request. Petitioner did not offer what or who was the source of that information.

Petitioner was referred by Respondent to MedVoc Rehabilitation for vocational rehabilitation counselling. Respondent had not immediately commenced vocational counselling by that time of but did pay maintenance benefits beginning June 21, 2014. Petitioner testified that he began conducting his own self-directed job search on September 22, 2014 because Respondent threatened to cut off his maintenance benefits if he did not.

On November 10, 2014 Respondent scheduled an initial vocational rehabilitation counselling meeting at Petitioner's attorney's office with his attorney and Julie Bose of MedVoc Rehab. Ms. Bose's November 12, 2014 initial report stated that she believed Petitioner was employable at an entry-level wage of approximately $9.25/hour to $11.25/hour (RX #13). Ms. Bose performed a labor market survey and issued a report on December 15, 2014. She opined that Petitioner was employable in positions such as retail sales manager trainee, customer service, and electronic assembly and that he could earn an average of $12.45/hour.

Petitioner saw Dr. Bruce Kline, his primary care physician, on December 1, 2014 (PX #3). He was there for a refill of his hydrocodone but in a smaller dose. Dr. Kline's review of systems noted no report of back pain but a history of lumbago. The exam of the musculoskeletal system was normal but a tight low back was noted. Dr. Kline diagnosed backache. He prescribed Norco. Dr. Kline did not document when Petitioner's backache began.

On January 13, 2015 Petitioner followed up with Dr. Kline. Petitioner wanted to go to a pain clinic. The review of systems and findings on clinical exam were identical to those on December 1. Petitioner was diagnosed with lumbago and he was to have an

MRI of the lumbar spine. He was given a note indicating that he was under the doctor's care for chronic back pain. He required narcotic medication to control his pain and could not drive while taking them. He was referred to Loyola Pain Clinic for evaluation and for 4 treatments.

On January 14, 2015 Petitioner had an MRI of the lumbar spine at MacNeal Memorial Hospital (PX #4). The MRI revealed minimal degenerative disc disease and desiccation from L3 through S1 and a posterior annular tear at L5-S1., not significantly changed. There was no disc herniation, spinal canal stenosis, or neuroforaminal stenosis. This was compared to the study of November 15, 2011.

On January 19, 2015 Dr. Kline noted that MRI was unremarkable and unchanged from the previous MRI. The review of systems and clinical exam notes were also unchanged. Dr. Kline prescribed physical therapy for 4-6 weeks, 2-3 visits per week. On February 26, 2015 Dr. Kline released Petitioner to return to work full duty without restrictions.

Petitioner testified that he had requested a release to return to work without restrictions from Dr. Kline. Later he qualified that testimony by saying he did not request a full duty release.

On January 26, 2015 Petitioner was evaluated at MacNeal for outpatient physical therapy on referral by Dr. Kline (PX #4). Petitioner noted his low back history from December 2010. He testified that he received physical therapy at MacNeal through April 3, 2015.

On January 15, 2015 Petitioner saw Dr. Meda Raghavendra in the Department of Anesthesiology Division of Pain Management at Loyola University Medical Center (PX #6). Petitioner's complaints were lumbar pain radiating into the left leg and sacroiliac pain. Petitioner complained of sharp pain, usually 9/10. He had a history of low back pain after a lifting injury in October 2013. Pain radiated over the L4 root distribution. He also complained of occasional numbness and tingling. Petitioner's history of low back pain in 2010 with epidural injections was noted. An MRI of the lumbar spine of January 14, 2015 was read as normal. Dr. Raghavendra diagnosed a recurrence of left lumbosacral pain and left L4 radicular pain. A multi-modal approach to pain management was recommended, including Gabapentin trial, try to taper off HC-APAP, and consider an EMG/NCV to better evaluate radiculopathy if any, but Petitioner was reluctant since a prior EMG was painful.

On January 28, 2015 Petitioner saw Dr. Raghavendra again. Petitioner had not tried the Gabapentin. He wondered if he could be weaned off of the Norco because he shook when he missed his dose. There was concern of possible dependency on Norco. Dr. Raghavendra performed a left L4-5 transforaminal epidural injection for degenerative disc disease.

On April 29, 2015 Petitioner saw Dr. Theodore Fisher at Illinois Bone & Joint Institute (PX #7). Petitioner reported he had recurrent back problems as a ramp agent. His most recent injury was on October 3, 2013, when he went to lift a bag and felt a

sharp pain on the right side of his low back. He reported the pain then progressed to his left side as well as left lower extremity radiculopathy extending to the left great toe. Petitioner reported his recent history of physical therapy and injections. He stated he had not had any symptoms in the past 2 to 3 months. He denied any back pain or lower extremity symptoms. Petitioner wanted a release slip from a spine surgeon. He stated he did not take any medication currently for pain. Dr. Fisher noted that a prior MRI indicated a herniated disc which was not evident on a subsequent scan.

Dr. Fisher's assessment was 1) history of lumbar herniated nucleus pulposus and 2) lumbago and radiculopathy, now resolved. Dr. Fisher noted "no reason why he cannot return to work full duty as of today." Petitioner was at MMI and had no symptoms. As for weaning off the Norco, he was only taking a half at night and there was no reason why he could not stop without incident. Petitioner could return if he developed any new symptoms. Otherwise, he was to follow up on an as needed basis.

Julie Bose and Michael Wyness testified on behalf of Respondent. Ms. Bose is a certified vocational rehabilitation counsellor and Mr. Wyness is a job placement specialist for MedVoc. They testified to the vocational and job search counselling provided to Petitioner. Ms. Bose opinied that Petitioner's self-directed job search was not effective. Petitioner made cold call applications by asking whether the prospective employer would hire someone with work restrictions. Both Ms. Bose and Mr. Wyness testified that Petitioner consistently failed to comply with directions and recommendations for his job search. Petitioner consistently failed to properly document his job search contacts. On cross-examination Ms. Bose conceded that a client in pain may not be totally motivated in a job search.

Mr. Wyness testified that Petitioner did not comply with directions to make personal contacts to apply for jobs. Petitioner testified that he felt those demands were unreasonable because the personal contacts required driving. Petitioner did not believe it was safe for him to drive while taking prescribed narcotic pain medication. Petitioner told Mr. Wyness that he could only drive short distances, such as driving his children to and from school. Petitioner also resisted applying for jobs he did not feel qualified for.

Mr. Wyness further testified that Petitioner did not appear to seriously engage in practice job interviews. He also testified that Petitioner objected to what he thought were lies about job applications. Mr. Wyness clarified that the coaching was not about lying but about phrasing in a positive manner.

Petitioner did not perform a minimum of 25 hours per week on his job search, he refused to take public transportation stating he would be in too much pain and it would "take forever," he did not take MedVoc's mock interview seriously, he did not document his job searches at all in some weeks, and sometimes only spent a few minutes every few days looking for a job.

In the end, Petitioner was unable to find a job through the services of MedVoc.

Ms. Bose testified that Petitioner's average weekly wage for Respondent was $1,038.80 and was $498.00 at an hourly rate of $12.45/hour, for a differential of

$540.80 per week. A computed wage differential in accord with the Act would be $360.53.

Petitioner testified that he was paid full salary for the time off work from October 4, 2013 through December 26, 2013 pursuant to Respondent's agreement with the union; he was paid TTD benefits from December 27, 2013 through June 20, 2014, and then was paid maintenance benefits from June 21, 2014 through February 20, 2015. Petitioner testified that his maintenance benefits were suspended on February 20, 2015 but never received any written notice from Respondent as to why the benefits were being stopped at that time. Pettioner presented no evidence that a written request for resumption of maintenance benefits was sent to Respondent.

Petitioner and Respondent engaged in a union grievance process. Petitioner underwent an examination with a third party physician, Dr. Avi Bernstein, who returned Petitioner to work full duty as a ramp agent on September 21, 2015. Respondent reinstated Petitioner full duty as a ramp agent on October 7, 2015. Petitioner was subsequently paid his full salary from February 28, 2015 through October 6, 2015.

CONCLUSIONS OF LAW

J: Were 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 whole of Petitioner's case rests on the credibility of his subjective complaints.

The Arbitrator found Petitioner to be a witness of questionable credibility. There were numerous examples of Petitioner exaggerating the extent of his subjective pain and physical limitations, notably complaining of 10/10 pain without seeking emergency care. There were numerous examples of Petitioner exhibiting pain-free behavior during medical examination, Dr. Lami in particular, and during the FCE. Petitioner continually complained of radicular numbness and tingling when, inconsistently, he had normal clinical neurological findings. The Arbitrator also noted that during the lengthy trial of this matter Petitioner did not exhibit any apparent pain behaviors.

Further, Petitioner's lack of compliance with vocational rehabilitation counseling adversely affected his credibility. Finally, Petitioner finally, the Arbitrator noted that was an incomplete and inherent in accurate historian for various physicians who treated or examined him. In particular he did not disclose his extensive history of back strain injuries dating back to 2004. He did not accurately describe to examining physicians the extent of his medical care for his 2010 low back injury.

Petitioner's medical care was driven by his subjective complaints more than any objective findings. The Arbitrator does note that initially Petitioner's lumbar MRIs demonstrated degenerative changes and a herniated L4-5 disc, as noted by Dr. Salehi.

However, no healthcare professional opined that the L4-5 herniation was caused by the October 3, 2013 lifting incident at work. A later scan showed that the herniation had dissipated. Nonetheless, Petitioner's complaints of pain throughout the records and testimony varied so greatly that it is apparent that Petitioner used his complaints of pain to obtain a desired outcome.

The Arbitrator finds the MMI opinion of Salehi on June 20, 2014 to be persuasive, in light of all the evidence. Dr. Lami concurred on September 25, 2014 when he found no objective reason for why Petitioner could not return to full duty work, even given the caveat that Petitioner may be limited by his history of back problems. Dr. Fisher's later opinions are merely confirming. Drs. Salehi, Lami, and Fisher are orthopedic specialists and, therefore, their opinions carry more weight than a general practitioner such as Dr. Kline. The medical care subsequent to June 20, 2014 was driven by Petitioner's subjective complaints, which the Arbitrator finds questionable.

Therefore, the Arbitrator finds that Petitioner reached MMI on June 20, 2014 and no further medical treatment was warranted after this date. The prior medical care was reasonable and necessary and shall be paid by Respondent in compliance with the fees schedule in accord with §8 .2 of the Act, if not previously paid.

K: What temporary benefits are in dispute? Maintenance

The Arbitrator finds that Petitioner failed to prove that he is entitled to maintenance benefits after February 20, 2015. The Arbitrator notes that Petitioner received his regular wage beginning on February 28, 2015 and continues to receive such.

In regard to the one week of maintenance in dispute, this is denied due to Petitioner's non-compliance with vocational rehabilitation. The credible evidence in testimony by Julie Bose and Michael Wyness clearly showed Petitioner's lack of good faith efforts with vocational rehabilitation counselling. In addition, the evidence also clearly showed that Petitioner had achieved MMI at least by September 25, 2014, according to Dr. Lami.

Furthermore, the Arbitrator finds Petitioner was not credible in his testimony at trial. Petitioner's behavior during the pendency of his claim is suggestive of an effort to manipulate the workers' compensation process for his personal gains.

The Arbitrator notes that Petitioner received his regular wage beginning on February 28, 2015, which continues.

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

The Arbitrator finds that Petitioner is entitled to 8% loss of use of a Person-as-a-whole, or 40 weeks of permanent partial disability under §8(d)2 of the Act.

Petitioner was diagnosed with a herniated disc at L4-5 without neural compression and lumbosacral spondylosis and he underwent two L4-5 transforaminal epidural steroid injections. The evidence demonstrated that the L4-5 herniation was

pre-existing. Petitioner also went through physical therapy. The Arbitrator notes that Petitioner filed his Application for Adjustment, 11 WC 10704, with Respondent for his December 29, 2010 injury involving herniated discs at L4-5 and L5-S1 for which he underwent physical therapy, an MRI, and spinal injections (RX #1). There was no competent opinion offered here that Petitioner sustained a new herniated disc at L4-5. The overwhelming evidence supports the conclusion that Petitioner suffered an aggravation of his long-standing symptomatic low back, as opined by Drs. Walsh and Lami.

Based on all the evidence the Arbitrator concludes Petitioner sustained a lumbar sprain/strain on October 3, 2013 which aggravated pre-existing injuries and degenerative conditions.

The Arbitrator evaluated permanent partial disability pursuant to §8.1b of the Act:

(i) No AMA impairment rating was offered in evidence. Therefore, the Arbitrator places no weight on this factor.

(ii) Petitioner was employed as a ramp agent prior to the accident, which is in the HEAVY Physical Demand category. Petitioner returned to work full duty as a ramp agent and continues to perform his job duties. Petitioner is capable of performing his occupation as a ramp agent. The Arbitrator places great weight on this factor.

(iii) At the time of the accident Petitioner was 34 years old. Petitioner had a statistical life expectancy of 46 years and a statistical worklife expectancy of 27 years. No direct evidence was presented as to how Petitioner's age might affect his disability. The evidence showed that Petitioner had pre-existing degenerative changes and effects of prior injuries in his lumbar spine. These conditions are likely to be susceptible to aggravation, as happened to Petitioner on October 3, 2013. However, there was no evidence that the injury sustained on October 3, 2013 caused anything other than a temporary aggravation. Therefore, lesser weight is given to this factor.

(iv) Petitioner has returned to full duty work with Respondent as a result of a successful grievance decision. There is no evidence that Petitioner's earning capacity has been impaired by his back injury. Therefore, the Arbitrator gives this factor great weight.

(v) Petitioner was diagnosed with a herniated disc at L4-5 without neural compression and lumbosacral spondylosis and he underwent two L4-5 transforaminal epidural steroid injections. Petitioner also went through physical therapy. The Arbitrator notes that Petitioner filed his Application for Adjustment, 11 WC 10704, with

Respondent for his December 29, 2010 injury involving herniated discs at L4-5 and L5-S1 for which he underwent physical therapy, an MRI, and spinal injections (RX #1). There was no competent opinion offered here that Petitioner sustained a new herniated disc at L4-5. The overwhelming evidence supports the conclusion that Petitioner suffered an aggravation of his long-standing symptomatic low back, as opined by Drs. Walsh and Lami.

Based on all the evidence the Arbitrator concludes Petitioner sustained a lumbar sprain/strain on October 3, 2013 which aggravated pre-existing injuries and degenerative conditions.

As a result, based on all the evidence the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 8% loss of use of a person-as-a-whole, or 40 weeks of permanent partial disability pursuant to §8(d)2 of the Act.

M: Should penalties be imposed upon Respondent?

The Arbitrator finds that Petitioner failed to prove that he was entitled to penalties pursuant to §19(k) and §19(l) or attorneys' fees pursuant to §16 of the Act. The evidence, taken as a whole, demonstrated that genuine issues were in dispute. The evidence did not establish that Respondent was either vexatious or frivolous in disputing Petitioner's claims.

Therefore, Petitioner's Petition for Penalties is denied.

March 15, 2016

Steven J. Fruth, Arbitrator

17IWCC0171

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

REGINALD LITTLE,

Petitioner,

vs.

NO: 14 WC 007867

BACCI PIZZERIA & STATE TREASURER
AS EX-OFFICIO CUSTODIAN OF
THE INJURED WORKERS' BENEFIT FUND,

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 nature and extent, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission finds that Petitioner's injuries warrant a permanency award of 3% of Petitioner as a whole under §8(d)2 of the Act. In reducing the Arbitrator's award, we note that Petitioner is not under any formal medical care, does not take any prescription medications, and does not have any long-term effects from his injuries. In addition, all of Petitioner's imaging studies returned within normal results, and there was no evidence presented that Petitioner's injuries equated to anything beyond a soft tissue injury. Finally, Petitioner returned to the same position without restrictions.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $286.00 per week for a period of 11-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

17IWCC0171

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $286.00 per week for a period of 15 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of use of 3% of Petitioner as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the medical bills of AMCI Oak Park Medical Center for $8,666.00 and American Diagnostic MRI for $1,700.00 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.

The Illinois State Treasurer as *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 §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. 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 the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $18,000.00. 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: MAR 2 2 2017

Charles J. DeVriendt

Joshua D. Luskin

Kevin W. Lamborn

CJD/dmm
O: 3/8/17
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LITLE, REGINALD
Employee/Petitioner

Case# **14WC007867**

BACCI PIZZERIA & STATE TREASURER & EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

17IWCC0171

On 9/7/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1315 DWORKIN AND MACIARIELLO
GERALD CONNOR
134 N LASALLE ST SUITE 1515
CHICAGO, IL 60602

0000 BACCI PIZZERIA
2212 W NORTH AVE
MAYWOOD, IL 60153

0639 ASSISTANT ATTORNEY GENERAL
CHARLENE C COPELAND
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

171WCC0171

17IWCC0171

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

Reginald Little
Employee/Petitioner
v.
Bacci Pizzeria & State Treasurer & Ex-Officio-Custodian of the Injured Workers' Benefit Fund
Employer/Respondent

Case # **14 WC 7867**

An *Application for Adjustment 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 **4/22/2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

N. ☐ Is Respondent due any credit?

O. ☐ Other ____

FINDINGS

On the date of accident, **2/8/2014**, Respondent ***was*** operating under and subject to the provisions of the Act.
On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

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

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

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

In the year preceding the injury, Petitioner earned **$18,720.00**; the average weekly wage was **$360.00**.

On the date of accident, Petitioner was **30** 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 §8(j) of the Act.

ORDER

Respondent shall pay Petitioner and Petitioner's Attorneys all reasonable and necessary medical services pursuant to the Illinois Fee Schedule, as provided in Section 8(a) of the Act, including the medical bills of **AMCI Oak Park Medical Center for $8,666.00** and **American Diagnostic MRI for $1,700.00**.

Respondent shall pay Petitioner permanent partial disability benefits of **$286.00/week** for **30** weeks, because the injuries sustained **6%** loss of use of a person-as-a-whole, as provided in § 8(d)2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits from **2/9/2014 to 5/1/2014**, or **11 & 5/7** weeks, at a rate of **$286.00/week**.

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.

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 §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 §4(d) and §5(b) of the 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

September 7, 2016
Date

SEP - 7 2016

Reginald Little v. Bacci Pizzeria & State Treasurer & Ex-Officio-Custodian of the Injured Workers' Benefit Fund
14 WC 07867

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?

Petitioner was the only witness to testify at arbitration.

STATEMENT OF FACTS

Respondent Bacci Pizzeria did not carry Workers' Compensation Insurance on the date of the accident as confirmed by NCCI documentation (PX #1). Respondent Bacci Pizzeria was given due and proper notice of the hearing date of April 22, 2016 (PX #8).

Petitioner testified that he was an employee of Respondent Bacci Pizzeria on February 8, 2014. Bacci Pizzeria is an Illinois restaurant with about twenty-five employees. Petitioner was paid weekly by Bacci Pizzeria to perform certain services. A contract for a Workers' Compensation Settlement between Petitioner and Respondent for a date of accident of May 6, 2014 was entered into evidence as evidence of an employer-employee relationship and that Respondent was operating under the Act in 2014 (PX #7). Petitioner has only a high school education.

On February 8, 2014 Petitioner was carrying a pan of butter on a flight of stairs at work when he tripped and fell down the stairs. Petitioner felt pain to his back, neck, hand, head, and shoulder.

Petitioner testified that he notified his manager, Dominic, orally right after the accident. An Application of Adjustment was filed with the Workers' Compensation Commission within forty five days of the accident (PX #6).

Petitioner testified that he earned $360.00 per week and was single with two dependents under 18. A Workers' Compensation lump sum settlement contract with Respondent for the May 6, 2014 accident corroborated this testimony (PX #7).

Petitioner presented to Loyola University Medical Center on February 9, 2014 (PX #2). Petitioner reported that he fell down stairs the day before. He complained of head pain, back pain, neck pain, and shoulder pain. X-rays were obtained, which were negative for fracture. A CT of the head did not show any abnormality. Petitioner was ordered off work until February 11, 2014, when he could return to work with restrictions. Petitioner was advised to follow up with his primary care provider.

Petitioner testified that when his symptoms persisted, he consulted Dr. Foreman at AMCI Oak Park Medical Center on February 11, 2014 (PX #3). AMCI records (PX #3) indicate Petitioner was seen by Schweta Kasbekar on February 11. It was noted that Petitioner reported that he was on duty as a pizza-maker for Bacci's Pizzeria, when he slipped on some stairs while carrying down a pan of butter. He twisted his body before hitting the left side of his head, left shoulder, and low back against cement steps. He reported a brief loss of consciousness. Petitioner complained of 8-9/10 pain.

Petitioner was diagnosed with concussion, cervical sprain, thoracic sprain, lumbar sprain, shoulder sprain, cervical radiculopathy, and hand sprain. Petitioner began a regular course of treatment and therapy 3-4 days per week provided by Schweta Kasbekar, Jared Thomure, Stephanie Martinez, and Cindy Mui. Petitioner was to remain off work until revaluation by Dr. Foreman on February 12.

Petitioner followed up with Dr. Foreman on February 12, 2014. An MRI of the left shoulder was ordered. Petitioner was advised to remain off work until reevaluation on March 6.

The left shoulder MRI, done February 18, 2014, was unremarkable (PX #4).

On March 6, 2014 Petitioner was reevaluated by Dr. Foreman (PX #3). Petitioner complained of continued headaches and occasional dizziness. The cervical and lumbar spines were painful to movement. The left shoulder was also painful. Dr. Foremen's diagnoses were the same. Petitioner was advised to where an arm sling and wrist brace, and advised to remain off work until reevaluation. Petitioner continued to receive therapy throughout February and March and one session of work conditioning in April.

On May 1, 2014 Dr. Foreman released Petitioner to regular work duties on May 1 (PX #3).

Petitioner now works at another pizzeria. Petitioner testified that he still has some pain in his back, neck, and shoulder.

CONCLUSIONS OF LAW

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

The Arbitrator finds that evidence showing that Respondent Bacci Pizzeria was operating under the Illinois Workers' Compensation Act was unrebutted. Petitioner proved that Respondent Bacci Pizzeria was operating under the Act at the time of the accident.

B: Was there an employee-employer relationship?

The Arbitrator finds that evidence showing that an employee-employer relationship existed between Petitioner and Respondent Bacci Pizzeria was unrebutted. Petitioner proved that an employee-employer relationship existed at the time of the accident.

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

The Arbitrator finds that evidence established that the accident arose out of and in the course of Petitioner's employment. There was no evidence rebutting Petitioner's evidence of the accident arising out of and in the course of Petitioner's employment.

D: What was the date of the accident?

The Arbitrator finds the date of the accident was February 8, 2014

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

The Arbitrator finds that Petitioner proved he gave timely notice of the accident to Respondent Bacci Pizzeria. There was no evidence to the contrary.

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

The Arbitrator finds that Petitioner proved that his current condition of ill-being is causally related to his workplace accident on February 8, 2014. He sought medical care the next day at Loyola University Medical Center with complaints of pain in his head, neck, left shoulder, and back. He followed up at AMCI Oak Park Medical Center on February 11, 2014, where he was diagnosed with concussion, cervical sprain, thoracic sprain, lumbar sprain, shoulder sprain, cervical radiculopathy, and hand sprain. He was treated with physical therapy supervised by Dr. Michael Foreman until discharge on May 1, 2014. Dr. Foreman noted that Petitioner's injuries were related to his work accident. This is cooborated by the circumstantial evidence of the chain of events between the accident and the beginning of medical care.

Petitioner was taken off work throughout that time. He testified that he still has some pain to the back, neck, and shoulder.

G: What were Petitioner's earnings?

The Arbitrator finds that Petitioner's earned $360.00 per week.

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

Petitioner was 30 years old at the time of the accident.

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

Petitioner was single with two dependents under the age of 18 at the time of the accident.

J: Were 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 care and therapy he received at Loyola University Medical Center and at AMCI Oak Park Medical Center was reasonable and necessary to cure or relieve the effects of the injuries he sustained at work on February 8, 2014. The evidence within Petitioner's medical records was unrebutted.

Accordingly Respondents shall pay, adjusted in accord with the fee schedule provided in §8.2 of the Act, $8,660.00 to AMCI Oak Park Medical Center and $1,700.00 to American Diagnostic MRI, as provided by §8(a) of the Act.

K: What temporary benefits are in dispute? TTD

On February 9, 2014 Petitioner was ordered off work until February 11 by medical staff at Loyola Medical Center. On February 11, 2014 medical staff at AMCI Oak Park Medical Center on February 11, 2014 ordered Petitioner to remain off work until revaluation with Dr. Foreman on February 12. On February 12, 2014 Petitioner was advised to remain off work until reevaluation on March 6. On March 6, 2014 Petitioner was advised to remain off work until reevaluation. Dr. Foreman released Petitioner to regular work duties on May 1, 2014.

The Arbitrator finds that Petitioner is entitled to total temporary disability benefits from February 8 through May 1, 2014, 11 & 5/7 weeks at the statutory minimum rate of $286.00/week.

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

The Arbitrator evaluated Petitioner's permanent partial disability in accord with §8.1b(b) of the Act:

(i) No AMA impairment rating was admitted in evidence. The Arbitrator cannot give any weight to this factor.

(ii) Petitioner was employed as a pizza maker at the time of his accident. Petitioner currently works as a pizza-maker for another employer. Petitioner has only a high school education and has had limited job experience. Petitioner is dependent on his physical well-being to earn a living. Because Petitioner was able to return to the same occupation as before the Arbitrator gives moderate weight to this factor.

(iii) Petitioner was 30 years old at the time of his accident. He has a statistical life expectancy of 50 years and a statistical worklife expectancy of 29 years. The Arbitrator notes that Petitioner sustained sprains and strains and that radiology studies were unremarkable. The Arbitrator notes that younger persons readily recover from such injuries with little or no continuing problems. The Arbitrator therefore gives little weight to this factor.

(iv) There was no evidence that Petitioner's earning capacity was affected by his injuries. He was able to find new work as a pizza maker after his release from medical care. The Arbitrator gives no weight to this factor.

(v) Petitioner was diagnosed with soft tissue sprains and strains. Radiology studies were unremarkable. He responded to medical care and therapy to the point where he could return to work as a pizza maker. The Arbitrator gives moderate weight to this factor.

In light of all the evidence the Arbitrator concludes that Petitioner sustained a permanent partial disability of 6% loss of a person-as-a-whole, 30 weeks.

Steven J. Fruth, Arbitrator

September 7, 2016

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kerry Beavers,
Petitioner,

vs.

NO: 14 WC 9707

17IWCC0133

Marion Castellano and
Injured Workers Benefit Fund,
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 employer/employee relationship, accident, notice, benefit rate, medical expenses, permanency and non-insured status and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission notes that the following people were in attendance at the April 13, 2016 Arbitration Hearing: Petitioner and an attorney from the Attorney General's Office as the representative of the Injured Workers' Benefit Fund. Respondent, Marion Casetellano, did not appear at the Arbitration Hearing.

Petitioner's testimony was the sole evidence used to support that the fact that Respondent/Marion Castellano's business was subject to the Illinois Workers' Compensation Act. Without anything more, Petitioner's testimony stood unrebutted that Respondent/Marion Castellano's business is subject to Section 3 of the Illinois Workers' Compensation Act.

Unlike the prior issue, there is additional evidence beyond Petitioner's testimony that addresses the issue of Petitioner's credibility in general and as it relates to the alleged January 25, 2014 work accident. The Commission finds that the Arbitrator correctly found that the

17IWCC0133

medical evidence supports a finding that Petitioner is not credible. More specifically, Petitioner's contemporaneous medical records indicate that Petitioner reported no history that his accident occurred while at work. In addition, he indicated that this was not a workers compensation claim, that he had no employer and that he was a self-employed roofer. Furthermore, he stated he was unemployed and his insurer carrier was listed as Illinois Medicaid. Lastly, the surgery records indicate Petitioner had scar tissue in his left foot even though Petitioner reported he had no prior injuries to his left foot. All of this evidence impeached and/or undermined Petitioner's testimony as to his work status and why he did not report the alleged work accident. Pursuant to Shell Oil v. Industrial Commission 2 Ill.2d 590 (1954), the Commission affirms the Arbitrator's finding that Petitioner is not credible. In so finding that Petitioner is not credible, the Commission further finds that it need to address the underlying issues in this case.

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment on January 25, 2014, his claim for compensation is hereby denied.

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

DATED: MAR 3 - 2017

MB/jm

O: 2/9/17

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Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BEAVES, KERRY
Employee/Petitioner

Case# **14WC009707**

17IWCC0133

MARION CASTELLANO AND DAN RUTHERFORD AS THE ILLINOIS STATE TREASURER AS EX-OFFICIO OF THE ILLINOIS INJURED WORKERS' BENEFIT FUND A/K/A IWBF
Employer/Respondent

On 7/15/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

2333 WOODRUFF JOHNSON & PALERMO
DEXTER EVANS
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

0000 MARION CASTELLO
1613 YOST AVE
MARION, IL 62959

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

17IWCC0133

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

- [x] Injured 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

KERRY BEAVERS
Employee/Petitioner

v.

MARION CASTELLANO and Dan Rutherford, as the Illinois State Treasurer as Ex-Officio Custodian of the ILLINOIS INJURED WORKERS' BENEFIT FUND a/k/a IWBF
Employer/Respondent

Case # **14** WC **9707**

Consolidated cases: _____

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

DISPUTED ISSUES

A. [x] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [x] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [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. [ ] 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. [x] Other **Respondent Marion Castellano's Non-Insured Status**

FINDINGS

On **January 25, 2014**, Respondent ***was not*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent.

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

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

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

In the year preceding the injury, Petitioner earned **$0**; the average weekly wage was **$0**.

On the date of accident, Petitioner was **50** 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

As explained in the Arbitration Decision, Petitioner failed to prove by a preponderance of the evidence that Respondent Marion Castellano was operating a business of any kind that would subject him to the Illinois Workers' Compensation Act. Petitioner further failed to prove by a preponderance of the evidence that an employer-employee relationship existed between Respondent and himself. All benefits are denied.

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

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

Signature of Arbitrator

July 10, 2016
Date

JUL 15 2016

17IWCC0133

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

KERRY BEAVERS
Employee/Petitioner

v. Case #: 14 WC 9707

MARION CASTELLANO and Dan Rutherford,
As the Illinois State Treasurer as Ex-Officio Custodian of the
ILLINOIS INJURED WORKERS' BENEFIT FUND a/k/a IWBF
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

This matter proceeded to trial without the presence of the purported employer Marion Castellano. Mr. Castellano was given proper notice of the hearing, as evidenced by Petitioner's Exhibit 6, and did not appear personally or through counsel. The Injured Workers' Benefit Fund was present through counsel.

Petitioner testified Respondent Castellano was a friend of his girlfriend's, was looking for someone to work for him, and called Petitioner. Petitioner testified Mr. Castellano built houses and on this particular project he was adding a room onto an existing house. He testified Mr. Castellano had a shop where he fabricated houses, and then moved them to sites. Prior to being hired, Mr. Castellano called Petitioner to discuss his knowledge of building and his pay. He testified Mr. Castellano wanted him to frame the walls and trusses and decking of the addition to the house, and that he had been doing this kind of work since he was 20 years old. The house in question had previously been built by Mr. Castellano, and the current project was the addition of a room over the storm cellar. Petitioner testified he was to be paid $15 per hour and was to work at least five days per week, eight hours per day. Petitioner testified that Mr. Castellano told him he wanted him to continue working for him after this project was done, on other new homes he was planning to build.

Petitioner testified he began working for Respondent Castellano on December 30, 2013. Mr. Castellano picked him up every day and took him to the jobsite around 8:00 a.m. and drove him home at the end of the workday around 4:00 p.m. Petitioner testified Mr. Castellano told him each day what he wanted done and how, and that he never told him it was up him how to do things. He gave specific instructions on how he should be performing work. Petitioner testified

Mr. Castellano provided ladders, extension cords, framing squares, and all the building materials. Petitioner provided his own skill saw, screw gun, and hammer.

Petitioner testified he worked eight hours each day on December 30 and 31, 2013, and was paid $240 cash for the two days. He testified he worked for Mr. Castellano from January 1, 2014, through January 25, 2014, when the weather allowed, for a total of 50 hours. He testified Mr. Castellano paid him $600 by check and that he still owed him another $150 for the 50 hours worked in January 2014. He was not aware of Mr. Castellano taking taxes out of the check.

Petitioner testified Respondent Castellano was present at the work site while he worked, but usually sat in his car or was inside the house talking to the owner. He testified Mr. Castellano gave him instruction on what to do every day and how to do it, and supervised him from time to time. Petitioner testified he did not believe he could stray from what he was told, or do things the way he wanted. Mr. Castellano decided when the lunch breaks were and usually brought lunch to the job site, for a 30 minute break. Petitioner testified he was not able to decide on his own that he was done for the day and leave the project, and that he would get fired if he did so. He was not allowed to set his own hours in any way, and Mr. Castellano always determined what hours he was working. Petitioner testified Respondent Castellano would call him the night before or that morning and tell him when he was going to pick him up.

As part of his work for Respondent Castellano at the Marion job site, Petitioner testified he framed the walls for the doors and windows and bolted them to the floor, put plywood on the walls, and built the trusses. Petitioner testified he had to build the trusses several different times because Mr. Castellano's original figures did not work out and he was instructed to make changes. He then put the decking on, which he described as the material the roof is nailed to, like plywood. He then put the nose boards on and started felting the roof. Petitioner testified Mr. Castellano provided all of the materials used at the Marion job site, which included 2x4s, 2x6s, 2x8s, plywood felt, and concrete anchor bolts, and that he did not provide any materials.

Petitioner testified that on January 25, 2014, Respondent Castellano picked him up at 11:00 and drove him to the Marion job site. Mr. Castellano instructed him to get the roof felted that day, so that it could be shingled before the bad weather moved in. Petitioner testified he was carrying felt up to the roof on a ladder and was even with the bottom of the roof when the wind blew the ladder and him and he fell about eight feet to the ground. The roll of felt landed on top of him. After the fall his left foot hurt and he could not put pressure on the foot. Petitioner did not know if Mr. Castellano saw him fall, but he did tell him what happened. He testified that Respondent Castellano helped him to the car and drove him several places to see a doctor, but every place was closed since it was a Saturday. He testified Mr. Castellano's son-in-law was a chiropractor, and that he took Petitioner to his home. He informed Petitioner that he believed his foot was broken. Respondent Castellano told Petitioner if it was still hurting on Monday he would take him to the hospital, but he did not want to take him to the hospital at that time, as it cost too much.

Petitioner testified Respondent Castellano did in fact take him to Marion Diagnostic Center Monday morning. He was told he needed to see a specialist, and he went to The Orthopedic Institute and was treated by Dr. Stephen Young. He testified that he completed an

intake sheet, on which he marked that it was not a worker's compensation claim. He testified he did so because it was his understanding that Respondent Castellano did not have worker's compensation insurance, and that he didn't think it would be a worker's compensation claim.

Petitioner testified he eventually underwent surgery on February 18, 2014, and had pins and screws placed in his left foot. He had a second procedure done on May 16, 2014, to remove the pins and screws. During his recovery he wore a boot for three months and was in pain. He testified Dr. Young wanted him to do physical therapy but he did not do so, as his girlfriend became ill and he had to take care of their grandchild. He last saw Dr. Young on June 20, 2014, and has not had any treatment since then.

With regard to current complaints, Petitioner testified he has a constant aching pain in his left foot. If he walks or stands for too long his foot swells and turns black and blue. He has trouble walking, it is painful, and he walks with a limp. He testified he did not return to work for Respondent Castellano and has not worked since the accident because he cannot be on his foot for long periods of time and cannot climb a ladder. He has looked for work, but his limitations have prevented him from being hired. Petitioner testified he can no longer participate in his hobbies of hiking, golfing, and playing basketball. If he is on his feet for three to four hours he has a lot of pain in his left foot.

On cross-examination, Petitioner testified that he was paid cash by Respondent Castellano for the first two days he worked, that he was not aware of any taxes taken out, and that he did not receive any kind of pay stub for the payment. He was paid by a check for $600 but did not recall if it was out of Mr. Castellano's business or personal account, and he did not have the cancelled check at trial. He acknowledged that he had no documentation showing he was employed by Respondent Castellano. He confirmed that Mr. Castellano provided all building materials, but that he provided his own skill saw, hammer, and screw gun.

Petitioner conceded that Mr. Castellano picked him up and drove him to the job site because he did not drive at that time, nor does he currently drive. As such, that was the most convenient way for him to get to the job site. He acknowledged that since Mr. Castellano was driving, he set the hours, and Petitioner worked the hours that Mr. Castellano worked. Petitioner acknowledged that the hours worked per week varied, depending on the weather, that during the month of January 2014 he only worked a total of 50 hours, and that there were multiple weeks where he did not work a full week. He testified he did not have any other jobs or projects he was working on during that time, but if he had been offered a job with more hours he probably would have taken it.

Petitioner reviewed the Patient Intake Form he completed at The Orthopedic Center and acknowledged it was his handwriting and his signature. He acknowledged that he indicated this was not a worker's compensation claim. He conceded that he wrote that he was a "roofer" for occupation and that he responded "none" for employer. He denied, however, that he actually was a self-employer roofer at that time and denied ever having been a self-employed roofer.

Petitioner testified he last saw Dr. Young on June 20, 2014, that he did not do the physical therapy that Dr. Young recommended, and that he never followed up with Dr. Young

regarding any complaints. He acknowledged that Dr. Young did not give him any work restrictions when he last saw him. Petitioner testified he has two braces for his foot, which were not prescribed by any doctor, but he cannot wear shoes when he has it on. He testified he had tried to find another job but conceded he did not have any documentation at trial showing any of the job searches he had performed.

Following his accident, Petitioner presented for treatment to the walk-in clinic at Marion Diagnostic Center on January 27, 2014. He reported he had fallen off a ladder two days prior and had pain across the top of his left foot. It was noted there was swelling and bruising. Left foot x-rays were taken which showed a Lisfranc type fracture and dislocation of the second, third, fourth, and fifth metatarsals which appeared laterally displaced relative to the tarsal bones. There were longitudinal fractures along the base of the second metatarsal and other fractures were suspected. He was put into a boot and referred to Dr. Young, an orthopedist. PX1.

On January 29, 2014, Petitioner presented to Dr. Steven Young of The Orthopaedic Institute of Southern Illinois. He completed an intake form and reported he had fallen off a ladder on January 25, 2014, and injured his left foot. He listed his occupation as "roofer" and listed his employer as "none". Dr. Young noted Petitioner stated he was on a ladder when the wind blew and blew him over on the ladder, injuring his left foot. He fell on his left foot and felt severe pain. It was noted he had been seen at Marion Walk-In Clinic and x-rays found a Lisfranc injury. He rated his pain at 10/10. Dr. Young noted Petitioner was currently self-employed as a roofer. On examination, Petitioner had severe swelling of the left foot, severe tenderness on palpation of the midfoot, and was unable to weight bear. Dr. Young's assessment was left foot Lisfranc injury and he advised Petitioner it was a surgical issue. He was placed on the surgery schedule for an open reduction internal fixation. Dr. Young advised Petitioner that the injury and/or surgery would more than likely affect his gait even after he healed. PX2.

On February 3, 2014, a Nurse's Note to the file stated that the hospital billing office called and stated Petitioner's surgery would be on hold until further notice. They were attempting to obtain information from IDPA for coverage and would call with an answer as soon as possible. On February 5, 2014, a Nurse's Note to the file stated the hospital was waiting for a letter with proof of application for IDPA from the DHS department. The Note indicated Petitioner was contacted that morning, was not aware he needed the letter, and that he would go to the DHS office that day to obtain the letter for the hospital. PX2.

On February 18, 2014, Petitioner underwent open reduction and internal fixation of left foot Lisfranc fracture dislocation by Dr. Young. It was noted the metatarsals were substantially displaced at the tarsometatarsal articulation of all joints one through five. The Arbitrator notes that the admission cover sheet from Heartland Regional Medical Center lists Petitioner's occupation as "unemployed", and the Payor as "Illinois Medicaid". PX2, PX3.

Petitioner followed up with Dr. Young on March 5, 2014. Sutures were removed and it was noted that the incision site was healing well. X-rays showed pins and screws were in good placement. Petitioner was to remain nonweightbearing and return in one month. He returned to Dr. Young on April 3, 2014, and reported he was doing well. His pain was well controlled and he remained nonweightbearing in a fracture boot. It was noted the incision had healed nicely,

there was no erythema or drainage, and light touch sensation was intact. X-rays showed the hardware remained in good placement. Petitioner was to remain nonweightbearing. PX2.

On May 7, 2014, Petitioner followed up with Dr. Young, at which time he recommended removal of the pins. Petitioner underwent the surgical removal of the hardware on May 16, 2014. He followed up with Dr. Young on May 29, 2014. Sutures were removed and it was noted his wounds had healed nicely. X-rays showed overall good alignment as well as a substantial amount of disuse osteopenia. Petitioner was allowed to start weightbearing with a postop shoe, going from two crutches to one crutch to no crutches. PX2.

On June 20, 2014, Petitioner returned to Dr. Young. X-rays showed the fracture appeared to be healed and the joint spaced looked good and had not moved. Dr. Young recommended Petitioner start therapy and was told he could weightbear as tolerated. He was to follow up in one month or sooner if he was having issues. PX2. The Arbitrator notes this is the last record from Dr. Young, which is consistent with Petitioner's testimony.

Petitioner submitted into evidence a Certification from the National Council on Compensation Insurance (NCCI), which stated that they had no record of policy information showing that Respondent Marion Castellano had any worker's compensation insurance from the period of January 1, 2014, to July 23, 2014. PX5.

Petitioner also submitted into evidence a copy of a letter sent to Marion Castellano on January 13, 2016, via Federal Express and U.S. Mail. The letter stated that the worker's compensation claim brought against him by Petitioner was scheduled for a date certain trial on April 13, 2016. It further advised Mr. Castellano that his appearance was necessary on that date but that if he chose not to appear the case would proceed to trial on that date. Included in this exhibit was a FedEx shipping label, but the label does not appear to include any documentation of receipt by Mr. Castellano. PX6.

CONCLUSIONS OF LAW

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

In support of the Arbitrator's decision relating to issue (A), whether Respondent was operating under and subject to the Illinois Workers' Compensation Act, and issue (B), whether there was an employer-employee relationship, the Arbitrator finds the following:

A claimant has the burden of proving by a preponderance of the credible evidence all elements of the claim, including that any alleged state of ill-being was caused by a workplace accident. *Parro v. Industrial Commission*, 260 Ill. App.3d 551, 553 (1st Dist. 1994). Liability cannot be premised upon imagination, speculation, or conjecture, but must arise from facts established by a preponderance of the evidence. *Illinois Bell Tel. Co. v. Industrial Comm'n*, 265 Ill.App.3d 681, 685 (1st Dist. 1994).

Uncorroborated testimony will support an award for benefits only if a consideration of all the facts and circumstances support that decision. *Gallentine v. Industrial Comm'n*, 201 Ill.App.3d 880, 888 (2nd Dist. 1990); (citing *Caterpillar Tractor Co. v. Industrial Comm'n*, 83 Ill.2d 213 (1980)).

Petitioner failed to prove by a preponderance of the evidence that Respondent Marion Castellano was operating a business of any kind that would subject him to the Act. Petitioner further failed to prove by a preponderance of the evidence that an employer-employee relationship existed between Respondent and himself.

In so concluding, the Arbitrator finds significant that Petitioner provided no evidence of any kind which corroborated his testimony at trial, which would establish that Mr. Castellano operated a business or trade or that he was employed by Mr. Castellano. There were a number of ways to provide such evidence, such as an advertisement for services by Mr. Castellano, or a copy of his contractor license, or testimony from his customers. Of note, Petitioner testified as to the location of the alleged accident and that Mr. Castellano had actually built the house. The homeowner, however, was not called as a witness to corroborate any of Petitioner's testimony. Petitioner testified he found out about the job with Mr. Castellano because his girlfriend was friends with Mr. Castellano. His girlfriend, however, was not called as a witness to corroborate any of his testimony. The Certification from NCCI as to the lack of worker's compensation insurance for Mr. Castellano is not dispositive, as it presumes that Mr. Castellano had a business for which he would need to provide such insurance. Petitioner provided no evidence other than his own testimony that Respondent Marion Castellano operated a building company. As such, he did not prove by a preponderance of the evidence that Respondent Castellano was operating under and subject to the Act.

Further, Petitioner failed to prove by a preponderance of the evidence that an employer-employee relationship existed with Respondent Castellano. In so concluding, the Arbitrator again finds significant the lack of any corroborating evidence of such a relationship. Petitioner relied exclusively upon his own testimony to establish this relationship, and the Arbitrator is not persuaded. The medical records, in fact, directly contradict Petitioner's testimony with regard to his purported employment by Mr. Castellano.

Petitioner completed an intake form by hand at his initial evaluation with Dr. Young on January 29, 2014. He wrote he was injured when he fell off a ladder, which is consistent with all of the medical records and his testimony. However, he circled "no" to the question of whether this was a workman's compensation claim. He wrote that his occupation was "roofer", and for employer he wrote "none". Dr. Young's report of that same date reflects that he took a history from Petitioner and that Petitioner reported he was on a ladder when the wind blew him and the ladder over. There is no indication whatsoever that this occurred on any job site. Dr. Young also noted Petitioner "is currently self-employed as a roofer".

In addition, Petitioner underwent surgery on February 18, 2014, at Heartland Regional Medical Center. The first page of their records is Petitioner's personal information. In the section for Employer Address, it was noted "Unemployed" and the occupation was listed as "unemployed".

The Arbitrator recognizes that Petitioner's testimony was that he did not report this as a work accident because he did not believe Respondent Castellano had worker's compensation insurance. However, the Arbitrator is not persuaded by Petitioner's testimony, which was self-serving and uncorroborated by any other evidence. It was, in fact, contradicted by his statements to his medical providers made contemporaneous with his treatment. Further, the Arbitrator notes that even though Petitioner was consistent in reporting that he was hurt when he fell off a ladder, he at no time indicated this occurred while he was doing any kind of work, even in his capacity as a "self-employed roofer". Without such information, one could just as easily conclude that Petitioner was on a ladder to take down his Christmas decorations or to clean snow off of his roof or to reattach a gutter that had come loose in a storm. The Arbitrator simply cannot speculate as to these details and is not persuaded by Petitioner's uncorroborated and self-serving testimony.

Petitioner has failed to prove by a preponderance of the evidence that Respondent Marion Castellano was operating under and subject to the Act, and that an employer-employee relationship existed with Mr. Castellano. All benefits are denied. All other issues are moot and the Arbitrator makes no conclusions with regard to those issues.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kelly Joiner,
Petitioner,

17IWCC0163

vs.

NO: 14 WC 14685

City of Chicago,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 30, 2016, is hereby affirmed and adopted.

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

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

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

DATED: MAR 21 2017
o3/8/17
KWL/rm
046

Kevin W. Lamborn

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0163

JOINER, KELLY
Employee/Petitioner

Case# 14WC014685

07WC041419

CITY OF CHICAGO
Employer/Respondent

On 3/30/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0704 MARTAY LAW OFFICE
WILLIAM H MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
DANIEL WELLNER
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

17IWCC0163

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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

Kelly Joiner
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **14** WC **14685**

Consolidated cases: **07 WC41419**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **2/19/2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0163

FINDINGS

On **4/16/14**, 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 **$76,596**; the average weekly wage was $1,473.00

On the date of accident, Petitioner was **45** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$15,996.32** for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of **$15,996.32**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $982/week for 62&5/7 weeks, commencing 4/17/14 through 6/20/15, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $15,996.32 for benefits paid to Petitioner.

Respondent shall pay to Petitioner $13,577.30 for medical services incurred shown in Petitioner's Group Exhibit 1, pursuant to Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for any medical services paid.

Respondent shall pay Petitioner permanent partial disability benefits of $721.66/week for 20 weeks, because the injuries sustained caused the 4% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

FINDINGS OF FACT

Petitioner was employed as a labor for Respondent on April 16, 2014 and was using a rake to grade concrete. While pulling the rake, she felt pain in her low back with pain shooting into her leg. She sought treatment at MercyWorks on the date of injury. She reported to MercyWorks that she experienced sharp pain in her lower back shooting down her legs and right hip pain. A physical examination of the hip and back was performed and she was diagnosed with low back and right hip pain. She was treated with pain medications and taken off work. It was noted that Petitioner wanted to treat with Dr. King, who she presented to on May 24, 2014. It appears that he was provided Petitioner with medications. In a form apparently completed and signed by Petitioner, she indicated "N/A" for a series of symptoms including "back/joint pain". Tr. pp. 22-23; PX9 & 11.

Petitioner also came under the care of a chiropractor, Dr. Kopsian. On April 25, 2014, Petitioner described symptoms of aching, numbness and tingling in her neck bilaterally, sharp and aching pains in her mid-back and pain in the low back. Petitioner described the pains as "similar to the prior injury". She mentioned that she was asymptomatic prior to the April 16, 2014 injury. Dr. Kopsian performed a physical examination and diagnosed Petitioner as having cervicalgia, thoracalgia, lumbalgia and radiculitis/neuritis. Dr. Kopsian began a course of treatment including ultrasound and electrical muscle stimulation. He recommended a pain management specialist and physical therapy for further evaluation and treatment. PX10.

On April 28, 2014, Petitioner presented to Dr. Neeraj Jain, referred by Dr. Diadula of MercyWorks, complaining of constant neck and back pain. She was diagnosed with "lumbar discogenic pain, lumbar facet syndrome and lumbosacral radiculopathy; cervical discogenic pain, cervical facet syndrome and cervical radiculopathy." She referenced her 2007 injury and provided a history of feeling a pop in her back while pushing a bucket. She also reported an immediate on-set of neck and upper extremity pain, in addition to low back pain. The Arbitrator notes that there does not appear to be a report of immediate neck pain. It was his "opinion that the patient's symptoms for which she is being seen today are directly related to the injury" and "that the treatment rendered this far has been reasonable and of necessary frequency and duration... based on patient's history, physical exam, imaging studies, and medical records that I have been provided and reviewed thus far" Dr. Jain also stated that "It is my opinion to a reasonable degree of medical certainty that the patient did have an underlying degenerative condition that was silent and asymptomatic, commensurate with her age and not likely to be symptomatic over her lifetime or in need of treatment. As a result of the injury the condition was rendered symptomatic and in need of the treatment that was recommended or rendered by acceleration, precipitation, or aggravation of the asymptomatic condition. Delay in authorization adversely affects outcome both in terms of habituation of medication, psychology decline and affliction. It also decreases likelihood of functional return to work and symptom resolution". He continued her off work and prescribed "Flexeril, Mobic, tramadol and Protonix". PX1, pp. 3-5.

Petitioner returned to Dr. Jain in June, 2014. He noted that Petitioner had a lumbar MRI scan which showed "2mm neural foraminal disk bulging with moderate bilateral neural foraminal stenosis exacerbated by mild facet hypertrophy at L3-4; and a broad-based 2mm annular bulge with mild neural foraminal stenosis exacerbated by facet hypertrophy at L4-5. A cervical MRI scan showed some pre-existing asymptomatic facet arthropathy, but no acute changes. It appears the petitioner had an appointment scheduled with a neurologist. Dr. Jain recommended bilateral L3-4 and L4-5 transforaminal epidural steroid injections and selective nerve blocks. He also recommended cervical facet injections at C3-4, C4-5 and C5-6. These injections were performed in the summer of 2014. PX12.

On July 24, 2014, Petitioner was seen by Dr. Jesse Butler, at the request of the Respondent, for an independent medical evaluation ("IME"). Dr. Butler reviewed medical records from her prior injury and medical records following the April 2014 injury. Petitioner provided a history of her April 16, 2014 injury. He performed a physical examination and found that Petitioner had some mild tenderness. Straight leg raising was negative. He reviewed the lumbar scan of May 28, 2014 and found it to be normal. There were no disc herniations, stenosis, annular tears or bulging. RX4.

Dr. Butler concluded that Petitioner had a minor lumbar strain with chronic non-objective pain disorder. He noted that Petitioner had a normal MRI; and that there did not appear to be any relationship between the prior injury from 2007, other than prolonged deconditioning that would have occurred from being out of work for seven years before returning as a concrete grater. He did not agree that her treatment was reasonable or necessary; and opined that she did not need any further treatment and could return to work without restrictions.

On August 18, 2014, Dr. Graf examined Petitioner at the request of Respondent. He noted that she complained of right hip, groin and back pain and neck pain, which was not constant. Dr. Graf performed a thorough physical examination and reviewed medical records. He noted Petitioner had pain out of proportion with the evaluation and multiple inconsistencies under evaluation. He could not really comment in detail on the case because he had no imaging, such as the MRI scan. RX3.

On October 29, 2014, Petitioner was seen by Dr. Freedburg at Suburban Orthopedics, complaining of neck, back and right hip pain. She testified that she had been referred to this doctor, by a friend. On written forms, Petitioner indicated that she was injured while grating concrete. Dr. Freedburg took a physical examination, x-rays and noted positive findings. He diagnosed Petitioner as having lumbar neuritis, radiculitis and cervical radiculitis. He also diagnosed her with right hip pain. He recommended medication, a home exercise program and physical therapy; and he took her off work. He also specifically disagreed with Dr. Butler's IME findings.

Petitioner returned to Dr. Freedburg on December 17, 2014. Petitioner indicated that she no major change. She was complaining of sharp pain radiating bilaterally into her legs. Dr. Freedburg indicated that he wanted to review her old medical records. He causally related Petitioner's condition to her work injury and continued her off work status. PX13.

Petitioner remained off work for the period of April 17, 2014 to June 30, 2015 and returned to work for Respondent on July 1, 2015. She worked full time and full duty as a laborer in the same position she had prior to the injury. She had a raise based upon the union contract. She was laid off as a seasonal employee on December 15, 2015. She collected unemployment benefits and has actively reapplied with the respondent for any position available. She is no longer under active medical care and could not recall when she last sought treatment. Currently, Petitioner takes over-the-counter pain medication and denies having new injuries since August 2014. Petitioner testified that she performs home exercises and stretches and has to be careful when bending. Tr. pp. 26-40.

CONCLUSIONS OF LAW

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

A claimant has the burden of proving, by a preponderance of the evidence, all of the elements of her claim. It is the function of the Commission to judge the credibility of the witnesses and resolve conflicts in medical evidence. *See, O'Dette v. Industrial Commission,* 79 Ill. 2d. 249, 253, 403 N.E.2d 221, 223 (1980). In deciding questions of fact, it is the function of the Commission to resolve conflicting medical evidence, judge the credibility of the witnesses and assign weight to the witnesses' testimony. *See,* R&D *Thiel,* 398 Ill. App.3d at 868; *See also, Hosteny v. Workers' Compensation Commission,* 397 Ill. App. 3d 665, 674 (2009).

For an employee's workplace injury to be compensable under the Workers' compensation Act, she must establish the fact that the injury is due to a cause connected with the employment such that it arose out of said employment. See, *Hansel & Gretel Day Care Center v. Industrial Commission,* 215 Ill. App.3d. 284, 574 N.E.2d 1244 (1991). It is not enough that Petitioner is working when accident injuries are realized; Petitioner must show that the injury was due to some cause connected with employment. See, *Board of Trustees of the University of Illinois v. Industrial Commission,* 44 Ill. 2d 207 at 214, 254 N.E.2d 522 (1969).

Proof of prior good health and change immediately following and continuing after an injury, may establish that an impaired condition was due to the injury. *Hopkins v. WSNS Telemundo,* 02 IIC 0946, 99 W.C. 42128 (2002). In determining that an employee was entitled to compensation for aggravation of a pre-existing injury in *Hopkins,* the Commission noted that petitioner was in good health prior to the fall, he had no restrictions prior to his fall; and following his fall he suffered a marked decrease in his health and ability to function at work.

A preponderance of the evidence supports that Petitioner's injuries are causally related to the April 16, 2014 accident. The treating records of Advanced Physical Medicine, Dr. Jain and Dr. Freedburg show treatment to the neck, upper and lower back and shoulders. Petitioner's testimony references an injury to her low back and pain shooting down to her leg. The records from MercyWorks on the date

of injury show complaints to the low back and hip only show a diagnosis of lumbar and hip pain. The earliest record from Advanced Physical Medicine, dated April 24, 2014, shows that Petitioner provided a history of injuring her low back.

While Dr. Butler's opines that Petitioner only had a lumbar strain, noting a lack of objective findings and Dr. Graf's examination notes pain out of proportion with the evaluation and multiple inconsistencies, the Arbitrator finds the opinions of Drs. Jain and Freedburg to be more persuasive. Therefore, the Arbitrator finds that Petitioner has proven, by a preponderance of the evidence that her current condition of ill-being of 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?

The Arbitrator finds that Petitioner current condition of ill-being of causally related to the accident therefore, awards to Petitioner $13,547.30 in unpaid medical bills offered by Petitioner at trial from all providers. All bills will be paid pursuant to the Illinois medical fee schedule.

K. What temporary benefits are in dispute? TTD

Based upon the findings with regards to causation, the Arbitrator finds that Respondent paid of temporary total disability benefits for the period of April 17, 2014 to August 8, 2014. Respondent shall pay Petitioner temporary total disability benefits for the period of April 17, 2014 to June 30, 2015.

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

Neither Petitioner nor Respondent offered an AMA report, however the Arbitrator will still consider each factor listed per Section 8.1b of the Act.

(i) No impairment rating

(ii) Petitioner did return to work full duty, as a laborer and worked from July, 2015 until she was laid-off as a seasonal employee mid-December, 2015.

(iii) Petitioner was 45 years old at the time of this injury and will have continued back problems for a longer period of time than an older person.

(iv) If Petitioner is recalled to return to employment by Respondent City, her earning capacity should not be affected, however, if Petitioner is not re-hired by Respondent then her earning capacity may well be limited.

(v) The evidence of disability is corroborated by the treating records and Petitioner's current complaints of ill-being.

Based on the above factors, the Arbitrator finds Petitioner sustained permanent injuries that resulted in 4% loss per Section 8(d-2 of the Act or twenty five (20) weeks disability at the rate of $721.66 per week.

17IWCC0163

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
07WC41419 & 14WC14685
SIGNATURE PAGE

Signature of Arbitrator

March 30, 2016
Date of Decision

MAR 30 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph J. Brdlik, Jr.,
Petitioner,
vs.
Aramark Schools Facilities, LLC.,
Respondent.

NO: 14 WC 17405
17IWCC0146

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, temporary total disability, 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 June 1, 2016 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $66,000.00. 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: MAR 3 - 2017
o-1/19/17
DLG/jsf
045

David Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRDLIK JR, JOSEPH J
Employee/Petitioner

Case# **14WC017405**

ARAMAR SCHOOL FACILITIES LLC
Employer/Respondent

17IWCC0146

On 6/1/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

2337 INMAN & FITZGIBBONS LTD
MARK S CARTER
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Joseph J. Brdlik, Jr.
Employee/Petitioner

v.

Aramark School Facilities, LLC
Employer/Respondent

Case # **14** WC **17405**

Consolidated cases: ___

17IWCC0146

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Geneva** , on **5/9/2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **2/21/2014**, 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. Order:

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

In the year preceding the injury, Petitioner earned $ **89,684.40**; the average weekly wage was $**1,724.70**.

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

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

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

Respondent shall be given a credit of $**28,252.23** for TTD, $**0** for TPD, $ **0** for maintenance, and $**0** for other benefits, for a total credit of $**28,252.53**.

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

ORDER

Respondent shall pay Petitioner temporary partial disability benefits of $1,149.80/week for 25-3/7 weeks, commencing 4/7/14 through 4/21/14 and from 9/2/14 through 2/11/15, as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical services of $10,691.17, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $721.66/week for 75 weeks, because the injuries sustained caused the 15% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

5/27/16
Date

JUN 1 - 2016

17IWCC0146

FINDINGS OF FACT

This claim involves a Petitioner alleging injuries sustained while working for the Respondent on February 21, 2014. This case was previously tried pursuant to Section 19(b) of the Act and a decision was entered by Arbitrator Carolyn Doherty finding for the Petitioner on the issues of causation and the need for surgery to Petitioner's left shoulder. Arbitrator Doherty's decision was entered on August 25, 2014 and was not reviewed by either party. This matter proceeded to hearing before this arbitrator on the issues of: 1) medical expenses; 2) TTD; and 3) nature and extent. Petitioner also had a duplicative filing under case number 15 WC 12250, which was dismissed by this arbitrator.

The facts will not be repeated in their entirety. However, in summary, Petitioner is a union plumber who has worked for a period of time for Respondent and sustained an injury on February 21, 2014, where he injured his left shoulder. This occurred while Petitioner was clearing ice and snow from a storm drain. Petitioner continued to work. The condition of pain and difficulties with his left shoulder continued and he sought medical treatment with Dr. Brian Forsythe on April 7, 2014. Thereafter he underwent diagnostic workup and was restricted to light duty.

A section 12 examination was performed by Dr. Lawrence Lieber who determined that there was a lack of causal connection and that Petitioner could work full duty. Petitioner then sought a second opinion from Dr. Guido Marra at Northwestern Medical Faculty Foundation. Dr. Marra determined that the injury, sustained while breaking up ice with a twenty-five pound bar, was the catalyst that caused the disruption in the shoulder joint. Dr. Marra determined surgical repair was necessary, and subsequently directed Petitioner to undergo such repair.

Arbitrator Doherty heard the matter on July 9, 2014, and entered her decision on August 12, 2014. That decision provided that Respondent pay workers' compensation benefits for lost time from April 7, 2014, to April 21, 2014, and also that Petitioner was entitled to prospective medical treatment, including surgery as recommended by Dr. Marra.

At the instant hearing, Petitioner testified that he underwent surgical intervention on September 24, 2014, at Elmhurst Memorial Hospital at the hands of Dr. Marra. Dr. Marra's pre-op diagnosis was a large SLAP tear involving the base of the biceps tendon. Dr. Marra performed surgical intervention to repair this anomaly and to perform a microfracture and remove loose bodies.

Thereafter, Petitioner underwent physical therapy with ATI Physical Therapy from September 29, 2014, through December 17, 2014. ATI then recommended to the physician that Petitioner start work conditioning and work hardening to address functional capabilities so he may return to work; they requested the doctor consider those modalities three times a week for six weeks.

On December 22, 2014, Dr. Marra advised Petitioner he could return to restricted duty with no lifting greater than five pounds, no overhead or repetitive work, and to revisit the doctor following completion of his work hardening protocol. Respondent suspended temporary total disability benefits after Dr. Lieber determined, in a report dated November 21, 2014, that Petitioner was able to return to employment with limited use of his left upper extremity, no overhead activity, and lifting a maximum of 25 pounds to chest level. Dr. Lieber also opined that upon completion of the overall physical therapy and potential cortisone injection, Petitioner should be able to return to full and unrestricted employment on approximately February 1, 2015.

17IWCC0146

Thereafter, Petitioner returned to see Dr. Marra on February 12, 2015. Based upon Petitioner's work hardening activities and his concerted effort to return to full duty, as documented in the records offered into evidence, Petitioner underwent a functional capacity evaluation (FCE). The FCE determined that he could return to work at the heavy physical demand level. However, they documented that he had significant burning around the anterior of his left shoulder and continued soreness with overhead and long lever arm activities. The therapist documented that Petitioner stated his arm did not feel right.

Petitioner, following the release by Dr. Marra on February 12, 2015, returned to work and resumed his job activity. He has consistently performed his job duties up to the date of hearing on May 9, 2016, without the need to return to Dr. Marra or any other physician.

Since the initial injury in February 21, 2014, Petitioner did not suffer any further injuries to his left shoulder. Petitioner testified that he still has difficulties using his arm, especially with overhead activities. He has found that he has lost strength. He suffers weakness in certain physical motions that are required by his employment, particularly with regards to overhead lifting. It disrupts his sleep and the burning and throbbing continue unabated.

Petitioner offered into evidence an exhibit demonstrating that there is an unpaid medical bill from ATI. During a pre-trial conference, it was determined that the issue concerned a conflict of opinions between Dr. Lieber in November of 2014, Dr. Marra, and the therapist.

CONCLUSIONS OF LAW

1. With regard to the issue of medical expenses, the Arbitrator finds that the Petitioner's medical treatment related to his left shoulder has been reasonable and necessary. The Arbitrator notes that the medical expense dispute relates to a bill from ATI for Petitioner's physical therapy as part of the treatment plan set forth by Petitioner's treating physician, Dr. Marra. Those records disclose that Petitioner underwent demanding physical therapy within a matter of days following his surgical intervention in September of 2014. Petitioner continued to progress, as the records of ATI demonstrate, and it is clear through Dr. Marra's records that Petitioner's efforts, specifically in work conditioning and work hardening, led to his ability to put forth a very heavy physical effort in his job. The therapy ultimately resulted in Petitioner returning to full duty work, which he has successfully performed for approximately the last fourteen months. The medical expense incurred and submitted to arbitration at the time of this hearing demonstrates an amount owed to ATI for this disputed therapy in the amount of $10,691.17. Given the excellent results of the treatment in question, the Arbitrator concludes that the medical treatment from ATI was reasonable and necessary in alleviating Petitioner's work-related condition and awards the cost of this treatment to Petitioner.

2. Regarding the issue of TTD, the Arbitrator finds that the Petitioner is entitled to temporary total disability benefits from April 7, 2014, to April 21, 2014, and also from September 2, 2014, the day of the surgical intervention, until his release to return to work on February 12, 2015. This is a total of 25 3/7 weeks. In support of this finding, the Arbitrator relies on the Petitioner's unrebutted testimony and the medical evidence. Specifically, the Arbitrator finds persuasive the opinions of Dr. Marra, who authorized Petitioner off work for the time period in question. Furthermore, the evidence shows that Petitioner, by going through a concerted physical therapy and work hardening regimen, was capable of recuperating from his injury and the surgery to the point where he was able to resume his job without restrictions. Given these facts, the Arbitrator concludes that the Petitioner was temporarily totally disabled for the time periods alleged. Accordingly, Respondent shall pay Petitioner TTD benefits for the 25-3/7 weeks in question, and shall receive a credit for any TTD it has

17IWCC0146

already paid to Petitioner.

3. Pursuant to Section 8.1b of the Act, for accidental injuries occurring after September 1, 2011, permanent partial disability shall be established using five enumerated criteria, with no single factor being the sole determinant of disability. Per 820 ILCS 305/8.1b(b), the criteria to be considered are as follows: (i) the reported level of impairment pursuant to subsection (a) [AMA "Guides to the Evaluation of Permanent Impairment"]; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. Each factor will be addressed below.

(i) Level of Impairment. The record contains an impairment rating of 7% impairment of the upper extremity, or 4% of Individual as a Whole, as determined by Dr. Lieber in a November 25, 2015 report, pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment (RX 3). The doctor noted the Petitioner had a Class 1 minor impairment; associated residual loss, but overall normal function and associated subjective complaints. The Arbitrator therefore gives considerable weight to this factor.

(ii) Occupation. Petitioner was employed as a plumber at the time of the accident and he was able to return to work in his prior capacity as a result of said injury. The Arbitrator gives significant weight to this factor.

(iii) Age. Petitioner was 47 years old at the time of the accident. The Petitioner is relatively young, was released to full duty, is performing the same job, and has not returned to his physician in over a year. The Arbitrator gives some weight to this factor.

(iv) Future Earning Capacity. There was no evidence presented regarding the Petitioner's future earning capacity and therefore the Arbitrator gives no weight to this factor.

(v) Evidence of Disability. There was evidence of disability corroborated by the treating medical records showing that as a result of his February 21, 2014 work accident, Petitioner sustained injuries resulting in large SLAP tear involving the base of the biceps tendon and requiring Petitioner undergo surgery followed by physical therapy, work hardening and work conditioning to address this work-related condition. Although the records further show that the Petitioner could return to full duty work pursuant to a FCE, the records also document Petitioner's continued complaints of burning and soreness with certain activities. Furthermore, the Petitioner credibly testified that he continues to experience pain, decreased strength, decreased range of motion and difficulty with overhead work, and activities such as lifting, pulling, pushing, and sleeping. The Arbitrator gives significant weight to this factor.

Based on all these factors, the Arbitrator finds that as a result of his February 21, 2014 work accident, the Petitioner sustained injuries resulting in a 15% loss of use of his person as a whole.

STATE OF ILLINOIS)	☒ Affirm and adopt	☐ 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

Roger Grasher,

Petitioner,

17IWCC0194

vs. NO: 14 WC 20029

FRM Logistics and Injured Workers' Benefit Fund,

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, employment 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 11, 2016 is hereby affirmed and adopted.

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

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

17IWCC0194

The party commencing 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: MAR 2 9 2017
KWL/vf
O-3/14/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0194

GRASHER, ROGER
Employee/Petitioner

Case# **14WC020029**

FGM LOGISTICS AND INJURED WORKERS' BENEFIT FUND
Employer/Respondent

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

If the Commission reviews this award, interest of 0.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5364 LAW OFFICE PATRICK JENNETTEN
316 S W WASHINGTON ST
UNIT 1A
PEORIA, IL 61602

3650 SPRAUGE & URBAN
BLAKE MEINDERS
26 E WASHINGTON ST
BELLEVILLE, IL 62220

4948 ASSISTANT ATTORNEY GENERAL
WILLIAM H PHILLIPS
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
ARBITRATION DECISION

17IWCC0194

ROGER GRASHER
Employee/Petitioner

Case # **14** WC **20029**

v.

Consolidated cases: **N/A**

FRM LOGISTICS and 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 **Michael Nowak**, Arbitrator of the Commission, in the city of **Collinsville**, on **08/19/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **03/17/14**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent.

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

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

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

The parties stipulated that Petitioner's average weekly wage was **$1,316.99**.

On the date of accident, Petitioner was **70** years of age, ***married*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$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 an employee-employer relationship did not exist, benefits are denied.

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

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

Michael K. Nowak, Arbitrator

07/30/16
Date

AUG 11 2016

FINDINGS OF FACT

Petitioner asserts that he was employed by Respondent FGM Logistics (hereinafter FGM) on March 17, 2014, and that he sustained accidental injuries arising out of his employment. (AX 1) FGM denies the existence of any employee/employer relationship and has presented no evidence that they possessed Workers' Compensation insurance at any time. (PX 4) The Injured Workers' Benefit Fund was named as a party and was represented by the Attorney General's Office.

Petitioner testified that he has been a truck driver since 1996. Petitioner stated that he called respondent looking for a place to work in December 2013. Petitioner testified that he received some paperwork from FGM and speculated that these were probably both Department of Transportation and FGM papers. Petitioner signed and submitted his paperwork to FGM at their office in East St. Louis. Petitioner indicated that he refrained from working during a few weeks in December 2013 so he could smoke meat. Petitioner testified that he didn't believe he could drive for someone other than FGM, but he never asked. Petitioner confirmed that no taxes were withheld from his checks, and that he paid his own taxes.

Petitioner has owned his truck since December 17, 1999; 15 years before he started driving for FGM. While driving for FGM, Petitioner stored his truck in his home town of Oden, Illinois, not at an FGM facility. While driving for FGM, Petitioner complied with DOT and ICC regulations requiring him to place a decal with FGM's logo on his truck door. Petitioner was required to inspect his truck and trailer every time he drove for FGM. Petitioner was responsible for maintaining and repairing his own truck.

Petitioner testified that he got loads for FGM through a dispatcher who was located in East St. Louis. Petitioner described the East St. Louis yard as having numbered trailers awaiting delivery near an office and a repair shop. On cross examination, Petitioner clarified that the yard in East St. Louis was owned by a railroad. Petitioner testified that he purchased his liability insurance through FGM and stated that his fuel charges were deducted from his checks. Petitioner stated that FGM purchased his license plates for him, but deducted the cost from his pay. Petitioner testified that after his accident the insurance payout went to him and was not given to FGM.

When asked if he had a supervisor, Petitioner speculated that either Roy, his dispatcher, or Mike Farmer, who gave out the gasoline checks, was his supervisor. Petitioner denied ever meeting with FMG regarding discipline or conduct. Petitioner was not required to wear a uniform and was not aware of any rules about hair or tattoos.

Petitioner denied working for any other trucking companies during the period he drove for FGM. Petitioner testified that he typically picked up loads from East St. Louis, Illinois or Sesser, Illinois. Petitioner stated that once in a while he would pick up a load from Indiana. Petitioner denied maintaining or paying for any of the trailers he hauled for FGM. Petitioner testified that he could take a job or decline a job whenever he wanted, but indicated that he would not get paid if he didn't take any jobs. Petitioner testified that he didn't decline too many loads because he didn't work for FGM for very long. Petitioner stated that there were no repercussions from FGM for declining routes. Petitioner testified that he did not have scheduled hours, but if he took a load he was obligated to deliver it on time. Petitioner testified that FGM sometimes suggested routes to

him, but they were not mandatory. Petitioner kept trip longs, as mandated by DOT. Petitioner confirmed that his only duties for FGM were driving his truck and servicing (hooking and unhooking) the loads.

Frank Meyer testified that he is the owner of FGM Logistics, a Missouri company which was initially run out of his house. Mr. Meyer testified that he is the only employee of FGM and that his business is logistics. Mr. Meyers stated that he runs his business by getting requests for transportation emailed to his phone and distributing those requests to independent contractors via a dispatcher. Mr. Meyers testified that FGM logistics currently owns approximately 13 semi-trucks but has never owned any trailers.

Mr. Meyer testified that Petitioner was classified as an independent contractor. Petitioner was paid by 1099 without any taxes or benefits withheld from his paycheck. (Rx 11) Mr. Meyer testified that Petitioner was responsible for insurance, truck maintenance, truck repairs, fuel costs, and weigh station costs. Mr. Meyer confirmed that truck decals are required by the United States Department of Transportation. Mr. Meyer stated that FGM does not have a dress code or uniform because their drivers are independent contractors. Mr. Meyer indicated that Petitioner's situation at FGM was unique in that he only drove there for a short period of time and was frequently unable or unwilling to make runs. Mr. Meyer testified that, as an independent contractor, Petitioner was free to choose whether or not he would take a load; and he was never disciplined or admonished for refusing a load.

Mr. Meyer testified that the dispatching for FGM was run by Meyer Logistics, a company owned by his father, which maintained a physical office in East St. Louis. Mr. Meyer testified that his drivers regularly take time off and drive for other companies, particularly during grain season. Mr. Meyer indicated that FGM did not have a policy on whether passengers were allowed in vehicles, but he noted that assistants or driving teams are very common. Mr. Meyer testified that FGM did not dictate or control what routes their drivers utilized. Mr. Meyer indicated that FGM offered advances for the costs associated with fuel and license plates, but stated that these expenses were repaid by drivers through paycheck deductions. According to Mr. Meyer, FGM did not have a handbook and did not perform driver evaluations. Mr. Meyer indicated that Petitioner could stop driving at any time he wanted. Mr. Meyer clarified that FGM does not own the trailers Petitioner hauled and indicated that these were the property of the steamship lines (railroads).

Petitioner signed an Independent Contractor/Owner Operator Contract. (Rx 1) The contract specifically identifies Petitioner as an independent contractor. (Id p2) The contract further states that Petitioner is responsible for his own truck maintenance, fuel, and insurance. (Id) The contract states that Petitioner "shall have absolute discretion with respect to the manner and method of performing hauling services under this agreement". (Id p 3) The contract allows either party to terminate the agreement without cause upon the completion of any assignment. (Id p 4) Petitioner's wage records indicate that he was paid $1.45 per mile with deductions for fuel, cargo and liability insurance, and license plates. (Px 5, Rx 6)

Petitioner testified that on March 17, 2014 he awoke in Morganfield, Kentucky. After dropping off his load in Morganfield, Petitioner drove to a yard in East St. Louis, Illinois where he turned in his empty trailer and hooked his truck up to another load intended to be delivered to Morganfield that same night. While driving through Morganfield that evening, Petitioner lost track of his surroundings and drove his truck through a T intersection, off the road, and down an embankment.

Petitioner was transported from the scene of the accident via helicopter to St. Mary's Hospital and was quickly taken into surgery. (Px 8) Petitioner underwent a debridement and laceration closure of his left knee as well as a right thoracoscopy on the date of his accident. (Id) Imaging of Petitioner taken at St. Mary's showed a fracture of the left C7 transverse process, a moderate central disc protrusion at C6-7, fractures of the right T2-T9 process, fractures of his right scapula and right ribs, and a proximal left humeral fracture. (Id) Petitioner's ribs showed significant inward displacement. (Id)

After being discharged from the hospital, Petitioner stayed in Centralia Manor, a nursing home, until he recovered sufficiently to return home. (Px 11) Petitioner then continued his treatment with Dr. James Stiehl and Dr. Mark Murfin. (Px 9, 10) Petitioner underwent physical therapy for his left shoulder in attempt to improve his range of motion, and recovered 160 degrees of forward flexion. (Px 10)

Petitioner described his recovery as "slow" and indicated that it took him six to seven months to learn to walk again. Petitioner testified that he experiences pain in his rib cage, limited range of motion in his left shoulder, and problems navigating steps due to his knee. Petitioner testified that he is able to drive his own car, but has not attempted to drive any commercial machinery since the accident. Petitioner does not now ambulate with a cane and states that he is "not really" under a doctor's care at present.

CONSLUSIONS

Issue (A): Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

Section 1(b)2 of the Act provides:

> Every person in the service of another under any contract of hire, express or implied, oral or written, including persons whose employment is outside of the State of Illinois where the contract of hire is made within the State of Illinois, persons whose employment results in fatal or non-fatal injuries within the State of Illinois where the contract of hire is made outside of the State of Illinois, and persons whose employment is principally localized within the State of Illinois, regardless of the place of the accident or the place where the contract of hire was made, and including aliens, and minors who, for the purpose of this Act are considered the same and have the same power to contract, receive payments and give quittances therefor, as adult employees.

Respondent asserts that it is a Missouri Corporation not subject to the Illinois Workers' Compensation Act. While the Respondent has its principal place of business listed as Missouri, it is the address of the owner's home. Respondent is in the business of hauling freight by truck. Petitioner testified that he typically picked up loads from East St. Louis, Illinois or Sesser, Illinois. Petitioner stated that once in a while he would pick up a load from Indiana. Respondent's owner admitted that he routinely dispatches loads to be hauled by semi-trucks out of various locations in Illinois. He himself works out of the East St. Louis facility up to 60% of the time. Petitioner testified that he has been a truck driver since 1996. Petitioner stated that he called Respondent looking for a place to work in December of 2013. Petitioner testified that he received some paperwork from FGM which he signed and submitted to FGM at their office in East St. Louis.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that the overwhelming weight of the evidence establishes that the contract between Petitioner and Respondent was finalized within the State of Illinois when Petitioner turned in his paper work in East St. Louis, and further the relationship between the parties was principally localized within the State of Illinois. The Arbitrator therefore finds that Illinois jurisdiction is proper under Section 1(b)2 of the Act.

Issue (B): Was there an employee-employer relationship?

The question of whether an employee-employer relationship exists presents a question of fact unique to each individual case. There is no black and white rule for determining the issue. When considering the issue fairly recently, the Appellate Court in *Steel & Mach. Transp., Inc. v. Ill. Workers' Compensation Comm'n* wrote:

> Whether a claimant is classified as an independent contractor or an employee is crucial, for it is the employment status of a claimant which determines whether he is entitled to benefits under the Act. *Earley v. Industrial Comm'n, 197 Ill. App. 3d 309, 314, 553 N.E.2d 1112, 143 Ill. Dec. 126 (1990)*; see also *Roberson v. Industrial Comm'n, 225 Ill. 2d 159, 174, 866 N.E.2d 191, 310 Ill. Dec. 380 (2007)* (noting that an employment relationship is a prerequisite for an award of benefits under the Act). For purposes of the Act, the term "employee" should be broadly construed. *Ware v. Industrial Comm'n, 318 Ill. App. 3d 1117, 1122, 743 N.E.2d 579, 252 Ill. Dec. 711 (2000)*. Nevertheless, the question of whether a claimant is an employee remains one of the most vexatious in the law of workers' compensation. *Roberson, 225 Ill. 2d at 174*. The difficulty arises from the fact-specific nature of the inquiry. *Roberson, 225 Ill. 2d at 174*. Notably, many jobs contain elements of both an employment and an independent-contractor relationship. *Kirkwood v. Industrial Comm'n, 84 Ill. 2d 14, 20, 416 N.E.2d 1078, 48 Ill. Dec. 556 (1981)*. Since there is no clear line of demarcation between the status of an employee and an independent contractor, no rule has been, or could be, adopted to govern all cases in this area. *Roberson, 225 Ill. 2d at 174-75*; *Kirkwood, 84 Ill. 2d at 20*.
>
> To assist in determining whether a person is an employee, the supreme court has identified a number of factors. Among the factors cited by the supreme court are: (1) whether the employer may control the manner in which the person performs the work; (2) whether the employer dictates the person's schedule; (3) whether the employer compensates the person on an hourly basis; (4) whether the employer withholds income and social security taxes from the person's compensation; (5) whether the employer may discharge the person at will; and (6) whether the employer supplies the person with materials and equipment. *Roberson, 225 Ill. 2d at 175*. Another relevant factor is the nature of the work performed by the alleged employee in relation to the general business of the employer. *Roberson, 225 Ill. 2d at 175*; *Ware, 318 Ill. App. 3d at 1122*. The label the parties place on their relationship is also a consideration, although it is a factor of "lesser weight." *Ware, 318 Ill. App. 3d at 1122*. The significance of these factors rests on the totality of the circumstances, and no single factor is determinative. *Roberson, 225 Ill. 2d at 175*. Nevertheless, the right to control the

work and the nature of the work are the two most important considerations. *Kirkwood, 84 Ill. 2d at 21*; *Ware, 318 Ill. App. 3d at 1122.*

Steel & Mach, 392 Ill. Dec. 873, 33 N.E.3d 674 at 682 (Ill. App. 1st Dist. 2015)

In this case the label the parties placed on their relationship was that of an independent contractor. Although it is a factor of "lesser weight," it none the less favors a finding that Petitioner was an independent contractor.

The nature of the work in this case was delivering freight by truck. Petitioner is required by law to have a CDL to perform his job. However, Petitioner's skill is that of a truck driver and FGM's business is that of a logistics company. While FGM may argue that its primary focus is on dispatching and facilitating the movement of cargo and not its physical transportation, this distinction is too fine to be persuasive. Petitioner is a truck driver and FGM is a trucking company. Although not overwhelmingly so, this factor supports an employee/employer relationship.

The Independent Contractor agreement adopted by the parties states that Petitioner "shall have absolute discretion with respect to the manner and method of performing hauling services under this agreement". This understanding is reinforced by testimony from both parties indicating that Petitioner was not required to drive any particular routes or maintain any degree of contact with a representative of FGM during or after his deliveries. Petitioner was also at liberty to drive for other companies at his discretion while driving for FGM. Petitioner was unclear as to who he believed was his supervisor; he did not receive any discipline or performance reviews at any time during his interactions with FGM, and there was no handbook outlining how Petitioner's duties were to be performed. It is important that FGM did not impose any dress code or appearance standard on its drivers. The factor of control weighs heavily in favor of an independent contractor relationship.

Petitioner was not obligated to work any specific hours or days. This arrangement went so far as to allow Petitioner to abstain from working at all for several weeks to allow him to smoke meats over the holidays. This factor weighs heavily in favor of an independent contractor relationship.

Petitioner was paid only when a delivery was made. His pay was calculated based on a rate of $1.45 per mile. While FGM did deduct money from Petitioner's checks for fuel, license plates, and insurance, none of these deductions can be considered a departure from the fundamental nature of the economic relationship between Petitioner and FGM. By all accounts Petitioner drove when he wanted to and was paid per mile for all of his trips. This suggests an independent contractor relationship.

Petitioner was paid via a 1099 and no taxes were withheld from Petitioner's pay. This suggests an independent contractor relationship.

Both parties had an equal right to terminate their contractual relationship upon completion of any delivery. Both the mutuality of the termination provision and the condition linking termination to the completion of individual deliveries suggest an independent contractor relationship based on services performed and not an employee relationship designed to be maintained indefinitely.

The final factor identified by the court is whether the employer supplies the person with materials and equipment. A significant component of this factor is Petitioner's ownership of his truck. Petitioner's truck is the primary tool utilized in his job and he owned it for 15 years prior to contracting with FGM. It is significant that when his truck was destroyed, Petitioner alone collected the whole of the insurance payment. Petitioner did utilize trailers during the course of his employment; however neither FGM nor Petitioner owned these trailers. The trailers were owned by the railroads and were returned after completion of each delivery. Petitioner paid for the fuel consumed during his travels. Therefore, as Petitioner provided his truck and fuel, and FGM did not provide any tools or equipment used by Petitioner during the course of his duties, this factor suggests an independent contractor relationship.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds an employee-employer relationship did not exist between the parties. Petitioner was an independent contractor. Benefits are, therefore denied. Because the relationship of employee-employer did not exist between the parties all remaining issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Thomas Leverett,

Petitioner,

vs. NO. 14WC022015

17IWCC0118

City of Harrisburg,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, casual connection, choice of physicians and caregivers, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 9, 2016 is hereby affirmed and adopted.

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

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

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

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

DATED: FEB 2 7 2017
SJM/sj
o-2/9/17
44

Stephen J. Mathis

David L. Gore

Mario Basurto

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

LEVERETT, THOMAS
Employee/Petitioner

Case# **14WC022015**

17IWCC0118

CITY OF HARRISBURG
Employer/Respondent

On 2/9/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1167 WOMICK LAW FIRM CHTD
CASEY VAN WINKLE
501 RUSHING DR
HERRIN, IL 62948

0180 EVANS & DIXON LLC
MICHAEL A KARR
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

17IWCC0118

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)

THOMAS LEVERETT
Employee/Petitioner

v.

CITY OF HARRISBURG
Employer/Respondent

Case # 14 WC 22015

Consolidated cases: N/A

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

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **June 2, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**78,505.07**; the average weekly wage was $**1,509.71**.

On the date of accident, Petitioner was **49** 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 $ for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $ **0**.

Respondent is entitled to a credit of $**0** for any medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay the medical bills found in Petitioner's Exhibit 6 subject to the Medical Fee Schedule pursuant to Section 8(a) of the Act and with Respondent receiving credit in the amount of $54,517.86 for medical bills previously 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.

Nancy Rendany
Signature of Arbitrator

February 4, 2016
Date

ICArbDec19(b)

FEB 9 - 2016

FINDINGS OF FACT AND CONCLUSIONS OF LAW

At the time of Petitioner's 19(b) hearing, the issues in dispute centered on Petitioner's left knee injury. While Petitioner also claims injuries to his neck, left shoulder, and toe (see AX 2 and record) those issues were reserved for another hearing.

The Arbitrator finds:

Petitioner works as a police officer for the City of Harrisburg, Respondent herein.

On February 18, 2010 Petitioner underwent a left knee MRI after having slipped on ice a few days earlier. Both chronic and acute changes were noted. Petitioner had serious internal derangement with complete disruption of his ACL with "kissing bone bruises" involving the lateral femoral condyle as well as the proximal tibial condyles; an extensive cleavage tear involving the posterior horn of the medial meniscus; moderate joint effusion; far advanced Grade II tricompartmental osteoarthritis involving the anterior and medial compartments with multiple intra-articular loose bodies; and a focal spot of osteochondritis dissecans involving the mid portion of the lateral femoral condyle. Petitioner's lateral meniscus was noted to be intact. (RX 2)

On June 2, 2013, Petitioner, 49 years of age, was involved in an undisputed accident while making an arrest. At that time a suspect suddenly spun around and placed Petitioner in a choke hold. A fellow officer attempted to intervene and pushed Petitioner and the suspect through a doorway causing both to fall over a recliner and onto an end table and lamp before ending up on the floor. As the other officer pushed Petitioner and the suspect, Petitioner's knee twisted and popped. When Petitioner got up after the accident he noticed he was bleeding from both his face and knee and felt pain in all areas.

After the accident, Petitioner began treatment for his left knee at Primary Care in Harrisburg. At the time of his June 13, 2013 visit with Dr. Winkelman, Dr. Winkleman noted the work accident and took a history of the injured body parts of Petitioner. Petitioner's complaints included buckling of his left knee with pain, swelling and the sensation of "it pulling apart." Dr. Winkelman noted Petitioner's prior history of left knee surgery. His diagnosis included left knee internal derangement. Dr. Winkleman ordered an MRI of Petitioner's left knee and allowed Petitioner to continue working without limitation "for now." (PX 1)

Petitioner underwent the MRI on June 19, 2013, and it showed severe arthritic changes and an almost complete obliteration of Petitioner's medial meniscus. (PX 1)

On June 21, 2013, Petitioner returned to Dr. Winkleman reporting continued instability in his left knee. Dr. Winkleman felt a referral to a specialist was necessary and referred Petitioner to Dr. Wente at the Bonutti Clinic. (PX 1)

Petitioner presented to Dr. Wente at the Bonutti Clinic on July 8, 2013. Dr. Wente took a history from Petitioner regarding the work accident and noted his left knee pain. Dr. Wente compared the MRI of Petitioner's left knee from February 18, 2010 with the MRI of June 19, 2013. Dr. Wente felt that there were degenerative changes through the entire left knee and that Petitioner had advanced degenerative joint disease. Dr. Wente's plan of treatment was to offer medication and some injections to try and return Petitioner to his pre-accident level of physical activity. Dr. Wente felt that the only

thing that could be done surgically would be a total knee replacement. Dr. Wente also issued a prescription for medication and told Petitioner to return in four to six weeks.

Petitioner was examined at Primary Care on July 2, 2013 in follow up and his ongoing knee pain was noted. (PX 1, 14/51)

On July 31, 2013 Petitioner began treating with Dr. Bernardi for neck complaints stemming from the work accident. The doctor ultimately performed neck surgery on Petitioner in September of 2013. Petitioner was taken off work from the date of surgery through the end of the year. As of December 11, 2013 Dr. Bernardi felt Petitioner could return to work at the beginning of the year without any restrictions. It was anticipated Petitioner would be at maximum medical improvement with regard to his neck around February 1, 2014. (PX 3)

Petitioner was examined by Dr. Knight, his primary care physician, on December 27, 2013 for a release to return to work after his cervical fusion procedure. While Dr. Bernardi had released him, Petitioner advised the doctor that Respondent was also requesting a release from his primary care physician. Petitioner reported he was doing fine and was ready to return to work. No discussion or reference to Petitioner's left knee was made in the office note. (PX 1)

After recovering from his neck surgery Petitioner returned to work in January of 2014.

On June 2, 2014 Petitioner again presented to Primary Care Group where he was seen by Dr. Knight. Petitioner's primary complaint was left knee pain and, according to the office note, "The onset of the knee pain has been gradual and has been occurring in a persistent pattern for years (PT STATES THAT HE HAD AN INJURY ABOUT A YEAR AGO AND IS HAVING A FLARE UP IN THE LEFT KNEE. IT SWELLS AND AT TIMES HE IS UNABLE TO BEAR WEIGHT. USING ICE EVERY DAY TO BE ABLE TO WORK.) The course has been gradually worsening." (PX 1, 5/51) The knee pain was characterized as a dull aching in the entire knee. Petitioner noted difficulty arising from a chair and difficulty going up and down stairs. Petitioner's physical exam included generalized swelling of his left knee with decreased range of motion and painful movements. Tenderness on both the medial and lateral sides of Petitioner's knee was noted. An x-ray, MRI, and referral to an orthopedist, Dr. Bonutti, were ordered. Petitioenr was allowed to continue working full duty. (PX 1)

Petitioner's subsequent MRI, taken on June 9, 2014, revealed osteoarthritis, a tibial plateau fracture, a high grade tear of the ACL with scarring, a partial tear of the MCL with scarring, a radial tear of the posterior horn of the lateral meniscus with extrusion of the body and multiple loose bodies throughout the joint. (PX 4)

Petitioner signed his Application for Adjustment of Claim herein on June 23, 2014. (AX 2)

Upon the referral of his attorney, Petitioner then presented to Dr. J. T. Davis on June 25, 2014 at which time he gave Dr. Davis a history of his work accident and the knee problems he had been dealing with over the previous year. Petitioner informed Dr. Davis that he had been very active before the accident running several miles a week and walking several miles a day. Petitioner told the doctor that since his June of 2013 accident he had been experiencing significant difficulties in his knee with pain ("4/10") that he characterized as dull, sharp, aching, and throbbing and localized deep within his knee. Petitioner reported the pain was worse with steps and sudden stops. Additional complaints included swelling, a feeling of giving away, instability, fatigue, and radiating pain. Petitioner was taking anti-inflammatories and had done exercises. He was working full duty. On examination the doctor noted mild to moderate effusion, a lack of extension, patellofemoral crepitus and both medial and lateral joint line

tenderness. He reviewed both Petitioner's MRI and x-rays which revealed tri-compartmental osteoarthritis as well as a high grade ACL tear, evidence of prior meniscus issues and surgeries with some questionable tearing, degenerative in nature medially and a radial tear laterally. Dr. Davis diagnosed Petitioner with tri-compartmental osteoarthritis to the left knee with meniscus tearing both medially and laterally. They discussed various treatment modalities including injections, arthroscopic surgery, and a total knee replacement all of which were somewhat dependent upon Petitioner's desire to continue working as a police officer. Dr. Davis was of the opinion that Petitioner's accident was a direct cause for Petitioner's pain through an exacerbation of his underlying degenerative arthritic condition with possible contributions to meniscal tearing. "It is a new meniscal tearing versus exacerbation of underlying degenerative meniscal state." (PX 4)

On July 1, 2014 Petitioner was again seen at Primary Care Group for a small laceration sustained when a cabinet he was carrying dropped on his head. (PX 1)

Petitioner returned to see Dr. Davis on November 20, 2014 at which time the doctor recommended arthroscopic surgery, given the Supartz injection had not helped. (PX 4)

Petitioner underwent left knee surgery on March 19, 2015. The post-operative diagnoses were left knee medial meniscal tear; left knee arthritis; and left knee loose body with synovitis. Petitioner's procedures included a partial medial meniscectomy, a partial synovectomy, removal of loose bodies, extensive debridement of tibial and patellar osteophyte complexes as well as intra-articular adhesions, and a left knee injection. (PX 4)

Post-operatively, Dr. Davis ordered physical therapy. As of March 30, 2015 Dr. Davis was noting swelling in Petitioner's left knee along with discomfort. A venous Doppler, TED hose, Mobic, and physical therapy were ordered. Petitioner was advised against work. He was to return in one month at which time they would discuss injection therapy. The doctor cautioned that, ultimately, a knee replacement procedure might be necessary if he failed to respond to the arthroscopic procedure. (PX 4)

Petitioner's persistent pain complaints and feeling of instability were noted at the next visit of April 13, 2015. Modified work duties were given. (PX 4)

Petitioner then presented to Dr. Bonutti at Bonutti Clinic on June 30, 2015 at which time he gave a history of his work accident and persistent pain thereafter that had culminated in arthroscopic surgery in March of 2015 which Petitioner felt only made him worse. Petitioner reported that his leg felt like it wanted to buckle and give away and he was experiencing a constant aching and discomfort and the inability to squat, twist, or bend. Dr. Bonutti noted in his office note that the operative report had not mentioned the status of Petitioner's ACL. Treatment options were noted with Petitioner expressly desiring a total knee replacement. The consequences of the procedure in terms of lifestyle activity (ex. running) were discussed. Petitioner was given work restrictions. (PX 2)

At the request of Respondent, Petitioner underwent an examination pursuant to Section 12 of the Act on July 20, 2015 with Dr. Mirkin at Tesson Ferry Spine and Orthopedic Center. The examination included Petitioner's left shoulder, left knee and neck. After the exam, Dr. Mirkin issued a written report. (RX 1 – Res. Ex. 2) For purposes of this decision, Dr. Mirkin's exam and report will be limited to Petitioner's left knee. Petitioner was noted to deny any problems with his left knee before his work accident although the doctor noted Petitioner had undergone an MRI of his left knee in February of 2010 that showed an ACL tear and "significant abnormalities". Petitioner's chief complaint that day was left knee pain and the inability to run, an activity Petitioner was regularly engaged in prior to his accident. (RX 1 – Res. Ex. 2, p. 1)

Dr. Mirkin's report included a review of Petitioner's medical records and information supplied to him by Respondent's counsel. Based upon his review of the records, x-rays taken that day in his office, and his examination of Petitioner's left knee, Dr. Mirkin believed that Petitioner sustained an aggravation of his knee problem with the incident in question. (RX 1 – Res. Ex. 2, p. 4) He felt Petitioner had end stage osteoarthritis and would be a candidate for a total knee arthroplasty but he also needed to try and lose weight. He wrote, "I cannot dispute that the incident in question may have aggravated his symptomatology." He felt the need for treatment was his pre-existing degenerative arthritis which in natural history is to progress over time. (Id.)

Dr. Mirkin issued an addendum on September 24. 2015 noting that the 2010 MRI of Petitioner's left knee showed severe osteoarthritis, ACL insufficiency and meniscal pathology. He further stated that he felt the need for the knee replacement surgery was caused by the pathology that pre-existed the incident of June, 2013 as the nature of the condition was progressive and would have been accelerated by Petitioner's morbid obesity. (RX 1 – Res. Ex. 3, p. 1)

Petitioner underwent a total knee replacement on October 14, 2015 at St. Anthony's Memorial Hospital. Petitioner's post-operative diagnoses included osteoarthritis, contractures, severe patellar baja, Osgood-Schlatter lesion, and range of motion from only 10 to 80 degrees. Dr. Bonutti noted in his operative report that the procedure was complex and took twice as much surgical time. (PX 2)

Post-operatively, Petitioner underwent physical therapy at Joyner Therapy Services. As of October 27, 2015, Petitioner was using a cane for assistance when ambulating. He was doing home exercises and outpatient therapy. He was to return to see the doctor on January 19, 2016. (PX 2)

The deposition of Dr. Bonutti was taken on October 27, 2015. (PX 5) Dr. Bonutti testified that Petitioner told Dr. Wente on July 8, 2013 that he had undergone a knee arthroscopy ten years earlier and had done reasonably well thereafter. (PX 5, p. 6) He also testified that in light of Petitioner's earlier arthroscopic procedure, Petitioner had experienced some trauma or injuries in the past and he did have degenerative joint disease which the doctor, based upon Petitioner's history, was significantly exacerbated post-traumatically and then substantively worsened by another arthroscopic procedure. (PX 5, p. 9) Dr. Bonutti felt Petitioner's condition and need for surgery was due to the work accident. (PX 5, pp. 10-11)

Dr. Bonutti noted Dr. Davis didn't address Petitioner's ACL in his operative note. He, himself, suspected Petitioner injured it in 2013.

Dr. Bonutti acknowledged that he didn't review the 2010 MRI. He also testified that Dr. Wente believed that Petitioner had an injury to his ACL before June of 2013 or, at least, a partial injury. He saw nothing acute on the 2013 MRI. Dr. Bonutti believed that Petitioner had undergone a rapid progression of his degenerative condition I his knee after the surgery with Dr. Davis and that the condition would have progressed rapidly regardless of an injury to Petitioner's ACL.

Dr. Bonutti testified that he released Petitioner to return to work on July 18, 2013.

Dr. Mirkin's deposition was taken on November 13, 2015. (RX 1) Dr. Mirkin testified that Petitioner's endstage arthritis and chronic ACL deficienty was not caused by the June 2013 accident. He also testified that Petitioner needed a total knee replacement but he would have needed one eventually even if the work accident had not occurred. (RX 1, pp. 8-9)

On cross-examination Dr. Mirkin testified that he felt it "hard to believe" that Petitioner was fairly active prior to his work accident; however, he acknowledged that that is what Petitioner told him. (RX 1, p. 10)

Petitioner's case proceeded to trial on December 9, 2015. Petitioner was the sole witness at the hearing. The issues in dispute were causal connection, medical bills, and whether Petitioner had exceeded his choice of physicians.

Petitioner testified that he had no problems with his left knee before his accident. However, he acknowledged that he underwent an MRI of his left knee in 2010. Petitioner expressed uncertainty as to what the MRI was for but he assumed he must have been having some problems at the time and wanted his knee looked at. According to Petitioner, the problem then went away.

Petitioner testified that between 2010 and June 2, 2013, accident he had been regularly going to a local bike path to jog or walk about five miles. This was during the week days. On the nights that Petitioner worked he was allowed to go during his lunch hour to a local track and walk five miles. Petitioner testified that he was doing these workouts whenever he worked and he would do the bike path workout on the other days of the week. Petitioner testified that he was keeping track of his exercise with his wife and that at the time of the accident on June 2, 2013, he weighed 232 pounds.

Petitioner testified at trial that his knee symptoms did not improve with medication but he was also dealing with a neck injury from the work accident and decided to go through that treatment and surgical repair first. Medical records introduced into evidence corroborate Petitioner's testimony regarding his decision to proceed with neck surgery. Petitioner was released to return to work for his neck as of January 30, 2014.

Petitioner further testified that when he returned to work in January of 2014 he did so as a detective and not a patrolman. Petitioner described that his job duties as a detective were less physical than that of patrolman. Petitioner testified that after returning to work he was still taking medication for pain with his knee and that his pain in his knee never did subside from the time he had been treated at Bonutti Clinic. Petitioner testified that his knee ached, hurt, started to buckle and came out of socket.

Petitioner testified that he returned to Primary Care in Harrisburg and saw Dr. Knight on June 2, 2014, complaining about pain and discomfort in his knee. He told Dr. Knight that he had to ice his leg daily to get through the day.

Petitioner testified that he sought treatment with Dr. Davis in June of 2014 because he was on Naproxen and didn't want to have to drive two hours to Effingham to see Dr. Wente. Dr. Davis' office was in Marion. According to Petitioner, Dr. Davis gave him an option of undergoing an arthroscopy or a knee replacement and Petitioner wished to proceed more conservatively.

Petitioner testified that the surgery with Dr. Davis did not go well. After a short recovery and an attempt to get Petitioner's pain under control, Dr. Davis informed Petitioner that a knee replacement was his next step to fix his knee problem. Petitioner testified that he then wished to go back to Dr. Bonutti.

Petitioner testified that he underwent a total knee replacement on October 14, 2014 and that he is still recovering. He is currently undergoing therapy and doing great as he is walking up to four miles per day. Petitioner anticipates being released to light duty in January of 2016.

On cross-examination Petitioner was asked if he had an injury in 2010 when he slipped on ice and he replied, "Possibly." He agreed if that was stated in the history it would be correct he just didn't recall any further treatment after the MRI, however.

Petitioner denied that anyone had recommended a total knee replacement to him before June of 2013. He also acknowledged undergoing a prior left knee arthroscopic surgery for a meniscus tear but he didn't recall when. Following the surgery, Petitioner denied any further problems with his knee.

Petitioner also acknowledged that he tried walking for exercise after the 2014 accident but he couldn't do so due to the condition of his knee. He also acknowledged that he continued working full duty until he underwent his neck surgery. Petitioner testified that after Dr. Bernardi released him from care for his neck he tried getting back into physical activity (walking) because he had been gaining weight but that was when his knee "started failing" again. Petitioner explained that it would buckle once or twice a week and he even fell and hit his head once. He then resumed treatment. Petitioner denied having any problems working as a detective between January and June of 2014.

Petitioner was asked who referred him to Dr. Davis and he testified that he was told by "workmen's comp" that the "new knee pain" was going to be a different claim. Petitioner did not think that was right so he contacted an attorney who suggested he see Dr. Davis in Marion. Petitioner was familiar with Dr. Davis as he had treated his son. Additionally, Petitioner did not want to have to drive so far to see a doctor.

Petitioner acknowledged that Dr. Davis didn't take him off work from his detective duties. He further testified that the injections with Dr. Davis provided temporary relief and then his knee got worse. Petitioner was off work recovering from Dr. Davis' surgery and was released to light duty work in mid-April but was then taken off work completely in conjunction with the total knee replacement. Petitioner also testified that when Dr. Davis discussed a total knee replacement with him he said it would be up to Petitioner to choose who would perform the procedure. When asked about the referral to Dr. Bonutti and the fact that the doctor said Petitioner was a self-referral, Petitioner wouldn't disagree.

On further cross-examination Petitioner testified that he would disagree with Dr. Knight's June 2014 history of a flare-up as it was a continuing problem in his knee.

The Arbitrator concludes:

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

Petitioner's current condition of ill-being in his left knee is causally related to his undisputed accident of June 2, 2013. In so concluding the Arbitrator relies upon Petitioner's credible testimony, a chain of events, and the more persuasive opinions of Dr. Bonutti over those of Dr. Mirkin.

Petitioner's treatment to his left knee prior to the accident appears undisputed. Petitioner's treatment to his left knee injury after the accident through July 8, 2013 also appears undisputed. Respondent acknowledges that Petitioner sustained an accident but contends that Petitioner sustained a temporary aggravation of a pre-existing knee condition as a result of that accident which resolved by July 8, 2013.

Petitioner's testimony at trial and, as reflected in the history given to every physician who treated him after the work injury of June 2, 2013, was that he was very active physically prior to his

accident and, even more specifically, he had been running several miles a week and had been walking 5 to 10 miles a day, prior to his accident. Petitioner's testimony regarding this was unrebutted. While Dr. Mirkin found it hard to believe, no one else did and Petitioner was working full duty as a patrolman.

Dr. Mirkin, who evaluated Petitioner as an independent medical examiner doctor, opined that Petitioner had end-stage osteoarthritis for which he, too, recommended a total knee replacement. Dr. Mirkin opined that Petitioner's knee condition was multifactorial and while he wasn't asked about an aggravation theory when deposed, he did address it in his earlier report, noting that the work accident might have aggravated Petitioner's condition. While Dr. Mirkin opined that the need for a knee replacement was based on pathology that was present prior to Petitioner's work accident, he was not asked if the work accident accelerated the need for a total knee replacement.

The Arbitrator notes that Dr. Wente on July 8, 2013, suggested that the only surgical option for Petitioner was a total knee replacement. This opinion was given barely one month after the work accident and before any gap in treatment. No doctor had recommended a total knee replacement prior to Petitioner's work accident.

Dr. Davis also gave an opinion that the work injury sustained in June of 2013 was a direct cause for Petitioner's pain through an exacerbation of his underlying degenerative condition with possible contributions to meniscal tearing. He continued by stating that, "It is a new meniscal tearing versus exacerbation of underlying degenerative mensical tear."

After the arthroscopic procedure was a failure Petitioner was treated by Dr. Bonutti who recommended a total knee replacement. Dr. Bonutti opined that if Petitioner was as active as he had described to him in his history prior to the work accident then certainly the trauma from the work accident contributed to Petitioner's condition. Dr. Bonutti also opined that he was certain that the arthroscopic procedure that was performed by Dr. Davis contributed to Petitioner's rapid deterioration of his symptoms and his range of motion function. Dr. Mirkin did not address this possibility.

With regard to Petitioner's testimony, the Arbitrator finds it to be credible. Petitioner's testimony was unrebutted and he credibly explained how he was feeling and progressing during his one year gap in knee treatment. The Arbitrator recognizes that Petitioner was able to work full duty a significant amount; however, he credibly explained how he felt while working and also underwent a change in position within the police department that lessened the amount of time he was on his feet. In the end, he wasn't asymptomatic prior to June of 2014.

Based upon the foregoing, the Arbitrator finds ongoing causation, relying on the expert opinions of both Dr. Davis and Dr. Bonutti, and the credible testimony of Petitioner.

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 that all services to Petitioner's left knee based on the testimony of Dr. Davis, Dr. Bonutti and Dr. Mirkin were reasonable and necessary. The Arbitrator also finds that the need for the total knee replacement was causally connected to the work accident of June 2, 2013, and, therefore, the appropriate charges for that treatment is the responsibility of Respondent. Respondent shall pay the medical bills set forth in Petitioner's Exhibit 6 subject to the Medical Fee Schedule and Respondent shall receive credit in the amount of $54,517.86 for bills previously paid.

Issue O. Did Petitioner exceeding his choice of physicians?

Petitioner has not exceeded his choice of physicians as allowed under the Act.

Petitioner's family care for medical is taken care of through Primary Care of Harrisburg. Dr. Winkleman at Primary Care referred Petitioner to Dr. Wente at Bonutti Clinic on June 21, 2013.

Petitioner then sought treatment from Dr. Davis as his second choice.

After treating with Dr. Davis, Petitioner returned to the Bonutti Clinic where he was treated by Dr.Bonutti. Bonutti Clinic was Petitioner's first choice for care. Dr. Davis was Petitioner's second choice for care. That there was a gap in time and change in doctors at the Clinic doesn't make the resumption of care at Bonutti Clinic in 2014 a third choice. Given the circumstances in June of 2014 (including information being provided to him by "workmen's comp") Petitioner credibly explained why he went to Dr. Davis and how, later on, when Dr. Davis told him the choice of surgeons was ultimately his, he returned to Bonutti Clinic.

****

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

Bari Hansen,
Petitioner,

vs.

NO: 14 WC 27603

17IWCC0153

VCNA Prairie Material,
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, 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 22, 2015, 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.

17IWCC0153

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

DATED: MAR 10 2017

Joshua D. Luskin

o-03/08/17
jdl/wj
68

Charles J. DeVriendt

Kevin W. Lamborn

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

HANSEN, BARI
Employee/Petitioner

Case# **14WC027603**

VCNA PRAIRIE MATERIAL
Employer/Respondent

17IWCC0153

On 12/22/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.51% 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:

3259 McCREEDY GARCIA & LEET PC
MICHAEL P McCREEDY
10008 S WESTERN AVE
CHICAGO, IL 60643

1109 GARFALO SCHNEIDER HART & STORM
ANDREW RANE
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

17IWCC0153

☐ Injured 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)

Bari Hansen
Employee/Petitioner

v.

VCNA Prairie Material
Employer/Respondent

Case # 14 WC 27603

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 **Maria S. Bocanegra**, Arbitrator of the Commission, in the city of **Chicago**, on **October 14th, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0153

FINDINGS

On the date of accident, **June 30th, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$35,880.00**; the average weekly wage was **$690.00**.

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

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

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$$26,910.00** for other benefits, for a total credit of **$26,910.00**.

Respondent is entitled to a credit of **$26,910.00** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that Petitioner failed to prove she sustained an accident arising out of and in the course of her employment with Respondent. The claim for compensation is ***denied.***

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

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

Signature of Arbitrator

12-21-15
Date

DEC 22 2015

17IWCC0153

FINDINGS OF FACT

Bari Hansen ("Petitioner") was employed by VCNA Prairie Material ("Respondent") as a billing analyst at the time of the incident. She began her employment with the Respondent in that capacity in 2012, approximately 2 years prior to the incident. As a billing analyst, the Petitioner's job duties including working on the billing account for Prestige, a client of the Respondent's. She had been working on the Prestige account during the entire 2-year time frame. Her work involved setting up computer software to isolate billing information. She primarily used a billing program called SAP.

In the afternoon of June 30th, 2014, the Petitioner was performing her work as usual. At approximately 2:30pm that afternoon, she received an email from her supervisor, asking that she set up a "variant" showing dates, customer names and yardage for the Prestige account. A co-worker, Mary Navedo, had also received the same assignment from the supervisor.

Petitioner testified that the variance did not work correctly the first time she tried. Therefore, she testified that she went over to the desk of Mary Navedo ("Navedo") and asked her for help. She further testified that Navedo walked back Petitioner's desk with her and stayed there for as much as 30 minutes while they tried various things to work it out. She testified that Navedo was at her desk the entire time. She testified that, once the variance worked, she raised her left hand waiting to receive a "high five" from Navedo. She then testified that Navedo gave her a high five causing her to let out a scream. Petitioner was excited that she and Navedo had solved the problem assigned to them by her supervisor. Unfortunately, Navedo was holding a binder clip in her right hand from a bag of chips she had just opened. When the hands of Hansen and Navedo met, Hansen injured her left hand. Navedo testified that she was not expecting the high five from Petitioner and put her hand up instinctively, which had the chip clip still in it.

Both witnesses agreed that the high five was not given in an overly aggressive manner or disproportionately hard slap. It was a typical high five one would expect between co-workers not engaged in athletic activity. Petitioner testified that she received some minor first aid at the office and finished up her workday, which was essentially almost over. She testified that she sought medical attention 2 days later, on July 2nd, 2014.

Respondent presented the testimony of Ms. Mary Navedo. Navedo was a senior billing analyst for the Respondent at the time of the incident. She testified that she was working on the project simultaneously with the Petitioner. She testified that, as a billing analyst, both she and the Petitioner ran projects and reports such as this all day long, multiple times per day. She testified that the first time they ran the numbers; they did not match up correctly. She changed some of the parameters and the numbers matched up. At that point, she walked to the Petitioner's desk alone and was there for a "few minutes." Once the parameters were set up on Petitioner's computer, Ms. Navedo reached for a bag of chips that was on an adjacent desk. Navedo heard Petitioner say "woo-hoo" and saw the Petitioner's left hand coming at her. She instinctively held up her hand. She testified that the hand was coming at her so fast that she did not even have time to set down the binder clip. Navedo testified that it was not her intention to give Petitioner a "high five." In support of that position, Petitioner testified that she has given "high-fives" in the past, but none with something in her hand, at least to her recollection. She specifically denied that she initiated the "high-five".

Respondent offered into evidence a document entitled, "Injury/Illness/Incident & cause analysis report. Petitioner testified that she may have filled out certain parts versus what was completed by another individual at

VCNA Prairie. Petitioner wrote, in part, "I went to give her a high five..." Petitioner acknowledged that she completed that section of the incident report.

After injuring her hand, Petitioner received general first aid from Respondent, which included a band aid and bandage to stop the bleeding. Petitioner's exhibit 4 is medical records from Excel Occupational Health. On July 2, 2014, Petitioner was examined by Dr. Joseph Laluya. The history given to Dr. Laluya was consistent with the testimony of Petitioner. After an examination, Dr. Laluya's impression was: "left hand contusion, along with a small abrasion noted over the dorsal aspect of the left PIP joint." Dr. Laluya provided discharge instructions and released Petitioner with no restrictions.

Petitioner returned as instructed to Dr. Laluya on July 8, 2014. Dr. Laluya's impression was "left hand and wrist contusion. This is a somewhat unusual case as the patient was high fiving another employee after completing a project. The patient's complaints are fairly diffuse at this point and it does not appear that she has made tremendous progress. With the color changes and what appears to be some hypersensitivity to stimuli, one must consider an insult to the autonomic nervous system."

Petitioner began physical therapy and "desensitization" at Physical Therapy and Rehabilitation per Dr. Laluya's prescription. The history provided by Petitioner to the physical therapist was consistent with Petitioner's testimony. Petitioner reported to the physical therapist, "I get these strong pains in my palm. I do my work but it's painful. I have to take breaks while working because of pain." On July 18, 2014, the physical therapist was concerned about Petitioner's condition and secured an appointment with Dr. Laluya. Dr. Laluya opted to take her off work completely. Petitioner has not returned to work since being taken off on July 18, 2014.

Dr. Laluya referred Petitioner to Midwest Hand Surgery. On July 21, 2014, petitioner saw Dr. Nicholas Speziale. Px3. Dr. Speziale ordered an EMG test and ruled out nerve compression and carpal tunnel syndrome. On August 7, 2014, Dr. Speziale concluded, "This patient may have complex regional pain syndrome." Even after continued physical therapy focusing on pain sensitivity, Petitioner's pain persisted. On August 25, 2014, Dr. Speziale and Dr. Laluya agreed Petitioner should be referred to a pain specialist.

Petitioner's exhibit 2 is records from Dr. Ebby Jido, a pain management specialist at Christ Hospital. On his September 26, 2014 physical examination, Petitioner exhibited all the classic, objective signs of CRPS including left hand discoloration and mottling as well as allodynia. "This is clearly signs and symptoms of sympathetically mediated pain." Petitioner's treatment with Dr. Jido included an auxiliary nerve block on October 1, 2014, stellate ganglion blocks on October 10, and 16, 2014 and ablation of the stellate ganglion block on December 16, 2014. Petitioner testified to additional treatment by Dr. Jido in 2015, but these records were not included in Petitioner's exhibits. Petitioner testified she continues to be under the care of Dr. Jido.

CONCLUSIONS OF LAW

ISSUE (C) Whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent?

In order to recover benefits under the Act, a claimant bears the burden of proving by a preponderance of the evidence that his injury "ar[ose] out of" and "in the course of" his employment. *820 ILCS 305/2* (West 2010). Both elements must be present to justify compensation. Given the totality of the evidence in this case, the Arbitrator finds that the Petitioner failed to meet that burden. Accordingly, the Petitioner's claim for benefits under the Act is denied. As an initial matter, the Arbitrator notes that both Petitioner and Navedo were

credible in their recollection of events. Although there was some discrepancy on the actual time of the occurrence, the Arbitrator does not find Petitioner to be incredible in this regard. It appears as though it was simply error in reporting the approximate time of the occurrence.

a. Arising Out Of

The requirement that the injury arise out of the employment concerns the origin or cause of the claimant's injury. The occurrence of an accident at the claimant's workplace does not automatically establish that the injury "arose out of" the claimant's employment. *Parro v. Industrial Comm'n, 167 Ill. 2d 385, 393, 657 N.E.2d 882, 212 Ill. Dec. 537 (1995).* "The 'arising out of' component is primarily concerned with causal connection" and is satisfied when the claimant has "shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Sisbro, Inc., 207 Ill. 2d at 203.* There are three types of risks to which employees may be exposed:

(1) risks that is distinctly associated with employment;

(2) risks that are personal to the employee, such as idiopathic falls; and

(3) neutral risks that do not have any particular employment or personal characteristics.

Potenzo v. Illinois Workers' Compensation Comm'n, 378 Ill. App. 3d 113, 116, 881 N.E.2d 523, 317 Ill. Dec. 355 (2007). With respect to the third category, "[i]njuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public." The increased risk may be either *qualitative* (*i.e.*, when some aspect of the employment contributes to the risk) or *quantitative* (such as when the employee is exposed to the risk more frequently than members of the general public by virtue of his employment). See, *Lynch Special Services v. Industrial Commission*, 76 Ill.2d 81 (1979).

In this case, Petitioner claims she injured her hand while giving a "high-five" to a co-worker, which in and of itself may be said to be an activity of everyday life. There was no evidence that the injury was caused by a risk distinctly associated with employment (#1). Testimony from both Petitioner and Navedo established that the employment duties as a billing analysis included working with computer software to handle billing for various clients. It was not established that giving a "high-five" was an employment duty or risk. There is also no evidence that the injury was caused by a risk personal to the employee, like an idiopathic fall (#2).

Thus, the injury in question is one of neutral risk origin, without any particular employment or personal characteristics. Accordingly, an analysis of whether the neutral risk was one in which the Petitioner was exposed to of a greater degree than the general public, either qualitatively or quantitatively, is appropriate. Here, Petitioner failed to provide any business purpose for giving the high five, other than being elated to have solved a task. Qualitatively, there is no evidence that she was directed to, expected to or otherwise required to praise, congratulate or celebrate completion of work tasks. There was also no evidence that some aspect of the employment, i.e. working with spreadsheets or a computer, contributed to the risk. Quantitatively, Petitioner did not present any evidence that the neutral risk of high-fiving was one she was exposed to of any greater degree than the general public. She did not show that this act was one performed by her or other workers regularly and if so, how often. This conclusion is supported by Navedo's testimony, which essentially established that she was startled by Petitioner's voluntary act that she instinctively put up her hand, which had a chip clip in it still. The Arbitrator finds that Petitioner's accident was caused by actions personal to the Petitioner which voluntarily increased her risk of injury or constituted horseplay. See, *Kaschub v. Darien-Woodridge Fire Protection Dist.*, 12 IWCC 232 (Mar. 7, 2012).

b. In the Course Of

The "in the course of employment" element refers to the time, place, and circumstances surrounding the injury. *Sisbro, Inc. v. Industrial Comm'n, 207 Ill. 2d 193, 203, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003)*. That is to say, for an injury to be compensable, it generally must occur within the time and space boundaries of the employment at a place where the employee may reasonably be in the performance of his (her) duties, and while the employee is fulfilling those duties or engaged in something incidental thereto. *Lynch*, supra.

The Arbitrator has concluded Petitioner failed to meet her burden as to the arising out of component and is not inclined to address the second prong required for accident. Nevertheless, it cannot be said that the Petitioner was fulfilling her duties or engaged in something incidental thereto. There was no testimony to suggest that the "high-five" was part of the Petitioner's duties as a billing analyst or in any way related to her work as a billing analyst. The Petitioner had completed her work duties, a routine activity that she performs several times per day, at the time of the incident. Her actions were purely personal and did not benefit her employer in any way. Therefore, even under the "in course of" prong, Petitioner has failed to prove accident.

ISSUE (F) Whether Petitioner's current condition of ill being causally related to the injury?
ISSUE (L) What temporary benefits are in dispute?

Having found Petitioner failed to prove she sustained an accident arising out of and in the course of her employment with Respondent; the remaining disputed issues are rendered ***moot***.

Signature of Arbitrator

12-21-15
Date

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

David Bent,

Petitioner,

vs.

NO: 14 WC 35764

Countrywide Payroll & Solutions, Inc.

Respondent,

17IWCC0126

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue(s) of accident, prospective medical, employee/employer relationship, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 13, 2016, is hereby affirmed and adopted.

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

17IWCC0126

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.

DATED: MAR 2 - 2017
o020917
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

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

BENT, DAVID
Employee/Petitioner

Case# **14WC035764**

COUNTRYWIDE PAYROLL & HR SOLUTIONS INC
Employer/Respondent

17IWCC0126

On 5/13/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0384 NELSON & NELSON
NATHAN C LANTER
420 N HIGH ST
BELLEVILLE, IL 62220

2795 HENNESSY & ROACH PC
JENNIFER YATES WELLER
415 N 10TH ST SUITE 200
ST LOUIS, MO 63101

17IWCC0126

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)

DAVID BENT
Employee/Petitioner

v.

COUNTRYWIDE PAYROLL & HR SOLUTIONS, INC.
Employer/Respondent

Case # **14** WC **035764**

Consolidated cases: **N/A**

17IWCC0126

An *Application for Adjustment 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 **JULY 17, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0126

FINDINGS

On the date of accident, **September 11, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* 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 $**reserved**; the average weekly wage was $ **reserved**.

On the date of accident, Petitioner was **33** years of age, ***married*** with **3** dependent children.

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

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

Respondent is entitled to a credit of **$8,053.28** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $15,049.58, as set forth in Petitioner's exhibit 6, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall also authorize and pay for prospective medical treatment as recommended by Dr. Omiyi, as provided in Sections 8(a) and 8.2 of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Michael K. Nowak, Arbitrator

5/6/16
Date

ICArbDec19(b)

MAY 13 2016

FINDINGS OF FACT

On the date of hearing Petitioner was 33 years old, married, with three dependent children. Petitioner began his employment with the Respondent in October 2006. In September 2014 he was a truck driver. He would operate an 18-wheel truck in a multi-state area making deliveries of food products to Kentucky Fried Chicken, Taco Bell, and Quiznos restaurants. His job duties also involved unloading the truck with use of a ramp and a two-wheel handcart.

Before September 2014 Petitioner suffered two prior right knee injuries and filed two Illinois Workers' Compensation claims. The first injury occurred on 11/07/07, claim number 08 WC 035592, and the other on July 2008, claim number 08 WC 035593, while working for the Respondent. He underwent arthroscopic surgery by Dr. Bonutti in 2008. In February 2009 Dr. Bonutti released Petitioner to return to work full duty with no restrictions. Petitioner returned to work as a truck driver for the Respondent. The 08 WC 035592 claim settled for 2.5% loss of use of the right leg and the 08 WC 035593 claim settled for 20% of the right leg, 6% of a left arm, and 2.5% man as a whole. Petitioner also suffered an injury to his neck and left arm on 07/16/05. That claim settled for 2.15% man as a whole.

Before September 2014 Petitioner received occasional chiropractic care from Dr. Clinton Smith for his low back. The most recent appointment for his low back prior to this accident occurred on 05/11/11. Petitioner did return to Dr. Smith between 05/11/11 and 09/11/14 for treatment to this right elbow.

For a significant period of time before 09/11/14 Petitioner didn't receive any treatment for his low back, neck, or lower extremities, did not experience any significant pain in his right leg, right knee, low back, or neck, and was able to perform his job duties fully. In 2013 he passed a DOT physical.

The parties agree that on 09/11/14 Petitioner sustained an accident which arose out of and in the course of his employment at a Kentucky Fried Chicken store in Olathe, Kansas. As he was finishing his delivery he slipped and fell on soap and grease which was on the restaurant's floor. He landed hard on his back, neck, head, shoulders, and right hip and buttocks. When he fell his right foot got caught underneath a rack of pots and pans, twisting his right knee. Petitioner immediately called the Respondent's nighttime shift manager, Brandon Lake, and reported the injury. Petitioner finished his shift, which included three more stops, and drove back to the warehouse. While traveling he felt woozy and dizzy and experienced back pain, neck pain, right hip pain, and a bad headache.

On 09/12/14 Petitioner completed an Employee Report of Accident/Injury. (RX 2) He indicated injuries to his head, neck, back, trunk, shoulders, right arm, right hip, and butt. Petitioner testified he did not mention his foot getting caught underneath the rack because he wasn't thinking of it at the time.

On 09/12/14 Petitioner sought treatment at St. Joseph's Hospital's emergency room. The history taken was consistent with Petitioner's testimony. The ER record noted Petitioner had an immediate headache after the fall and feeling nauseous while he finished his shift. A contusion was noted at multiple shoulder sites. The triage assessment noted he had a limping gait and complaints of pain to his posterior neck, back, and right hip. X-rays of the lumbar spine, thoracic spine, and right shoulder were negative. A CT scan of the head was normal. Cervical spine CT showed mild dextroscoliosis suggesting muscle spasm. The diagnosis was an acute

cervical spine strain, minor head injury, and back pain. He was given a Torodol injection. He was told not to work for 5 days.

On 09/17/14 Petitioner sought treatment from Dr. Clinton Smith, D.C. Petitioner's complaints were neck and shoulder pain. The diagnoses were neck sprain, thoracic sprain, and torticollis. Dr. Smith provided manipulation to Petitioner's upper cervical spine. Petitioner underwent chiropractic care on 09/17/14, 09/19/14, and 09/24/14. During those appointments, muscle spasm was noted.

On 09/24/14 Petitioner completed a second Employee Report of Accident/Injury at the request of Madeline in Respondent's human resource department. At that time he indicated that when he fell on 09/11/14 he twisted his knee and the pain had gotten progressively worse. He also indicated injuries to his head, neck, back, trunk, shoulders, butt, and right knee. (RX 3)

On 09/24/14 Petitioner reported to Dr. Smith that his upper back and neck pain had resolved. Petitioner's main complaint was his right knee. He reported it was very stiff and sore when getting up from a seated position. Flexing and extending the knee were almost impossible and this came on immediately after the injury. Dr. Smith's examination of the knee showed exquisite tenderness. Dr. Smith noted Petitioner was able to work but was doing so with a limp. Dr. Smith ordered right knee x-rays which were negative. The diagnosis was knee strain. Therapy was provided and he was placed in a knee brace.

Petitioner testified he did not suffer any new injuries between 09/11/14 and 09/24/14. He testified he mentioned his right knee pain on 09/24/14 because his other body parts had stopped hurting as badly as they had immediately following the accident.

On 09/25/14 Dr. Smith noted Petitioner's right knee had improved overall 10%. The knee was still quite tender and sore. He did not see any internal derangement. Petitioner was told to continue wearing the brace. On 09/26/14 Dr. Smith ordered a right knee MRI which showed mild chondromalacia, suspect small ganglion in the posterior lateral aspect of the knee joint space near the tibia fibular articulation, small joint effusion, and no evidence of a meniscal tear.

On 10/06/14 Dr. Smith reviewed the right knee MRI report and noted Petitioner was still having pain and limping. He didn't know what was causing Petitioner's residual pain other than maybe some slight fluid in the knee. Dr. Smith released Petitioner from care.

On 10/16/14 Petitioner saw Dr. Didi Omiyi, an orthopedic surgeon. Petitioner's chief complaint was right knee pain. Dr. Omiyi noted Petitioner had a constant sharp pain mostly in the anterior aspect of his knee and a dull aching and throbbing on the medial and lateral aspects. Petitioner complained of big toe numbness. Petitioner also described right-sided low back pain. On physical exam, the range of motion of the knee was limited to 120 degrees due to discomfort. Dr. Omiyi noted the knee was swollen, found a positive patella grind with compression of the kneecap and the patella, and evoked a positive McMurray test. Dr. Omiyi's diagnosis was right knee sprain and chondromalacia. He reviewed the right knee x-rays and MRI and told Petitioner they showed no structural injury. He administered a Marcaine injection for diagnostic and therapeutic purposes. He also prescribed anti-inflammatories and physical therapy.

On his own, Petitioner began using a crutch. He also used a cane. Sometime around 10/30/14 he fell at home while using the cane. He fell on his left knee. The fall did not cause any significant increase or change in his condition. It did not increase his right knee complaints.

On 10/30/14 Petitioner returned to Dr. Omiyi. The right knee injection did not provide any relief, and his knee got worse after the injection. Dr. Omiyi reviewed Petitioner's cervical and lumbar CT scans and noted they showed no fracture, dislocation, or bony abnormalities. Physical exam demonstrated significant discomfort with ROM of the knee. Petitioner had weakness in his right leg. Petitioner had some tenderness to palpation over his lumbar spine and over his right-side SI joint. He also had mild tenderness to palpation over the left thoracic spine. Dr. Omiyi suspected extraarticular causes of Petitioner's pain, due to the lack of positive response to the injection, right leg weakness, tingling in his toes, and occasional tingling in fingers. He recommended evaluation of Petitioner's spine with an MRI to detect any radicular causes of the pain and neurological symptoms. He ordered MRIs of Petitioner's lumbar, thoracic, and cervical spine. He also recommended Petitioner follow-up with his primary care physician who was prescribing pain medication and muscle relaxers.

On 11/18/14 Petitioner underwent MRIs of his lumbar, thoracic, and cervical spine. The radiologist's impression of the lumbar MRI was (1) the lumbar vertebral body heights and alignment was preserved without evidence of a disc bulge or focal protrusion; and (2) focal T11-12 disc protrusion causing mild central canal narrowing. The impression of the thoracic MRI was T11-12 focal disc protrusion mildly effacing the anterior thecal space. The impression of the cervical MRI was unremarkable.

On 11/21/14 Petitioner returned to Dr. Omiyi. Petitioner reported no improvement of his symptoms, tingling in his bilateral upper extremities, weakness in his right lower extremity, giving out of his right knee, having to ambulate with a crutch, and pain in the anterior aspect of his right knee. He was taking prescription pain medication and muscle relaxers that were not providing significant relief. If he sat for long periods of time his symptoms got worse. When he elevates his leg, the symptoms get a little bit better. Dr. Omiyi reviewed the lumbar, thoracic, and cervical MRIs and thought they were essentially unremarkable, other than a mild disc bulge in the lumbar spine. Dr. Omiyi indicated that none of the diagnostic evaluations had shown anything structurally that could be causing Petitioner's significant amount of pain for this amount of time. Dr. Omiyi did not believe there was anything that required surgical intervention. Dr. Omiyi did believe Petitioner's pain needed to be controlled, so he recommended Petitioner have an evaluation by a pain management specialist. Dr. Omiyi didn't believe Petitioner could fully perform his job duties, so he recommended light duty work, and was willing to revise this recommendation when Petitioner followed up with him after the pain management evaluation. Petitioner was allowed to drive but no loading, unloading, heavy lifting, pushing, or pulling.

On 05/05/15 Petitioner returned to Dr. Omiyi as a follow-up for back pain and right knee pain. He noted Petitioner was still using a crutch and had returned to work under restrictions. Petitioner was still complaining about low back pain and numbness and tingling in both of his legs and his right toes feel numb. He reports a twitch in his left arm with manipulation of his neck. He felt his neck was locking up. It would pop and feel stiff. He was getting occasional headaches and having pain at the base of his skull and down into his shoulder blades. Petitioner continued to take pain medication and muscle relaxers. Dr. Omiyi stated Petitioner seemed to exhibit a lot of pain which was not well-controlled. Dr. Omiyi continued to believe Petitioner was a candidate for pain management evaluation. He kept Petitioner under work restrictions.

The evidence deposition testimony of Dr. Didi Omiyi was offered into evidence. He opined Petitioner suffered an injury to his right knee, neck, and back due to the fall on 09/11/14. (PX 7, p. 22) He believed Petitioner's right knee and back symptoms were related to his fall on 09/11/14 because Petitioner was not having any symptoms prior to 09/11/14. *Id.*, at 23 More specifically, he opined the underlying right knee arthritis was aggravated and made symptomatic by the 09/11/14 fall. Dr. Omiyi didn't find anything structurally wrong in the knee that required surgical intervention. *Id.*, at 18 He indicated that he referred Petitioner to pain management because he was concerned Petitioner was experiencing complex regional pain syndrome (CRPS) as a result of his injuries. *Id.*, at 18, 22. Dr. Omiyi opined the 09/11/14 fall was a cause for the need for the treatment her provided and his recommendation for pain management. *Id.*, at 24-25. He did not believe Petitioner had yet reached MMI. *Id.*, at 25-26. He believed Petitioner should be evaluated by pain management to find out if there's anything that could be done from a interventional standpoint to help control Petitioner's pain. *Id.* He believed the treatment he provided was reasonable and necessary. *Id.*, at 26. On cross-examination, Dr. Omiyi indicated his referral for pain management was due to Petitioner's ongoing right knee complaints as well as lumbar, thoracic, and cervical pain. *Id.*, at 38).

A Section 12 examination was performed by Dr. Russel Cantrell on 10/02/14. The evidence deposition testimony of Dr. Cantrell was offered into evidence by the Respondent. His diagnosis was a concussion and cervical, thoracic and lumbar strains. (RX 1. p. 17) He believed these conditions had resolved with the course of treatment Petitioner had received. *Id.* He believed Petitioner had reached MMI for the diagnosed conditions and did not require any additional treatment. *Id.*, at 17-18. He didn't believe he needed any work restrictions as a result of those conditions. *Id.*, at 18. He didn't believe Petitioner sustained any specific injury to his right knee as a result of the work accident from 09/11/14. *Id.* He didn't believe the 09/11/14 fall was an aggravating factor to any pre-existing condition in Petitioner's right knee. *Id.*, at 19. He didn't believe he required any further medical treatment or work restrictions for his right knee. *Id.* He believed Petitioner had reached MMI for his right knee. *Id.* He didn't believe Petitioner had a diagnosis of CRPS. *Id.*, at 20. He didn't believe Petitioner needed any further evaluation or workup for a possible CRPS diagnosis. *Id.*, at 21. On cross-examination Dr. Cantrell indicated that he was unaware of any medical records indicating that in the days, weeks, and months before 09/11/14 Petitioner had experienced any significant back or neck pain or right leg pain. *Id.*, at 22-23. Further, he didn't have any information suggesting Petitioner was unable to perform his job duties to the fullest in the days, weeks, and months leading up to 09/11/14. *Id.*, at 24.

At the time of hearing, Petitioner testified right kneecap is painful. He still walks with a limp. His right leg has not been pain free since the 09/11/14 fall. His back and neck have not been pain free since the 09/11/14 fall. He currently takes Hydrocodone and Flexeril prescribed by his primary care physician Dr. Davidson. He is currently working for the Respondent full time, but under restrictions, as a transportation manager. Petitioner wishes to undergo the treatment, including the evaluation by pain management, as recommended by Dr. Omiyi.

CONCLUSIONS

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

In order to prevail on a claim for benefits under the Act, the employee must establish, among other things, that his or her current condition of ill-being is causally connected to a work-related injury. *St. Elizabeth's Hospital v. Workers' Compensation Comm'n,* 371 Ill.App.3d 882, 887, 309 Ill.Dec. 400, 864 N.E.2d 266

(2007). The accidental injury need neither be the sole causative factor nor the primary causative factor, as long as it was *a* causative factor in the resulting condition of ill-being. *Sisbro, Inc.*, 207 Ill.2d at 205, 278 Ill.Dec. 70, 797 N.E.2d 665. "The relevant question is whether the evidence supports an inference that the accidental injury aggravated the condition or accelerated the processes that led to the claimant's current condition of ill-being." *Mansfield v. IWCC*, 2013 IL App (2d) 120909WC (2013)

In *Absolute Cleaning/SVMBL v. IWCC*, 409 Ill.App.3d 463, 351 Ill.Dec. 63, 949 N.E.2d 1158 (4th Dist. 2011), the court considered the issue of causation in the context of an aggravation of a pre-existing condition. The court found persuasive the fact that the Petitioner was able to work without restrictions prior to the injury, and that the Petitioner's pre-existing complaints had abated by the time of the work related accident at issue. *Id* at 470. Further, the court noted that the treating physician opined that the claimant's work exacerbated or caused her condition and need for surgery, and even the examining physician believed Petitioner complaints of pain. *Id.* Based on this, the court concluded that, "a rational trier of fact could have agreed with the Commission's finding that the claimant's condition of ill-being was causally related to her work." *Id.*

The Arbitrator finds Petitioner to be a creditable witness. Petitioner's testimony that he did not experience any significant pain in his right leg, right knee, low back, neck or back in the days, weeks, and months before September 2014 is unrefutted. He was able to fully perform his job duties and was under no restrictions. It is not lost on the Arbitrator that Petitioner's first post accident complaint of right knee pain was on 09/24/14, almost two weeks post accident. However, in light of the other significant injuries sustained by Petitioner in the accident, including a concussion, the Arbitrator does not find it unreasonable that Petitioner would not fully appreciate his knee condition until the other symptoms began to subside. Dr. Omiyi opined Petitioner suffered an injury to his right knee, neck, and back due to the fall on 09/11/14. He believed Petitioner's right knee and back symptoms were related to his fall on 09/11/14 because Petitioner was not having any symptoms prior to 09/11/14. He opined the 09/11/14 fall was a cause for the need for the treatment her provided and his recommendation for pain management. The Arbitrator finds the testimony and opinions of Dr. Omiyi more persuasive than those of Dr. Cantrell.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that his current condition of ill-being is causally related to the 09/14/11 undisputed 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?

The Arbitrator concludes all of the medical treatment provided to Petitioner was reasonable and necessary. Respondent is to pay the medical bills of $15,049.58, as identified in Petitioner's Exhibit 6, pursuant to Sections 8(a) and 8.2 of the Act.. Respondent is entitled to a credit of $8,053.28 under Section 8(j) of the Act.

Issue (K): Is Petitioner entitled to any prospective medical care?

The Arbitrator concludes Petitioner is entitled to prospective medical care as recommended by Dr. Omiyi, including an evaluation by pain management and all concurrent and subsequently related treatment.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tristy Haversburk,

Petitioner,

vs.

NO: 14 WC 37315

17IWCC0179

Illinois Department of Revenue,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of prospective medical 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 9, 2016, is hereby affirmed and adopted.

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

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

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

The party commencing 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: MAR 24 2017
o030917
DLG/mw
045

David L. Gore

Stephen Mathis

Kevin W. Lamborn

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

HAUVERSBURK, TRISTY
Employee/Petitioner

Case# **14WC037315**

ILLINOIS DEPT OF REVENUE
Employer/Respondent

17IWCC0179

On 8/9/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0149 LAW OFFICES OF WARREN E DANZ
MICHAEL SUE
710 N E JEFFERSON
PEORIA, IL 61603

4138 ASSISTANT ATTORNEY GENERAL
WARREN WILKE
500 S SECOND ST
SPRINGFIELD, IL 62704

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

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

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

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

AUG 9 - 2016

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

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Tristy Hauversburk
Employee/Petitioner

v.

Illinois Department of Revenue
Employer/Respondent

Case # **14** WC **037315**

Consolidated cases: _____

17IWCC0179

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **April 22, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **September 26, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

No Average Weekly Wage was Alleged

On the date of accident, Petitioner was **50** 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 for all medical expenses and TTD payments.

Respondent is entitled to a credit for all medical expenses paid by its group health carrier under Section 8(j) of the Act.

ORDER

Respondent shall pay the reasonable and necessary medical services of $14,759.28, as provided in Sections 8 (a) and 8.2 of the Act.

Respondent shall pay for the prospective medical care of the Petitioner's left wrist, as explained in the accompanying Find of Facts and Conclusions of Law; Respondent is not liable for the prospective medical care of the Petitioner's left elbow.

In no instance shall this award be a bar to a subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

D. Dyan McCarty

8/4/2016

AUG 9 - 2016

The Arbitrator hereby makes the following findings of fact: 17IWCC0179

Petitioner is an employee of the Illinois Department of Revenue. Petitioner testified that, as of the date of trial, she had been employee for five years. Petitioner alleged that on September 26, 2014, she injured her left hand while using a large staple remover. Pictures of this remover are found in the exhibits to the depositions of each of the physicians. At trial, Petitioner confirmed that the pictured staple remove remover was substantially similar, if not identical to, the staple remover involved in her injury. Petitioner stated that while she was removing the staple, the staple remover kicked or flipped backwards and landed on her left hand between her fifth and fourth knuckles. According to Petitioner's testimony, it was not just that the remover merely flipped back, but that because she was putting pressure on the remover it came down upon and crushed the area between the fourth and fifth knuckles with significant force.

The medical records in the file demonstrate that Petitioner sought treatment on the date of injury, that she consistently treated since her injury, and that she was seeking and obtaining treatment as of the date of trial. As of the date of trial, Petitioner only had conservative treatment consisting of work restrictions, physical therapy, an injection, and palliative pain management. Petitioner, by way of this 19(b) hearing is requesting further medical treatment which consists of, but is not limited to, surgery to her left wrist and elbow.

Initial medical records show that the Petitioner was seen at St. John's Priority Care on the accident date. (RX 6) The history indicates that she did not want to be seen, but that she was told to be evaluated by her employer. She was diagnosed with a hand contusion and declined to have an x-ray. She returned to Priority Care on October 8, 2014 with a history of continuing pain since the accident, which was worsening that morning. (Id) She was referred to Dr. Sharma of the Springfield Clinic on October 10, 2014, and diagnosed with fifth MCP joint pain. Dr. Sharma ordered occupational therapy, which began on October 22. Her history at that time was ongoing pain in the 5th digit, aggravated by grabbing stacks of paper with her left hand. The pain level was described to be between 8 and 10 on a 10 point scale. Her examination by the therapist showed moderate tenderness to palpation of the MCP joint of the 5th digit with increased swelling. She was found to have signs and symptoms consistent with the referring diagnosis of sprain/contusion of the MCP joint of said digit. (Id) She continued to treat through Springfield Clinic, and eventually was referred to Dr. Ma, an orthopedist, whom she saw on December 2, 2014. He treated her conservatively over the course of the next nine months, with treatment consisting of therapy, work restrictions and medications. Nerve conduction studies were performed by Dr. Trudeau on December 22, 2014, and they revealed moderate to severe ulnar neuropathy of the left wrist.

Petitioner testified, with corroboration by the above medical records, that she began having pain proximal to the wrist traveling up to the elbow around the time of her nerve tests. Dr. Ma' examinations from December on noted positive Tinel's signs for ulnar neuropathy at both the left wrist and elbow, and he carried a diagnosis of cubital tunnel syndrome as well as a wrist entrapment at the canal of Guyon. (PX 2) On August 18, 2015, the Petitioner switched her care over to Dr. Cummings, an occupational medicine specialist in Peoria, Illinois. He arrived at the same diagnosis, and has attempted to refer the Petitioner to Dr. Garst, an orthopedic surgeon in Peoria, for surgery. The Respondent has refused to authorize said referral.

Petitioner has continued to work since the date of accident, limiting the use of her left hand since around the time she began with Dr. Ma. She has been turning in his restrictions to Dave Klintworth, the Respondent's workers comp coordinator. Mr. Klintworth testified and verified that he had been receiving her work slips.

Conclusions of Law

Initially, the Arbitrator must explain some procedural issues which have delayed the issuance of this decision. The Respondent's attorney filed two post trial motions, both of which requested additional evidence be allowed into the record.

The first motion asked that physical therapy records from the Springfield Clinic for treatment in July 2015 be admitted. As the Petitioner's attorney has not objected to the motion, the Arbitrator has allowed the records into evidence, and they are marked for identification as Respondent's Exhibit 9.

The second motion alleges that the Petitioner's attorney engaged in an ex parte communication with the Arbitrator by submitting his proposed decision to the Arbitrator without immediately sending a copy to the Respondent's attorney. The Arbitrator denies this motion, but does include the motion and relevant documents in the record as a rejected exhibit, Respondent's Exhibit 10.

While the Respondent is entitled to receive the proposed decision of the Petitioner, he is not entitled to that document until the time has elapsed for submitting both proposed decisions. Commission Rule 7030.80 outlines the procedure for submitting proposed decisions in a simultaneous fashion. The rule does not provide that one side should be able to read his opponent's proposed decision before preparing and submitting his own. Were that the rule, it would give the party last to file an unfair advantage over the party first to file. In this case, proposed decisions were due on June 6. Petitioner's attorney sent in his decision on May 23. The parties agree that once the deadline of June 6 passed, the Petitioner's attorney sent his proposed decision to the Respondent's attorney. The submission of the prosed decision early by the Petitioner's attorney was proper under the Rule referenced above. It did not amount to an ex parte communication because the Respondent was sent the decision as soon as he was entitled to it after the time for filing had elapsed.

The Arbitrator finds that the only issue to be decided in this Section 19 b proceeding is whether the Petitioner's left cubital tunnel is causally related to her accidental injury. The Respondent, while stipulating to causation between the Petitioner's left wrist condition and her accident at arbitration, has proposed that the claim be denied in its entirety in his proposed decision.

The Request for Hearing, commonly known as the Stip Sheet, was signed by both parties and admitted into evidence as Arbitrator's Exhibit 1. On it the Respondent agreed to accident. It indicated a dispute without explanation to causation. Under medical, Respondent wrote that it had no liability for elbow trauma. Most importantly, the parties added bold language to paragraph 13 which deals with other issues. The language is as follows:

MAIN issue in dispute is Prospective Treatment for Petitioner's Left Cubital Tunnel. Respondent has accepted responsibility to Petitioner's left hand, but not the left Cubital Tunnel. Also, other issue in dispute is unpaid medical bills.

The Arbitrator finds that the law is clear on the issue. The Respondent is bound by its signed stipulation. In Walker v. The Industrial Commission, the Appellate Court dealt with the same issue. The Respondent on the stip sheet said that the Petitioner was temporarily totally disabled a period of 84 weeks. The Commission on review found the Petitioner only entitled to 29 plus weeks of benefits. Citing the clear language of Commission Rule 7030. 40, which remains in effect, the Court ruled the stip sheet was binding on the parties and found the Commission could not find an amount of TTD less than 84 weeks. Walker v. The Industrial Commission, 345 Il. App. 3d 1084 (2004).

Based upon the above, the Arbitrator finds that the Respondent stipulated that the Petitioner's left carpal tunnel was causally related to her accident and is now bound by that stipulation.

The Arbitrator now will address the causation issue as it pertains to cubital tunnel.

First of all, the Arbitrator notes that the Petitioner was struck by the staple remover over the 5th metacarpal joint of the left hand. There was no evidence offered to show any pre-existing injuries or treatment to either the hand or elbow. While she didn't initially think her injury was significant, she realized after about two weeks of work that she might have a problem. Her treatment records from October 8, 2014 forward show consistent complaints of pain and swelling over the lateral aspect of her left hand. Dr. Williams, whom the Arbitrator finds to be persuasive, testified that the point of impact on the Petitioner's hand matched the dermatomal pattern for an ulnar nerve entrapment at the wrist. (RX 1 at 29) Dr. Trudeau's electrical studies in mid December of the same year found the condition to be moderately severe. Finally, all three physicians who testified found a causal connection between the accident and the Petitioner's nerve entrapment at the wrist.

The Arbitrator does, however, question the causal link between the accident and cubital tunnel. First of all, the Petitioner testified that she did not notice any proximal symptoms until after her nerve studies. Dr. Williams noted from his review of the early medical records that there was no indication that the Petitioner had any swelling proximal to the wrist. (RX 1 at 24, 47) He said that in order for a double crush injury to have occurred, swelling would have been required. (Id)

Dr. Ma stated that the injury to her hand could render the ulnar nerve more vulnerable, but that the Petitioner would not have cubital tunnel just because of an injury to the 5th metacarpal joint. (RX 2 at 72) He said that there would have had to have been a second injury to the elbow or repeated use of the arm for the vulnerability to become activated. (Id at 71)

The Arbitrator finds that the opinions of Dr. Cummings, though thorough, are unpersuasive for two reasons. First, unlike the other two physicians Dr. Cummings is neither a hand nor upper extremity specialist. Second, much of Dr. Cummings' opinion is couched in terms that indicate possibilities and potentials, and lacks the certainty found in the opinions of the other physicians. This uncertainty is perhaps best described by the fact that Dr. Cummings could not decide between four differing causation

theories. Moreover, Dr. Cummings' opinion was at times paradoxical without adequate explanation. For instance, in attempting to explain how Petitioner could have symptomology immediately following the accident, which was potentially indicative of elbow neuropathy, only to have that symptomology disappear then reappear Dr. Cummings stated that "sometimes these nerve problems take a while to develop." (PX 6 Pg. 71). This statement did nothing to address the fact that Petitioner had alleged cubital tunnel symptomology shortly after the accident, which by its very nature would defy the explanation of taking a while to develop. Generally, Dr. Cummings offered no adequate explanation as to how an elbow neuropathy, which was first diagnosed in July of 2015, could be causally connected to an accident that occurred in September of 2014 when an EMG/NCV from December of 2014 showed no evidence of any neuropathy at the elbow. Based upon the above, the Arbitrator finds that the Petitioner has failed to prove that her cubital tunnel condition is related to her accident, and denies the future medical requested for that condition.

Respondent also raises questions about the Petitioner's credibility which must be addressed. First of all, they allege that the Petitioner altered one of the work restriction slips provided by Dr. Ma. The slip, signed by the doctor, has a date of July 11, 2015. It was shown by the testimony of Mr. Klintworth that the slip was received by him on June 17, 2015. Dr. Ma testified on the issue, and it appears to the Arbitrator that his office likely changed the date on the slip from its original date of June 11, 2015. Dr.Ma explained that he issued a series of work slips over the course of his treatment. The slips look identical except for the date on which they were signed. The doctor testified that he did issue a slip with restrictions on June 11. (RX 2 at 42) Dr. Ma said that his office could have changed the date on that slip to July 11, as his restriction had not changed. More importantly, Mr. Klintworth essentially testified that the work slip in question was not important. When he received the slip he contacted the Petitioner and told her of the problem. She then went back to Dr. Ma and got a corrected slip. Mr. Klintworth received the slip, presumably sent it on to TriStar, and did nothing more about it. The Petitioner has continued to work with restrictions and has continued to provide slips to the Respondent. The Arbitrator finds that the slip issue has no bearing on the Petitioner's credibility.

Next the Respondent contends that statements and conduct by the Petitioner during one of her periods of physical therapy were inconsistent with her claimed injuries, which had an adverse effect on her credibility. Respondent's argument has no merit.

The Respondent's attorney questioned Dr. Ma at length during his deposition on November 3, 2015, concerning the PT entries. (RX 2 at 21-30) Dr. Ma answered each question in the same manner. None of the entries changed his opinions as to diagnosis or causation. He said that the Petitioner could have ulnar neuropathy at the wrist despite being able to hold her purse and phone at therapy and making some inconsistent pain complaints during the course of said therapy. The Arbitrator notes that the nerve studies done about six months prior to the therapy showed moderate to severe neuropathy at the wrist. Thus, the use of her hand and arm while in physical therapy does not diminish the objective evidence of neuropathy.

In conclusion, the Arbitrator finds the Petitioner has shown a causal connection between her accident and her ulnar wrist neuropathy. He orders the Respondent to pay for the proposed treatment for that condition. The Arbitrator further finds the Petitioner has failed to prove causation between said

accident and her cubital tunnel of the elbow, and denies the proposed treatment for that condition. Respondent is ordered to pay the bills contained in PX 7, to the extent allowed under the fee schedule.

18,248

ILLINOIS WORKERS' COMPENSATION COMMISSION
APPEARANCE OF REPRESENTATIVE

Please see the other side of this form.

Brenda Mehlberg
Employee/Petitioner

v.

Hillsboro Community School District #3
Employer/Respondent

Case # 16 WC 21296

17IWCC0179

I hereby enter my appearance as counsel ☒ co-counsel ☐ for the petitioner ☐ respondent ☒.

Michael Baggot
Signature of attorney

MICHAEL R. BAGGOT 4234
Attorney's name and IC attorney code# [1] (please print)

847-781-5200 mbaggot@rnbk.com
Telephone number E-mail address

QBE The Americas
Name of respondent's insurance/service company (please print)

RIPES NELSON BAGGOT & KALOBRATSOS,
Firm's name

650 E DEVON AVENUE SUITE 110
Street address

ITASCA IL 60143
City, State, Zip code

ATTENTION, ATTORNEY. A co-counsel appearance must be accompanied by a copy of the original *Attorney Representation Agreement* with the co-counsel's signature. Please indicate where the Commission should send notices:

☐ Name and address listed above

PROOF OF SERVICE

If the person who signed the *Proof of Service* is not an attorney, this form must be notarized.

I, Mollie Thiriot, affirm that I delivered ☐ mailed with proper postage ☒

in the city of Chicago a copy of this form

at 5:00 PM on 3/16/17 to each party at the address(es) listed below.

James K. Keefe, Jr.
Keefe & DePauli, P.C.
#2 Executive Drive
Fairview Heights, IL 6220895

++

+

Mollie Thiriot
Signature of person completing *Proof of Service*

Signed and sworn to before me on 3-16-17

Marisol Lugardo
Notary Public

OFFICIAL SEAL
MARISOL LUGARDO
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 06/14/20

[1] The Commission assigns code numbers to attorneys who regularly appear before it. To obtain or look up a code number, contact the Information Unit in t
Chicago office or any of the

REJECTION OF APPEARANCE 17IWCC0179

Date _____

To: Michael R. Baggot
Ripes Nelson Baggot & Kalobratsos, PC.
650 E Devon Avenue, Suite 110
Itasca, IL 60143

Your appearance has been rejected for the following reason(s):

_____ No case number is listed.

_____ The wrong case number is listed.

_____ You did not attach the *Attorney Representation Agreement.* This is required for a petitioner's counsel.

_____ You did not provide a copy of the original *Attorney Representation Agreement* with your signature. This required for a petitioner's co-counsel.

_____ Proof of service was not provided.

_____ You did not indicate where notices should be sent.

_____ Another attorney is listed as counsel, and he or she has not withdrawn or been dismissed.

_____ Other: _____

_____

_____

If you have questions, please contact any Commission office. Return the corrected form to:

DATA ENTRY UNIT
ILLINOIS WORKERS' COMPENSATION COMMISSION
100 W. RANDOLPH STREET, #8-200
CHICAGO, IL 60601

18,248

ILLINOIS WORKERS' COMPENSATION COMMISSION
APPEARANCE OF REPRESENTATIVE

Please see the other side of this form.

Brenda Mehlberg
Employee/Petitioner

v.

Hillsboro Community School District #3
Employer/Respondent

Case # 16 WC 21296

17IWCC0179

I hereby enter my appearance as counsel ☒ co-counsel ☐ for the petitioner ☐ respondent ☒.

Michael Baggot
Signature of attorney

MICHAEL R. BAGGOT 4234
Attorney's name and IC attorney code# [1] (please print)

847-781-5200 mbaggot@rnbk.com
Telephone number E-mail address

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Name of respondent's insurance/service company (please print)

RIPES NELSON BAGGOT & KALOBRATSOS,
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I, Mollie Thiriot affirm that I delivered ☐ mailed with proper postage ☒

in the city of Chicago a copy of this form

at 5:00 PM on 3/16/17 to each party at the address(es) listed below.

James K. Keefe, Jr.
Keefe & DePauli, P.C.
#2 Executive Drive
Fairview Heights, IL 6220895

++

+

Mollie Thiriot
Signature of person completing *Proof of Service*

Signed and sworn to before me on 3-16-17

Marisol Lugardo
Notary Public

OFFICIAL SEAL
MARISOL LUGARDO
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 06/14/20

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_____ Other: _____

_____

_____

If you have questions, please contact any Commission office. Return the corrected form to:

DATA ENTRY UNIT
ILLINOIS WORKERS' COMPENSATION COMMISSION
100 W. RANDOLPH STREET, #8-200
CHICAGO, IL 60601

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

Susan Bryant,

Petitioner,

vs.

NO: 14 WC 37575

17IWCC0170

Lurie Children's Hospital of Chicago,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, medical expenses, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 22, 2016, is hereby affirmed and adopted.

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

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

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

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

DATED: MAR 2 2 2017
TJT:yl
o 3/7/17
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

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

BRYANT, SUSAN
Employee/Petitioner

Case# **14WC037575**

LURIE CHILDREN'S HOSPITAL OF CHICAGO
Employer/Respondent

17IWCC0170

On 3/22/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0328 LEWIS & DAVIDSON LTD
RICHARD C SCHOLLENBERGER
ONE N FRANKLIN ST SUITE 1850
CHICAGO, IL 60606

2965 KEEFE CAMPBELL BIERY & ASSOC
MATTHEW IGNOFFO
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

17IWCC0170

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)

Susan Bryant
Employee/Petitioner

v.

Lurie Children's Hospital of Chicago
Employer/Respondent

Case # 14 WC 37575

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maria Bocanegra**, Arbitrator of the Commission, in the city of **Chicago**, on **January 19, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0170

FINDINGS

On the date of accident, **July 28, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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 **$68,763.24**; the average weekly wage was **$1,322.37**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **5** 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 **$17,747.60** for TTD, **$7,901.06** for TPD, **$0** for maintenance, and **$18,829.75** for other benefits, for a total credit of **$44,478.41**. Respondent is entitled to a credit of under Section 8(j) of the Act for all necessary and related medical expenses.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$881.58/week** for **92-1/7th weeks**, commencing **July 29, 2012** through **October 20, 2012**; from **December 2, 2012** through **January 26, 2013**; from **September 23, 2013** through **November 3, 2013** and from **April 9, 2014** through **July 15, 2015**, as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$17,717.60** for temporary total disability benefits a credit of **$18,829.75** for short term disability benefits that have been paid.

Respondent shall pay Petitioner temporary partial disability benefits of **$746.46/week** for **26-1/7th weeks**, commencing **July 16, 2015** through **January 14, 2016**, as provided in Section 8(a) of the Act. Respondent shall be given a credit **$7,901.06** for TPD.

Respondent shall pay reasonable and necessary medical services of **$62,602.66**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize, approve and pay for the surgical recommendations of Drs. Tack and Goldberg.

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

3-21-2016
Date

MAR 2 2 2016

17IWCC0170

FINDINGS OF FACT

Susan Bryant's ("Petitioner") employment with Ann & Robert H. Lurie Children's Hospital of Chicago ("Respondent") began in March of 2012 as a registered nurse. Petitioner testified she could not recall being on pain medication as of March 2012. Prior to beginning her job, she filled out a four-page document submitted into evidence as Rx6. Petitioner testified she personally prepared this document. Petitioner admitted at or around February 16, 2012 she was taking Norco pain medication but could not remember what this pain medication was for.

Petitioner testified that on July 28, 2012, the date of her accident, she was working in Respondent's Neonatal Intensive Care Unit as a Registered Nurse. Prior to her accident, she denied receiving any treatment for her low back. She testified that she did have typical backaches prior to the accident that would resolve with Ibuprofen, which she attributed to being the mother of five.

On that date, she began her shift at 7:00 pm. At approximately 8:30 pm, she was doing hands on care for an eight-pound baby who had received a spina bifida repair. As Petitioner turned and started to step forward to hand the baby off, the mother reclined the chair. The legs popped open in front of Petitioner, causing her to overextend and fall forward with the baby. Petitioner then noticed "immediate sharp pain in her lower back."

Petitioner reported the incident to her charge nurse, Maureen, who asked her if she wanted to go home. Petitioner testified she told Maureen she would try to finish her shift, which ended at 7:00 am. During her remainder of her shift, she took Ibuprofen, but as the night progressed, it got worse. She described sharp pains in her low back and numbness and tingling down her right leg.

The next morning, on July 29, 2012, around 7:30 am, Petitioner was taken by the charge nurse to Respondent's emergency room department and evaluated by Dr. Reynolds. She complained of back pain after transferring an infant from a warmer to his mother the day before. Deep right hip pain, tingling/numbness of the lateral right thigh were noted. Exam of the low back was tender at the paraspinal on the right side at L5-S1. Tingling laterally and at the top of the right thigh without loss of sensation was noted. Straight leg raise (SLR) was positive bilaterally. Px1:2. She was diagnosed with acute back pain with radicular pain and was transferred to Northwestern Memorial Hospital Emergency Department by wheelchair. *Id.*

On that same date, at the Northwestern Memorial Hospital Emergency Department, Petitioner was seen by Dr. Emily Baran. Px2. Petitioner related she was transferring a baby when she had to bend further than anticipated. She complained of pain to the right lower back and right hip with numbness to the lateral right thigh. Right lumbar spine "radiating down L leg with some paresthesias to outer leg"[1] was noted. Petitioner confirmed she was currently on no medications and had no significant past medical history of back pain. SLR was negative on the left and positive on the right. Impression was sciatic pain following rapid back flexion with intact strength and sensation. Differential diagnosis was sciatic pain versus atypical presentation of kidney stones, but CT for stones was negative. Petitioner was prescribed Norco and Valium for sciatic pain. A referral to spine surgery and corporate health was given.

[1] The medical record references right leg and thigh through the remainder of the record.

On August 9, 2012, Petitioner was seen at Northwestern Corporate Health Services by Dr. Joseph Mitton. Px3. An onset of low back pain when handing off an eight-pound baby and reaching out to avoid dropping the infant was noted. She related she felt immediate pain in the right low back which improved but then increased by morning. She was unable to sit or stand without pain to the right leg. Exam showed loss of lumbar motion and positive SLR on the right. Diagnosis was lumbar strain with radiculopathy. Norco, physical therapy and an MRI of the lumbar spine were ordered. Petitioner was given a ten-pound lifting limit with no repetitive bending, twisting or leaning; and be able to change positions from sitting to standing to moving about as needed. Petitioner testified that work was not provided within these restrictions.

On August 15, 2012, Petitioner began recommended physical therapy at NovaCare Rehabilitation. Px5. Treatment was regularly provided through January 28, 2013. On August 16, 2012, MRI of the lumbar spine showed L3-4, L4-5 and L5-S1 minimal central spinal stenosis secondary to small focal central disc bulge at each level, no focal disc herniation and multilevel facet arthrosis was present at the same levels. Px4:8.

On August 16, 2012, Dr. Mitton noted no improvement, continued low back pain with radiation into the right leg with intermittent tingling over the right calcaneus area of the foot. Px3. The MRI was reviewed. Diagnosis was unchanged and he thought Petitioner may be a candidate for a lumbar epidural steroid injection (LESI) and was referred to Dr. Stanford Tack. Prior restrictions were continued.

On August 27, 2012, Dr. Tack evaluated Petitioner. Px9. He noted her history of accident, onset of low back and right leg radicular pain without improvement to date. He found the MRI showed multilevel disc desiccation, annular tear at L4-5, all without significant spinal stenosis. He diagnosed right lumbar radiculopathy secondary to annular tear at L4-5 and recommended a LESI at that same level. Work restrictions were issued. Petitioner testified Respondent did not or could not accommodate those.

On September 6, 2012, at the referral of Dr. Tack, Petitioner underwent and Dr. Simon Adanin performed an initial LESI at L5-S1. Px6. Pre and post-operative diagnosis was "LSR" and "HNP @ L5/S1." Dr. Adanin reported that Petitioner presented with a work-related injury low back pain radiating to right lower extremity with numbness refractory to meds and physical therapy. He noted that the L5-S1 bulge effaced the ventral epidural fat contacting the thecal sac at the origin of the S1 nerve root sleeves. Mild bilateral facets arthrosis was present. Petitioner testified that following the injection her symptoms were at first worst, but then got a little better for a couple of days.

On September 18, 2012, Dr. Tack noted initial improvement after an epidural injection but that Petitioner's improvement had plateaued. Px4. She reported ongoing predominantly right-sided radicular pain associated with back pain. Dr. Tack recommended continued physiotherapy, a second LESI and continued work restrictions. On September 27, 2012, Dr. Jason Hennes performed a second LESI at L5-S1 on the right for a diagnosis of lumbar disc herniation and lumbar radiculitis. Px6. Petitioner reported decreased pain but still present post injection. Px6.

On October 8, 2012, Dr. Tack noted the second injection was effective in reducing Petitioner's leg discomfort but that she was still experiencing some back pain. He confirmed she had not been allowed to return to restricted work. Noting substantial improvement, he wanted to increase work restrictions and would consider an eventual release to unrestricted work. Px4.

On October 15, 2012, Petitioner presented for re-evaluation at NovaCare. Px5:40-42. Petitioner was noted to have more localized pain but low back pain continued to limit standing, bending, walking and

transitional activities such as turning over in bed and going from sit to stand. On October 22, 2012, Dr. Tack reported that Petitioner had increased her physical activity with significant reduction in back pain and that she was no longer taking pain medication. He released her to work without restrictions and advised her to follow up in one month for a final evaluation. Petitioner testified that returned to and performed her customary work schedule 12-hour shifts, 3 times per week. She testified her low back, right leg and right hip symptoms worsened during her shifts.

On November 9, 2012, Petitioner's family physician, Dr. Todd Paxton, indicated Petitioner could return to regular work as of November 12, 2012. Px10:44. On November 12, 2012, Petitioner returned to Dr. Tack and reported that she experienced increased low back pain with prolonged activity at work. Dr. Tack "had a discussion with Petitioner regarding her relative lack of progress over a five-month period of time." He did not encourage her to continue work at that time and agreed to treat her symptomatically and attempt to progressively increase her work activities as symptoms allow. He noted that if symptoms remained refractory and her work tolerance was poor, she may be a candidate for consideration of surgical intervention. He recommended a discogram prior to any intervention to determine the symptomatic level(s). Px4.

On December 3, 2012, Petitioner's therapist again performed a re-evaluation. Px5. Therapists noted continued radicular pain that increased after working 2 days in a row that remained over the weekend. On December 10, 2012, Dr. Tack noted Petitioner was tolerating work but working two days in a row greatly aggravated symptoms. The doctor noted discussion was had between Petitioner and Respondent to have work conditioning before returning to regular work. Dr. Tack noted that Petitioner was not exhibiting substantial improvement. He agreed to work conditioning but cautioned it was not a form of back treatment but rather a form of conditioning for attempted return to work. Surgical intervention was again considered as a last option. Px4.

On January 28, 2013, NovaCare noted Petitioner was "currently not able to work secondary to dysfunction. She has attempted to return with 10# lifting restriction, however the 12 hour shifts were too much for her back." Assessment was pain in low back currently localized recently radiating to the leg area. Petitioner was limited in lifting tolerance, standing, walking, carrying, push/pulling and stooping required for work. Petitioner stated that she still had twinges of pain and lifting required more time and care with technique but overall she was feeling well. She stated she felt ready to return to work. Between January 2nd through January 28th of 2013, Petitioner completed eleven additional therapy sessions at NovaCare. Petitioner had demonstrated ability to push and pull 70 pounds, occasional lifting of 25 pounds from waist to shoulder, and carrying 30 pounds close to her body. The recommendation was a return to full duty work. Px5.

On January 28, 2013, Petitioner returned to Dr. Tack after completing work conditioning and asked to be returned to work. Dr. Tack recommended she return to work limited to 8-hour shifts, 3-days per week for two weeks followed by return to full duty. Px4.

On March 4, 2013, Petitioner was evaluated by Dr. Tack's APN for follow up of low back pain. She did not have any radiculopathy symptoms. Her back pain had again increased when she returned to work. She had been able to tolerate 8-hour shifts but when she worked 12-hour shifts, she had difficulty concentrating, increased pain and discomfort towards the end of those shifts. On days she worked she did not take her Norco prescription and her cognitive abilities were impaired by pain. Restrictions were again decreased to 8-hour shifts 3-days per week. She was ordered to follow up with Dr. Tack in one month. Dr. Tack later issued a work status note dated March 15, 2013 increasing work to 12-hour shifts at 2-days per week. Px4.

On April 29, 2013, Petitioner saw returned to Dr. Tack for chronic low back pain due to multi-segment disc degeneration. She had been working 12-hour shifts 2-days per week. Petitioner continued to note improvement in symptoms and activity tolerance. She was exercising and was able to complete a 5K walk the previous weekend. Pain medication was sporadic. He recommended symptomatic treatment and released her to regular work of 12-hour shifts 3-days per week effective May 5, 2013. She was to follow up as needed.

Petitioner testified that she returned to her regular schedule on May 5, 2013 through September 2013 and performed her job when she could. She was intermittent on FMLA because her back was still causing problems. There was no treatment during this time. She testified that two weeks before seeing Dr. Tack on September 6, 2013, she had been stuck on a Metra train for six hours during rush hour. After this, she had intense pain and returned home without appearing for work. She tried rest and ice, which did not help. She said because of this, she returned to Dr. Tack. Her recollection at trial was corroborated in a physical therapy note.

On September 6, 2013, Dr. Tack confirmed Petitioner presented for a recurrent episode of low back pain radiating to her right lower extremity. He noted she had known disc degeneration with an annular tear at L4-5 and minor degenerative changes at L3-4 and L4-5. He noted that she had been back to work functioning fairly well until approximately two weeks ago when a recurrent episode of back pain with radiation occurred. He recommended repeat epidural injections and took her off work. Surgical options were again discussed to address discogenic pain. Follow up was ordered. Px4. Petitioner testified she contacted Respondent's Workers' Compensation Insurer requesting approval for the injection but it was not approved. Petitioner stated she used her health insurance.

On September 9, 2013, Dr. Eun-Kyu Koh performed a third LESI, this time at L4-5 on the right for a diagnosis of herniated nucleus pulpous and radiculitis. Px6. Petitioner testified she had only a day or two of relief following this injection. On September 23, 2013, Petitioner followed up with Dr. Tack for exacerbation of discogenic back pain. She reported that the injection had provided little relief. Dr. Tack confirmed the chronicity of her symptomology and the extent of time lost from productive employment over the course of the past year and several months. He recommended re-visiting physiotherapy for three to four weeks and reviewing her potential for returning to work. If she was still incapable of performing her occupational tasks due to severity of back pain, then consideration of surgery may be appropriate. Based on prior imaging, Dr. Tack believed fusion at L4-5 would be required but wanted a discography to confirm symptoms. If surgery was not elected, then she would be considered at maximum medical improvement (MMI). He released her to sedentary occupational activities.

On October 17, 2013, and October 23, 2013, Petitioner received physical therapy at NovaCare using her group health insurance. Px5. Petitioner presented with constant pain in the low back right side greater than the left side that increases with prolonged positions of sitting, standing, walking and prohibits bending or lifting. Her pain went into her buttocks and upper thighs with intermittent numbness and tingling in the leg area. Her pain level would vary from 2-9 out of 10. Petitioner paid $160.00 for these two visits. Petitioner testified that she could not afford to continue her physical therapy. She explained that she was the only income for her household and she could do the exercises at home.

On October 28, 2013, Petitioner presented to Dr. Tack. Petitioner stated her back had "improved greatly" and she had just started therapy again. Return to work issues were discussed. She wanted to return to work. Therapy was to continue. Dr. Tack released her to regular work effective November 3, 2013 but recommended she continue physiotherapy and return in one month. Px4. At trial, Petitioner explained she asked for the

release because she is a single mother of five, and needed to be at work full time, plus she loved what she did being a nurse and missed it greatly.

Petitioner testified that she returned to unrestricted work on November 3, 2013. When asked about her symptoms after November 3, 2013, Petitioner testified "I have never been pain free. I always have a certain level of pain. Again, some days are a little better than others and I am able to do more. But if I do too much, I pay for it." Petitioner further testified she did not treat with Dr. Tack between November 2013 and April 2014. Petitioner testified that on March 30, 2014, she applied for short term disability benefits. Petitioner confirmed she received these short term disability benefits from March 30, 2014 through September 27, 2014 in the amount of $18,829.75. Rx3.

On April 8, 2014, Dr. Paxton noted Petitioner presented with lower back pain from an injury in July 2012 and that exacerbation occurs from time to time and the pain had now been getting worse since the 29th of March. On April 9, 2014, she returned to Dr. Tack for a recurrent episode of back pain with intractable radicular pain. Dr. Tack confirmed that he had been seeing Petitioner and she had been performing physical therapy on a recurrent basis as well as a continuous basis independently. Petitioner felt intervention was necessary. The doctor noted that fusion surgery would require work-up, including a new MRI and discography. He re-reviewed the MRI from 2012, noting mild disc desiccation at L3-4, moderate disc degeneration changes with an annular tear at L4-5, Modic reactive change. He also noted mild-to-moderate dis degeneration with annular protrusion at L5-S1. He recommended an updated lumbar MRI, discography and then likely a lumbar fusion. Petitioner was prescribed Medrol Dosepak and Oxy IR. Petitioner was recommended to be off work until further notice. Px4.

On April 14, 2014, a repeat MRI showed L3-4, L4-5 and L5-S1 mild degenerative disc/spondylitic changes including small disc bulge, mild ligamentous prominence and facet arthrosis together causing minimal to mild central spinal stenosis but no foraminal stenosis or lateral recess stenosis. There was no significant change from the prior study. On April 16, 2014, Dr. Tack reviewed the MRI and found annular tear or HIZ[2] in the posterior annulus at L4-5 with mild to moderate spinal stenosis, significant facet arthropathy with fluid in the L4-5 facet joints as well as moderate Modic changes around the L4-5 discs eccentric to the right side. After a discussion of her frustration with inability to work and quality of life, he recommended a discogram followed by fusion. Medications and work restrictions were continued. Px4.

On April 30, 2014, discogram and post-discogram CT scan was performed by Dr. Strimling. The doctor's impression was that both the L4-5 and L5-S1 levels were contributing to Petitioner's pain complex. Petitioner reported pain at all levels except L3-4. Px4. He noted radiographic evidence of disc degeneration and annular disruption with posterior central radial tears. Post-discogram CT scan showed evidence of disc degeneration with mild disc bulging and posterior central radial tears from the level of L3-L4 through L5-S1.

On May 2, 2014, Petitioner returned to Dr. Tack. He confirmed the discogram was positive for concordant pain at L4-5 and L5-S1. Some discomfort was noted at L3-4 which was not typical of her condition. The doctor discussed the findings with Petitioner, noting her prolonged conservative care including repeated episodes of physical therapy, injections and medications. Petitioner was desirous of surgical treatment and he recommended fusion at L4-5 and L5-S1 along with post-operative care.

Petitioner testified she attempted to use group health for her surgery but was denied. She then asked Dr. Tack to write a letter stating it was not work related in order to get approval. In response, Dr. Tack provided a

[2] High intensity zone.

note dated May 16, 2014, stating that Petitioner's "current symptoms are not occupationally related. She has a condition that has been present over a multiple-year period and is characterized by recurrent episodic back pain with minimal trauma. There is no active workman's compensation claim for this condition. Treatment recommendations are based on a degenerative condition and not based on a traumatically induced condition." Rx5. On May 20, 2014, Petitioner saw Dr. Paxton for pre-surgical clearance for a lumbar laminectomy and fusion of L4, L5 and S1 requested by Dr. Tack. Px10. Petitioner testified that her group health insurance still refused to authorize her surgery.

On June 22, 2014, Dr. Tack authored a narrative report, stating that Petitioner suffered for the past two years with recurrent episodic low back pain, that she received an extensive course of repeated physical therapy, symptomatic management including analgesics and anti-inflammatory agents, epidural steroid injections, and activity modifications. He recommended the surgery as the logical definitive treatment choice for the patient as a result of failure of a multiyear treatment program for discogenic pain. He stated there were no other options that would offer any reasonable expectation of significant functional improvement. Petitioner testified that after the surgery was not authorized, she stopped seeing Dr. Tack because there was nothing else he could do for her. Thereafter, her low back condition was treated by her family doctor, Dr. Todd Paxton at Aurora Health Center. Px10.

On September 15, 2014, Petitioner saw Dr. Paxton, who noted she awaited a recommended lumbar surgery. She continued to have back pain and radiating pain down the right leg. She had increased anxiety issues. Her treating back doctor had stopped giving her medications due to insurance issues. Medications for chronic low back pain, anxiety, depression and radiculopathy were prescribed.

On October 17, 2014, Petitioner saw Dr. Paxton for chronic low back pain and radiating pain down the right leg. Medications for chronic low back pain, anxiety, depression and radiculopathy were prescribed.

On February 2, 2015, Petitioner returned to Dr. Paxton for low back and radiating pain. He noted she was having insurance/work comp issues and recently lost both her job and insurance. Medications were prescribed for anxiety/stress, radiculopathy and chronic back pain.

On February 16, 2015, Petitioner was seen at the request of her counsel by Dr. Edward Goldberg for an independent medical evaluation. Px14. He authored a report recommending a fusion at L4-5 and L5-S1. In his report, he stated that he could not give a causation opinion as to whether it was due to the accident, noting that the condition was initially aggravated by the accident but Petitioner reported that she continued to have symptoms that waxed and waned. He further noted that if she was not asymptomatic after returning to work, her condition of ill-being would be due to the original accident and that it had just progressed in terms of symptomatology.

On March 20, 2015, Dr. Paxton's office noted that it called an insurance company for possible disability determination forms and was told there were no open claims for Petitioner. On April 20, 2015, Petitioner saw Dr. Paxton for follow up of back pain and radiating pain down the right leg. He noted she was getting help with insurance/work comp issues. Neurological exam was positive for weakness and numbness. Px10. Follow up was ordered. Petitioner testified that she eventually stopped seeing Dr. Paxton because she lost her private group health insurance. After losing her health insurance, Petitioner got on state aid but Dr. Paxton's office did not accept it.

On June 4, 2015, Respondent secured surveillance video, approximately 3.5 minutes in total length. Petitioner is observed walking at a slow pace into a Hobby Lobby store, getting into her car and driving. Rx7. At trial, Petitioner confirmed her identity in the video and that the house and gold Chevy Impala belonged to her. She testified that at the time the video was taken, she was not free of pain.

On June 8, 2015, at Respondent's request Petitioner was seen by Dr. Andrew Zelby for Section 12 evaluation. Rx4. Dr. Zelby noted Petitioner's history of injury, followed by conservative care in the form of therapy, work conditioning and three injections. Petitioner admitted to a release to full duty work in May 2013 but that her back and right leg pain did not subside, causing her to miss work here and there. She also admitted to a flare up of pain in mid-2013, specifically recalling being stuck on a train for several hours in August 2013. She received additional medical care without relief. She was again released to full duty work in October 2013 and experienced another flare up of pain in March 2014. She had been off of work since then. The doctor noted a history of obesity. At the time of the visit, Petitioner related that almost any activity exacerbated her pain but that she was able to drive a car and put on shoes and socks. Exam was normal and positive for non-organic pain responses. The doctor reviewed medical records and his impression was mild lumbosacral spondylosis and low back pain. He read the MRI to show mild degenerative changes without neural impingements and without any acute or post-traumatic abnormalities. He found her reported symptoms inconsistent with objective findings. He did not agree with Petitioner's regimen of medications and stated she was able to return to full duty work. He diagnosed her with a prior history of obesity and stated she should be counseled on the relationship between weight and spine problems.

Petitioner testified that on July 16, 2015 she started working for Northwest Auto and Tire. She explained that the company is owned by her father and her work duties consist of running its Facebook page and ordering parts. Wage records confirm gross earnings of $4,987.00. Px13.

On August 18, 2015, Petitioner began treating with Dr. Oana Nisipeanu using state public aid benefits. Px11. She gave a history of back pain radiating into the right thigh after over extending at work, fluctuating in nature and occurring persistently. Medications were refilled and she recommended a psychological consult for depression. Petitioner returned for refills in October, November and December of 2015.

On November 25, 2015, at approximately 12:30 pm., Petitioner sought care at the Emergency Room of Vista Medical Center because her pain medications were not working and because she had been incontinent of urine five times over the past two days. Px12. After a lumbar CT scan, the diagnosis was acute on chronic exacerbation of sciatica right side. She was advised to follow up with a neurosurgeon if the incontinence recurred.

Later that same date, Petitioner testified she was at home and upon getting up from the couch, her right leg collapsed. She said her right leg was numb and tingling at the time. She returned to the emergency room at approximately 10:45 p.m., seeking care for a laceration to her scalp when she fell at home. She received a head CT and repair of a three centimeter laceration to the right frontal scalp. She was directed to follow up.

On November 30, 2015, the parties took the evidence deposition of Dr. Edward Goldberg. Px14. He testified that Petitioner's MRI findings were consistent with her clinical presentation in her treatment records; he noted that between April 2013 and September 2013, he found no change in Petitioner's presentation or symptoms. Dr. Goldberg opined that her diagnosis was unchanged and that of annular tear at L4-5 and L5-S1. He further testified that between October 2013 and April 2014, Petitioner reported her symptoms were unchanged and that the recommendation for discography remained the same. Dr. Goldberg testified that the

results of the discography, in his opinion, matched the findings on MRI. Dr. Goldberg diagnosed Petitioner with aggravated degenerative disc disease at L4-5 and L5-S1 along with radiculitis. The doctor opined that Petitioner was a candidate for fusion at both levels based on failure of conservative, non-operative care, functional limitations in activities of daily living and provocative valid discography testing. Dr. Goldberg identified two factors he considers when forming an opinion regarding whether an accident aggravated a pre-existing condition. He first considers the absence of symptoms prior to the accident. Dr. Goldberg agreed that Petitioner denied any prior lumbar problems. He also considers the continuity of pain following the trauma. The doctor testified that Petitioner exhibited a continuity of pain that waxed and waned if consistent through the time frame of treatment. He did note there were gaps in treatment but for which Petitioner reported ongoing symptoms. Regarding causation, he could not give an opinion but noted that Petitioner was never asymptomatic.

On December 3, 2015 and December 5, 2015, Respondent again secured surveillance video, approximately 16 minutes in total length, in which Petitioner is seen for several minutes walking at a slow pace, carrying small grocery bags, getting into her car and driving. Rx7. The video begins with several unidentified people entering a vehicle and driving away. The Arbitrator notes the similarity between that car and the car parked right next to it – both appear to look like gold Chevy Impalas. The video continues to focus on one parked gold car. Petitioner is then seen shopping at Jewel grocery. She is seen standing shopping or waiting in line. The video then captures Petitioner Aldi grocery store, standing and walking using a larger sized grocery cart. She stops to shop for children's toys but ultimately purchases none. Next, she is observed walking slowly to the car with a Jewel cart and loading bread and milk into her car. The items are in a Jewel grocery bag.

The video next captures her driving and parking in an Aldi parking lot. She grabs a large cart, enters Aldi and exits with a few items in hand. Petitioner is then seen parked at or near her home. She takes her groceries out of the back of the car. Petitioner testified she had no recollection of this day's events. The video next captures the same car on December 5, 2015 at the end of the 7am hour. Rx7. She is seen entering and exiting the car of various occasions. She is seen arriving and entering a church. She testified it was for the baptism of her children.

On December 15, 2015, the parties took the evidence deposition of Dr. Zelby. Rx4. He recounted Petitioner's history of accident. Dr. Zelby found no past medical history of prior episodes or similar symptoms. She reported sitting and standing tolerance of less than one hour, and walking tolerance as less than two blocks. Dr. Zelby opined that his physical examination was completely normal. As part of his evaluation, Dr. Zelby reviewed Petitioner's MRI reports but did not review the actual films. Based on the reports, Dr. Zelby opined that Petitioner has disc bulges, mild degeneration in the facets, no nerve impingement and mild stenosis. Dr. Zelby agreed that in his own practice he would not make a decision regarding surgery without reviewing the films personally. Dr. Zelby also agreed that sometimes he finds things on an MRI film that are not mentioned in an MRI report. Dr. Zelby agreed that the most current medical records he was asked to review was dated September 2013. As a result, Dr. Zelby provided no opinion regarding Dr. Tack's findings of April 2014 or the discogram findings. Dr. Zelby opined that there is no medical evidence to suggest Petitioner sustained any permanent disability as a result of the reported injury. He also stated there was no evidence Petitioner was not qualified to return to all of her regular job duties without restriction by November 2012 at the latest. He stated that even if Petitioner sustained acute annular tears as commented on by Dr. Tack, these would have healed within three to four months. Dr. Zelby stated that Petitioner was not a candidate for surgery.

At trial, Petitioner stated she attended a cheerleading event for her daughter at the beginning of 2014, a Cubs baseball game in August 2015, a Bible retreat in September 2015 and a Kentucky trip. She stated she

attempted to sell beauty products through a multi-level marketing company without success. She testified she cares for her own children and is not financially or physically responsible for her fiancé's children. She admitted her social media account states she is a stay at home mom but she explained that she put that because that is what she has been for the last couple of years. She testified her goal is not to be a stay at home mother but to return to work.

CONCLUSIONS OF LAW

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

It is undisputed Petitioner was employed by Respondent on July 28, 2012 as a neonatal nurse and that on that date, she sustained an accepted low back injury on this date when transferring an eight-pound infant.

The Arbitrator notes that through Petitioner's first release from care, October 22, 2012, Petitioner underwent conservative care by way of physical therapy, injections and work conditioning. During this time, Dr. Tack opined that Petitioner may require a fusion surgery if her symptoms remained refractory and her work tolerance remained poor. Petitioner testified that she returned to work after the October 2012 release and that her symptoms were worsening. She continued to treat with Dr. Tack and physical therapists in November and December of 2012. Fusion surgery was discussed and work shift hours were lowered. In January 2013, Petitioner completed work conditioning and asked to be allowed to return to regular work schedule. In March 2013, she once again returned to Dr. Tack's office, noting that she had been working her regular shift and experiencing worsening symptoms. Her shifts were once again reduced from 12-hour to 8-hour shifts. A month later, shifts were modified to 12-hour shifts, twice per week. In April 2013, Petitioner related she was tolerating work and was allowed to return to work full duty. Upon her release to full duty work, it is notable that Dr. Tack did not place Petitioner at maximum medical improvement but rather recommended continued "symptomatic treatment." She was ordered to follow up as needed. Medical evidence shows Petitioner would not return to Dr. Tack until September 2013.

Between her second release to full duty work in April 2013 and September 2013, Petitioner credibly explained that she was not pain or symptom free. Further, her testimony was that her ongoing symptoms required her to take FMLA leave intermittently during this period. Her testimony is unrebutted on this fact.

During this time, Petitioner candidly testified that in August of 2013, her pain worsened after being stuck on a Metra train for 6 hours. Dr. Tack's September 2013 records support Petitioner's testimony in this regard by confirming that she returned for persistent functionally limiting symptoms. Dr. Tack characterized her then condition as "*known* disc degeneration with an annular tear at L4-5 and minor degenerative changes at L3-4 and L4-5." The Arbitrator notes that no doctor concluded Petitioner's exacerbation following the train incident to be an intervening injury so as to break any causal connection. Further, while Petitioner's symptoms may have increased during this time, Dr. Tack's characterization of Petitioner's condition is essentially unchanged from prior visits. Dr. Tack recommended a third LESI and reiterated that Petitioner may require surgery if her symptoms remained refractory. Dr. Tack's records around this time also confirm Petitioner's testimony that between April 2013 and September 2013, she missed work for ongoing pain and symptoms, specifically stating that over the course of the past year and some months, Petitioner's symptomology had remained chronic causing an extent of time lost from productive employment.

Petitioner testified that without workers' compensation benefits for treatment and lost wages, she had no option but to ask Dr. Tack to release her to regular work on October 28, 2013. The doctor again released Petitioner back to work full duty. Petitioner's testimony is again corroborated by Dr. Tack's October 2013 note,

wherein he wrote that "return to work issues were discussed" but that "she wanted to return to work:" This being the third attempt at a release to full duty work, the Arbitrator notes that Dr. Tack recommended continued physiotherapy. Thus, Dr. Tack did not believe Petitioner to be at MMI from her original injury at this time, as the doctor ordered continued therapy and follow up care.

Petitioner testified she did not treat with Dr. Tack between November 2013 and April 2014. During this time, Petitioner stated she continued to experience pain, prompting an application for short term disability benefits. Petitioner again returned to Dr. Tack in April 2014 for a recurrence or flare up of back pain from a back injury in July 2012. Again, no doctor determined that Petitioner's flare up of pain was an intervening injury or accident so as to break any casual connection. A new MRI in 2014 showed no change when compared to the 2012 MRI, further supporting the Arbitrator's conclusion that Petitioner suffered no intervening injuries so as to break any causal connection. A discogram was performed and found concordant pain at L4-5 and L5-S1. Fusion surgery was again prescribed. Petitioner testified that her group health insurance denied approval and she admitted she directed Dr. Tack to write a letter stating that her condition was not work related. The Arbitrator is not persuaded that Dr. Tack actually believed Petitioner's lumbar condition and need for fusion surgery was not work related; he subsequently authored a narrative report indicating that her condition was from a failure of "multiyear" treatment for discogenic back pain. He further identified the recurrent episodic low back pain as two years in duration, which the Arbitrator notes is almost exactly two years from the date of Petitioner's work accident. Further, Dr. Tack's initial letter stating her condition was not work related stated there was no active workers' compensation claim, which the Arbitrator infers that Dr. Tack meant Petitioner's claim was in fact work related in his opinion but that at some point prior had been denied by workers' compensation. The Arbitrator's conclusion is supported by a later record dated March 20, 2015, where Dr. Paxton's office noted there were no open claims for Petitioner.

Following the inability to have surgery approved, Petitioner switched care to her primary doctor, Dr. Paxton. From that time until the date of her last treatment, November of 2015, Petitioner has largely been followed for pain medication management to treat her episodic chronic low back and right leg pain. Records show that Petitioner also presented to the emergency room in November 2015 for a fall that she attributed to her ongoing right leg symptoms. The Arbitrator notes that through out these records, Petitioner identifies her work accident as the precipitating cause. In summary, the Arbitrator does not find Petitioner's gaps in treatment indicative of a resolved lumbar condition or of maximum medical improvement. Each gap in treatment has been persuasively addressed and demonstrates Petitioner's ongoing waxing and waning of symptoms, prompting repeated returns to medical treatment with intermittent attempts to return to work.

Petitioner offered the medical opinions of Dr. Edward Goldberg. Dr. Goldberg reviewed her medical records, both sets of MRI films and the discogram films. He confirmed that although there was no neurological compression of the nerve found, he identified, similar to Dr. Tack, pain generators at L4-5 and L5-S1 caused by annular tears with extravasation and degenerative disc disease. He opined this was causing Petitioner's back pain and right leg radiculitis. Regarding causation, the Arbitrator notes that Dr. Goldberg was reluctant to contradict Dr. Tack's statement that Petitioner's condition was not work related and further notes Respondent's objection to the hypothetical posed to Dr. Goldberg during his testimony. However, the Arbitrator need not rely or address Dr. Goldberg's response to this as there is sufficient evidence in the record to conclude, as Dr. Goldberg did, that Petitioner was asymptomatic prior to the work accident, that her condition was unchanged through out her treatment as observed in the two MRIs and discogram result and that she has never been asymptomatic after the work accident. Thus, under a chain of events theory, Petitioner has proven by a preponderance of the evidence her current condition of ill-being is causally related to her work accident.

In addressing Dr. Zelby's opinions, the Arbitrator finds them less persuasive. First, he did not review any actual MRI film and only reviewed medical records through September 2013. Second, Dr. Zelby concluded there was no nerve impingement which, on its face, is not inconsistent with Dr. Goldberg's conclusion that he also observed no physical nerve compression. However, Dr. Zelby's opinion failed to address the annular tears identified by Dr. Goldberg on both MRI and discogram, which were determined to the source of Petitioner's pain generators. Further, Dr. Zelby noted that there was a disc effacing the epidural fat along the S1 nerve root but dismissed it. The Arbitrator notes that as early as September 2012, Dr. Adanin found this very same finding significant in deciding to proceed with the first LESI at L5-S1. Third, Dr. Zelby generally concluded that Petitioner's MRI was consistent with age related changes without further explanation. Fourth, his findings were the only findings to conclude that Petitioner's exam was normal, that Petitioner exhibited non-organic signs and that her complaints matched no objective findings. Fifth, Dr. Zelby suggested a correlation if not casual connection between Petitioner's alleged history of obesity and lumbar spine condition, which he had previously concluded was only degenerative in nature and age-related. The Arbitrator notes a steady, sharp and continuous gain in Petitioner's weight following her work accident as noted through out her medical records. However, insufficient explanation is given by Dr. Zelby for this assertion. In short, the Arbitrator finds the opinions of Dr. Goldberg more persuasive than Dr. Zelby's on the issue of Petitioner's condition of ill-being.

The Arbitrator also takes the opportunity to review the surveillance video submitted by Respondent. Rx7. Having carefully reviewed the video, the Arbitrator assigns no weight to the video surveillance in its entirety; noting that the video appears to be edited so as to be unreliable in its veracity or weight to be assigned. Therefore, the video lacks credibility. Specifically, Petitioner is seen at a Jewel grocery, standing or waiting in line with a *small* grocery cart. This occurs in the 15-hundred recording hour, as the video is captured in military time. Next, the video captures Petitioner at an Aldi grocery store, standing and walking using a *larger sized* grocery cart with a yellow or orange bag of chips or pretzels. The Aldi shopping also occurs in the 15-hundred hour. Next, she is observed walking slowly to the car with the *smaller* Jewel cart and loading bread and milk into her car. The items are in a *Jewel* grocery bag. The Arbitrator notes the shopping at both stores is recorded in the 15-hundred hour time frame while the loading of the grocery bags, shown after, occurs in the 14-hundred hour time frame. How or why the 15-hundred hour time frame is shown first, before the 14-hundred hour time frame, is unclear. After Petitioner loads the Jewel groceries, the video next purports to capture her appearing to drive and return back to Aldi and park in the Aldi parking lot. She grabs a large cart, enters Aldi and exits with a few items in hand. The Arbitrator notes at least one of the items appeared in the earlier video showing Petitioner shopping inside of the Aldi. All of this activity occurs in the 14-hour time frame. In short, the video is edited to appear to show Petitioner shopping all day and even returning to the Aldi store. It is evidence that shopping times have been edited and/or reversed. The Arbitrator notes that even if the videos were unedited, the Petitioner is observed performing benign day to day activities, for which she even admitted to Respondent's doctor she was able to tolerate, such as driving. The Arbitrator also observed instances in the video were Petitioner appears to walk slowly or with a slight limp, particularly during the grocery shopping.

In light of the above, the Arbitrator concludes that Petitioner's current condition of ill-being is causally connected to her accident of July 28, 2012.

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

Having found in favor of Petitioner on the issue of causal connection, the Arbitrator finds that the medical services that were provided to Petitioner were reasonable and necessary and that Respondent has not

paid all appropriate charges for same. The Arbitrator notes the gross amount, before payment, adjustment or discount, of Petitioner's medical bills as follows:

Px4	IBJI/Dr. Tack	$3,988.00
Px5	NovaCare – out of pocket	$160.00
Px6	Hawthorne Surgery Ctr	$19,265.00
Px7	NorthShore/Dr. Koh	$1,290.00
Px8	Advocate	$16,348.50
Px9	Adv. Radio. Consult.	$4,582.00
Px10	Dr. Paxton	$2,194.00
Px11	Dr. Nisipeanu	$2,288.07
Px12	Vista Med Ctr ED	$12,487.09
TOTAL CHARGES		**$62,602.66**

Medical records show that these bills were incurred as a result of treatment related to Petitioner's lumbar spine as recommended by her treating doctor, Dr. Tack. The record also shows that bills were incurred as a result of Petitioner losing her group health insurance and needing to switch care. The bills also reflect emergency room treatment, which the Arbitrator finds to be related to Petitioner's work accident.

In light of the foregoing, Respondent shall pay reasonable and necessary medical services of **$62,602.66**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

ISSUE (L) What temporary benefits are in dispute?

Temporary Total Disability

Petitioner seeks temporary total disability benefits from July 29, 2012 through October 20, 2012; from December 2, 2012 through January 26, 2013; from September 23, 2013 through November 3, 2013 and from April 9, 2014 through July 15, 2015 or for 92-1/7th weeks. Ax1.

Respondent paid temporary total disability from July 29, 2012 through October 20, 2012, and from December 2, 2012 through January 26, 2013. Payments made for these periods total $17,747.60. Rx1. Respondent seeks credit for this amount paid. Ax1.

The dates in which Petitioner alleges she was temporarily totally disabled correspond to appropriate medical work restrictions as issued by her treating doctors. As to the first unpaid period, Petitioner provided the September 6, 2013 office note of Dr. Tack taking Petitioner off work. Thereafter, on October 28, 2013, Dr. Tack released Petitioner to return to work effective November 3, 2013.

As to the second unpaid period, Petitioner presented the April 9, 2014 office note of Dr. Tack taking her off work pending further notice. Through July 15, 2015, she was regularly under the care of her primary care physician receiving medications to manage her low back pain and radiculitis. From April 16, 2014 through October 1, 2014, Petitioner received short term disability payments from Respondent totaling $18,829.75. Rx3.

Petitioner claims that this period ended on July 15, 2015, the day before she started part time work with Northwest Auto & Tire, Inc. on July 16, 2015. Px13. The Arbitrator rejects Dr. Zelby's opinion that Petitioner was capable of returning to work during these periods as those opinions have already been addressed, supra, as less persuasive.

Having found in favor of Petitioner on the foregoing issues, Respondent shall pay Petitioner temporary total disability benefits of **$881.58/week** for **92-1/7th weeks**, commencing **July 29, 2012** through **October 20, 2012**; from **December 2, 2012** through **January 26, 2013**; from **September 23, 2013** through **November 3, 2013** and from **April 9, 2014** through **July 15, 2015**, as provided in Section 8(b) of the Act. Against this award, Respondent shall be given a credit of **$17,717.60** for temporary total disability benefits that have been paid. In addition, Respondent shall be given a credit of **$18,829.75** for short term disability benefits that have been paid.

Temporary Partial Disability

Petitioner seeks temporary partial disability from October 21, 2012 through December 1, 2012; from January 27, 2013 through May 4, 2013 and from July 16, 2015 through January 19, 2016 or for 46-6/7th weeks. Ax1. Respondent paid temporary total disability from October 21, 2012 through December 1, 2012 and from January 27, 2013 through May 4, 2014. Rx1. Payments made for these periods total $7,901.06 over 9 payments. Rx1. Respondent seeks credit for this amount paid. Ax1. Thus, the disputed period is July 16, 2015 through January 19, 2016. This disputed period reflects the time in which Petitioner has worked for her father's tire company.

Petitioner testified that during the relevant periods noted above, she returned to work with modified restrictions, which decreased the number of hours worked per shift. The Arbitrator finds that Petitioner was temporarily partially disabled for the periods sought by Petitioner. Ax1. Petitioner submitted evidence indicating that she worked for and was paid weekly by Northwest Auto & Tire, Inc. from July 16, 2015 through January 14, 2016 earning a gross total of $5,298.56 over 26-1/7th actual weeks. Px13. During this period, Petitioner remained under Dr. Tack's order of no work until further notice. Petitioner also remained under the care of per her primary care doctors for unresolved low back pain.

When the employee is working light duty on a part-time basis or full-time basis and earns less than he or she would be earning if employed in the full capacity of the job or jobs, then the employee shall be entitled to temporary partial disability benefits. 820 ILCS 305/8(a). Having found in favor of Petitioner on all foregoing issues, the Arbitrator finds that Petitioner is entitled to temporary partial disability benefits. Petitioner has proven entitlement to such benefits from July 16, 2015 through January 14, 2016, which reflects the dates Petitioner worked on a part-time basis. Px13. Temporary partial disability benefits shall be equal to two-thirds of the difference between the average amount that the employee would be able to earn in the full performance of his or her duties in the occupation in which he or she was engaged at the time of accident and the gross amount which he or she is earning in the modified job provided to the employee by the employer or in any other job that the employee is working. Thus, Petitioner benefit is as follows: 66% x ($1,322.37 – ($5,298.56 / 26-1/7th wks.)) or $746.46 for each week of temporary partial disability. The Arbitrator declines to award temporary partial disability through the date of hearing, as Petitioner only showed entitlement for TPD through January 14, 2016 – the date of her last pay check or pay period. See Px13. While Petitioner may have worked after this date, no earnings after January 14, 2016 were submitted into evidence and therefore the Arbitrator is unable to calculate any benefit amount. Respondent shall pay Petitioner temporary partial disability benefits of **$746.46/week** for **26-1/7th weeks**, commencing **July 16, 2015** through **January 14, 2016**, as provided in Section 8(a) of the Act. Respondent shall be given a credit **$7,901.06** for TPD.

17IWCC0170

ISSUE (O) Prospective Medical Care

The Arbitrator incorporates the findings of fact and conclusions of law as though fully set forth herein and relies upon same in concluding that Petitioner's current condition of ill-being has not yet stabilized and she is not yet at maximum medical improvement.

In support thereof, the Arbitrator notes that Dr. Tack discussed surgical intervention in November 2012, December 2012, September 2013, April 2014 and May 2014. In February 2015, Dr. Goldberg evaluated Petitioner, agreeing with Dr. Tack that Petitioner had failed conservative care and was a surgical candidate for fusion at L4-5 and L5-S1. Dr. Tack on several occasions noted Petitioner's condition to be multiyear in length and refractory to care. Dr. Goldberg correctly pointed out that Petitioner was never asymptomatic based upon his review of her medical treatment records and based upon her statements to him. The Arbitrator relies on these opinions over the opinion of Dr. Zelby, which was previously found to be less persuasive, *supra*. Petitioner has testified she wishes to have the surgery prescribed and recommended by her doctors.

Therefore, Respondent shall authorize, approve and pay for the surgical recommendations of Drs. Tack and Goldberg.

Signature of Arbitrator

3-21-2016
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF)
CHAMPAIGN

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Aaron Dain,

Petitioner,

vs.

NO: 14 WC 43137

C.H.I Overhead Doors, Inc.,

17IWCC0168

Respondent.

DECISION AND OPINION ON REVIEW

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

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

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

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

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

DATED: MAR 2 2 2017
TJT:yl
o 3/14/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

DAIN, AARON
Employee/Petitioner

Case# **14WC043137**

C H I OVERHEAD DOORS INC
Employer/Respondent

17IWCC0168

On 7/6/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4535 ATTEBERRY PC ATTORNEYS AT LAW
DENNIS R ATTEBERRY
220 W MAIN CROSS
TAYLORVILLE, IL 62568

1970 MEYER CHAPEL PC
ROCHELLE FUNDERBURG
306 W CHURCH ST
CHAMPAIGN, IL 61820

17IWCC0168

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

AARON DAIN
Employee/Petitioner

v.

C.H.I OVERHEAD DOORS, INC.
Employer/Respondent

Case # 14 WC 43137

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Urbana**, on **May 12, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the 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 _____

17IWCC0168

FINDINGS

On the date of accident, **May 28, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 N/A causally related to the accident.

In the year preceding the injury, Petitioner earned **$56,264.84**; the average weekly wage was **$1082.02**.

On the date of accident, Petitioner was **40** 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 **$n/a** for TTD, **$n/a** for TPD, **$n/a** for maintenance, and **$n/a** for other benefits, for a total credit of **$n/a**.

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

ORDER

Petitioner failed to prove that he sustained an accident arising out of and in the course of his employment with the Respondent, and therefore, Petitioner is entitled to no award.

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

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

D. Dyan McCarty

Signature of Arbitrator

7/2/2016

Date

ICArbDec19(b)

JUL 6 - 2016

Findings of Fact

In support of the decision herein, the Arbitrator makes the following findings regarding the issues raised at arbitration:

Petitioner is a forty year old truck driver who has worked in that capacity for the Respondent since June of 2012. His job requires him to make deliveries of overhear doors and materials to up to fifteen customers per day. He alleges that on May 28, 2014, he was making a delivery in Ohio and sustained an injury to his lower back. He testified that the injury occurred as he was reaching forward into the back of his truck to remove some flexible springs, weighing between sixty and eighty pounds. As he reached forward and pulled the springs towards him, he said he felt a pop with tightness in the back. He says that he told three co-workers, whom he identified as Luke, Dave and another worker whose name he could not recall. He said that Luke helped him after the accident, and that he called his employer, Levi Miller, reporting the accident. Though he was in pain, the Petitioner said that he continued to do his regular job duties. He first sought medical treatment on July 11, 2014, by calling his family physician, Dr. Baumberger. (PX 11)

Petitioner has had back problems since he was 12 years old, and has seen a chiropractor for those problems since he was 12 years old, starting out at three times a week and then tampering off until he sees a chiropractor several times a year. He consulted Christian County Chiropractic for chiropractic care on May 16, 2014, complaining of pain in his lower back extending to his right side. (PX 5)

He saw Dr. Baumberger on May 12, 2014. The records from Dr. Baumberger for that visit state that the Petitioner's big issue was pain in the lower back, primarily the lumbar spine. He told Dr. Baumberger that he was taking two Aleve every day for the pain. At that visit he told Dr. Baumberger that he was thinking about leaving his job as a truck driver and going back to school to become an occupational therapist. He asked the doctor to send him for a MRI or a CT scan because he had not been able to get any relief from his chiropractic care or the medication.

On May 14, 2014, there was an office note in the records of Dr. Baumberger that Petitioner wanted to see a back doctor. X-rays of the spine indicated that the back looked ok but that the Petitioner had a mild scoliosis and some gallstones which can cause some right sided back pain. Dr. Baumberger concluded that an MRI was not needed. On May 15, 2014, there was another note from Dr. Baumberger's office stating that they spoke to Petitioner and referred him to Dr. Tan. A later note on May 15, 2014 reflects that the Petitioner told Dr. Tan's office that this was work related, and that Dr. Tan would not see Workers' Comp cases and referred the case back to Dr. Baumberger. Although Petitioner denied calling Dr. Baumberger's office on May 15, 2014, the office notes indicate a return call to the Petitioner at either his home or on his cellphone, stating that his back pain is not Workers' Comp; he just had a DOT physical two days before seeing Dr. Baumberger and he passed his DOT exam; and that he needed to do the physical therapy evaluation and treat for four to six weeks.

The next record for Dr. Baumberger states that there was a referral for Dr. Dold which was scheduled for July 21, 2014. As of July 11, 2014, the Petitioner had called in stating that he had a lot of back pain and would like a referral to a neurosurgeon. There was no mention of any worker-related accident of May 28, 2014.

Dr. Dold, with Decatur Neurosurgery Associates, saw the Petitioner on September 3, 2014. The consultation report with Dr. Dold stated that the Petitioner had back pain since he was 12 years old and that the most recent exacerbations started about three months ago. There was no mention of any work-related accident of May 28, 2014 or any other date. Dr. Dold's impression was that Petitioner had chronic back pain with some perhaps mild to moderate radicular features with the right leg complaints. At a follow up exam with Dr. Dold on September 22, 2014, Petitioner reported back pain on and off since he was 12 years old but this time he indicated that the recent episodes started about three or four months ago after a heavy physical lifting twisting type maneuver. There was again, no mention of any incident at work. Dr. Dold recommended conservative treatments such as physical therapy or a pain clinic but Petitioner declined that treatment. Dr. Dold indicated that he should continue with exercise and could continue with his usual activities using common sense precautions. The radiology report of September 15, 2014 showed degenerative endplate disease inferiorly at L4 and superiorly at L5, otherwise, normal MRI of the lumbar spine.

While undergoing the physical therapy prescribed by Dr. Baumberger and Dr. Dold, Petitioner told his therapist that he had ridden his bicycle on October 2, 2014 for six miles and that he did not have any pain from doing the six mile bike ride. He first saw Dr. Payne on October 30, 2014, and he told Dr. Payne's nurse practitioner that his back problems had been very manageable up until May 24, 2014. Other than physical therapy and anti-inflammatories, he has received no other treatment from any doctor. He told his physical therapist that he called Dr. Payne because he did not want to go back to see Dr. Dold, and testified that he did not want to see Dr. Dold because Dr. Dold said he could not be in as much pain as he claimed.

The notes from Dr. Baumberger's office dated October 21, 2014 reflect that the Petitioner saw Dr. Dold and wanted a second opinion. Dr. Baumberger referred him to Dr. Rehman, a neurosurgeon at St. Mary's Hospital in Decatur. Further notes dated October 21, 2014 state that Petitioner did not want to see Dr. Rehman at that time. The final report of Dr. Baumberger dated January 13, 2015 stated that Petitioner originally had a physical with Dr. Baumberger on May 12, 2014 at which time he complained of pain in the middle and lower back, primarily lumbar spine right paravertebral. He was thinking about leaving his job as a truck driver and going back to school to become an occupational therapist. He had been seeing a chiropractor and had not been able to get any relief from his medication, relying on Aleve. The note then indicates that he later told the doctor that he hurt his back at work and this would be going through Workers' Comp, and that he had hurt his back on May 28. He wanted a referral for a neurosurgeon and was referred to Dr. Dold. Dr. Dold referred him for physical therapy but the Petitioner stated that he could not work and do the therapy. Dr. Dold told him that he needed to continue to work, and Petitioner became angry and refused to go back. Dr. Baumberger then referred the Petitioner to the neurosurgeon at St. Mary's but he did not go, requesting to see Dr. Payne in Springfield.

The final note in the Petitioner's records with Dr. Baumberger is dated February 25, 2015 stating that physical therapy called and that Petitioner had declined those services.

Although Petitioner denied taking himself off work on October 10, 2014, the Doctor's records reflect that he did take himself off work on that date. He admitted that he had no off work slip from anybody for October 10, 2014, and no doctor took him off work until he saw Dr. Payne on October 30, 2014. He has not been back to work since October 10, 2014.

He has not seen any physician for his back since February 19, 2015, nor has he sought treatment in any emergency room for any back problem. He currently takes over the counter medications for the back pain.

Petitioner testified that he applied for and received short term disability benefits from the company and was paid from October 25, 2014 through February 19, 2015. He filled out an application for the short term disability

which was admitted as Respondent's Exhibit No. 3. One of the questions was whether he had ever had the same or similar condition in the past, and he answered no.

At arbitration, Petitioner's job search was admitted into evidence as Exhibit No. 9. He testified regarding some of the jobs that he applied for, including returning to Respondent as a safety director or a dispatcher. He admitted that Safety Director was a management position and he had no management experience except for that of owning his own trucking company which was a company of one. He testified that he had never managed any employees before. He has never trained as a safety director or received a certification of any kind. He also testified that he wanted to be a router which requires computer skills. Although he testified that he had sufficient computer skills to do such a job, he told the vocational rehab counselor that he has keyboarding skills of 15 to 20 words per minute and that his computer skills are somewhat limited.

In examining the job search records that Petitioner provided, there were many jobs that he applied for which he had no qualifications. For example, he applied for the position of Deputy Director for the Illinois Board of Higher Education although he had no idea what that position required. He applied to be a counselor for LCFS although he had no qualifications for that position. He applied Assistant Vice President of Finance for Horace Mann although he had no qualifications to serve in that position. In a number of positions he applied for required qualifications that he did not have, including management experience.

Conclusions of Law

The Arbitrator finds that the Petitioner failed to prove that an accident occurred on the date of May 28, 2014 that arose out of and in the course of Petitioner's employment by Respondent. Although Petitioner called Respondent to report an accident while delivering materials in Indiana, Petitioner did not seek immediate medical attention. Petitioner admitted that the first time he saw a doctor for the incident was September 2014. He did not go to the emergency room or seek other medical attention in the interim.

Petitioner was aware that accident was a contested issue at arbitration, but presented no corroborative evidence to support his contention that an accident had occurred. None of the three co-workers testified and his employer, Mr. Miller was not subpoenaed to testify. He did not contact a physician for medical care until July 11, and the notes from that conversation contain no reference to an accident. He also saw his chiropractor, Dr. Polovitch, on August 8, 2014, and received treatment. There is no mention of any accident in his notes. Comparing that note to one for pre-accident care on March 14, 2014, leads the Arbitrator to conclude no accident occurred. In the earlier note, Dr. Polovitch noted the history that the Petitioner had hit his hand on a door prior to the visit. It seems that some reference to the May 28 accident would be in the doctor's notes if the Petitioner had mentioned it. Similarly, Dr. Dold's initial treatment note of September 3 contains no specifics as to any accident. The Petitioner apparently did discuss his work duties with the doctor. One would think that some reference to the specific accident would be in the notes as well if it was discussed. Finally, Dr. Dold's notes from his examination on September 3 and the pre-accident notes from Dr. Baumberger on May 12 are similar in terms of the Petitioner's complaints. Prior to the accident, the Petitioner complained of right sided low back pain and wanted Dr. Baumberger to schedule an MRI. Post accident, the Petitioner told Dr. Dold that he had right side lumbar pain which the doctor described as mechanical. An MRI was prescribed.

In summary, the Petitioner's failure to report his alleged accident to any of his initial treating doctors, along with the absence of any corroborative witnesses to the alleged occurrence leads the Arbitrator to conclude that no accident occurred. The claim is denied.

15 WC 28181

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Constance G. Farmer,	)	
	)	
Petitioner,	)	
	)	NO. 15 WC 28181
	)	
	)	
St. John's Home Health Care,	)	
	)	
Respondent.	)	

ORDER

This matter comes before the Commission on the Petitioner's Motion to Enforce the Arbitration Award. The parties appeared before Commissioner Ruth W. White in Collinsville on February 6, 2017 and a record was taken.

On October 28, 2016 Arbitrator Melinda Rowe-Sullivan entered an award in favor of Petitioner wherein Respondent was ordered to pay Petitioner the sum of $381.49 per week for a period of 62.5 weeks as provided in §8(d)2 of the Act, because the injuries caused 12.5% loss of use of the person as a whole. The Arbitrator's Decision became final after 30 days.

Respondent did not tender payment to Petitioner regarding the above referenced award for 55 days after the 30 day review window. Respondent's failure to tender payment to Petitioner is unreasonable and vexatious. Therefore, the Commission hereby finds that Petitioner is entitled to penalties pursuant to §19(k) and §19(l) for Respondent's nonpayment of the Arbitrator's award for 55 days.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $1,498.71 pursuant to §19(k) and $1,650.00 pursuant to §19(l).

DATED: MAR 1 - 2017
RWW/plv
r-2/6/17
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Ruth W. White
Ruth W. White

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

Robert Prince,
Petitioner,

vs.

NO: 15 WC 00865

17IWCC0134

State of IL/Shawnee
Correctional Center,
Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission notes that Petitioner treated with Dr. Jeff Jones for a low back injury through August 21, 2014. On August 21, 2014, Dr. Jeff Jones indicated that Petitioner's right calf pain had resolved. Petitioner reported his pain was tolerable at that time. Dr. Jeff Jones advised him that he could continue with his regular activities at work. He was to use ibuprofen as needed for his back pain and he told him that if he developed any new leg pain at any time he should call. Lastly, he discharged the Petitioner from his formal care and released him back to work with no restrictions. From August 21, 2014 through November 24, 2014, Petitioner did not call Dr. Jeff Jones for a return visit and Petitioner went without treatment for three months.

On or about November of 2014, Petitioner sought treatment from Dr. Larry Jones, his primary care doctor, and Dr. Jones prescribed physical therapy. On November 24, 2014, Petitioner underwent a physical therapy evaluation at Rehabilitation Unlimited. Petitioner reported he had right sided low back pain and that his prior radicular pain was now centralized. He further reported he was not able to sleep and his goal was to improve his sleep, decrease his pain and improve his mobility. Other than the initial physical therapy evaluation, no physical therapy records were placed into evidence. The Commission knows from the medical bill that was entered into evidence that Petitioner attended three sessions of physical therapy from

December 1, 2014 through December 10, 2014. Since the Commission was not presented any medical records from Dr. Jones or physical therapy records it is unclear why Petitioner was prescribed physical therapy, what treatment Petitioner received in physical therapy and why Petitioner only went to three sessions of physical therapy. The Commission finds that after Petitioner's physical therapy there was again a three month period of time with no medical treatment being rendered. During this same time, Petitioner was working his regular job with no physical restrictions.

Upon a referral from his attorney, Petitioner started treating with Dr. Raskas on March 9, 2015. At this time, Petitioner reported he had no particularly bothersome symptoms during the day but that he was being more symptomatic at night. He also reported his pain was aggravated by exercise and sitting/standing for long periods. Petitioner reported to Dr. Raskas that his first round of physical therapy was mainly modalities rather than active core strengthening. Since the Commission was not provided with the records, it is unclear whether this is a correct statement. Petitioner also reported to the doctor that he never had any prior injury on the job. This latter statement was refuted by Petitioner's cross-examination testimony where it is revealed that he had three prior claims and received one settlement for a prior low back work injury. In total, Petitioner had an additional twelve sessions of physical therapy over an additional one month period. Dr. Raskas prescribed Naproxen rather than Ibuprofen with the understanding that the Naproxen was to be used as an arthritic medicine. There is no indication as to whether Petitioner filled the prescription or not. Lastly, Dr. Raskas recommended an epidural steroid injection at L5-S1 to calm down the inflammation but again there is no indication that Petitioner actually received this injection. Petitioner did report after the twelve sessions of PT that his back pain was tolerable and that his primary goal of being able to sleep in bed again was met.

Based on the above, the Commission finds that Petitioner reached maximum medical improvement as of August 21, 2014 when he was released from formal medical care by Dr. Jeff Jones. Thereafter, he received no treatment for a period of three months and he did not contact Dr. Jeff Jones once he believed he needed additional treatment but rather contacted Dr. Larry Jones. Regardless of these events, the fact still remains that once Pet. sought additional treatment three months removed from Dr. Jeff Jones' discharge visit, Petitioner failed to prove that his visit with Dr. Larry Jones and the resulting three physical therapy visits were causally related to his April 4, 2014 work accident. It is Petitioner's burden to prove up all of the elements of his claim. While the Commission can discern out that Petitioner had additional treatment via the medical bills, the Petitioner failed to introduce the corresponding medical records into the record to support his position that the additional treatment was causally related and/or reasonable and necessary to treat his condition. Petitioner's case is further weakened by an additional three month gap where no treatment is given, while Petitioner continued to work his full time job without any restrictions and the fact that when Petitioner does seek treatment again it is upon the behest of his attorney. Given all of the above, the Commission modifies the Arbitrator's decision and finds Petitioner failed to prove the medical treatment he received after August 21, 2014 is causally related to the April 4, 2014 work accident. The Commission further finds that the Petitioner failed to prove that the medical treatments that were rendered after August 21, 2014 were reasonable and necessary to cure or relief Petitioner of the injuries he sustained as a result of the April 4, 2014 work accident.

17IWCC0134

Lastly, the Commission notes Petitioner's MRI shows that there was no nerve root impingement. Thus, the Commission is left with Petitioner's subjective residual pain complaints, Petitioner's report on April 27, 2015 to Dr. Raskas that the majority of his pain has resolved and Dr. Raskas' note that Petitioner has progressed well with physical therapy. Having reviewed the Arbitrator's consideration of the five factors needed to determine permanency and taking into consideration Petitioner's last report to the doctor and the doctor's comments, the Commission finds Petitioner is entitled to 4% man as a whole under Section 8(d)2 of the Illinois Workers' Compensation Act.

IT IS THEREFOR ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $721.66 per week for a period of 20 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 4% loss of a man as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner medical expenses in the amount of $2,650.00 under §8(a) of the Act.

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

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

DATED: MAR 3 - 2017

MB/jm

O: 2/9/17

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Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PRINCE, ROBERT
Employee/Petitioner

Case# **15WC000865**

STATE OF ILLINOIS/SHAWNEE CORR CTR
Employer/Respondent

17IWCC0134

On 7/28/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

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

0558 ASSISTANT ATTORNEY GENERAL
FARRAH A HAGAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

JUL 28 2016

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

17IWCC0134

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 Prince
Employee/Petitioner

v.

State of Illinois/Shawnee Corr. Ctr.
Employer/Respondent

Case # **15** WC **00865**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Herrin**, on **July 17, 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 **(after 8/21/14)**?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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 **Did Petitioner exceed his choices of physician?**

FINDINGS

On **April 4, 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 **$65,459.00**; the average weekly wage was **$1,258.83**.

On the date of accident, Petitioner was **40** years of age, ***married*** with **2** dependent child(ren).

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

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

Respondent shall be given a credit of **$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 **$any benefits paid through group** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $10,816.04, as set forth in PX1, as provided in Sections 8(a) and 8.2 of the Act.

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

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, Respondent shall pay Petitioner permanent partial disability benefits of $721.66/week for 50 weeks, because the injuries sustained caused the 10% loss of the body 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.

Michael K. Nowak, Arbitrator

6/24/16
Date

ICArbDec p. 2

JUL 28 2016

FINDINGS OF FACT

Petitioner is a 40-year-old correctional supply supervisor I at Shawnee Correctional Center/Hardin County Work Camp. The Parties stipulated that Petitioner sustained accidental injuries that arose out of and in the course of his employment on April 4, 2014, when a bolt broke in the chair he was seated in and caused him to fall and strike his back. Petitioner testified that he could recall no prior treatment or injuries to his lower back. Respondent stipulated that its dispute as to causal connection and liability for medical expenses arose only from a gap in treatment after August 21, 2014. Respondent also disputed choices of physician and the nature and extent of the disability.

Petitioner first sought care with his primary physician, Dr. Larry Jones on April 15, 2014. Dr. Jones noted pain, difficulty arising from a kneeling position, discomfort, tightness, stiffness, and right calf pain. He further noted that Petitioner took Ibuprofen and cyclobenzaprine for pain. Dr. Larry Jones treated Petitioner conservatively with massage therapy. The records from Integrated Health reflect that the massage therapy came at the order of the "Treating Physician: L. Jones," along with an attached prescription slip and accompanying letter that confirm same. (PX4). Dr. Larry Jones also referred Petitioner for an MRI of his lumbar spine, which showed a small disc protrusion at L5-S1 with mild stenosis, facet arthropathy, and significant foraminal encroachment creating mild compression of the L5 nerve roots within the foramina. (PX5). On July 17, 2014, Dr. Larry Jones referred Petitioner to Dr. Jeff Jones in Carbondale. (PX4).

Dr. Jeffery Jones saw Petitioner on August 21, 2014, and noted in the history of present illness that Petitioner suffered from constant, worsening lumbar spine/low back pain described as "throbbing, aching and discomforting." (PX6). He specifically noted that, "The symptoms occur constantly. The problem is worse. Currently the patient states that the symptoms are moderate-severe." *Id.* Dr. Jeffery Jones noted that Petitioner's right calf pain was likely related to his L5-S1 disc herniation. *Id.* Petitioner's symptoms were aggravated by flexion, daily activities, walking, and extension. *Id.* After reviewing Petitioner's MRI, Dr. Jeffery Jones offered the following provider comments:

> I had a chance to see Robert today in consultation and to review his MRI of the lumbar spine. Robert does indeed have degenerative disc disease at L5/S1 however his back began to bother him after falling off a stool approximately 4 months ago at work. He initially did have some right calf pain which was likely due to a disc herniation at L5/S1 however this has resolved. He does think that the pain is tolerable at this time and therefore I told him he can continue his regular activities at work and he may use ibuprofen as needed for the back pain. I did tell him that if he develops any new leg pain at any time he should give us a call. We will release him from our care at this time and he can follow up with us on a when necessary basis. *Id.*

Petitioner was then referred by his primary physician, Dr. Larry Jones, for a physical therapy evaluation at Rehab Unlimited on November 24, 2014, and the therapist recommended traction and other modalities, which

were rendered through December 31, 2014. (PX8). Petitioner's complaints were identical to his prior complaints – lumbar back pain, lack of sleep secondary to pain and discomfort, and limited range of motion. *Id.* Dr. Larry Jones is listed as the attending physician in the "Encounter Information" and the referring physician in the "Patient Evaluation" record. *Id.*

Petitioner's second choice of physician began with Dr. David Raskas, who he saw on March 9, 2015. (PX7). Dr. Raskas took a history of the injury and noted that while Petitioner's day symptoms were tolerable, he had significant pain at night and with activity. Petitioner's pain continued to be aggravated with exercise, prolonged sitting and standing. His symptoms were identical to those complained of during his earlier visit with Dr. Jeffery Jones. (PX6). Dr. Raskas noted that Petitioner's therapy mainly consisted of modalities rather than core strengthening. (PX7). He thus recommended a course of physical therapy for active stretching and strengthening, and also prescribed an epidural steroid injection at L5-S1 and Naproxen for aggravation of his lumbar arthritis. *Id.* Petitioner completed his strengthening therapy at Rehab Unlimited as instructed. (PX8).

On follow-up, Dr. Raskas noted improvement in Petitioner's condition. (PX7, 4/27/15). Although Petitioner was not entirely pain-free, Dr. Raskas noted that the majority of Petitioner's pain was resolved, and Petitioner felt well enough to be released from care. Petitioner advised Dr. Raskas that he was able to "sit in his bed again which he had not been able to do since his injury." *Id.*

Petitioner testified that although therapy improved his complaints, his symptoms have not completely resolved and his back continues to become sore with any type of activity. Petitioner stated, "I have to adjust to everything that I do." (T.16). As a Supply Supervisor, Petitioner is required to lift heavy boxes of supplies on a daily basis. (T.16). He experiences a constant pain in his back when he sits or stands for prolonged periods of time. He testified that his ability to sleep has improved, but he still occasionally wakes in the night and has to switch to sleeping in his chair to get the rest of the night's sleep. Petitioner testified that he is unable to coach his son's baseball team or practice with his son due to his injury.

CONCLUSIONS

Issue O: Did Petitioner exceed his choices of physician?

Petitioner first sought care with his primary physician, Dr. Larry Jones (PX3), who referred Petitioner to Integrated Health for therapy (PX4), to CT and Open MRI Center for a lumbar spine MRI (PX5), to Dr. Jeffery Jones for consultation (PX6), and to Rehab Unlimited for therapy in November (PX8). Hence, all of these providers fall within Petitioner's first choice under the Act.

Petitioner's second choice began with Dr. Raskas (PX7), who referred Petitioner back to Rehab Unlimited for different therapy approach (PX8).

The Arbitrator finds that Petitioner did not exceed his choices of physician.

Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?
Issue (J): Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services? (After 8/21/14).

Respondent stipulated that its dispute as to causal connection and liability for medical expenses arose from a gap in treatment after August 21, 2014. (T.4, 5). There is no evidence in the record to refute the reasonableness and necessity of any of the treatment Petitioner received. The Arbitrator notes that only 3 months elapsed between Petitioner's visit with Dr. Jeffery Jones and his therapy at Rehab Unlimited on beginning on November 24, 2014; and only 3 months elapsed between Petitioner's final therapy visit on December 10, 2014, and his initial visit with Dr. Raskas on March 9, 2015. (PX6; PX8).

In this case Petitioner's symptoms and complaints remained consistent throughout his treatment. At no point in time did his complaints alter or deviate from his initial complaints. The Arbitrator finds that the gaps in treatment are insignificant and entirely reasonable. Petitioner had a reasonable expectation that his condition would heal without significant care. His primary care physician (Dr. Larry Jones) advised him that "he should do fine" shortly after the injury in April. When he continued to complain of symptoms and was referred to Dr. Jeffery Jones, he was released from care on his first visit in August. When his symptoms still failed to improve completely he sought care from Dr. Raskas. The medical evidence does not support the conclusion that Petitioner reached maximum medical improvement on August 21, 2014. Significantly, no physician expressly placed Petitioner at "maximum medical improvement." Petitioner's primary care physician, Dr. Larry Jones, obviously did not believe that Petitioner was at maximum medical improvement, as he referred Petitioner for another course of subtle therapy prior to Petitioner seeking care with Dr. Raskas. (PX8, 11/24/14) As noted by Dr. Raskas, no appropriate elevated conservative approach, such as true physical therapy (core strengthening) or injection had yet been attempted, despite Petitioner's persistent symptoms. (PX5; PX7). Significantly, Petitioner testified that the care recommended and provided by Dr. Raskas improved his condition.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that his current condition or ill-being is causally related to the accident. The Arbitrator further finds that Petitioner is entitled to all of the care and treatment rendered through the date of hearing. Respondent shall therefore pay reasonable and necessary medical services of $10,816.04, as set forth in PX1, as provided in Sections 8(a) and 8.2 of the Act.

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

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither Party submitted an AMA 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 serve as a Supply Supervisor for Respondent, and his job requires lifting boxes of supplies on a daily basis. Given the nature of Petitioner's injury and his significant increase of complaints with activity, the Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 40 years old at the time of his injury. Given the significance of his injury, the labor intensity of his job, and the extended number of years with which Petitioner must live and work with his disability, the Arbitrator therefore gives *greater* weight to this factor.

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

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner sustained a disc protrusion and aggravated his degenerative spinal condition. His MRI confirmed L5-S1 facet arthropathy and significant foraminal encroachment creating compression on the L5 nerve root. Petitioner testified that despite the improvement from therapy, his symptoms have not completely resolved and his back continues to become sore with any type of activity. Petitioner has modified all of his activities to cope with his condition. He experiences pain in his back when he sits or stands for prolonged periods of time. Although he testified that his ability to sleep improved, he still occasionally wakes in the night and has to switch to sleeping in his chair to get a complete night's sleep. The Arbitrator therefore gives *greater* weight to this factor.

Based upon the foregoing, the Arbitrator finds that Petitioner sustained serious and permanent injuries that resulted in the 10% loss of his body as a whole.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Anthony Scartpzzi,

Petitioner,

17IWCC0150

vs.

NO: 15 WC 1459

Sutton Ford,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 25, 2016 is hereby affirmed and adopted.

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

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

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

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

DATED: MAR 8 - 2017
KWL/vf
O-2/28/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

17IWCC0150

SCARTPZZI, ANTHONY
Employee/Petitioner

Case# **15WC001459**

SUTTON FORD
Employer/Respondent

On 2/25/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.45% 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:

2208 CAPRON & AVGERINOS PC
DANIEL F CAPRON
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

0210 GANAN & SHAPIRO PC
JOSEPH P BRANCKY
210 W ILLINOIS ST
CHICAGO, IL 60654

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)

17IWCC0150

Anthony Scartozzi
Employee/Petitioner

v.

Sutton Ford
Employer/Respondent

Case # 15 WC 01459

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maria Bocanegra**, Arbitrator of the Commission, in the city of **Chicago**, on **December 10, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0150

FINDINGS

On the date of accident, **April 28, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$53,924.00**; the average weekly wage was **$1,037.00**.

On the date of accident, Petitioner was **48** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of **$23,308.70** for TTD. The parties stipulate to a four day overpayment of TTD for which Respondent is entitled to credit; and further stipulate that Petitioner is entitled to receive one day's wages for attending Respondent's Section 12 exam.

ORDER

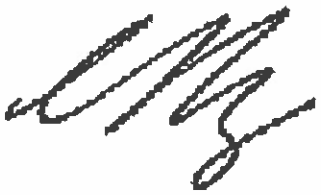
Respondent shall authorize and pay for the treatment recommended by Dr. Chang.

Respondent shall pay Petitioner the reasonable and necessary medical services of $6,300.38, 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.

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

2-25-2016
Date

ICArbDec19(b)

FEB 25 2016

FINDINGS OF FACT

Anthony Scartozzi ("Petitioner") testified he has worked as an auto mechanic for the past 30 years. For the past 8 year, he has worked for Sutton Ford ("Respondent"). Petitioner testified his job duties as a general mechanic include removing transmissions, rebuilding engines and performing tune ups.

Petitioner testified he treated with a chiropractor back approximately 13 years prior to his work accident. Between the last time he treated for his back and this work accident, he suffered no injuries, had no symptoms and no treatment to the low back.

Petitioner testified and the partied agreed at trial that he suffered a work accident on April 28, 2014 and injury to the low back after bending down to the floor to lift a differential weighing approximately 60 pounds. He testified that as he picked it up and put it out in front of him with both arms to place it on a cart; he felt a pull in his back.

He was transported via ambulance to the emergency room of St. James Hospital. He complained of right sided low back pain after lifting an object onto a cart. On exam, he was tender on the right near L3-4. X-rays of the lumbar spine were within normal limits and showed mild L5-S1 degenerative disc disease. He was diagnosed with a lumbar strain and prescribed Flexeril. Px1. Petitioner testified he received a Toradol injection to his arm.

Petitioner saw Dr. Mark Odehnal at Medical Specialists on 4/29/14 for unrelated follow up and unrelated refill of medications. A notation of the recent emergency room visit and low back pain was made.

Petitioner testified that he returned to work and was referred by the owner of the dealership to a chiropractor, Dr. Ralph Kruse. Px2. On 4/30/14, Petitioner was evaluated by Dr. Krause on referral from "Sutton Ford," complaining of intermittent burning and aching pain in his lower back since injuring it at work after lifting a heavy object to place it onto a cart. Petitioner complained that the pain had initially been in his right low back but was now in his left low back, left buttock, and left hip. Petitioner treated with Dr. Kruse on 5/2/14, 5/3/14, 5/5/14, 5/7/14, 5/9/14, 5/12/14, 5/14/14. During this time, he reported difficulty driving, getting in and out of his car and with walking. Dr. Kruse also placed Petitioner on restricted duty. At the time of the Petitioner's final visit to Dr. Kruse on 5/14/14, his lower back pain persisted. Petitioner indicated to Dr. Kruse that he would continue treatment with a provider chosen by the employer. Px2.

On 5/15/14, Petitioner presented to Ingalls Occupational Health complaining of 7 out of 10 left lower back pains described as sharp and moderate to severe in nature. Px3. Petitioner related the pain seemed to be made worse by bending and sitting and improved with rest. He admitted to a past history of lower back pain. On exam, he was tender to palpation in the mid to lower left back and midline spine at L5-S1. Flexion and lateral bending was reduced. Straight leg raise was positive on the left. Gait was antalgic. New lumbar x-rays showed dis space narrowing at L5-S1, small osteophytes at the lower facet joints. Petitioner was prescribed Naproxen, Flexeril, physical therapy and light duty.

On 5/16/14, Petitioner reported to Ingalls therapists that he had suffered back pain prior to the 4/28/14 back injury and had been seeing a chiropractor for "maintenance." Rx4. On 5/23/14, Petitioner returned to Ingalls. Px3. He reported low back pain, 1-2 out of 10. On exam, flexion was limited but SLR was negative,

gait was normal, extension was full and lateral side bend was normal. Naproxen, light duty and therapy were continued.

On 5/27/14, Petitioner reported to therapists at Ingalls 0 out of 10 pains and could pinpoint any specific activity when pain occurs. On 5/28/14, Petitioner reported to therapists 1 out of 10 pains, morning stiffness in the back but that therapy was helping. On 5/30/14, Petitioner reported to his physical therapist 1 out of 10 pains and a burning feeling in the low back and buttocks. On 6/2/14, Petitioner reported soreness with movements in therapy and rated his pain 3 out of 10. Assessment suggested a mild SI joint dysfunction. On 6/4/14, physical therapy progress note indicated that Petitioner reported 50% improvement and that he was able to bend over without pain. Under assessment, therapists wrote that objectively, Petitioner was function and that complaints were mostly subjective. He had met all short term and long term goals. A work capacity evaluation was recommended. At trial, Petitioner testified his physical therapy did not help improve his condition.

On 6/6/14, Petitioner was re-evaluated by advance nurse practitioner Dawn Anthony. Px3. He reported 0-2 out of 10 pains. He reported sharp pain, mild to moderate in severity. He noticed it was intermittent and made worse with certain movements. On exam, Petitioner was tender on palpation in the lower left back and midline spine at L5-S1 and left piriformis/hip. The right S1 was tender. Flexion and extension were normal but produced pain. Gait was normal. SLR was positive for pain on the left. Physical therapy was put on hold and he was instructed to undergo an MRI, which revealed discogenic degenerative changes at L5-S1 without evidence of significant central or foraminal stenosis at any level.

On 7/11/14, Petitioner followed up with Ingalls Memorial for a post-MRI evaluation. Px3. He reported lower back pain at 0-2 out of 10 shooting down to his left anterior thigh. Petitioner again reported a history of lower back pain but with no procedures or surgery. Petitioner's recent MRI was reviewed. No motor or sensory deficits were noted in the left leg. Diagnosis was low back pain. He was released to full duty work, advised to continue home exercise, Naproxen and encouraged to follow up with a pain specialist. Petitioner was told to return with any change or increase in symptoms. At trial, Petitioner testified he did not pursue the pain management referral as he did not like needles. Petitioner was paid temporary total disability (TTD) benefits through 7/11/14 and returned to work after that time. Rx1, Ax1.

Petitioner testified he returned to his job as an automobile mechanic for Respondent on 7/12/14. He testified that he continued to experience lower back pain, was not symptom free and that he decided to seek treatment with Dr. Edwards, whom he identified as the chiropractor that treated him 13 years earlier for the low back.

On 10/27/14, Petitioner was seen by Dr. Edwards, DC. Px4. He reported an onset of low back pain after lifting a differential at work. He reported 3 out of 10 pains in the low back with radiating to the left glute and sometimes to the left leg. He was diagnosed with lumbar sprain/strain, lumbar disc syndrome, lumbar instability and lumbar facet syndrome. Light duty was prescribed. Respondent began paying TTD on 10/27/14. Rx1, Ax1. Records show Petitioner continued chiropractic care with Dr. Edwards through 11/3/14 and did not return for treatment until 12/1/14. Px4. During this time, TTD benefits continued. Rx1, Ax1.

On 11/24/14, Petitioner underwent a Section 12 exam with Dr. Timothy Payne at the request of Respondent. Rx5. The doctor recorded a history of injuring the low back on 4/28/14 after lifting a differential at work. The doctor reiterated Petitioner's treatment to date, noting that he presented for emergency care, was referred to occupational health, was referred to a chiropractor and recently sought out his own second opinion with another chiropractor. At that visit, Petitioner complained of pain primarily in the lower back with pain

down the left leg, with occasional giving way. He also reported lumbar stiffness and decreased lumbar motion. Examination found: normal gait, normal heel-toe walk normal, negative compression test, limited flexion and extension intact bilateral bending, discomfort in the midline without significant paralumbar pain. Straight leg raise was negative. Petitioner has tightness with FABER maneuver consistent with piriformis tightness in the leg and tightness in pelvic rotation consistent with piriformis tightness of the lower back. MRI was reviewed, along with Illinois form 454, an incident report and ICW Workers' Compensation Claim Summary. The doctor concluded that Petitioner's objective findings are substantiated by his limited range of motion of the lumbosacral spine and tightness with pelvic rotation and piriformis flexibility on the left. Dr. Payne found no symptom magnification. Dr. Payne recommended formal work conditioning to stabilize the back and work on flexibility over chiropractic modalities. The doctor noted Petitioner had "component disuse atrophy secondary to being inactive following his injury of the back." The doctor concluded Petitioner "sustained a lumbar strain to the lower back and myofascial pain of the lower pelvis…" and found that the mechanism of injury was consistent with a lumbar injury, taking into account Petitioner's prior back strains 10-20 years ago. Finally, the doctor recommended light duty, related to the work injury.

On 12/1/14, Petitioner returned to Dr. Edwards for continued chiropractic care for the low back through 2/9/15, after which Dr. Edwards referred him to ATI Physical Therapy. Px4-5. During this time, Petitioner reported pain down the left hip and left thigh. On 12/9/14, Petitioner followed up with his primary care physicians. Rx7. It was noted he was off of work for his lower back pain that was being followed by a chiropractor.

Petitioner testified the adjustor requested he comply with Dr. Payne's request for work hardening instead of chiropractic treatment. Petitioner testified some TTD was delayed and disputed as a result. This is reflected in the TTD payment history, as Petitioner's TTD for January was delayed until 2/18/15. Rx1. Petitioner retained counsel and an Application for Adjustment of Claim was filed 1/16/15.

On 2/11/15, Petitioner began physical therapy at ATI Physical Therapy at the referral of Dr. Edwards. Px6:46. Therapists noted Petitioner presented with signs and symptoms consistent with a diagnosis of lumbar pain and osteoarthritis. Petitioner reported left lower back pain that radiated down to the left lower extremity. Functional limitations included stairs, driving, getting dressed, lifted overhead, sustained sitting, sustained standing, shoveling and walking. Treatment consisted of weighted exercises, treadmill work, stretching, core stabilization and manual therapy. On 2/20/15, ATI progress note indicated that Petitioner had decreased pain but reported fatigue with standing and sitting. Pains ranged from 0-1 out of 10. On 3/6/15, therapists noted Petitioner continued to have decreased pains but with fatigue in standing and walking. Pain levels were unchanged. On 3/9/15, Petitioner followed up with Dr. Edwards. Px5. He reported continued lower back/left glute pain down the left leg, ranging from 0-4 out of 10 in pain. Petitioner reported overall improvement. On 4/6/15, a therapy progress noted Petitioner was able to lift and carry 60 pounds for up to 100 feet. Px6:32

On 4/8/15, Dr. Edwards noted that Petitioner presented for symptoms related to an episodic onset date of 10/27/14. Petitioner reported low back ache and stiffness and pain down the left leg only part of the time. Decreased range of motion was noted. Improvement noted, Petitioner was released from care and encouraged to follow up as needed. On 4/9/15, Petitioner followed up with Ingalls, who noted full range of motion at waist, no pain reproduced in the lower back, negative SLR, negative slump test and normal gait. Petitioner was also given full clearance to return to work. Rx3.

Petitioner testified that he remained off of work thru 4/6/15 and requested a release to return to work so that he would not lose his job. Rx1. Petitioner testified that he was not symptom free in the back. Petitioner

testified he wanted to see an orthopedic surgeon. Consequently, Respondent scheduled a second Section 12 exam.

Respondent scheduled him for a return visit with Dr. Timothy Payne on 6/16/15. Rx6. Dr. Payne summarized Petitioner's treatment after the initial Section 12 exam and noted Petitioner continued to have ongoing complaints, primarily morning stiffness and focal trigger points in the lower back on the left side. Lifting overhead aggravated the low back. Petitioner also reported some paresthesias in the anterior left thigh. Petitioner also reported returning to work with episodic flare ups of pain in the left paralumbar area going to the left lower back and left proximal and anterior thigh. Exam showed difficulty in heel-toe, normal range of motion, diminished knee and ankle jerk bilaterally. Straight leg raise was negative and there was no tenderness of the piriformis flexibility. The doctor recommended home exercise and an EMG due to paresthesias and minimal sensory changes in the anterior left thigh to rule out lumbar radiculopathy versus meralgia paresthetica. If the EMG reflected the former, then pain management treatment might be needed. If it reflected the latter, then Petitioner would be at MMI. Dr. Payne felt that Petitioner could continue to work full duty in the meantime.

Petitioner testified he went to Medical Specialists in Schererville on 7/6/15 seeking a referral to an orthopedic specialist. Rx7. Petitioner complained of back pain and stated he had been following up with a back specialist. Petitioner stated he would like the name of a different back specialist, as he was not sure he wanted to see the specialist he had been directed to. Petitioner said he was referred to Dr. Khanna at that time for a neurosurgical consultation.

Petitioner testified that he elected to see Dr. Mark Chang, an orthopedic surgeon, to obtain the script for the EMG that Dr. Payne had recommended. On 9/1/15, Petitioner saw Dr. Chang. Px7. On exam, Petitioner exhibited limited flexion and extension, mild weakness in the left ankle and great toe, decreased sensation in the dorsum of the left foot and negative SLR. The doctor read the MRI to show L5-S1 moderate disc degeneration, small central disc herniation causing slight spinal cord compression and moderate bilateral foraminal stenosis worse on the left side. Dr. Chang diagnosed chronic lower back pain with left L5 radiculopathy secondary to an L5-S1 disc herniation and foraminal stenosis. The doctor explained that he did find mild neurological problems with the left leg consistent with nerve irritation but that he did not believe the small herniation seen at L5-S1 was causing any direct impingement. Rather, the doctor believed the left leg pain was related to foraminal stenosis at that same level on the left due to facet arthropathy. Most likely, the work injury caused some aggravation of Petitioner's underlying degenerative condition. Dr. Chang recommended L5-S1 facet injections and left transforaminal epidural steroid injections, to be used both therapeutically and diagnostically. The doctor disagreed with the recommendation for an EMG and opined Petitioner was not yet at maximum medical improvement.

Petitioner testified he was honest to Dr. Chang. However, he testified he did not report to Dr. Chang he had been lifting an engine manifold at the time of the accident. Petitioner testified an engine manifold is a tube-like structure that carries fuel to the engine, and that it typically weighs 30 pounds. He also testified he did not tell Dr. Chang his chiropractor had given him permanent restrictions which his employer was not honoring.

Petitioner testified that he wants to pursue the treatment recommended by Dr. Chang. He also testified that he has a different view of needles now as he has realized he cannot continue to work like he has been with the lower back pain. He testified he currently still has lower back pain on the left side, down the left leg and that the left knee gives out. Petitioner testified that he did not have these symptoms before the accident. He also testified that since the date of accident, he has suffered no other accidents or incidents to the low back.

Petitioner testified he is currently working his full duty position as a mechanic. He testified he works his regular hours, which are Monday through Friday.

CONCLUSIONS OF LAW

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

Having considered Petitioner's credible and unrebutted testimony as well as all medical evidence submitted by both parties at trial, the Arbitrator concludes that Petitioner's current condition of ill-being with respect to the low back is causally related to his undisputed work accident occurring 4/28/14.

The medical evidence showed that Petitioner had previously treated for his low back approximately 13 years prior to the work accident. He credibly testified that between the time he was last seen for the low back and his work accident, he had no low back issues, symptoms or injuries. Petitioner also disclosed this prior treatment to his providers and to Dr. Payne, who adequately considered and addressed this prior treatment in reaching his initial conclusions in the first exam, which ultimately causally related Petitioner's condition to the work accident. The Arbitrator has considered the prior treatment in reaching this conclusion and finds that it is non-contributory to Petitioner's current condition of ill-being, as he was otherwise in a state of good health relative to the low back for almost 13 years prior to the work accident.

Subsequent to the work accident, the medical evidence documented an immediate onset of low back pain with eventual radiation down the left side, intermittently including down to the foot, knee and thigh. Subjectively, Petitioner reported at various times difficulty with prolonged sitting, standing, walking, and getting in and out of cars and morning stiffness. Petitioner was initially diagnosed with a lumbar strain by his treaters and an initial reading of the MRI acknowledged both disc bulging/protrusion entering the epidural space to some degree, facet changes and narrowing of the foramina bilaterally at L5-S1. The Arbitrator notes Dr. Payne causally related Petitioner's condition in November 2014 to the work accident, which he thought to be a lumbar strain. Based on the records, the Arbitrator also notes that the MRI was read, at that time, by treating nurse practitioner Dawn Anthony and Dr. Payne identically to what the radiologist interpreted. Px3, Rx5.

Despite this reading, Petitioner's subsequent treatment records, which primarily consisted of chiropractic and physical therapy treatments, noted some ongoing lower back and left leg symptomology. The Arbitrator notes Petitioner's self-evaluation of low levels of pain in those records and eventual release to work. Petitioner credibly testified, however, that he feared losing his job and requested a return to work. After Petitioner returned to work, he testified his low back and left leg pain returned. He apparently then requested additional treatment from Respondent. He was sent for a second exam with Dr. Payne who, although did not expressly causally related Petitioner's condition of ill-being to the work accident again, did indicate Petitioner may be at maximum medical improvement following certain recommended testing. The Arbitrator interprets this opinion as suggesting that Petitioner, at least at the time of the exam, was not yet at maximum medical improvement and that he still exhibited a lumbar condition of ill-being. The Arbitrator also notes that Dr. Payne's second report echoes and corroborates Petitioner's trial testimony that he continued to experience flare ups and symptoms at work in the low back and left leg.

Following the second Section 12 exam, Petitioner sought out care from both his primary doctor's office and Dr. Chang. Px2, Px7. Most recently, Dr. Chang has recommended injections over an EMG in order to therapeutically and diagnostically to determine whether Petitioner can obtain relief at the L5-S1 level, which he interpreted as pathologic of both disc herniation and moderate foraminal stenosis. Dr. Chang attributed Petitioner's left leg symptoms to the stenosis over the disc herniation, all of which he felt were likely aggravated

by the work accident. The Arbitrator adopts the opinions of Dr. Chang in finding causation, as the doctor provided a credible explanation of the cause and source of Petitioner's condition and symptoms. The Arbitrator does not discredit Dr. Payne's opinions and notes only that Dr. Payne's opinion is simply less complete than Dr. Chang's.

In so finding Petitioner's current condition of ill-being, the Arbitrator has considered Petitioner's gaps in treatment and notes the following: From July 2014 through October 2014 Petitioner attempted to return to work and re-entered treatment after experiencing ongoing symptoms. This was corroborated in his treatment records and in Dr. Payne's November 2014 report. From April 2015 through June 2015, Petitioner again attempted to return to work, stating he feared losing his job. He testified he was not symptom free during this work time and he testified he requested that Respondent authorize him to re-enter treatment once again. Dr. Payne's June 2015 report again corroborates this portion of his testimony. From June 2015 (Dr. Payne's evaluation) through September 2015, Petitioner worked while seeking out medical treatment. Although this period is not a gap in treatment, the Arbitrator is not persuaded by Respondent's argument that Petitioner has not sought out treatment, as none of the treatments recommended by Drs. Payne, Chang or APN Gloria Dillman during this same period appear to have been authorized or approved. Dillman did note that Petitioner wanted a different specialist referral but what referral or authorization, if any, was not addressed at trial. In the Arbitrator's view, the totality of these facts demonstrates a pattern of Petitioner attempting to work and experiencing flare ups, all of which are documented in the medical records, rather than a pattern of avoiding care. Based on the foregoing, the Arbitrator concludes that the Petitioner's current condition of ill-being relative to his lower back/lumbar spine is causally connected to his accident at work on 4/28/14.

ISSUE (K), (O) ***Is Petitioner entitled to any prospective medical care? PPD?***
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?***

Having resolved the causation issue in favor of Petitioner, the Arbitrator finds that, consistent with the opinions of Drs. Payne and Chang, the preponderance of the evidence suggests Petitioner's causally related lumbar spine/low back condition has not yet stabilized or otherwise resolved and that he is in need of further prospective medical treatment.

Similar to the dispute that arose between the parties in November 2014 regarding chiropractic care versus physical therapy, the current dispute is over whether Petitioner should receive an EMG as recommended by Dr. Payne or whether he should receive injections as recommended by Dr. Chang. Respondent asserts Petitioner should not be awarded prospective treatment as recommended by Dr. Chang as he previously declined similar treatment from Ingalls in July 2014. The Arbitrator views this evidence in favor of Petitioner. First, he credibly explained he now was ready to proceed as he does not want to continue experiencing his symptoms. Petitioner's conduct in this regard does not reflect attempts at secondary gain (i.e. protracting treatment recommendations in an effort to collect disability or to avoid working). In fact, during much of this time, he attempted to return to work in the condition he was in. Second, Petitioner's unrebutted and credible testimony on cross examination was that he went to Dr. Chang not for injections but in order to obtain the prescription for the EMG/NCV. In the Arbitrator's view, this testimony rebuts Respondent's position that Petitioner is attempting to avoid or protract treatment. By failing to authorize or approve the EMG/NCV recommended by Dr. Payne, Respondent should not now be entitled to argue that Petitioner has delayed his own treatment options when his conduct shows otherwise.

Dr. Chang is recommending pain management, similar to earlier recommendations for pain management by Ingalls and APN Gloria Dillman. Dr. Chang credibly explained that he believed Petitioner's low back pain and left leg symptoms to be caused in part by the foraminal stenosis from facet arthropathy. He also identified

small herniation at L5-S1 causing some spinal cord compression but did not feel it was causing any direct impingement. He further explained that the injections recommended would be used to both therapeutically to treat and diagnostically to confirm whether the foraminal stenosis was in fact the source of Petitioner's symptoms. The doctor related Petitioner's condition as aggravated by the accident. Petitioner has elected to pursue pain management. The Arbitrator finds this recommended treatment related, reasonable and necessary.

Respondent asserts Petitioner has exceeded his choice of physicians under the Act and therefore it is not responsible for the bills or treatment recommendations of Dr. Chang. Ax1. The record shows Petitioner sought emergency care with St. James Hospital following the work accident, which does not count as a choice under the law. Px1. Petitioner's unrebutted testimony was that he was eventually referred by Respondent to chiropractor Kruse and eventually Ingalls. Px2, Px3, Rx3. Dr. Kruse's medical chart reflects a notation that Petitioner was referred by Sutton Ford. Similarly, this assertion was echoed in Dr. Payne's first report. Petitioner testified that he sought out chiropractor Dr. Edwards on his own, which would constitute his first choice of physician. The dispute arises over whether Dr. Marek Odehnal is a choice of physician. Rx7. If so, then Dr. Chang would in fact be a third choice and therefore beyond the available choice of physicians under the current Act. Dr. Odehnal's record reflects that Petitioner was previously scheduled for an unrelated follow up and for refill of medications. In the Arbitrator's view, the doctor only made incidental notation of Petitioner's back pain. No treatment, medications or referrals were issued for the back injury or pain on that date. To the extent Petitioner continued to treat at Medical Specialists, the Arbitrator notes Petitioner's subsequent visits were all with advance practice nurse Gloria Dillman. Rx7. Under a plain reading of the Act, Dillman is not a physician and therefore it cannot be said Petitioner treated with Medical Specialists for this injury. Therefore, Petitioner did not exceed his choice of physicians and Dr. Chang is properly within the allowed choices under the Act.

In light of the foregoing, Respondent shall authorize and pay for the treatment recommended by Dr. Chang. Further, Respondent shall pay Petitioner the reasonable and necessary medical services of **$6,300.38**, 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.

Signature of Arbitrator

2-25-2016
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Angela Glenn,

Petitioner,

vs. NO: 15 WC 04795

Ford Motor Company,

Respondent,

17IWCC0187

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, medical care, causal connection, prospective medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 16, 2016, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 28 2017
O032317
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

GLENN, ANGELA
Employee/Petitioner

Case# **15WC004795**

FORD MOTOR COMPANY
Employer/Respondent

17IWCC0187

On 8/16/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0320 LANNON LANNON & BARR LTD
MICHAEL S ROLENC
200 N LASALLE ST SUITE 2820
CHICAGO, IL 60601

0075 POWER & CRONIN LTD
ADAM RETTBERG
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

17IWCC0187

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)

ANGELA GLENN
Employee/Petitioner

v.

FORD MOTOR COMPANY
Employer/Respondent

Case # **15** WC **4795**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **6/15/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **5/29/13**, 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 not causally related to the accident.

In the year preceding the injury, Petitioner earned **$33,948.72**; the average weekly wage was **$652.86**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **1** dependent child.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $264.00 to Illinois Spine & Scoliosis Center (date of service: 8/16/13), as provided in Sections 8(a) and 8.2 of the Act.

Further benefits are denied based upon the Arbitrator's finding that Petitioner's condition of ill-being causally connected to the injury of May 29, 2013, resolved by December 30, 2013.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

FINDINGS OF FACT

The disputed issues in this matter are: 1) accident; 2) notice; 3) causal connection; 4) medical bills; 5) temporary total disability; and 6) whether Petitioner is entitled to prospective medical treatment. *See*, AX1.

Angela Glenn, ("Petitioner"), testified that on May 29, 2013, she was employed by Ford Motor Company, ("Respondent"), following her initial hiring on or about September 10, 2010. She testified to additional, prior injuries that are the subject of other consolidated claims filed prior to the date of the subject injury. She has been seeing Dr. Blair Rhode on an ongoing basis, prior to May 29, 2013, for these claims. She had been released to light-duty work by Dr. Rhode, which Respondent was able to accommodate and thus she was working in this capacity as of May 29, 2013.

Beginning January 1, 2013, Petitioner was assigned to the "IP line". Petitioner described her duties as installing various instruments into the dashboards of vehicles being assembled at Respondent's manufacturing plant. She described some of the positions that she worked in this capacity as installing air vents, speakers, and speedometers.

Petitioner's testimony

On May 29, 2013, Petitioner was assigned to install speedometers into the dashboards of vehicles on the assembly line. This was a task she had previously performed on approximately ten (10) occasions at various times throughout that month. Upon arrival at the plant, she proceeded to her work station after checking in with her supervisor, Courtney. She was scheduled to work a full shift of approximately eleven (11) hours, running from 6 a.m. to 5 p.m. Petitioner testified that to install the speedometer, the part was placed in the partially-assembled vehicle's dashboard; then held in place by three screws that were driven in from the underside of the dashboard. To install these screws, Petitioner had to bend down to reach the underside of the dashboard, then look up to her left to see where to install the screws. While testifying, Petitioner was able to demonstrate these motions and the positions used. After performing this work for a period of time, she felt "something funny" in the left side of her neck, so she adjusted her position to be able to look up and to her right instead, while performing this task.

Petitioner testified that the speedometer weighed approximately one (1) pound; and she used a power drill in her right hand to place and tighten the three screws required for each installation. She estimated that she had installed between 300 and 400 such speedometers on May 29, 2013, prior to noting discomfort. She testified that over the course of a full day's work, she would install approximately 600 units in toto. On a typical day, Petitioner would have a 30-minute lunch break and three 15-minute breaks.

At some point after noting discomfort, Petitioner advised her supervisor, "Courtney," who gave her a pass to see a nurse at the on-site medical clinic. Petitioner advised the nurse of her complaints.

Petitioner testified that she provided a history of the onset of her discomfort as noted above and complained of left-sided neck pain going into her left shoulder. A medical record of the visit to the Ford medical clinic dated May 29, 2013 reflects that Petitioner was "complaining of L sided headache that goes down to L side of neck and shoulder." The record indicates that Petitioner denied any recent trauma and contains no history of discomfort following repetitive activity. Petitioner was released to continue working. RX4.

Petitioner returned to the same position on the following day, i.e., May 30, 2013, then began her weekend. She testified that her discomfort continued and at her next regularly, scheduled visit with Dr. Rhode, regarding a separate right shoulder injury, she advised him of this newly developed complaint. This note reflects a history provided by Petitioner of discomfort to the left side of her neck and left shoulder, following speedometer installation on May 29. Petitioner complained of pain upon attempting to turn her head to the left. Dr. Rhode prescribed a cervical MRI. She returned to Dr. Rhode on June 24, but the MRI had not yet been performed. The MRI was then performed on July 17 and interpreted as revealing cervical disc herniations at C4-5 and C5-6. When the petitioner returned to Dr. Rhode on July 22, he referred her to Dr. Anthony Rinella for further evaluation of her cervical spine. PX1 & 3.

On August 16, 2013, Petitioner presented to Dr. Rinella, providing a history of neck pain commencing on May 29, 2013 and described her activities of that day. Upon physical examination, Dr. Rinella noted that she had near-full range of motion of her neck, with a "mildly" positive Spurling's sign on the left, negative on the right. He noted diminished sensation in the left C6 nerve root distribution. He reviewed an MRI (according to Dr. Rinella's August 16, 2013 note this MRI was dated July 7, 2003, but as the accompanying records include only the MRI taken on July 17, 2003, the Arbitrator views this discrepancy as a typographical error on the doctor's part) and noted its findings.

Dr. Rinella felt that the forward flexing and twisting maneuvers, engaged in by Petitioner while working on May 29, 2013, had caused an aggravation of pre-existing cervical kyphosis, resulting in C6 radiculopathy on the left more than on the right. His diagnoses were cervical strain and cervical spondylotic radiculopathy. He recommended a course of physical therapy 3 days per week, and referred her to Dr. Abusharif for epidural steroid injections. He released her to work with a 10-pound weight restriction and restricted her to no overhead lifting. He advised follow-up in 4 to 6 weeks and the next note of September 27, 2013 indicates that Petitioner did not come in for the appointment that day. PX2.

Petitioner continued treatment, including physical therapy, for her other medical conditions. She underwent a left shoulder subacromial decompression and rotator cuff repair on September 3, 2013; and thereafter was seen for physical therapy at Orland Park Orthopedics on October 17, 2013. On this occasion, she complained of non-radiating left shoulder pain that was felt to be consistent with her recent surgery. She specifically denied "numbness, tingling, lateral arm pain, neck pain, instability, or "catching." Upon physical examination of her cervical spine, she displayed a full range of motion to

flexion, extension, lateral bending, and rotation; negative Spurling's signs and no evidence of atrophy. RX3.

Petitioner subsequently underwent an independent medical examination ("IME") at Respondent's request, pursuant to Section 12 of the Act regarding her left upper extremity (the subject of one of the companion cases) by Dr. Mark Levin on December 5, 2013. Petitioner did not list neck or cervical pain among her then current complaints. As part of this examination of an upper extremity, Dr. Levin performed a physical examination of the cervical spine, noting in his report:

> Examination of the cervical spine shows no pain over the cervicooccipital junction or over the earlobes with no pain over the cervical paraspinal muscles. She has full flexion and extension of the cervical spine with the ability to touch her chin to her chest and extend back 90 degrees. Right deviation is to 60 degrees and left deviation is to 65 degrees. There is no pain to palpation over the trapezius or medial borders of the scapula and no thoracic pain and no thoracic atrophy. There is no cervical or thoracic spasm. RX 2.

Petitioner then subsequently underwent an IME specific to the cervical spine on December 30, 2013, this time performed by Dr. Kern Singh. This examination report notes a number of the other injuries alleged by Petitioner for other body parts that are the subjects of companion cases, but includes in its medical chronology portion, the allegations of injury noted in Dr. Rhode's June 3, 2013 note, i.e., "June 3, 2013, Dr. Blair Rhode states the patient had right elbow and left shoulder pain. She developed sudden onset of severe left-sided cervical pain, with radiation. She was performing her job at this time when she had to look to the left and upwards, and she developed this pain while performing her job. Recommend MRI of the cervical spine." RX1.

Petitioner's current complaints to Dr. Singh were neck pain at 6 of 10 on a visual scale, which was worsening. The pain increased with sitting and bending forward and decreased with standing. Physical therapy had provided moderate relief. Upon physical examination, Dr. Singh noted that Petitioner "self limits range of motion at 10 degrees of flexion, 5 degrees of extension, and 5 degrees of axial motion." The remainder of the examination was entirely unremarkable. Dr. Singh noted positive Waddell findings for pain with percussion, pain with simulated axial loading, pain with simulated axial rotation, distracted straight leg raise and symptom magnification. Dr. Singh reviewed the MRI of July 17, 2003 and felt it revealed "diffuse cervical spondylosis with disk osteophytes at C5-6 and C6-7 with mild central canal compromise at C5-6 and C6-7."

Dr. Singh opined that Petitioner had sustained a soft tissue muscular strain during the work event of May 29, 2013. He opined that this cervical muscular strain had resolved, and any remaining complaints were related to a pre-existing condition of degenerative cervical spondylosis. Based upon his review of medical records relating to her ongoing shoulder treatment, he felt that her neck pain complaints were incidental in nature; and most consistent with a soft tissue strain that had since

resolved. He opined that no further work restrictions or medical treatment for the cervical spine was necessary or causally related to the work incident of May 29, 2013. Finally, he opined that the Petitioner's subjective complaints were not substantiated by objective findings noted in the medical records or his physical examination.

Petitioner testified that she subsequently spent time on treatment for her other injuries and did not return to Dr. Rinella until March 5, 2015. During the interim, she had continued her treatment with Dr. Rhode for conditions other than her cervical spine. On March 5, 2015, Dr. Rinella's note indicates that Petitioner continued to report neck pain radiating into her upper extremities. On the left this pain extended into the trapezial area and on the right it extended from the trapezial area down into the radial aspect of the forearm, into the right thumb. In addition, Petitioner noted lumbar tenderness extending into the lateral thighs bilaterally, but she felt that her neck pain was the more pressing concern. She rated her neck pain at a 10 on a 10-point visual scale and advised that she was not taking medication for her pain.

On physical examination at the visit of March 5, 2015, Dr. Rinella noted diminished rotation in the cervical spine to the left more than to the right, with a maximal rotation of 45 degrees. Her Spurling's signs were noted as equivocal. Petitioner's strength was intact, but she had diminished sensation in the C6 distribution bilaterally; and in the C7 distribution on the left side. Limitations were also noted as to range of motion of the lumbar spine.

Dr. Rinella restricted Petitioner from working and recommended a C4-5 and C5-6 anterior cervical discectomy and fusion. He opined that the petitioner's pain had "been present for several years and will not improve with further conservative management." No indication is given as to what conservative management had previously been obtained. Dr. Rinella additionally prescribed Norco for pain and recommended an EMG.

Petitioner continued to see Dr. Rinella or his physicians' assistant Douglas Stevens, on several additional occasions throughout 2015 and into 2016. Dr. Rinella continued to recommend surgery, and Petitioner testified that she wants to have the surgery. She additionally testified that Dr. Rinella had continued to keep her restricted from working, but that Dr. Rhode has since discharged her from care regarding her other medical conditions. She continued to work through August 29, 2013, but had not worked since, noting that she had undergone shoulder surgery on September 3, 2013. PX2.

At trial, Petitioner testified that her neck hurts constantly and characterized the pain as sharp. On cross-examination, Petitioner confirmed that Dr. Rinella's "off-work" restriction had been applied at her visit of March 5, 2015, not at the initial visit with him on August 16, 2013.

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CONCLUSIONS OF LAW

B. Did an accident occur on May 29, 2013, that arose out of and in the course of Petitioner's employment by Respondent?

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin v. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v. Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v. Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).

It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); see also *Hansel & Gretel Day Care Center v. Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor v. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal v. Industrial Commission*, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances support the decision. *See generally, Gallentine v. Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), *see* also *Seiber v. Industrial Commission*, 82 Ill.2d 87, 411 N.E.2d 249 (1980), *Caterpillar v. Industrial Commission*, 73 Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v. Workers' Compensation Commission*, 397 Ill.App. 3d 665, 674 (2009).

Petitioner testified that she experienced an unusual sensation of cervical pain that commenced on May 29, 2013, when she was engaged in installing speedometers during the course of her employment by Respondent. She testified that she notified her immediate supervisor "Courtney" on that day and this testimony was not rebutted by Respondent. While the medical record of Respondent's on-site clinic for Petitioner's visit on May 29, 2013 does not reflect a consistent history of injury, and in fact contains Petitioner's denial of any recent trauma; the circumstances were otherwise consistently reported by Petitioner to her subsequent doctors, and these reports were consistent with her testimony at trial. The Arbitrator finds that Petitioner has proven, by a preponderance of the evidence

that she sustained an accidental injury on May 29, 2013, arising out of and in the course of her employment by Respondent.

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

Petitioner testified in a credible and unrebutted manner, that she did provide notice to Respondent within the period required by the Act.

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

A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v Industrial Commission*, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a causal connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v. Industrial Commission*, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

Petitioner's onset of cervical pain on May 29, 2013 was consistently reported, although the exact circumstances alleged, varied from her initial visit of that date with the on-site medical clinic and the doctors' records that treated her on later dates. Petitioner's primary care doctor for her cervical spine, i.e., Dr. Rinella, characterized this injury initially as a cervical strain that had aggravated a pre-existing condition of cervical kyphosis. At his August 16, 2013 visit, Dr. Rinella recommended physical therapy, referred Petitioner to another physician for epidural steroid injections; and limited her to light-duty work.

It was not until her next visit, more than a year and a half later that Dr. Rinella recommended surgery, apparently relying on the petitioner's subjective complaints and the history provided. The Arbitrator notes that Petitioner's physical examination at the second visit with Dr. Rinella of March 5, 2015, is markedly different than that performed at the first visit of August 16, 2013. At the first visit, she had "almost full range of motion"; at the second, her left rotation was limited to 45 degrees. At the first, diminished sensation was reported only in the left C6 nerve root distribution; at the second, diminished sensation was noted in the C6 distribution bilaterally and in the C7 distribution on the left. At the first visit, a mildly positive Spurling's sign was noted on the left; at the second, Spurling's signs were equivocal.

Also, Petitioner's complaints changed from the first visit to the second. First, she complained of tenderness in the neck to the left trapezoidal area significantly (8/10) and less so to the right; at the second visit her complaints on the right were significant enough to note and extended from the trapezoidal area down to the radial aspect of her forearm to the right thumb.

Following that second visit of March 5, 2015, Dr. Rinella increased his prior work restriction, moving Petitioner from light duty to no work and instead of the previously, recommended conservative treatment, he now recommended multi-level anterior cervical discectomy and fusion. According to his note of that date, this dramatic change in recommendations relied on Petitioner's representation to him that her cervical pain had continued unabated during the nineteen (19) months since he had previously seen her; as there is no indication that Dr. Rinella had reviewed any of the intervening medical records.

Several intervening medical records contradict this conclusion. The Arbitrator notes that the physical therapy record dated October 17, 2013, introduced as Respondent's Exhibit 3, reflects Petitioner's representation that her left shoulder pain, at that time, was non-radiating and she specifically denied any neck pain.

The Arbitrator also notes the report of Dr. Levin dated December 5, 2013, which describes an unremarkable cervical examination and specifically notes that Petitioner "has full flexion and extension of the cervical spine with the ability to touch her chin to her chest" with no associated report of pain; and that Petitioner reported no pain on palpation over the trapezius. This highly contrasts Petitioner's reports of pain into the trapezius to Dr. Rinella on August 16, 2013, as well as her expanded complaints of pain at the later visit of March 5, 2015. The lack of range of motion limitations found by Dr. Levin is highly consistent with the similar essential lack of range of motion limitations noted by Dr. Rinella on August 16, 2013; as well as the full range of motion noted in Petitioner's physical therapy note of October 17, 2013; and the full range of motion noted by Dr. Singh at his subsequent examination of December 30, 2013.

The Arbitrator further notes Dr. Singh's findings of positive Waddell's signs at his independent medical examination of December 30, 2013, particularly the finding of symptom magnification. The Arbitrator views Dr. Singh's opinions as persuasive, given the fact that despite this finding, which seems to question the credibility of the petitioner's reports, Dr. Singh agrees that she sustained an accidental injury to her cervical spine, as noted in Dr. Rhode's note of June 3, 2013. Dr. Singh characterized this injury as a strain that had resolved as of the time of his examination, which the Arbitrator finds reasonable given the lack of objective findings noted by Dr. Singh, particularly in light of the similar lack of cervical complaints or deficits noted by Petitioner's physical therapist on October 17, 2013 and by Dr. Levin on December 5, 2013.

Between August 16, 2013 and March 5, 2015, while Petitioner was undergoing medical treatment for medical conditions other than her cervical spine, there is no evidence in the record of continuous or worsening cervical complaints during that period; other than Petitioner's assertions of same. These assertions are in direct contrast to the above-noted records that were generated in the period closely following the injury of May 29, 2013; and appear to form the sole basis for Dr. Rinella's later recommendations on March 5, 2015.

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Dr. Rinella opines that the petitioner's worsened cervical complaints of March 5, 2015 as indicative that her condition of ill-being has persisted and worsened throughout the intervening period, but there is no evidence to indicate that he was aware of medical records closer to his initial evaluation, that directly contradict this conclusion. As such, the Arbitrator finds the opinion of Dr. Singh to carry greater weight than that of Dr. Rinella; and finds that the injury of May 29, 2013 was properly characterized as a cervical strain that had resolved no later than the date of Dr. Singh's independent examination on December 30, 2013.

J. Were the medical services provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for such reasonable and necessary care?

The Arbitrator incorporates the findings relating to issues C), E), and F) as noted above. Having found that Petitioner's condition of ill-being related to the accidental injury of May 29, 2013 resolved by than December 30, 2013, the Arbitrator finds that the services so provided between those dates were reasonable and necessary to cure or relieve the Petitioner of her condition of ill-being. The Arbitrator notes that the Petitioner's visit with Dr. Rhode on June 3, 2013 was apparently previously scheduled in relation to a separate injury, and as such does not directly relate to this finding. The only noted visit, specific to the cervical strain that occurred during this range of dates, was the visit with Dr. Rinella on August 16, 2013, and Respondent will therefore be liable for payment of the bill for that visit pursuant to the medical fee schedule. The respondent is not liable for payment of bills for visits with Dr. Rinella commencing on March 5, 2015 and thereafter.

K. Is Petitioner is entitled to any prospective medical care?

The Arbitrator incorporates the findings relating to issues C), E), F), and J) as noted above. Having found that Petitioner's entitlement to medical benefits, causally related to the injury of May 29, 2013 ceased as of December 30, 2013, the Arbitrator denies prospective medical treatment sought, specifically but not limited to, the two-level anterior discectomy and fusion first proposed by Dr. Rinella on March 5, 2015.

L. What temporary benefits are in dispute?

The Arbitrator incorporates the findings relating to issues C), E), F), J), and K) as noted above. Petitioner's condition of ill-being relating to the injury of May 29, 2013 ceased to be causally connected to that injury by December 30, 2013, the date of Dr. Singh's independent examination. Dr. Singh found that no work restrictions relating to Petitioner's cervical spine were reasonable and necessary after that date, and it was not until March 5, 2015 that Dr. Rinella placed Petitioner on "off-work" status. Petitioner claims entitlement to TTD benefits commencing on May 28, 2016, and the Arbitrator denies such benefits as unrelated to Petitioner's injury of May 29, 2013.

17IWCC0187

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
15WC4795
SIGNATURE PAGE

Signature of Arbitrator

August 16, 2016
Date of Decision

AUG 16 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF WINNEBAGO)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rick Zentz,

Petitioner,

vs.

GKN of Rockford,

Respondent,

NO: 15 WC 05090

17IWCC0158

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, medical, prospective medical, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 7, 2016 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that 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 $16,000.00. 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: MAR 15 2017

Stephen J. Mathis
Stephen Mathis

David L. Gore
David L. Gore

EC/mas
o:2/23/17
43

17IWCC0158

SPECIAL CONCURRING OPINION

This case was scheduled for Oral Arguments on February 23, 2017 before a three-member panel of the Commission including members Mario Basurto, Stephen J. Mathis and David L. Gore, at which time Oral Arguments were either heard, waived or denied. Subsequent to Oral Arguments and prior to the departure of Mario Basurto on March 3, 2017, a majority of the panel members had reached agreement as to the results set forth in this decision and opinion, as evidenced by the internal Decision worksheet initialed by the entire three member panel, but no formal written decision was signed and issued prior to Commissioner Basurto's departure.

Although I was not a member of the panel in question at the time Oral Arguments were heard, waived or denied, and I did not participate in the agreement reached by the majority in this case, I have reviewed the Decision worksheet showing how Commissioner Basurto voted in this case, as well as the provisions of the Supreme Court in *Zeigler v. Industrial Commission*, 51 Ill.2d 137, 281 N.E.2d 342 (1972), which authorizes signature of a Decision by a member of the Commission who did not participate in the Decision. Accordingly, I am signing this Decision in order that it may issue.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

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

ZENTZ, RICK
Employee/Petitioner

Case# **15WC005090**

17IWCC0158

GKN OF ROCKFORD
Employer/Respondent

On 6/7/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1131 GESMER LAW OFFICES
BRAD A REYNOLDS
526 E JEFFERSON ST SUITE 118
ROCKFORD, IL 61107

4234 RIPES NELSON BAGGOT ET AL
MICHAEL BAGGOT
650 E DEVON ST SUITE 110
ITASCA, IL 60143

STATE OF ILLINOIS)SS.

COUNTY OF WINNEBAGO)

17IWCC0158

- ☐ Injured 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)

RICK ZENTZ
Employee/Petitioner

v.

GKN of ROCKFORD
Employer/Respondent

Case # **15** WC **005090**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Rockford, Illinois**, on **5-16-16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ 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

17IWCC0158

On the date of accident, **January 30, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$61,443.20**; the average weekly wage was **$1,181.60**.

On the date of accident, Petitioner was **65** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $787.73 for 12-4/7 weeks, from February 2, 2015 through April 30, 2015, as provided in Section 8(b) of the Act.

Respondent shall pay to Petitioner reasonable and necessary medical expenses of $5,963.25 as provided in section 8(a) of the Act, subject to the fee schedule of Section 8.2 of the Act. Respondent shall further reimburse Petitioner in the amount of $13.07 for out of pocket expenses.

Respondent shall authorize a lumbar epidural steroid injection.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Signature of Arbitrator

6/6/2016
Date

JUN 7 - 2016

ICArbDec19(b)

With respect to (C.) DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT, the Arbitrator finds as follows:

Petitioner Rick Zentz was hired by Respondent GKN of Rockford in October 1998. Petitioner worked both as an inspection supervisor and as a quality engineer for Respondent. Petitioner testified that in the early afternoon on January 30, 2015, he called employees Dave Banick (production engineer) and Todd Highland (inspection supervisor) to the tool crib in order to show a fixture to the two men and discuss its use. (RX 1) Petitioner testified that upon their arrival to the tool crib, he pulled out the machine spindle weighing 150 pounds from a lower shelf and laid the spindle on its side. Next, he stood the machine spindle up to place the fixture on its base and as he did so, he felt discomfort in his lower back. Petitioner stated that initially, he thought that his low back discomfort was due to a muscle pull or strain. The meeting broke up between the three workers and Petitioner continued to do his regular job. Petitioner provided that as he continued to work, his low back discomfort worsened and he developed shooting pain within 30 minutes of moving the spindle. Petitioner indicated that at that time, he paged his immediate supervisor, Marty Bowers, twice over the shop intercom system. Petitioner stated that his supervisor did not answer his pages, and as a result he went out onto the shop floor to locate his immediate supervisor to report his work injury. Petitioner testified that he looked "shop wide for 20 minutes" but was unable to locate his supervisor on the shop floor so he returned to his office. Petitioner stated that five to ten minutes after arriving back at his office, he was paged to report to the Human Resources office.

Petitioner testified that when he reported to HR he was met by Marty Bowers and the head of HR Mindy Nitz. Petitioner testified Ms. Nitz informed him immediately that he was being laid off due to a company down turn. Petitioner testified he had always had good performance reviews and it was a "complete surprise to me" that he was being laid off by Respondent. Petitioner indicated he was told to promptly gather up his personal belongings and then he was immediately escorted out of the building by Ms. Nitz. Petitioner testified that when he arrived home, he again called his supervisor using Respondent's regular phone number and left a message for Marty Bowers to return his call. Petitioner stated he called Mr. Bowers again on Saturday morning using Mr. Bowers' cell phone number and left another message for Mr. Bowers to return his call. Petitioner testified Marty Bowers never returned either of his two phones messages from Friday or Saturday. Petitioner testified both on direct examination and cross examination that he did not actually report the work injury to his employer until February 3, 2015 when he sent in a formal report of the work accident. See Respondent's Exhibit 1.

Marty Bowers testified in Respondent's case in chief. Mr. Bowers was Petitioner's immediate supervisor on January 30, 2015. Mr. Bowers testified that he recalled January 30, 2015 because that was the date GKN laid Petitioner off. Bowers testified he had been doing training in the training office on January 30th and that when he completed the training materials he paged Petitioner to HR. Bowers testified that he met Petitioner briefly in the hallway outside of the HR office but that the two men did not talk. Bowers walked Petitioner into the HR office where Mindy Nitz promptly notified Petitioner he was being laid off due to a company slow down. Bowers testified that during the meeting where Petitioner was laid off, Petitioner did not report injuring his low back earlier in the day. Bowers testified he did receive two messages from Petitioner after he was escorted out of the building on January 30, 2015. Bowers testified that Petitioner left him a message Friday evening and on Saturday morning inquiring about his personal belongings in both messages but not mentioning any work injury. Mr. Bowers testified he did not return either of the two phone messages left by Petitioner.

Mindy Nitz also testified in Respondent's case in chief. Ms. Nitz was the HR manager for GKN of Rockford on January 30, 2015. Ms. Nitz testified that Marty Bowers paged Petitioner to the HR office on

January 30, 2015. Ms. Nitz testified that when Petitioner arrived at the HR office she notified him he was being laid off due to a company down turn. Ms. Nitz testified that during this meeting, Petitioner never reported that he injured his low back earlier that day while working for Respondent. Ms. Nitz testified she escorted Petitioner out of the building shortly after notifying him that he was laid off and that she did not observe Petitioner showing any visible signs of an injury at that time. Ms. Nitz acknowledged she received a formal written report (marked as Respondent's Ex. 1) of a work injury from Petitioner on February 3, 2015.

Respondent disputes accident. Respondent does not dispute timely notice of a work injury pursuant to Section 6(c) of the Act. See Arbitrator's Exhibit 1. Respondent presented testimony that their policy was that all injuries be reported immediately.

17IWCC0158

To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that she has suffered a disabling injury which arose out of and in the course of his employment. Sisbro v. Industrial Commission, 207 Ill. 2d 193, 203, 797 N.E.2d 665, 671-672 (2003). An injury occurs within the course of an employee's employment if the injury occurs within the time and space boundaries of the employment. Id. An injury "arises out" of an employee's employment when the employee was performing acts he was instructed to perform by his employer, acts which the employee might reasonably be expected to perform relating to his assigned duties. Id. For an injury to arise out of the employment its origin must be in some risk connected with or incidental to the employment so as to create a causal connection between the employment and the accidental injury. Caterpillar Trucker Company v. Industrial Commission, 129 Ill. 2d 52 (1989). A risk is incidental to employment where it belongs to or is connected with what an employee has to do in fulfilling his duties. Id.

After considering the entire record, the Arbitrator finds Petitioner sustained his burden of proving an accident that arose out of and in the course of his employment by Respondent on January 30, 2015. Several reasons support this finding.

First, Petitioner was seen at Immediate Care on February 2, 2015 (three days following the work injury) where he reported injuring his low back while lifting a heavy object at work on January 30, 2015. (PX2) The IWCC has long recognized the importance of the content of claimant's medical records in determining proof an accident. See Shafer v. Illinois Worker's Compensation Commission, Ill. App. Fourth 100505 WC (2011) (holding IWCC finding that claimant suffered a work related accident was not against the manifest weight of the evidence where Petitioner provided a consistent history of injury to her medical providers).

Second, Petitioner testified that his injury was witnessed by at least three GKN employees- David Banick, Todd Highland, and Tom Cook. Respondent did not call any of these three employees to testify at the hearing and Petitioner's testimony about how he was injured was unrefuted.

Third, the Arbitrator is not persuaded on this record that Petitioner's failure to report the work injury to Respondent until February 3, 2015 establishes that he did not suffer a work injury on January 30, 2015 as maintained by Respondent. Petitioner testified he did attempt to report his work injury to Marty Bowers prior to being informed he was laid off. Petitioner paged Bowers twice over the shop intercom and then searched for Bowers on the shop floor in order to report his injury. Bowers testified he was in training in the training office prior to paging Petitioner to the HR office. This explains why Petitioner could not find Bowers on the shop floor and why Bowers did not hear Petitioner's two pages. The Arbitrator is persuaded by Petitioner's testimony that he was in complete shock after being notified by Ms. Nitz in the HR office that he was laid off. Petitioner's testimony that he always received strong employment reviews from GKN in his nearly 17 years of employment was not refuted by Respondent nor its witnesses. Both Bowers and Nitz testified that Petitioner had no warning ahead of January 30, 2015 that he was going to be laid off that day. Both Bowers and Nitz agreed that Petitioner was at the very least not happy about the news that he was laid off. The Arbitrator heard the testimony of all the

witnesses and is persuaded that the news of losing his long time job without warning is an adequate explanation for Petitioner's failure to report his work injury to Respondent during the meeting on January 30, 2015. Petitioner did attempt to reach Marty Bowers on the evening of the work injury and the following morning but Bowers refused to return either of Petitioner's calls. Petitioner also made efforts to obtain his phone records prior to the parties' hearing. (PX3) Ms. Nitz testified she did not instruct Marty Bowers to save the two messages left by Petitioner.

17IWCC0158

With respect to (F.) IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, the Arbitrator finds as follows:

Petitioner was initially seen at Beloit Clinic Convenient Care on February 2, 2015 by Dr. Olszewski for complaints of low back pain. The history was of a 65 year old male with complaints of lower back pain "states at work Friday felt "pull" in his back while lifting a heavy object" and is not improving. (PX2) Physical exam was within normal limits. The diagnosis was lumbar sprain. Medications were prescribed and Petitioner was instructed to follow up if his symptoms worsened. (PX2)

Petitioner was next seen by his regular physician Dr. William Fitzgerald on February 9, 2015. (PX2) Dr. Fitzgerald noted Petitioner as seen for acute LBP with left leg radiation which "started after lifting a heavy object at work". Physical exam revealed a positive straight leg raise test at 45 degrees on the left while sitting in a chair. X-rays revealed minimal, grade 1 retrolisthesis of L4 over L5 with mild disc space narrowing at L4-5. The diagnosis was acute sciatic. Petitioner was placed on light duty work restrictions. (PX2)

On February 24, 2015, Petitioner reported slow improvement in his symptoms since their onset. Diagnosis remained acute low back pain. Petitioner was continued on light duty restrictions. (PX2) Petitioner was next seen on March 11, 2015 by Dr. Fitzgerald for LBP and sciatica. Petitioner reported two instances of his left leg going numb and worsening low back and leg pain. Diagnosis remained acute low back pain and acute sciatica. A lumbar MRI was discussed. The plan remained activity modification and medications. (PX2)

Petitioner completed the lumbar MRI ordered by Dr. Fitzgerald on May 1, 2015. PX 2. The lumbar MRI revealed a bulging disc at L3-4. (PX 2) Dr. Fitzgerald reviewed the lumbar MRI noting that Petitioner had a "slipped disc" and recommending an epidural (steroid shot). (PX 2)

Petitioner testified that prior to January 30, 2015 he had no past medical history of injury or treatment regarding his low back. Petitioner provided that he missed no time from work for low back or leg pain prior to January 30, 2015.

Petitioner was asymptomatic and not actively treating for any low back or leg pain until he lifted the 150 pound spindle at GKN on the date of injury. A review of the medical records confirms Petitioner had a negative past medical history concerning his low back and left leg. Petitioner credibly testified he lifted a heavy spindle on January 30, 2015 and felt a muscle pull while doing so. Petitioner developed shooting left leg pain within 30 minutes of his injury. Petitioner was seen by medical doctors beginning on February 2, 2015 who diagnosed him with acute low back pain and acute sciatica after lifting a heavy object at work on January 30, 2015.

Based upon the above, and in light of Petitioner's negative past medical history concerning his low back, the Arbitrator finds that Petitioner sustained his burden of proof that his condition of ill being regarding his low back and left leg pain are causally related to his January 30, 2015 injury while lifting a heavy spindle based upon a chain of events theory. See International Harvester v. Industrial Commission, 93 Ill. 2d 59, 63-64 (1982)

(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 nexus

between the accident and the employee's injury). Respondent offered no opinion testimony concerning medical causation.

With respect to (J.) WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, the Arbitrator finds as follows:

Petitioner's Exhibit 4 contains the medical bills from Beloit Clinic where all medical treatment (as contained within PX 2) was rendered regarding's Petitioner's left lumbar sciatica from February 2, 2015 through May 1, 2015. Having found the requisite causal relationship, the Arbitrator finds all medical treatment rendered reasonable and necessary. Respondent introduced no evidence to the contrary. Total billed charges are $5,963.25. Respondent is ordered to pay the medical bill contained within PX 4 per the Illinois Fee schedule.

Petitioner paid $13.07 out of his pocket for doctor prescribed medications (diclofenac and cyclobenzaprine) on February 2, 2015 as shown in PX 4. Respondent is ordered to reimburse Petitioner for these out of pocket expenses in the amount of $13.07.

With respect to (K.) IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, the Arbitrator finds as follows:

Petitioner completed a lumbar MRI that was ordered by Dr. Fitzgerald on May 1, 2015. The lumbar MRI revealed a bulging disc at L3-4. Dr. Fitzgerald reviewed the lumbar MRI noting that Petitioner had a "slipped disc" and recommending an epidural (steroid shot). (PX 2)

Petitioner testified at the time of the hearing that he continued to experience low back and left leg pain since his work injury. Petitioner rated his pain at rest as 4 out of 10. With activity, Petitioner rated his pain 8 out of 10. Petitioner did purchase an inversion table (which he uses 45-60 minutes per day) and a clam shell brace for his low back following his work injury. Petitioner testified that neither the inversion table nor the brace have eliminated his low back and left leg pain. Petitioner testified he began a new job as a roving inspector on May 1, 2016 but that job involves lifting no more than 1-3 pounds and there is minimal if any bending and/or twisting. Petitioner is permitted to alternate between sitting, standing, and walking in his new job.

Respondent offered no medical opinion concerning Petitioner's need for any additional medical treatment at the time of hearing.

Based on the above, the Arbitrator finds that Respondent shall authorize the lumbar epidural injection recommended by Dr. Fitzgerald.

With respect to (L.) WHAT TEMPORARY BENEFITS (TTD) ARE IN DISPUTE, the Arbitrator finds as follows:

The Arbitrator finds Petitioner sustained his burden of proving accident and causal connection for the reasons stated above. Petitioner's Exhibit 1 is a series of off work and/or work status notes completed by Petitioner's treating doctors regarding his low back. Petitioner was excused off work from February 2, 2015 through February 3, 2015. Effective February 4, 2015 through April 30, 2015, Petitioner was permitted to work light duty due to left lumbar sciatica with limitations on lifting, standing, and sitting. Effective May 1, 2015, Petitioner was permitted by Dr. Fitzgerald to return to work without restrictions. Respondent, who laid Petitioner off on January 30, 2015, did not subsequently offer Petitioner light duty work after his lay off.

Therefore, Respondent is ordered to pay due and owing TTD to Petitioner from February 2, 2015 through April 30, 2015, a period of 12-4/7ths weeks.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Yaritin Gomez,

Petitioner,

vs. NO: 15 WC 7965

Compass Group,

Respondent.

17IWCC0160

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, extent of temporary total disability, medical expenses and prospective medical care and being advised of the facts and law, corrects a clerical error in the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission corrects the clerical error on Page 3 of the Arbitrator's Decision, which states that the case number is 15 WC 7967, to the correct case number of 15 WC 7965. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove a causal relationship exists between the accident of June 12, 2014 and Petitioner's condition of ill-being, her claim for compensation is hereby denied.

17IWCC0160

The party commencing 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: MAR 17 2017
LEC/maw
o01/26/17
43

David L. Gore

Stephen J. Mathis

SPECIAL CONCURRING OPINION

This case was scheduled for Oral Arguments on January 26, 2017 before a three-member panel of the Commission including members Mario Basurto, Stephen J. Mathis and David L. Gore, at which time Oral Arguments were heard. Subsequent to Oral Arguments and prior to the departure of Mario Basurto on March 3, 2017, a majority of the panel members had reached agreement as to the results set forth in this decision and opinion, as evidenced by the internal Decision worksheet initialed by the entire three member panel, but no formal written decision was signed and issued prior to Commissioner Basurto's departure.

Although I was not a member of the panel in question at the time Oral Arguments were heard and I did not participate in the agreement reached by the majority in this case, I have reviewed the Decision worksheet showing how Commissioner Basurto voted in this case, as well as the provisions of the Supreme Court in *Zeigler v. Industrial Commission*, 51 Ill.2d 137, 281 N.E.2d 342 (1972), which authorizes signature of a Decision by a member of the Commission who did not participate in the Decision. Accordingly, I am signing this Decision in order that it may issue.

L. Elizabeth Coppoletti

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

GOMEZ, YARITIN
Employee/Petitioner

Case# **15WC007965**

15WC007966
15WC007967

COMPASS GROUP
Employer/Respondent

17IWCC0160

On 7/28/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

5015 ESR LAW GROUP LLC
EDWARD S RUEDA
33 N LASALLE ST SUITE 3350
CHICAGO, IL 60602

0210 GANAN & SHAPIRO PC
JULIA A MURPHY
210 W ILLINOIS ST
CHICAGO, IL 60654

17IWCC0160

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)

Yaritin Gomez
Employee/Petitioner

v.

Compass Group
Employer/Respondent

Case # **15WC 7965**

Consolidated cases: **15WC 7966 &15WC 7967**

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

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **June 12, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$18,579.08**; the average weekly wage was **$357.29**.

On the date of accident, Petitioner was **27** years of age, ***married*** with **1** dependent child.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, 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's current condition of ill-being is not causally related to the June 12, 2014 accident, because she reached maximum medical improvement on July 17, 2014.

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

7.28.16
Date

ICArbDec19(b)

JUL 28 2016

FINDINGS OF FACT

Yaritin Gomez ("Petitioner") testified she worked for Compass Group ("Respondent") as a food server. She testified her job duties included preparing food, serving food and cleaning the kitchen area.

On April 15, 2013, Petitioner testified she was carrying something when she slipped and fell on her back. She sought treatment with Dr. Franco on April 23, 2013. (Pet.Ex. 1). She was diagnosed with back pain. (Id.)

Petitioner did not treat again for her low back until August 20, 2013 at Concentra, the company clinic. (Pet.Ex. 2). She reported low back pain, which was radiating down the leg. She reported receiving low back treatment, including an MRI, while she was out of the country. Examination was essentially normal. She was diagnosed with low back pain and directed to return to work full duty and she was released from care. (Id.).

Petitioner followed up with Dr. Franco on August 24th reporting low back pain and headaches. (Pet.Ex. 1). Dr. Franco recommended an MRI, which was performed on August 29, 2013 at St. Mary of Nazareth. (Pet.Ex. 3). The MRI was normal. (Id.).

Petitioner saw Dr. Franco again on September 10, 2013, and reported low back pain radiating down the right leg. Straight leg raise was positive for back pain only. Dr. Franco reviewed the MRI and stated the "MRI does not correlate with her symptoms." (Pet.Ex. 1).

One June 12, 2014, Petitioner testified she fell off a step-stool, which was approximately 2 to 2.5 feet high. She sought treatment at Concentra reporting pain in her head, neck, right shoulder and right elbow. She also reported stiffness in the low back. (Pet.Ex. 2). She was diagnosed with multiple contusions, and released to return to work with light duty restrictions. (Id.).

She continued treating with Concentra, and an MRI was performed. It was read by Dr. Bridgeforth as essentially normal on July 2, 2014. He further noted a positive battery of Waddell tests. (Id.). She was released to return to work full duty on July 7, 2014. (Id.). She was released at maximum medical improvement on July 17, 2014. (Id.).

Petitioner did not treat again for low back pain until February 16, 2015 with Dr. Franco. (Pet.Ex. 1). She reported pain in on the right side of her low back for a few months and abdominal pain. She was diagnosed with sciatica and Dr. Franco recommended an MRI of the lumbar spine. (Pet.Ex. 1). Petitioner testified Dr. Franco provided her with light duty restrictions at this appointment, but there is no corresponding light duty work note in the records.

Petitioner testified she went to work on February 17, 2015 and told them she could not lift more than ten pounds, but was told she needed a work note. Petitioner testified students helped carry boxes up the stairs for breakfast, but she had to unload them. She testified she bent over to pick up a box and heard a pop in her shoulder and back. She testified she reported low back pain to her supervisor and continued working for the day. She testified she later passed out due to pain.

The Chicago Fire Department took Petitioner to Norwegian American Hospital via ambulance. (Pet.Ex. 5). The Norwegian records state Petitioner reported right lower back pain radiating into the right leg for approximately six months. She advised she was seen by her personal physician the day before and required an MRI. (Id.). She stated her pain became worse when she bent over to pick up a box. (Id.). She was diagnosed with sciatica, anxiety and panic disorders and directed to follow up with Dr. Franco. (Id.).

On February 19, 2015, the MRI of the lumbar spine took place. It was positive for a 2 millimeter broad based disc protrusion. There was no central or foraminal stenosis present. (Pet.Ex. 1). The reading physician notes that the discs are normal in height and hydration at all levels. (Pet.Ex. 1). Petitioner saw Dr. Franco that day, as well, she reported that she was seen in the emergency room due to panic attacks and sciatica. The records do not indicate Petitioner reported the alleged work incident. Dr. Franco provided restrictions of no lifting greater than 15 pounds. (Id.). When Petitioner saw Dr. Franco on March 7th, she only reported the two prior incidents stating she had been in pain ever since. (Id.).

Petitioner sought treatment with Dr. Murtaza on March 9, 2015. She reported low back pain after picking up a box of bananas at work (Pet.Ex. 6). She was diagnosed with low back pain at L5-S1 and prescribed therapy and an EMG. (Id.). Dr. Murtaza re-evaluated her on March 11, 2015, and reviewed the MRI films. He stated the MRI films were essentially normal, but diagnosed a herniation at L5-S1 and recommended right transforaminal epidural steroid injections. (Id.). She was taken off work. (Id.). The injections took place on April 9, 2015 and April 23, 2015, and provided one day of relief. (Id.).

On March 17, 2015, Petitioner underwent an EMG/NCV. This was positive for evidence of a right L5-S1 radiculopathy. (Pet.Ex. 6).

Petitioner saw Dr. Dixon on May 1, 2015. He recommended an injection versus a L5-S1 microdiskectomy and decompression. (Pet.Ex. 6). Petitioner elected to undergo the surgery. (Id.). Petitioner continued treating with Drs. Murtaza and Dixon, receiving medications.

On November 25, 2015, Petitioner was evaluated by Dr. Wingate. Notes from the intake form state Petitioner was made to carry work materials up a staircase by her supervisor, this is also in the history portion of Dr. Wingate's report from that day. (Pet.Ex. 6). Dr. Wingate recommended a fusion at L5-S1. (Pet.Ex. 6).

Petitioner testified she flew first class to Michigan to have surgery with Dr. Wingate. Surgery was performed on December 9, 2015, and included a fusion at L5-S1. (Pet.Ex. 7). She followed up postoperatively on December 18, 2015 and February 18, 2016. She reported having radiation into the left buttock postoperatively. (Pet.Ex. 6). She reported having started physical therapy, which was increasing her pain on the left. She was directed to stay off work. (Pet.Ex. 6).

Petitioner was examined pursuant to Section 12 by Dr. Jay Levin on August 24, 2015. (Resp.Ex. 1A through 3B.). Dr. Levin opined Petitioner suffered a strain in 2013 for which she was released at MMI. (Resp.Ex. 1A, 1B). He opined she suffered a strain in 2014 for which she reached MMI four weeks post-accident. (Resp.Ex. 2A, 2B).

As for the February 17, 2015 incident, Dr. Levin reviewed the medical records and felt the history of accident provided to him was inconsistent with the records. He opined the MRI films were positive for minimal degenerative findings. (Resp.Ex. 3A, 3B). Dr. Levin opined Petitioner suffered from long standing chronic back pain, and that at best she suffered a strain from the February 17, 2016 incident. (Id.). He did not believe she required any treatment and released her to return to work full duty. (Id.).

Petitioner testified she has very little pain now and would like to continue treatment with Dr. Wingate. She initially testified she had no other workers' compensation claims, but later admitted to having filed a claim for her right ankle against ASI, Inc. She settled that claim on June 18, 2015. (Resp.Ex. 4).

CONCLUSIONS OF LAW

15WC 7965 – April 15, 2013 Accident

In support of the Arbitrator's findings relating to (F) is the Petitioner's present condition of ill-being causally related to the injury, the Arbitrator finds the following facts:

The Arbitrator concludes Petitioner failed to prove her current condition of ill-being is causally related to the April 15, 2013 incident. The Arbitrator further finds Petitioner reached maximum medical improvement as of August 20, 2013. In support thereof, the Arbitrator relies on the medical records of Concentra.

The records of Concentra substantiate Petitioner only treated on one occasion for the April 2013 incident. Her exam was essentially normal and she was released at MMI. (Pet.Ex. 2). The records of Concentra are supported by Dr. Levin's Section 12 opinions, as well. (Resp.Ex. 1A, 1B).

Therefore, the Arbitrator finds Petitioner's current condition of ill-being is not causally related to the April 15, 2013 incident, as she reached MMI by August 20, 2013.

15WC 7967 – June 12, 2014 Accident

In support of the Arbitrator's findings relating to (F) is the Petitioner's present condition of ill-being causally related to the injury, the Arbitrator finds the following facts:

The Arbitrator concludes Petitioner failed to prove her current condition of ill-being is causally related to the June 12, 2014 incident. The Arbitrator further finds Petitioner reached maximum medical improvement as of July 17, 2014. In support thereof, the Arbitrator relies on the medical records of Concentra and the Section 12 reports of Dr. Levin.

Petitioner sought treatment at Concentra immediately after the incident, and was diagnosed with multiple contusions, and released to return to work with light duty restrictions. (Pet.Ex. 2).

She continued treating with Concentra, and an MRI was performed. It was read by Dr. Bridgeforth as essentially normal on July 2, 2014. He further noted a positive battery of Waddell

tests. (Pet.Ex. 2). She was released to return to work full duty on July 7, 2014. (Id.). She was released at maximum medical improvement on July 17, 2014. (Id.). This release is supported by the opinions of Dr. Levin. (Resp.Ex. 2A, 2B). Petitioner sought no treatment for low back pain after this date.

As such, the Arbitrator concludes Petitioner's current condition of ill-being is not causally related to the June 12, 2014 incident, as she reached MMI for this accident on July 17, 2014.

15WC 7967 – February 17, 2015 Accident

In support of the Arbitrator's findings relating to (C) did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following facts:

The Arbitrator concludes Petitioner failed to prove an accident occurred which arose out of and in the course of her employment on February 17, 2015. In support thereof, the Arbitrator relies on the medical records of Dr. Franco, Petitioner's personal physician, the emergency room records of Norwegian American Hospital and Petitioner's testimony.

"To obtain compensation under this Act, an 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) (2013).

First, the Arbitrator notes Petitioner sought treatment for low back pain on the day before the alleged incident. She had not treated for her low back since July 17, 2014, even though she had seen Dr. Franco on numerous occasions. There are no complaints of low back pain until Petitioner saw Dr. Franco on February 16, 2015.

Petitioner testified she saw Dr. Franco on February 16th. Dr. Franco's records indicate Petitioner reported right sided low back pain beginning a few months earlier. She also reported numbness in the right leg for a few months. The records do not contain any mention of either earlier work injury or back pain relating to her employment with Respondent. Petitioner was diagnosed with right sided sciatica and prescribed an MRI of the lumbar spine. (Pet.Ex. 1). Petitioner testified Dr. Franco provided her with light duty restrictions on that day.

Additionally, the Arbitrator notes the medical records and testimony of Petitioner as to how the incident occurred is not consistent throughout the records. Petitioner testified she was going to serve breakfast on the date of incident. She stated some students assisted in bringing boxes upstairs to serve breakfast. She stated she bent over to get something out of a box when she had pain in her low back and right shoulder. She admitted she continued working that day, until she reportedly passed out.

The Chicago Fire Department took Petitioner to Norwegian American Hospital via ambulance. (Pet.Ex. 5). She reported right lower back pain radiating into the right leg for approximately six months. She advised she was seen by her personal physician the day before and required an MRI. (Id.). She stated her pain became worse when she bent over to pick up a box. (Id.). The records of Dr. Franco do not contain a history of the February 17, 2015 incident (Pet.Ex. 1).

On March 9, 2015, Petitioner told Dr. Murtaza she was picking up a 20 pound box of bananas when she felt a sharp pain in the low back. She stated the pain gradually increased throughout the day. (Pet.Ex. 6). The history contained in the records of Dr. Wingate from November 24, 2015 is that Petitioner was required to carry work materials up a stair case to the second floor. She reported lifting a box full of bananas when she felt a pop in the back and right shoulder. (Id.).

On August 24, 2015, Petitioner provided a history of Dr. Levin that she notices a box of bananas on the ground on the second floor of the building. She did not know what the box weight, and when she picked it up she had a sharp pain in her low back and shoulder. (Resp.Ex. 3A,3B).

Therefore, the evidence substantiates Petitioner treated for low back pain and was prescribed an MRI of the lumbar spine on the day before the alleged incident. Petitioner did not relate her pain to either of the prior incidents, and she had not sought any treatment for the low back for seven months until the day before the alleged incident. Therefore, the Arbitrator concludes Petitioner failed to prove an incident occurred which arose out of and in the course of her employment on February 17, 2015.

In support of the Arbitrator's findings relating to (F) is the Petitioner's present condition of ill-being causally related to the injury, the Arbitrator finds the following facts:

The Arbitrator concludes Petitioner failed to prove her current condition of ill-being is causally related to the February 17, 2016 incident. In support thereof, the Arbitrator relies on the Section 12 opinions of Dr. Jay Levin and the fact that Petitioner treated for her low back the day before the incident.

Petitioner's personal physician, Dr. Franco, saw Petitioner on the day before the incident. Petitioner reported low back pain for the past few months. She did not provide a history of accident, nor did she relate the pain to her work activities. (Pet.Ex. 1). She was diagnosed with sciatica and prescribed an MRI of the lumbar spine. (Id.). Petitioner testified she was even given light duty restrictions by Dr. Franco on that day, though she did not have it in writing. Petitioner provided the same information to Dr. Levin as it pertains to restrictions. (Resp.Ex. 3A, 3B). She went on to tell Dr. Levin that she called her doctor to get the restrictions in writing. (Id.).

Petitioner did not treat for her low back from July, 2014 until she saw Dr. Franco on February, 16, 2015, where she provided a history of a few months of low back pain. She did not relate it to either of the prior accidents or her work activities. Therefore, the Arbitrator concludes Petitioner's low back pain was pre-existing, and her current condition of ill-being is not related to the February 17, 2015 incident.

In support of the Arbitrator's findings relating to (J) were the medical services that were provided to Petitioner reasonable and necessary, and has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following facts:

Petitioner failed to prove she suffered a work related incident on February 17, 2015. Therefore, the Arbitrator finds Petitioner failed to prove the medical bills submitted were reasonable, necessary and causally related to the injury. The Arbitrator concludes Respondent is not liable for the medical treatment.

In support of the Arbitrator's findings relating to (K) is Petitioner entitled to any prospective medical care, the Arbitrator finds the following facts:

Petitioner failed to prove she suffered a work related incident on February 17, 2015. Therefore, the Arbitrator finds Petitioner failed to prove she is entitled to future medical care.

In support of the Arbitrator's findings relating to (K) what amount of compensation is due for temporary total disability, the Arbitrator finds the following facts:

Petitioner failed to prove she sustained injuries that arose out of and in the course of her employment with Respondent on February 17, 2015. Therefore, the Arbitrator concludes Petitioner failed to prove entitlement to temporary total disability benefits.

In support of the Arbitrator's findings relating to (O) has Petitioner exceeded her choice of physician pursuant to Section 8(a), the Arbitrator finds the following facts:

The Arbitrator concludes Petitioner did not exceed her two choices of physician pursuant to Section 8(a) of the Act. Petitioner's initial treatment was with her personal physician Dr. Franco. She then sought treatment with ION, which included Drs. Murtaza, Dixon & Wingate.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Yaritin Gomez,

Petitioner,

vs.

NO: 15 WC 7966

Compass Group,

17IWCC0161

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, extent of temporary total disability, medical expenses and prospective medical care and being advised of the facts and law, corrects a clerical error in the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission corrects the clerical error on Page 4 of the Arbitrator's Decision, which states that the case number is 15 WC 7967, to the correct case number of 15 WC 7966. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove a causal relationship exists between the accident of February 17, 2015 and Petitioner's condition of ill-being, her claim for compensation is hereby denied.

17IWCC0161

The party commencing 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: MAR 17 2017
LEC/maw
o01/26/17
43

David L. Gore

Stephen J. Mathis

SPECIAL CONCURRING OPINION

This case was scheduled for Oral Arguments on January 26, 2017 before a three-member panel of the Commission including members Mario Basurto, Stephen J. Mathis and David L. Gore, at which time Oral Arguments were heard. Subsequent to Oral Arguments and prior to the departure of Mario Basurto on March 3, 2017, a majority of the panel members had reached agreement as to the results set forth in this decision and opinion, as evidenced by the internal Decision worksheet initialed by the entire three member panel, but no formal written decision was signed and issued prior to Commissioner Basurto's departure.

Although I was not a member of the panel in question at the time Oral Arguments were heard and I did not participate in the agreement reached by the majority in this case, I have reviewed the Decision worksheet showing how Commissioner Basurto voted in this case, as well as the provisions of the Supreme Court in *Zeigler v. Industrial Commission*, 51 Ill.2d 137, 281 N.E.2d 342 (1972), which authorizes signature of a Decision by a member of the Commission who did not participate in the Decision. Accordingly, I am signing this Decision in order that it may issue.

L. Elizabeth Coppoletti

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

GOMEZ, YARITIN
Employee/Petitioner

Case# **15WC007966**

15WC007965
15WC007967

COMPASS GROUP
Employer/Respondent

17IWCC0161

On 7/28/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

A copy of this decision is mailed to the following parties:

5015 ESR LAW GROUP LLC
EDWARD S RUEDA
33 N LASALLE ST SUITE 3350
CHICAGO, IL 60602

0210 GANAN & SHAPIRO PC
JULIA A MURPHY
210 W ILLINOIS ST
CHICAGO, IL 60654

17IWCC0161

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)

Yaritin Gomez
Employee/Petitioner

v.

Compass Group
Employer/Respondent

Case # **15WC 07966**

Consolidated cases: **15WC 7965 &15WC 7967**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson** , Arbitrator of the Commission, in the city of **Chicago**, on **March 15, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **8(a) choice of physician**

FINDINGS

On the date of accident, **February 17, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did not* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is not* causally related to the accident.

In the year preceding the injury, Petitioner earned **$18,579.08**; the average weekly wage was **$357.29**.

On the date of accident, Petitioner was **27** years of age, *married* with **1** dependent child.

Respondent *has* paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Because Petitioner failed to prove she sustained an accident which arose out of and in the course of her employment, benefits are denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

7.28.16
Date

ICArbDec19(b)

JUL 28 2016

FINDINGS OF FACT

Yaritin Gomez ("Petitioner") testified she worked for Compass Group ("Respondent") as a food server. She testified her job duties included preparing food, serving food and cleaning the kitchen area.

On April 15, 2013, Petitioner testified she was carrying something when she slipped and fell on her back. She sought treatment with Dr. Franco on April 23, 2013. (Pet.Ex. 1). She was diagnosed with back pain. (Id.)

Petitioner did not treat again for her low back until August 20, 2013 at Concentra, the company clinic. (Pet.Ex. 2). She reported low back pain, which was radiating down the leg. She reported receiving low back treatment, including an MRI, while she was out of the country. Examination was essentially normal. She was diagnosed with low back pain and directed to return to work full duty and she was released from care. (Id.).

Petitioner followed up with Dr. Franco on August 24th reporting low back pain and headaches. (Pet.Ex. 1). Dr. Franco recommended an MRI, which was performed on August 29, 2013 at St. Mary of Nazareth. (Pet.Ex. 3). The MRI was normal. (Id.).

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She continued treating with Concentra, and an MRI was performed. It was read by Dr. Bridgeforth as essentially normal on July 2, 2014. He further noted a positive battery of Waddell tests. (Id.). She was released to return to work full duty on July 7, 2014. (Id.). She was released at maximum medical improvement on July 17, 2014. (Id.).

Petitioner did not treat again for low back pain until February 16, 2015 with Dr. Franco. (Pet.Ex. 1). She reported pain in on the right side of her low back for a few months and abdominal pain. She was diagnosed with sciatica and Dr. Franco recommended an MRI of the lumbar spine. (Pet.Ex. 1). Petitioner testified Dr. Franco provided her with light duty restrictions at this appointment, but there is no corresponding light duty work note in the records.

Petitioner testified she went to work on February 17, 2015 and told them she could not lift more than ten pounds, but was told she needed a work note. Petitioner testified students helped carry boxes up the stairs for breakfast, but she had to unload them. She testified she bent over to pick up a box and heard a pop in her shoulder and back. She testified she reported low back pain to her supervisor and continued working for the day. She testified she later passed out due to pain.

The Chicago Fire Department took Petitioner to Norwegian American Hospital via ambulance. (Pet.Ex. 5). The Norwegian records state Petitioner reported right lower back pain radiating into the right leg for approximately six months. She advised she was seen by her personal physician the day before and required an MRI. (Id.). She stated her pain became worse when she bent over to pick up a box. (Id.). She was diagnosed with sciatica, anxiety and panic disorders and directed to follow up with Dr. Franco. (Id.).

On February 19, 2015, the MRI of the lumbar spine took place. It was positive for a 2 millimeter broad based disc protrusion. There was no central or foraminal stenosis present. (Pet.Ex. 1). The reading physician notes that the discs are normal in height and hydration at all levels. (Pet.Ex. 1). Petitioner saw Dr. Franco that day, as well, she reported that she was seen in the emergency room due to panic attacks and sciatica. The records do not indicate Petitioner reported the alleged work incident. Dr. Franco provided restrictions of no lifting greater than 15 pounds. (Id.). When Petitioner saw Dr. Franco on March 7th, she only reported the two prior incidents stating she had been in pain ever since. (Id.).

Petitioner sought treatment with Dr. Murtaza on March 9, 2015. She reported low back pain after picking up a box of bananas at work (Pet.Ex. 6). She was diagnosed with low back pain at L5-S1 and prescribed therapy and an EMG. (Id.). Dr. Murtaza re-evaluated her on March 11, 2015, and reviewed the MRI films. He stated the MRI films were essentially normal, but diagnosed a herniation at L5-S1 and recommended right transforaminal epidural steroid injections. (Id.). She was taken off work. (Id.). The injections took place on April 9, 2015 and April 23, 2015, and provided one day of relief. (Id.).

On March 17, 2015, Petitioner underwent an EMG/NCV. This was positive for evidence of a right L5-S1 radiculopathy. (Pet.Ex. 6).

Petitioner saw Dr. Dixon on May 1, 2015. He recommended an injection versus a L5-S1 microdiskectomy and decompression. (Pet.Ex. 6). Petitioner elected to undergo the surgery. (Id.). Petitioner continued treating with Drs. Murtaza and Dixon, receiving medications.

On November 25, 2015, Petitioner was evaluated by Dr. Wingate. Notes from the intake form state Petitioner was made to carry work materials up a staircase by her supervisor, this is also in the history portion of Dr. Wingate's report from that day. (Pet.Ex. 6). Dr. Wingate recommended a fusion at L5-S1. (Pet.Ex. 6).

Petitioner testified she flew first class to Michigan to have surgery with Dr. Wingate. Surgery was performed on December 9, 2015, and included a fusion at L5-S1. (Pet.Ex. 7). She followed up postoperatively on December 18, 2015 and February 18, 2016. She reported having radiation into the left buttock postoperatively. (Pet.Ex. 6). She reported having started physical therapy, which was increasing her pain on the left. She was directed to stay off work. (Pet.Ex. 6).

Petitioner was examined pursuant to Section 12 by Dr. Jay Levin on August 24, 2015. (Resp.Ex. 1A through 3B.). Dr. Levin opined Petitioner suffered a strain in 2013 for which she was released at MMI. (Resp.Ex. 1A, 1B). He opined she suffered a strain in 2014 for which she reached MMI four weeks post-accident. (Resp.Ex. 2A, 2B).

As for the February 17, 2015 incident, Dr. Levin reviewed the medical records and felt the history of accident provided to him was inconsistent with the records. He opined the MRI films were positive for minimal degenerative findings. (Resp.Ex. 3A, 3B). Dr. Levin opined Petitioner suffered from long standing chronic back pain, and that at best she suffered a strain from the February 17, 2016 incident. (Id.). He did not believe she required any treatment and released her to return to work full duty. (Id.).

Petitioner testified she has very little pain now and would like to continue treatment with Dr. Wingate. She initially testified she had no other workers' compensation claims, but later admitted to having filed a claim for her right ankle against ASI, Inc. She settled that claim on June 18, 2015. (Resp.Ex. 4).

CONCLUSIONS OF LAW

15WC 7965 – April 15, 2013 Accident

In support of the Arbitrator's findings relating to (F) is the Petitioner's present condition of ill-being causally related to the injury, the Arbitrator finds the following facts:

The Arbitrator concludes Petitioner failed to prove her current condition of ill-being is causally related to the April 15, 2013 incident. The Arbitrator further finds Petitioner reached maximum medical improvement as of August 20, 2013. In support thereof, the Arbitrator relies on the medical records of Concentra.

The records of Concentra substantiate Petitioner only treated on one occasion for the April 2013 incident. Her exam was essentially normal and she was released at MMI. (Pet.Ex. 2). The records of Concentra are supported by Dr. Levin's Section 12 opinions, as well. (Resp.Ex. 1A, 1B).

Therefore, the Arbitrator finds Petitioner's current condition of ill-being is not causally related to the April 15, 2013 incident, as she reached MMI by August 20, 2013.

15WC 7967 – June 12, 2014 Accident

In support of the Arbitrator's findings relating to (F) is the Petitioner's present condition of ill-being causally related to the injury, the Arbitrator finds the following facts:

The Arbitrator concludes Petitioner failed to prove her current condition of ill-being is causally related to the June 12, 2014 incident. The Arbitrator further finds Petitioner reached maximum medical improvement as of July 17, 2014. In support thereof, the Arbitrator relies on the medical records of Concentra and the Section 12 reports of Dr. Levin.

Petitioner sought treatment at Concentra immediately after the incident, and was diagnosed with multiple contusions, and released to return to work with light duty restrictions. (Pet.Ex. 2).

She continued treating with Concentra, and an MRI was performed. It was read by Dr. Bridgeforth as essentially normal on July 2, 2014. He further noted a positive battery of Waddell

tests. (Pet.Ex. 2). She was released to return to work full duty on July 7, 2014. (Id.). She was released at maximum medical improvement on July 17, 2014. (Id.). This release is supported by the opinions of Dr. Levin. (Resp.Ex. 2A, 2B). Petitioner sought no treatment for low back pain after this date.

As such, the Arbitrator concludes Petitioner's current condition of ill-being is not causally related to the June 12, 2014 incident, as she reached MMI for this accident on July 17, 2014.

15WC 7967 – February 17, 2015 Accident

In support of the Arbitrator's findings relating to (C) did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following facts:

The Arbitrator concludes Petitioner failed to prove an accident occurred which arose out of and in the course of her employment on February 17, 2015. In support thereof, the Arbitrator relies on the medical records of Dr. Franco, Petitioner's personal physician, the emergency room records of Norwegian American Hospital and Petitioner's testimony.

"To obtain compensation under this Act, an 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) (2013).

First, the Arbitrator notes Petitioner sought treatment for low back pain on the day before the alleged incident. She had not treated for her low back since July 17, 2014, even though she had seen Dr. Franco on numerous occasions. There are no complaints of low back pain until Petitioner saw Dr. Franco on February 16, 2015.

Petitioner testified she saw Dr. Franco on February 16th. Dr. Franco's records indicate Petitioner reported right sided low back pain beginning a few months earlier. She also reported numbness in the right leg for a few months. The records do not contain any mention of either earlier work injury or back pain relating to her employment with Respondent. Petitioner was diagnosed with right sided sciatica and prescribed an MRI of the lumbar spine. (Pet.Ex. 1). Petitioner testified Dr. Franco provided her with light duty restrictions on that day.

Additionally, the Arbitrator notes the medical records and testimony of Petitioner as to how the incident occurred is not consistent throughout the records. Petitioner testified she was going to serve breakfast on the date of incident. She stated some students assisted in bringing boxes upstairs to serve breakfast. She stated she bent over to get something out of a box when she had pain in her low back and right shoulder. She admitted she continued working that day, until she reportedly passed out.

The Chicago Fire Department took Petitioner to Norwegian American Hospital via ambulance. (Pet.Ex. 5). She reported right lower back pain radiating into the right leg for approximately six months. She advised she was seen by her personal physician the day before and required an MRI. (Id.). She stated her pain became worse when she bent over to pick up a box. (Id.). The records of Dr. Franco do not contain a history of the February 17, 2015 incident (Pet.Ex. 1).

On March 9, 2015, Petitioner told Dr. Murtaza she was picking up a 20 pound box of bananas when she felt a sharp pain in the low back. She stated the pain gradually increased throughout the day. (Pet.Ex. 6). The history contained in the records of Dr. Wingate from November 24, 2015 is that Petitioner was required to carry work materials up a stair case to the second floor. She reported lifting a box full of bananas when she felt a pop in the back and right shoulder. (Id.).

On August 24, 2015, Petitioner provided a history of Dr. Levin that she notices a box of bananas on the ground on the second floor of the building. She did not know what the box weight, and when she picked it up she had a sharp pain in her low back and shoulder. (Resp.Ex. 3A,3B).

Therefore, the evidence substantiates Petitioner treated for low back pain and was prescribed an MRI of the lumbar spine on the day before the alleged incident. Petitioner did not relate her pain to either of the prior incidents, and she had not sought any treatment for the low back for seven months until the day before the alleged incident. Therefore, the Arbitrator concludes Petitioner failed to prove an incident occurred which arose out of and in the course of her employment on February 17, 2015.

In support of the Arbitrator's findings relating to (F) is the Petitioner's present condition of ill-being causally related to the injury, the Arbitrator finds the following facts:

The Arbitrator concludes Petitioner failed to prove her current condition of ill-being is causally related to the February 17, 2016 incident. In support thereof, the Arbitrator relies on the Section 12 opinions of Dr. Jay Levin and the fact that Petitioner treated for her low back the day before the incident.

Petitioner's personal physician, Dr. Franco, saw Petitioner on the day before the incident. Petitioner reported low back pain for the past few months. She did not provide a history of accident, nor did she relate the pain to her work activities. (Pet.Ex. 1). She was diagnosed with sciatica and prescribed an MRI of the lumbar spine. (Id.). Petitioner testified she was even given light duty restrictions by Dr. Franco on that day, though she did not have it in writing. Petitioner provided the same information to Dr. Levin as it pertains to restrictions. (Resp.Ex. 3A, 3B). She went on to tell Dr. Levin that she called her doctor to get the restrictions in writing. (Id.).

Petitioner did not treat for her low back from July, 2014 until she saw Dr. Franco on February, 16, 2015, where she provided a history of a few months of low back pain. She did not relate it to either of the prior accidents or her work activities. Therefore, the Arbitrator concludes Petitioner's low back pain was pre-existing, and her current condition of ill-being is not related to the February 17, 2015 incident.

In support of the Arbitrator's findings relating to (J) were the medical services that were provided to Petitioner reasonable and necessary, and has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following facts:

Petitioner failed to prove she suffered a work related incident on February 17, 2015. Therefore, the Arbitrator finds Petitioner failed to prove the medical bills submitted were reasonable, necessary and causally related to the injury. The Arbitrator concludes Respondent is not liable for the medical treatment.

In support of the Arbitrator's findings relating to (K) is Petitioner entitled to any prospective medical care, the Arbitrator finds the following facts:

Petitioner failed to prove she suffered a work related incident on February 17, 2015. Therefore, the Arbitrator finds Petitioner failed to prove she is entitled to future medical care.

In support of the Arbitrator's findings relating to (K) what amount of compensation is due for temporary total disability, the Arbitrator finds the following facts:

Petitioner failed to prove she sustained injuries that arose out of and in the course of her employment with Respondent on February 17, 2015. Therefore, the Arbitrator concludes Petitioner failed to prove entitlement to temporary total disability benefits.

In support of the Arbitrator's findings relating to (O) has Petitioner exceeded her choice of physician pursuant to Section 8(a), the Arbitrator finds the following facts:

The Arbitrator concludes Petitioner did not exceed her two choices of physician pursuant to Section 8(a) of the Act. Petitioner's initial treatment was with her personal physician Dr. Franco. She then sought treatment with ION, which included Drs. Murtaza, Dixon & Wingate.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with correction	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Yaritin Gomez,

Petitioner,

vs.

NO: 15 WC 7967

Compass Group,

17IWCC0162

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, extent of temporary total disability, medical expenses and prospective medical care and being advised of the facts and law, modifies the Decision of the Arbitrator and corrects a clerical error as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the Arbitrator's Decision to find that Petitioner had reached maximum medical improvement on September 10, 2013, rather than August 20, 2013 as the Arbitrator had found. Petitioner's accident of April 15, 2013 is verified by the First Report of Injury dated April 18, 2013. The parties also stipulated to the April 15, 2013 accident as per Request for Hearing form. Petitioner saw her primary care physician Dr. Franco on April 23, 2013 and his records for that date are unreadable. Petitioner underwent lumbar x-rays on that date, which were normal. Cervical x-rays on that date were non-acute. Petitioner did not seek treatment again until she saw Dr. Bridgeforth at Concentra on August 20, 2013 and reported that she had persistent pain and soreness during the interim. She had multiple subjective complaints. Dr. Bridgeforth opined, "The temporal sequence between her fall and her presentation is really quite long." Dr. Bridgeforth diagnosed back pain, released Petitioner to regular duty work, released her from care and indicated that her private doctor may consider a lumbar MRI.

17IWCC0162

Petitioner saw Dr. Franco on August 24, 2013 and in his Progress Notes that were readable, back pain, a fall and a questionable diagnosis of sciatica are noted. Dr. Franco ordered a lumbar MRI, which was performed on August 29, 2013 and read as normal. In his September 10, 2013 Progress Notes that are readable, Dr. Franco's assessment was right ankle pain and lumbar pain. Dr. Franco noted, "MRI does not correlate with her symptoms." §12 Dr. Jay Levin opined no causal connection.

The Commission corrects the clerical error on Page 3 of the Arbitrator's Decision, which states that the case number is 15 WC 7965, to the correct case number of 15 WC 7967. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove a causal relationship exists between the accident of April 15, 2013 and Petitioner's condition of ill-being, her claim for compensation is hereby denied.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 17 2017
LEC/maw
o01/26/17
43

David L. Gore

Stephen J. Mathis

SPECIAL CONCURRING OPINION

This case was scheduled for Oral Arguments on January 26, 2017 before a three-member panel of the Commission including members Mario Basurto, Stephen J. Mathis and David L. Gore, at which time Oral Arguments were heard. Subsequent to Oral Arguments and prior to the departure of Mario Basurto on March 3, 2017, a majority of the panel members had reached agreement as to the results set forth in this decision and opinion, as evidenced by the internal Decision worksheet initialed by the entire three member panel, but no formal written decision was signed and issued prior to Commissioner Basurto's departure.

Although I was not a member of the panel in question at the time Oral Arguments were heard and I did not participate in the agreement reached by the majority in this case, I have reviewed the Decision worksheet showing how Commissioner Basurto voted in this case, as well as the provisions of the Supreme Court in *Zeigler v. Industrial Commission*, 51 Ill.2d 137, 281 N.E.2d 342 (1972), which authorizes signature of a Decision by a member of the Commission

who did not participate in the Decision. Accordingly, I am signing this Decision in order that it may issue.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

GOMEZ, YARITIN
Employee/Petitioner

Case# **15WC007967**

15WC007965
15WC007966

COMPASS GROUP
Employer/Respondent

17IWCC0162

On 7/28/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.42% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

5015 ESR LAW GROUP LLC
EDWARD S RUEDA
33 N LASALLE ST SUITE 3350
CHICAGO, IL 60602

0210 GANAN & SHAPIRO PC
JULIA A MURPHY
210 W ILLINOIS ST
CHICAGO, IL 60654

17IWCC0162

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)

Yaritin Gomez
Employee/Petitioner

v.

Compass Group
Employer/Respondent

Case # **15WC 7967**

Consolidated cases: **15WC 7966 & 15WC 7965**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson** , Arbitrator of the Commission, in the city of **Chicago**, on **March 15, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ Is Petitioner entitled to any prospective medical care?
L. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **April 15, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$18,579.08**; the average weekly wage was **$357.29**.

On the date of accident, Petitioner was **26** years of age, ***married*** with **1** dependent child.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, 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's current condition of ill-being is not causally related to the April 15, 2013 accident, because she reached maximum medical improvement on August 20, 2013.

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

7.28.16
Date

ICArbDec19(b)

JUL 28 2016

FINDINGS OF FACT

Yaritin Gomez ("Petitioner") testified she worked for Compass Group ("Respondent") as a food server. She testified her job duties included preparing food, serving food and cleaning the kitchen area.

On April 15, 2013, Petitioner testified she was carrying something when she slipped and fell on her back. She sought treatment with Dr. Franco on April 23, 2013. (Pet.Ex. 1). She was diagnosed with back pain. (Id.)

Petitioner did not treat again for her low back until August 20, 2013 at Concentra, the company clinic. (Pet.Ex. 2). She reported low back pain, which was radiating down the leg. She reported receiving low back treatment, including an MRI, while she was out of the country. Examination was essentially normal. She was diagnosed with low back pain and directed to return to work full duty and she was released from care. (Id.).

Petitioner followed up with Dr. Franco on August 24th reporting low back pain and headaches. (Pet.Ex. 1). Dr. Franco recommended an MRI, which was performed on August 29, 2013 at St. Mary of Nazareth. (Pet.Ex. 3). The MRI was normal. (Id.).

Petitioner saw Dr. Franco again on September 10, 2013, and reported low back pain radiating down the right leg. Straight leg raise was positive for back pain only. Dr. Franco reviewed the MRI and stated the "MRI does not correlate with her symptoms." (Pet.Ex. 1).

One June 12, 2014, Petitioner testified she fell off a step-stool, which was approximately 2 to 2.5 feet high. She sought treatment at Concentra reporting pain in her head, neck, right shoulder and right elbow. She also reported stiffness in the low back. (Pet.Ex. 2). She was diagnosed with multiple contusions, and released to return to work with light duty restrictions. (Id.).

She continued treating with Concentra, and an MRI was performed. It was read by Dr. Bridgeforth as essentially normal on July 2, 2014. He further noted a positive battery of Waddell tests. (Id.). She was released to return to work full duty on July 7, 2014. (Id.). She was released at maximum medical improvement on July 17, 2014. (Id.).

Petitioner did not treat again for low back pain until February 16, 2015 with Dr. Franco. (Pet.Ex. 1). She reported pain in on the right side of her low back for a few months and abdominal pain. She was diagnosed with sciatica and Dr. Franco recommended an MRI of the lumbar spine. (Pet.Ex. 1). Petitioner testified Dr. Franco provided her with light duty restrictions at this appointment, but there is no corresponding light duty work note in the records.

Petitioner testified she went to work on February 17, 2015 and told them she could not lift more than ten pounds, but was told she needed a work note. Petitioner testified students helped carry boxes up the stairs for breakfast, but she had to unload them. She testified she bent over to pick up a box and heard a pop in her shoulder and back. She testified she reported low back pain to her supervisor and continued working for the day. She testified she later passed out due to pain.

The Chicago Fire Department took Petitioner to Norwegian American Hospital via ambulance. (Pet.Ex. 5). The Norwegian records state Petitioner reported right lower back pain radiating into the right leg for approximately six months. She advised she was seen by her personal physician the day before and required an MRI. (Id.). She stated her pain became worse when she bent over to pick up a box. (Id.). She was diagnosed with sciatica, anxiety and panic disorders and directed to follow up with Dr. Franco. (Id.).

On February 19, 2015, the MRI of the lumbar spine took place. It was positive for a 2 millimeter broad based disc protrusion. There was no central or foraminal stenosis present. (Pet.Ex. 1). The reading physician notes that the discs are normal in height and hydration at all levels. (Pet.Ex. 1). Petitioner saw Dr. Franco that day, as well, she reported that she was seen in the emergency room due to panic attacks and sciatica. The records do not indicate Petitioner reported the alleged work incident. Dr. Franco provided restrictions of no lifting greater than 15 pounds. (Id.). When Petitioner saw Dr. Franco on March 7th, she only reported the two prior incidents stating she had been in pain ever since. (Id.).

Petitioner sought treatment with Dr. Murtaza on March 9, 2015. She reported low back pain after picking up a box of bananas at work (Pet.Ex. 6). She was diagnosed with low back pain at L5-S1 and prescribed therapy and an EMG. (Id.). Dr. Murtaza re-evaluated her on March 11, 2015, and reviewed the MRI films. He stated the MRI films were essentially normal, but diagnosed a herniation at L5-S1 and recommended right transforaminal epidural steroid injections. (Id.). She was taken off work. (Id.). The injections took place on April 9, 2015 and April 23, 2015, and provided one day of relief. (Id.).

On March 17, 2015, Petitioner underwent an EMG/NCV. This was positive for evidence of a right L5-S1 radiculopathy. (Pet.Ex. 6).

Petitioner saw Dr. Dixon on May 1, 2015. He recommended an injection versus a L5-S1 microdiskectomy and decompression. (Pet.Ex. 6). Petitioner elected to undergo the surgery. (Id.). Petitioner continued treating with Drs. Murtaza and Dixon, receiving medications.

On November 25, 2015, Petitioner was evaluated by Dr. Wingate. Notes from the intake form state Petitioner was made to carry work materials up a staircase by her supervisor, this is also in the history portion of Dr. Wingate's report from that day. (Pet.Ex. 6). Dr. Wingate recommended a fusion at L5-S1. (Pet.Ex. 6).

Petitioner testified she flew first class to Michigan to have surgery with Dr. Wingate. Surgery was performed on December 9, 2015, and included a fusion at L5-S1. (Pet.Ex. 7). She followed up postoperatively on December 18, 2015 and February 18, 2016. She reported having radiation into the left buttock postoperatively. (Pet.Ex. 6). She reported having started physical therapy, which was increasing her pain on the left. She was directed to stay off work. (Pet.Ex. 6).

Petitioner was examined pursuant to Section 12 by Dr. Jay Levin on August 24, 2015. (Resp.Ex. 1A through 3B.). Dr. Levin opined Petitioner suffered a strain in 2013 for which she was released at MMI. (Resp.Ex. 1A, 1B). He opined she suffered a strain in 2014 for which she reached MMI four weeks post-accident. (Resp.Ex. 2A, 2B).

As for the February 17, 2015 incident, Dr. Levin reviewed the medical records and felt the history of accident provided to him was inconsistent with the records. He opined the MRI films were positive for minimal degenerative findings. (Resp.Ex. 3A, 3B). Dr. Levin opined Petitioner suffered from long standing chronic back pain, and that at best she suffered a strain from the February 17, 2016 incident. (Id.). He did not believe she required any treatment and released her to return to work full duty. (Id.).

Petitioner testified she has very little pain now and would like to continue treatment with Dr. Wingate. She initially testified she had no other workers' compensation claims, but later admitted to having filed a claim for her right ankle against ASI, Inc. She settled that claim on June 18, 2015. (Resp.Ex. 4).

CONCLUSIONS OF LAW

15WC 7965 – April 15, 2013 Accident

In support of the Arbitrator's findings relating to (F) is the Petitioner's present condition of ill-being causally related to the injury, the Arbitrator finds the following facts:

The Arbitrator concludes Petitioner failed to prove her current condition of ill-being is causally related to the April 15, 2013 incident. The Arbitrator further finds Petitioner reached maximum medical improvement as of August 20, 2013. In support thereof, the Arbitrator relies on the medical records of Concentra.

The records of Concentra substantiate Petitioner only treated on one occasion for the April 2013 incident. Her exam was essentially normal and she was released at MMI. (Pet.Ex. 2). The records of Concentra are supported by Dr. Levin's Section 12 opinions, as well. (Resp.Ex. 1A, 1B).

Therefore, the Arbitrator finds Petitioner's current condition of ill-being is not causally related to the April 15, 2013 incident, as she reached MMI by August 20, 2013.

15WC 7967 – June 12, 2014 Accident

In support of the Arbitrator's findings relating to (F) is the Petitioner's present condition of ill-being causally related to the injury, the Arbitrator finds the following facts:

The Arbitrator concludes Petitioner failed to prove her current condition of ill-being is causally related to the June 12, 2014 incident. The Arbitrator further finds Petitioner reached maximum medical improvement as of July 17, 2014. In support thereof, the Arbitrator relies on the medical records of Concentra and the Section 12 reports of Dr. Levin.

Petitioner sought treatment at Concentra immediately after the incident, and was diagnosed with multiple contusions, and released to return to work with light duty restrictions. (Pet.Ex. 2).

She continued treating with Concentra, and an MRI was performed. It was read by Dr. Bridgeforth as essentially normal on July 2, 2014. He further noted a positive battery of Waddell

tests. (Pet.Ex. 2). She was released to return to work full duty on July 7, 2014. (Id.). She was released at maximum medical improvement on July 17, 2014. (Id.). This release is supported by the opinions of Dr. Levin. (Resp.Ex. 2A, 2B). Petitioner sought no treatment for low back pain after this date.

As such, the Arbitrator concludes Petitioner's current condition of ill-being is not causally related to the June 12, 2014 incident, as she reached MMI for this accident on July 17, 2014.

15WC 7967 – February 17, 2015 Accident

In support of the Arbitrator's findings relating to (C) did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following facts:

The Arbitrator concludes Petitioner failed to prove an accident occurred which arose out of and in the course of her employment on February 17, 2015. In support thereof, the Arbitrator relies on the medical records of Dr. Franco, Petitioner's personal physician, the emergency room records of Norwegian American Hospital and Petitioner's testimony.

"To obtain compensation under this Act, an 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) (2013).

First, the Arbitrator notes Petitioner sought treatment for low back pain on the day before the alleged incident. She had not treated for her low back since July 17, 2014, even though she had seen Dr. Franco on numerous occasions. There are no complaints of low back pain until Petitioner saw Dr. Franco on February 16, 2015.

Petitioner testified she saw Dr. Franco on February 16th. Dr. Franco's records indicate Petitioner reported right sided low back pain beginning a few months earlier. She also reported numbness in the right leg for a few months. The records do not contain any mention of either earlier work injury or back pain relating to her employment with Respondent. Petitioner was diagnosed with right sided sciatica and prescribed an MRI of the lumbar spine. (Pet.Ex. 1). Petitioner testified Dr. Franco provided her with light duty restrictions on that day.

Additionally, the Arbitrator notes the medical records and testimony of Petitioner as to how the incident occurred is not consistent throughout the records. Petitioner testified she was going to serve breakfast on the date of incident. She stated some students assisted in bringing boxes upstairs to serve breakfast. She stated she bent over to get something out of a box when she had pain in her low back and right shoulder. She admitted she continued working that day, until she reportedly passed out.

The Chicago Fire Department took Petitioner to Norwegian American Hospital via ambulance. (Pet.Ex. 5). She reported right lower back pain radiating into the right leg for approximately six months. She advised she was seen by her personal physician the day before and required an MRI. (Id.). She stated her pain became worse when she bent over to pick up a box. (Id.). The records of Dr. Franco do not contain a history of the February 17, 2015 incident (Pet.Ex. 1).

On March 9, 2015, Petitioner told Dr. Murtaza she was picking up a 20 pound box of bananas when she felt a sharp pain in the low back. She stated the pain gradually increased throughout the day. (Pet.Ex. 6). The history contained in the records of Dr. Wingate from November 24, 2015 is that Petitioner was required to carry work materials up a stair case to the second floor. She reported lifting a box full of bananas when she felt a pop in the back and right shoulder. (Id.).

On August 24, 2015, Petitioner provided a history of Dr. Levin that she notices a box of bananas on the ground on the second floor of the building. She did not know what the box weight, and when she picked it up she had a sharp pain in her low back and shoulder. (Resp.Ex. 3A,3B).

Therefore, the evidence substantiates Petitioner treated for low back pain and was prescribed an MRI of the lumbar spine on the day before the alleged incident. Petitioner did not relate her pain to either of the prior incidents, and she had not sought any treatment for the low back for seven months until the day before the alleged incident. Therefore, the Arbitrator concludes Petitioner failed to prove an incident occurred which arose out of and in the course of her employment on February 17, 2015.

In support of the Arbitrator's findings relating to (F) is the Petitioner's present condition of ill-being causally related to the injury, the Arbitrator finds the following facts:

The Arbitrator concludes Petitioner failed to prove her current condition of ill-being is causally related to the February 17, 2016 incident. In support thereof, the Arbitrator relies on the Section 12 opinions of Dr. Jay Levin and the fact that Petitioner treated for her low back the day before the incident.

Petitioner's personal physician, Dr. Franco, saw Petitioner on the day before the incident. Petitioner reported low back pain for the past few months. She did not provide a history of accident, nor did she relate the pain to her work activities. (Pet.Ex. 1). She was diagnosed with sciatica and prescribed an MRI of the lumbar spine. (Id.). Petitioner testified she was even given light duty restrictions by Dr. Franco on that day, though she did not have it in writing. Petitioner provided the same information to Dr. Levin as it pertains to restrictions. (Resp.Ex. 3A, 3B). She went on to tell Dr. Levin that she called her doctor to get the restrictions in writing. (Id.).

Petitioner did not treat for her low back from July, 2014 until she saw Dr. Franco on February, 16, 2015, where she provided a history of a few months of low back pain. She did not relate it to either of the prior accidents or her work activities. Therefore, the Arbitrator concludes Petitioner's low back pain was pre-existing, and her current condition of ill-being is not related to the February 17, 2015 incident.

In support of the Arbitrator's findings relating to (J) were the medical services that were provided to Petitioner reasonable and necessary, and has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following facts:

Petitioner failed to prove she suffered a work related incident on February 17, 2015. Therefore, the Arbitrator finds Petitioner failed to prove the medical bills submitted were reasonable, necessary and causally related to the injury. The Arbitrator concludes Respondent is not liable for the medical treatment.

In support of the Arbitrator's findings relating to (K) is Petitioner entitled to any prospective medical care, the Arbitrator finds the following facts:

Petitioner failed to prove she suffered a work related incident on February 17, 2015. Therefore, the Arbitrator finds Petitioner failed to prove she is entitled to future medical care.

In support of the Arbitrator's findings relating to (K) what amount of compensation is due for temporary total disability, the Arbitrator finds the following facts:

Petitioner failed to prove she sustained injuries that arose out of and in the course of her employment with Respondent on February 17, 2015. Therefore, the Arbitrator concludes Petitioner failed to prove entitlement to temporary total disability benefits.

In support of the Arbitrator's findings relating to (O) has Petitioner exceeded her choice of physician pursuant to Section 8(a), the Arbitrator finds the following facts:

The Arbitrator concludes Petitioner did not exceed her two choices of physician pursuant to Section 8(a) of the Act. Petitioner's initial treatment was with her personal physician Dr. Franco. She then sought treatment with ION, which included Drs. Murtaza, Dixon & Wingate.

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

Martha McKay-Jones,
Petitioner,

vs.

Dart Container & Solo Cup Company,
Respondent.

17IWCC0166

NO: 15 WC 9472

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 20, 2016, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $46,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 1 2017
o3/8/17
KWL/rm
046

Kevin W. Lamborn

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0166

McKAY-JONES, MARTHA
Employee/Petitioner

Case# **15WC009472**

DART CONTAINER & SOLO CUP COMPANY
Employer/Respondent

On 6/20/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.40% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1752 LAW OFFICE OF RAYMOND L ASHER
200 W JACKSON BLVD
SUITE 1050
CHICAGO, IL 60606

1109 GAROFALO SCHREIBER STORM
ANDREW RANE
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

17IWCC0166

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g)
☐ Second Injury Fund (§8(e)18)
☒ None of the above

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

MARTHA MCKAY-JONES
Employee/Petitioner

Case #15 WC 9472

V.

DART CONTAINER & SOLO CUP COMPANY
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on May 27, 2016. After reviewing all of the issues, the stipulations of the parties and the evidence, it is hereby found and ordered as follows:

ISSUES:

A. ☐ Was the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to the respondent?

F. ☒ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☐ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☐ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☐ What temporary benefits are due: ☐ TPD ☐ Maintenance ☐ TTD?

L. ☒ What is the nature and extent of injury?

M. ☐ Should penalties or fees be imposed upon the respondent?

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On October 6, 2014, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $30,640.48; the average weekly wage was $589.24.
- At the time of injury, the petitioner was 61 years of age, married with no children under 18.
- The parties agreed that the petitioner received all reasonable and necessary medical services.
- The parties agreed that all bills for the medical services provided to the petitioner were paid.
- The parties agreed that the respondent paid $294.00 in temporary total disability benefits.
- The parties agreed that the petitioner is entitled to temporary total disability benefits for 5/7 weeks.

ORDER:

- The respondent shall pay the petitioner the sum of $353.54/week for a further period of 35.875 weeks, as provided in Section 8(e) of the Act, because the injuries sustained

caused the permanent partial disability to petitioner to the extent of 17.5% loss of use of her right hand.

- The respondent shall pay the petitioner compensation that has accrued from October 6, 2014, through May 27, 2016, and shall pay the remainder of the award, if any, in weekly payments.

RULES REGARDING APPEALS: Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Robert E. Williams

Signature of Arbitrator

June 20, 2016

Date

JUN 20 2016

FINDINGS OF FACTS:

The petitioner, a right-handed production handler II, sustained injuries to her right arm and hand, buttock and head on October 6, 2014, after slipping off a ladder and falling. She received immediate care at Excel Occupational Health for right wrist pain and swelling, mild head discomfort, mild tenderness over the second and third proximal metacarpal bones and mild tenderness in the anatomical snuffbox. X-rays revealed a minimally displaced dorsal fracture of her right distal radius. The diagnosis was a head contusion and a minimally displaced right distal radial fracture. She was placed on modified duties without use of her right arm and given a right wrist cast and sling. The petitioner sought care the same day at Mercy Hospital and Medical Center. The doctor's impression was right forearm radial fracture and skull contusion.

On October 14, 2014, the petitioner saw Dr. Samir Shah, who noted some soft tissue swelling over her right hand, tenderness to palpation around the distal radius and over the DRUJ and limited ROM of her fingers due to swelling and stiffness. The petitioner returned to work on October 15th. Dr. Shah noted some soft tissue swelling of the petitioner's right hand and minimal tenderness over the fracture site on October 28th. A custom orthosis was given to the petitioner and she started physical therapy for ROM of her digits on November 4th. The petitioner reported less pain on December 2nd and Dr. Shah noted improvement with her swelling and ROM. The petitioner reported continued progress on January 6, 2015, and February 3rd. The petitioner had fifty-four therapy sessions through March 17, 2015. An x-ray of her skull on February 27th was negative for fractures.

On March 17th, Dr. Shah noted some minimal swelling, mild flexion deformity of the small finger proximal interphalangeal joint at 20^0, grip strength of forty pounds and the ability to make a full fist and the ability to do all ADLs. Dr. Shah recommended a progressive increase in the number of work lines the petitioner was assigned.

On April 7th, the petitioner was evaluated by Dr. Fernandez at the request of the respondent. Dr. Fernandez opined that x-rays revealed excellent alignment at the distal radius, no residual malunion or nonunion deformity and some scattered degenerative changes of the small joints of the digits. Dr. Shah released the petitioner for unrestricted work on April 21st. On May 15th, Dr. Shah noted that the petitioner was doing okay and working full duty but complained of pain at the end of her shift. The doctor noted some minimal swelling of her right hand, some residual flexion deformity at the proximal interphalangeal joint and the ability to make a fist. Dr. Shah opined that she was at maximum medical improvement.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that her current condition of ill-being with her right hand is causally related to the work injury.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

An AMA impairment rating by Dr. Atluri on September 25, 2015, was 10% loss of use of the upper extremity. Dr. Atluri noted some residual deficits including stiffness and weakness in the hand. Regarding Section 8.1(b)(ii) of the Act, there was no impact on the petitioner's occupation due to her injury since she is still able to perform the essential functions of her job duties. There is no evidence concerning the impact of the

petitioner's injury in regard to her age or future earning capacity, as delineated in Section 8.1(b)(iii) through (iv) of the Act. No effect can be reasonably inferred from the evidence. Regarding Section 8.1(b)(v), the petitioner complains of the inability to pick up as many blanks as before, that she drop blanks more frequently and that she has weakness and difficulty grasping knives and cutting. The treating medical records only corroborate some weakness in her right hand.

The respondent shall pay the petitioner the sum of $353.54/week for a further period of 35.875 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 17.5% loss of use of her right hand.

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

Carson Ingram,

Petitioner,

17IWCC0190

vs.

NO: 15 WC 13864

I.D.O.T.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability, penalties and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 26, 2016 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.

DATED: MAR 2 9 2017
KWL/vf
O-1/24/17
42

Kevin W. Lamborn

Michael J. Brennan

DISSENT

The Arbitrator determined that Petitioner sustained accidental injuries arising out of and in the course of his employment on 12/19/14 when he stood up after inspecting a tailgate and struck his head on the bottom of a backhoe bucket. However, the Arbitrator found that Petitioner suffered nothing more than a myofascial neck strain and that he attained maximum medical improvement as of 3/12/15, based on the opinion of Dr. Shitut. I disagree with the Arbitrator's finding of no causation after 3/12/15, and therefore dissent from the majority opinion.

More to the point, I question the Arbitrator's denial of benefits after 3/12/15 based in part on alleged discrepancies contained in the histories recorded by various providers at the time of accident. Furthermore, I disagree with the Arbitrator's reliance on Dr. Shitut to cut off benefits in this case and would instead rely on the more reasoned opinion of orthopedic surgeon Dr. Gornet to the effect that Petitioner suffers from discogenic neck pain secondary to a disc herniation at C5-6 and that Petitioner's current condition of ill-being relative to his neck is directly related to the accident in question, particularly in light of Petitioner's consistent complaints of neck pain subsequent to 3/12/15 and the lack of an intervening injury.

As a consequence, I would reverse the Arbitrator's finding of no causation after 3/12/15 and would award benefits accordingly, including the payment of reasonable and necessary medical expenses as well as the authorization of additional medical treatment as recommended by Dr. Gornet.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

17IWCC0190

INGRAM, CARSON
Employee/Petitioner

Case# **15WC013864**

IDOT
Employer/Respondent

On 5/26/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1775 HUSTAVA, JOHN H PC
ANDREW NALEFSKI
101 ST LOUIS RD
COLLINSVILLE, IL 62234

3291 ASSISTANT ATTORNEY GENERAL
DIANA E WISE
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

1430 CMS BUREAU OF RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

MAY 26 2016

RONALD A.RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF **Madison**)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

17IWCC0190

Carson Ingram
Employee/Petitioner

v.

I.D.O.T
Employer/Respondent

Case # **15** WC **13864**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **March 17, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **December 19, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is not* causally related to the accident.

In the year preceding the injury, Petitioner earned **$45,760.00**; the average weekly wage was **$880.00**.

On the date of accident, Petitioner was **60** years of age, *married* with **0** dependent children.

Respondent *has not* paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit **for any benefits paid through group insurance** under Section 8(j) of the Act.

ORDER

Petitioner has failed to prove that his current condition of ill-being is causally related to the work injury of December 19, 2014. Furthermore, as the Arbitrator finds that Petitioner attained maximum medical improvement for his myofascial neck strain as of March 12, 2015 and that his current condition of ill-being is not related to the accident of December 19, 2014, Petitioner's request for prospective medical treatment is denied.

Given the Arbitrator's finding that Petitioner attained maximum medical improvement for his myofascial neck strain as of March 12, 2015, that his current condition of ill-being is not related to the accident of December 19, 2014, and that Petitioner was released to return to work without any restrictions by Dr. Shitut, the Arbitrator finds that Petitioner is not entitled to any temporary total disability benefits after March 12, 2015.

The Arbitrator denies Petitioner's request for penalties and fees.

Respondent shall pay the reasonable and necessary medical services **for treatment rendered during the timeframe of December 19, 2014 through March 12, 2015** included in Petitioner's Exhibit 12 as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider **for treatment rendered during the timeframe of December 19, 2014 through March 12, 2015** and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances **for treatment rendered during the timeframe of December 19, 2014 through March 12, 2015** with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses **for treatment rendered during the timeframe of December 19, 2014 through March 12, 2015** according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner. Respondent is entitled to a credit **for any benefits paid through group insurance** under Section 8(j) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

17IWCC0190

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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. Rice-Sullivan
Signature of Arbitrator

5/24/16
Date

ICArbDec19(b)

MAY 26 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

17IWCC0190

Carson Ingram
Employee/Petitioner

Case # 15 WC 13864

v.

Consolidated cases: N/A

I.D.O.T.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he is 62 years of age, is six feet tall and weighs 239 pounds. He testified that he has been a union teamster for approximately 41 years, and that he had two prior worker's compensation claims involving disfigurement and a shoulder injury. He denied that he ever hurt his head or neck. He testified that he worked for IDOT for two years as a "snowbird" which was a seasonal job involving plowing snow and maintaining the roads. He confirmed that prior to getting hired, he underwent a pre-employment physical and denied that he failed any of the physicals.

Petitioner testified that before he started working he had some problems with his hip related to a fall for which he took medications on an intermittent basis, and that he took a muscle relaxer and Hydrocodone for his injuries. He testified that he took the medications once a day or as needed. He testified that he was taking the medications when he was hired by IDOT both times, and that he disclosed it on his application. He testified that he underwent drug testing as well, and that his drug tests were negative.

Petitioner testified that the accident at issue occurred on Friday, December 19, 2014. He agreed that he was driving a dump truck for the State at that time, and that he and his crew had been at a job outside of Edwardsville, Illinois putting in a culvert. He denied operating the backhoe involved in the accident, and indicated that "Spurgeon" was doing so. He testified that the photographs of the backhoe were not of the backhoe at issue but rather reflected a similar backhoe, and that he took the photos just prior to arbitration. He also testified that he took the photograph of the road where the culvert was placed.

Petitioner testified that there were four people on the job site with him that afternoon, and that he was driving the truck. He testified that "Bob J", his foreman and Vic Spurgeon were there. He testified that towards the end of the day they were at the culvert, and that he was instructed to dump the sand. He testified that he backed up the truck, made the dump, pulled it up and moved over, came back again and made another dump and that it was at the time of either the second or third dump that the tailgate fell off. He testified that he got out and that the guys were laughing at him and joking around, and that they then proceeded to try to use the backhoe to put the tailgate back on. He testified that the supervisor was frustrated and stated that they needed to get the truck out of there.

Petitioner testified that he was standing at the rear of the truck on the driver's side and that the foreman was up in the bed of the truck climbing down, so Petitioner went to the front of the truck and, needing to make sure before he took off that everything was clear, he walked back towards the back of the truck. He testified that when he left he saw the backhoe go over the passenger side of the truck so he leaned over, looked down and then felt pressure coming down on his head. He testified that he "jerked" at the same time because he felt a presence, and that he jerked away, looked around and said that it hit him in the head. He testified that when he was struck in the head, he was knocked down and that it hit him in the center of his head. He denied wearing a hard hat, and further denied being knocked to the ground.

Petitioner testified that that Vic got out and asked what happened, and Petitioner responded by asking Vic why he hit him in the head. He stated that Vic denied hitting him in the head, so Petitioner told him to stop lying. He then testified that Vic apologized for hitting him, but then changed his testimony and stated that Vic did not apologize at that point. He testified that he then got in the truck and took it back to the yard. He testified that he then had another exchange with Vic wherein Vic asked if he was doing alright, to which Petitioner stated that he had pain after which Vic apologized.

Petitioner testified that the foreman jumped into the truck with him and asked what was going on. He testified that he told the foreman that Vic hit him in the head with the bucket, and that the foreman said that he did not see it because he must have been getting down from the truck. He testified that the foreman asked if he was alright, to which Petitioner responded that his neck was bothering him and that he had a headache. He testified that the foreman told him that he had to report the accident, to which Petitioner responded that he did not want to get anyone in trouble. He testified that he ultimately reported the accident that day and that he filled out an accident report.

Petitioner testified that when he got back, he asked Vic to come inside with him. He testified that they told Lonnie what happened, and that they were looking for Tom, the supervisor. He testified that Tom was not there, so Lonnie was next in charge so they told him what happened. He testified that Vic told him as he was walking out the door that he did not see Petitioner. He confirmed that his signature appeared on the accident report.

Petitioner testified that he did not work over the weekend, and that he returned to work on Monday. He testified that he talked to Tom Moore and told him what happened. He testified that he had seen a doctor at the emergency room, where he gave a consistent accident history. He agreed that he told the emergency room personnel that he was hit on the top of the head with a backhoe bucket, that his neck was hurting and that he had a headache. He testified that he worked all day on Monday and Tuesday as well, and that Wednesday was when he was supposed to see "Dr. Manju." He testified that he gave "Dr. Manju" the same accident history, and that he continued to treat with her which included prescriptions for physical therapy and medications. He testified that "Dr. Manju" took him off work.

Petitioner testified that he then came under the care of Dr. Shitut, an orthopedic surgeon. He testified that he gave Dr. Shitut a consistent accident history about being hit on the top of the head with a bucket, and that Dr. Shitut ordered an MRI of his neck. He testified that after Dr. Shitut reviewed the MRI, he released him to return to work but his symptoms did not go away. He agreed that Dr. Shitut released him to return to work on March 12, 2015, but testified that the next day he was at Dr. Manju's office complaining of problems with his neck. He testified that he was then referred to Dr. Gornet.

Petitioner testified that that the first time he saw Dr. Gornet was on May 6, 2015, and that he was still under his care and treatment. He testified that Dr. Gornet recommended a repeat MRI of his neck and that it was eventually performed. He agreed that the last time he saw Dr. Gornet was in February of 2016, at which time he was released to full duty work at Petitioner's request. He testified that he had no

income but was drawing unemployment. He initially testified that he believed that Dr. Gornet's bills had been paid, but when handed Petitioner's Exhibit 12 he then changed his testimony and stated that not all of the medical bills had been paid.

Petitioner testified that he always feels like something heavy is sitting on his shoulders and that he has shooting pains down his neck. He denied having these symptoms prior to the accident. He testified that he was not aware of a policy about wearing a hard hat on the job. He testified that when he first filed his claim, his benefits were initially denied. He testified that he received temporary total disability benefits, but then there was an allegation about drug seeking behavior. He testified that his son had the same name and also received medication on the same date. He testified that he was eventually terminated for fraud, but that it was never explained to him. He testified that he called and asked but received no response. He agreed that the termination date of February 19, 2015 sounded accurate. He testified that he worked out of Teamster Hall 525, but if there was an accident that happened at work no one suffered repercussions for the accident through the hall.

On cross-examination, Petitioner denied ever having had any pain in his low back or neck prior to the accident of December 19, 2014. He denied having any symptoms in the low back or up through the shoulders prior to the accident. He denied having any pain in his back shooting up through his mid-back prior to the accident, and he also denied having any pain, symptoms, aching or anything in his low back shooting up to his upper back. He agreed that before this accident he was already taking Flexeril and Hydrocodone. He testified that he would have to look to see if he filled the prescriptions given to him by the emergency room physician on either the day of the accident or the following Monday, but he agreed that if he did not fill the prescription for the Hydrocodone and Flexeril until Monday, he was already taking that medication that had been previously prescribed by his primary care physician. He agreed that he had seen Dr. Ramchandani extensively in the years prior to this accident.

On cross-examination, Petitioner testified that he believed that the emergency room personnel told him to see his doctor first before he returned to work. He testified that Dr. Ramchandani took him off work the day that she saw him, and then testified that he could not remember because he always had to keep calling and getting a work slip. He testified that he did not know that the nurse's note said that he had to call back after his visit and request an off work slip and that Dr. Ramchandani noted that she never stated that he needed to be off work at all. He testified that he did not recall calling Dr. Ramchandani's office on December 30th stating that he wanted to return to work full duty. He testified that he did not recall whether he called back several times and that it was not until December 30, 2014 that he was given a note taking him off December 24, 2014. He denied returning to Dr. Ramchandani's office on January 5th requesting a work clearance note on that date as well. He testified that all he knew was that he was to remain off work, and that he could not remember the dates.

On cross-examination, Petitioner testified that he thought he was notified that he was being terminated for a fraudulent workers' compensation in April, but his counsel indicated that the notice of termination was February 15, 2015. When asked if he challenged his termination through the union, Petitioner testified that he told the business agent to call him but he never did. He agreed that on February 19, 2015, he called Dr. Ramchandani and requested a referral to an orthopedic surgeon. He agreed that when he returned to work after the date of accident the following Monday and Tuesday, he was working full duty with no restrictions but indicated it was because he had not seen the doctor yet.

On cross-examination, Petitioner when asked if entire incident on December 19, 2014 with the backhoe and dump truck was because of an operator error on his part, responded that he was not sure but it was possible. He agreed that he was the only person driving the dump truck at that time. He agreed that there was a button that he would have to push to release the bottom in order for the gate to come off. He testified that he did not know for sure whether the gate would not release and come off if the button

were not pushed. He testified that he had operated dump trucks for about 41 years. He then testified that it was possible for the gate of the dump truck to fall off without pushing any buttons.

On cross-examination when asked if he was possibly embarrassed that this had occurred while he was driving the truck, Petitioner responded that something like this had never happened to him before and that the guys were laughing at him and told him he needed to retire. He denied believing that IDOT would not allow him to continue working with trucks if he could not operate them correctly. He denied being concerned about whether IDOT would bring him back as a "snowbird" if he was not able to operate the trucks correctly.

On cross-examination, Petitioner agreed that his signature appeared on Respondent's Exhibit 13. He agreed that when asked on the IDOT application in 2013 whether he had any back injury or chronic back pain, he indicated that he did not. He agreed that he indicated that he saw Dr. Manju/Dr. Vest on June 24, 2013, but testified that there was no reason that he failed to include on the form the treatment that he had by Dr. Manju and Dr. Vest in 2014. He agreed that he indicated that he was taking Vicodin at that time, and he further agreed that he was also taking Flexeril at that time. He testified that he may have made a mistake in failing to disclose his Flexeril use. He testified that he told the examining physician that he had seen Dr. Vest for his right hip and right shoulder pain issues.

On cross-examination, Petitioner testified that he is still taking Hydrocodone. He denied that Dr. Gornet told him not to take Hydrocodone and that he should take Meloxicam. He testified that he has been taking Meloxicam and Flexeril, and that he is continuing to get Hydrocodone from Dr. Manju. He testified that he has another appointment with Dr. Gornet scheduled for April 18th.

On redirect examination, Petitioner agreed that when he went to the emergency room on the date of the injury, he was given pain medication in addition to a prescription for pain medication.

Robert Jarzombeck was called as a witness by Respondent at the time of arbitration. Mr. Jarzombeck testified that he has worked as a temp at IDOT for seven years, and that he only works the winter season. He testified that he completed a witness report on December 23, 2014. He testified that he also had opportunity to look at a statement created by Don Sonnenberg which was created after he interviewed him about the incident with Petitioner, and that he agreed with the statements contained in the report.

Mr. Jarzombeck testified that on December 19, 2014, the tailgate was dropped down and had an automatic lock for the bolts that were holding the bottom part of the tailgate. He testified that to release it you had to push a button, and that when Petitioner dumped a load the tailgate dropped off and it was held by the two chains. He testified that there was no other way for the gate to fall off other than pushing the button, and that pushing the button and the gate coming off is not what should have occurred in this case.

Mr. Jarzombeck testified that they tried to put the gate on and it was impossible, so Petitioner was told to take the truck back and let them fix it back at the yard. He testified that they got it loaded into the truck, and that Petitioner came out of the cab of the truck and walked back. He testified that after the tailgate was lowered on the truck, the backhoe picked it up and moved it over to the left. He testified that Vic turned to him and said they were ready, and that the backhoe was not running. He testified that Petitioner came walking back. He denied that the bucket of the backhoe moved down and struck Petitioner, but stated that he saw Petitioner connect with the bucket of the backhoe with a bump. He testified that Petitioner stood straight up and it popped him on top of his head, and that he thought Petitioner was crouching and making sure that he could take the truck back to Hamel to get the tailgate fixed.

Mr. Jarzombeck testified that it looked like a "tap" and that Petitioner turned around and took the truck back. He testified that Dwayne turned around and climbed out of the back of the truck and asked Petitioner if he was all right. He testified that Petitioner continued working and drove back to Hamel. He testified that he then returned to where the backhoe was, and they all returned to the Hamel yard. He testified that he was there when Dwayne and Petitioner got back to the Hamel yard, and that they were just joking around. He testified that the backhoe was similar to that shown in Petitioner's Exhibit, but it had a scoop bucket rather than a claw bucket.

On cross-examination, Mr. Jarzombeck testified that he was still employed by IDOT and that he was a "snowbird." He testified that he has driven a truck as well, but has never had a problem with the gate falling off. He agreed that they were trying to put the gate back on the truck and were using the backhoe to lift the gate up. He testified that Vic was still in the cab when this was happening. He agreed that Petitioner went behind the truck to check out the back of the truck to make sure that it was safe to go back to the Hamel yard, that he was bent over and that he stood up and hit the top of his head on the bottom of the backhoe bucket.

Dwayne Beiser was called as a witness by Respondent at the time of arbitration. Mr. Beiser testified that he currently works for IDOT Hamel Operations, and that he works in highway maintenance. He testified that prior to working for IDOT, he was a supervisor at Missouri Department of Transportation and was also a retired Marine.

Mr. Beiser testified that he had opportunity to review the witness statement that he completed on December 23, 2014, and that he also had the opportunity to see a report that was created by Don Sonnenberg after he interviewed him about this incident. He testified that on December 19, 2014, he was part of a crew but was also the senior person on the crew so was the designated crew leader. He testified that on the day of the accident, they were on the third and final culvert that they were replacing and had pulled the culvert out of the ground and were in the process of doing a backfill. He testified that in order to do the backfill they had to bring the truck in at different angles each time to get the whole span of the culvert covered. He testified that they had pulled in for the third time and backed it up to the actual drop spot, dumped the bed and the gate had come off of the dog ears at the bottom of the bed and had come dislodged from the back of the head. He testified that there was a button that was used to release the switch and allowed the gate to swing up back and forth. He testified that the button had to have been pushed by the truck operator, and that Petitioner was operating the truck at the time.

Mr. Beiser testified that after the gate fell, they attempted to put the gate back onto the truck but they were not able to stabilize the gate in order to get it up there with one person. He testified that he determined it was not safe, so he directed that the truck be taken back. He testified that once he decided that it was not safe and they were not going to be able to do it, he was in the back of the truck and told the crew that the truck needed to be taken back to the yard. He testified that the backhoe was up in the area where they were trying to lift the gate up, and that the backhoe operator swung the backhoe over, got it over to the side of the truck and after he got out of the side of the truck, that's when he proceeded to get out of the back of the dump truck from the passenger's side.

Mr. Beiser testified that he got out of the passenger side of the bed, climbed down over the top of the culvert and as he came across the culvert over to where the backhoe was, Vic was getting out and made a statement about Petitioner. He testified that the way he was angled he was on the other side of the dump truck from where Petitioner was and that he did not actually see Petitioner come in contact with the bucket. He testified that Vic was not operating the backhoe at the time Petitioner hit his head because he was able to talk to Vic as he was walking towards him.

Mr. Beiser testified that Petitioner was pulling away to leave and then came back to the job site to pick him up. He testified that he got in the truck with Petitioner and they started to go back when Petitioner stated that Vic hit him with the backhoe. He testified that he was shocked and asked Petitioner if he was okay, and that Petitioner responded that he was all right but did think he felt something in his neck. He testified that Petitioner told him that he thought maybe that when he saw it he flinched and he might have done something to his neck at that time. He testified that he told Petitioner that this was something he needed to have covered and that it needed to be reported.

Mr. Beiser testified that when they got back to the yard, he had Petitioner, Vic and Bob meet at the fuel tanks and he asked all three of them at the time what happened. He testified that everybody started talking and he said they needed to go in and talk to Lonnie, who was the supervisor for the shed. He testified that they explained to Lonnie what happened and what was observed. He testified that he did not recall that when he was in the car with Petitioner headed back to the Hamel yard that he stated that Petitioner was hit by a pretty good "thud." He testified that he was not sure whether Vic had hit Petitioner with a moving bucket of a backhoe, as he did not witness it. He testified that he has been around backhoes for about 15 years and has been trained on how to safely operate a backhoe. He testified that it would be deadly if a person was hit with a moving bucket of a backhoe, and that the individual would be incapacitated very quickly.

On cross-examination, Mr. Beiser testified that he was still employed by IDOT and voluntarily appeared at arbitration. He agreed that it was his opinion that the only way the gate could come loose was through activation of a button. He testified that he did not recall what time the incident occurred, but he wanted to say it was after lunch on a Friday. He denied that everyone was in a hurry to get back to the shed. He agreed that he had heard the version of the story that Petitioner stood up and hit the underside of the bucket with his head, and testified that it would not cause any paralyzing-type injury in his opinion.

On redirect examination, Mr. Beiser testified that he had no reason to believe that that dump truck was not working correctly on December 19, 2014 because the gate was reattached back at the yard and the same vehicle was used to proceed back down to the job site to pick him up. He testified that he was not aware of any problems with the dump truck since the incident at issue.

Victor Spurgeon was called as a witness by Respondent at the time of arbitration. Mr. Spurgeon testified that he is currently working as an operating engineer out of Local 520 and is working at the Phillips 66 refinery. He agreed that he previously worked for IDOT as a full-time temp, and did such tasks as highway repair, snow removal and running equipment. He testified that on December 19, 2014, they were putting culverts across from Blackburn and that his job assignment was on a backhoe and helping with ground labor as needed. He testified that he has been on heavy machinery since he was 7 or 8 years old, and that he has been operating out of the union hall for 12-15 years and has run anything from small tractors to cranes.

Mr. Spurgeon testified that on the date of the accident, once the gate fell off they sat it off to the side and finished putting rock in the ditch. He testified that Dwayne got in the truck, they rigged the gate up with the backhoe to set it back on because the tailgate was pretty heavy but that they could not get it pinned. He testified that Dwayne signaled him to let down on it, and that he unhooked the chain and signaled him to swing off to the side. He testified that he swung off to the side and did not know if they were going to reconfigure the chain, so he shut the backhoe down with the bucket hanging off the side of the truck and turned in the seat to look at Bob and talk to him. He testified that the bucket was curled up in the air with the heel of the bucket up in the air. He testified that the backhoe was turned off so that he could hear what was going on, and that he felt a jolt while he was talking to Bob. He testified that he turned and looked, and that Petitioner had walked under the bucket and hit his head walking back out. He denied having moved the bucket of the backhoe so that it would strike Petitioner's head.

Mr. Spurgeon testified that he had seen people get "smashed" with a machine and that it could maim you if you were hit hard enough. He testified that for the way the gate fell off, the driver of the truck had to flip the air switch to open the gate. He testified that Petitioner was the only person at the time that would have been responsible for having to flip that switch, and that he was not aware of any way for the gate to have fallen off without the operator flipping that switch. He testified that after he felt the jolt, he asked Petitioner if he was alright and that Petitioner responded that he was fine, got in the truck and drove back to the yard. He testified that Petitioner talked to the lead worker at the yard and told him what happened, said he was fine, they put away the items for the day and everyone went home. He denied apologizing to Petitioner or stating that he was sorry that he hit him with a backhoe. He denied saying to Lonnie that he did not see Petitioner.

Mr. Spurgeon denied ever having been investigated for or cited for improperly operating a backhoe. He testified that if the backhoe was shut off, the bucket could be lowered by pushing on the levers but it could not be swung. He denied pushing on the levers when Petitioner was underneath it.

On cross-examination, Mr. Spurgeon agreed that Local 520 was an operator hall. He testified that he currently has a withdrawal card from the Teamsters. He testified that he was a card member when he works for IDOT. He testified that he felt the jolt of something hitting the bucket. He denied telling Petitioner that he was sorry that he got hurt and denied seeing him afterwards. He testified that he did not believe that Petitioner came back to work the following Monday. He agreed that he testified that the gate would not come off if everything was working correct, and further testified that it was a fairly new truck. He agreed that if something malfunctioned, the gate could possibly come off. He agreed that they were using the bucket of the backhoe to hold the gate up in order to try to get the pins in.

On cross-examination, Mr. Spurgeon testified that he did not remember if he was notified to be there for the arbitration hearing. He denied being subpoenaed to appear in December, but testified that he was subpoenaed to be there on the day of arbitration. He agreed that he was currently working for Conoco-Phillips, and that he was an operator. He testified that he did not know how many operators were working there every day, but agreed that he was not the only operator working there. He testified that he completed his written statement, talked to Don Sonnenberg, and talked to Tom Moore when he got the subpoena to appear in order to find out where he was going and what he was doing.

On cross-examination, Mr. Spurgeon agreed that in his statement he indicated that the bucket was hanging over the side of the truck, Petitioner walked under it and when he backed up he stood up and hit his head. He testified that he was able to see his peripheral field, and agreed that in his statement he indicated that the view he had was obstructed from the rear of the truck. He testified that at the time of this incident he was still in the cab of the backhoe. He testified that he did not remember raising his hands up over his head or making a gesture. He denied telling Petitioner that he was worried about his job with the State. He testified that he did not know if Petitioner worked the next Monday. He testified that when the bucket was curled and up, it was about six feet off the ground.

On redirect examination, Mr. Spurgeon testified that he did not remember if Petitioner worked the next Monday but knew that he did not work with him. He denied speaking with Petitioner the following Monday. He agreed that prior to testifying he was shown a copy of the witness statement that he completed on December 23, 2014 and that he was also shown a copy of the report prepared by Don Sonnenberg after he was interviewed.

On rebuttal, Petitioner agreed that he heard Mr. Spurgeon's testimony that he never said he was sorry. He testified that it was all lies.

The Application for Adjustment of Claim was entered into evidence at the time of arbitration as Arbitrator's Exhibit 2. The Application alleged a date of accident of December 19, 2014, that Petitioner was hit in the head from the bucket on a backhoe, and that the body parts affected included the neck and other parts. (AX2).

The medical records of St. Anthony's Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Petitioner was seen on December 19, 2014 with a noted arrival time of 19:55. The chief complaint was that of a head injury, and it was noted that Petitioner was at work and was hit on the top of his head with a bucket of a backhoe. Petitioner complained of pain to the head and stiffness to his neck. Petitioner denied loss of consciousness and denied memory loss. The primary impression was that of a head injury and the secondary impression was that of neck pain, and Petitioner was discharged home in stable condition and given prescription medications. (PX1).

Interpretive reports for imaging studies at St. Anthony's Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. A CT of the cervical spine performed on December 19, 2014 was interpreted as unremarkable. A CT of the head also performed on December 19, 2014 was also interpreted as unremarkable. (PX2).

The medical records of Dr. Manju Ramchandani were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. Petitioner was seen on December 24, 2014 in follow-up from the emergency room. It was noted that Petitioner worked with the highway department for 3 months of the year and was checking a truck for safety when a backhoe bucket struck him on the top of his head. Petitioner felt "stunned" but there was no loss of consciousness. Petitioner denied numbness, tingling or weakness, and denied nausea, vomiting or change in vision. It was noted that Petitioner found Vicodin helped lower the intensity of the pain which could get up to 8/10 at maximum. No acute progression of symptoms was noted, and a physical therapy referral was given. Petitioner was also prescribed Flexeril and Vicodin to use as needed for pain. (PX3).

Included within the records of Dr. Manju Ramchandani were several telephone notes, including one pertaining to a call from Petitioner on December 24, 2014 requesting an off work note for that morning. On December 26, 2014, Petitioner called requesting a note saying that he could return to work on December 29, 2014 without restrictions. On December 30, 2014, it was noted that Petitioner would like to know if a work release could be signed since Dr. Ramchandani was not back until January 7, 2015. A letter dated December 30, 2014 was issued by Courtney McFarlin, PA, indicating that Petitioner had an appointment on December 24, 2014 and to please excuse him from work on that date. (PX3).

The records of Dr. Manju Ramchandani reflect that Petitioner was seen on January 5, 2015 at which time he requested a work clearance. It was noted that Petitioner wanted to be referred to physical therapy, but it was unclear if a physical therapy referral had been made at his appointment on December 24, 2014. It was noted that Petitioner continued to take Vicodin as prescribed by the emergency room that he was also taking a muscle relaxer at night, and that this helped with the tightness of his muscles. Petitioner stated that his headaches had improved and that he did not have them daily, but rather "just once in a great while." Petitioner stated that he continued to feel the tightness in his neck muscles and in his upper back, but the muscle relaxer seemed to help. It was noted that Petitioner was willing to do physical therapy and that he had been off work since December 24, 2014. Petitioner stated most of his symptoms had improved other than the tightness in his upper back and neck area. The assessment was that of a cervical strain. Another physical therapy referral was issued, and it was noted that when Petitioner was seen by Dr. Manju in two weeks it would be determined if he was cleared to return to work without any restrictions. A letter was issued on that date as well, requesting that Petitioner be excused from work from December 25, 2014 to January 5, 2015. (PX3).

The records of Dr. Manju Ramchandani reflect that Petitioner was seen on January 19, 2015, at which time Petitioner stated that the physical therapy was helping his neck and shoulder pain and that it was much improved. Petitioner stated that he still had some tightness in the upper shoulders, and that there was pain at times but did seem to be improving with physical therapy. It was noted that Petitioner had two more weeks of physical therapy. Petitioner requested a refill of his medications and stated that he was not sure that he could go back to work at that time without any restrictions. The assessment was that of cervical muscle strain, and Petitioner was instructed to follow up in two weeks for reevaluation and that the prognosis was good for him to return to work without any restrictions. Petitioner was instructed to continue physical therapy. A letter was issued as well, requesting that Petitioner be excused from work from January 19, 2015 through February 4, 2015. (PX3).

The records of Dr. Manju Ramchandani reflect that Petitioner was seen on February 4, 2015, at which time he reported that he was doing better "slowly and surely." It was noted that the pain seemed to be lesser, but that it got worse in the evening and he still woke up with morning stiffness. It was noted that the spasms going down his neck had resolved. Petitioner did not report any neuropathy symptoms but still needed to take ½-1 Vicodin every day or every other day at most. Petitioner stated his symptoms were about 40% better since the incident, and that he was still getting headaches on the top of his head at the site where he was struck. Petitioner stated that he thought physical therapy had been helping. The assessment was that of a cervical strain, and it was noted that he was not reporting complete resolution of symptoms. Physical therapy was continued and he was referred to an orthopedist. It was noted that a full duty release was being held until he was evaluated by an orthopedist. (PX3).

The records of Dr. Manju Ramchandani reflect that Petitioner called in on February 16, 2015 requesting a 30-day supply of Hydrocodone, but that he was not due for a refill until February 19, 2015. Petitioner called in on February 19, 2015 again requesting a Hydrocodone refill as well as a referral to Dr. Shitut. (PX3).

The records of Dr. Manju Ramchandani reflect that Petitioner called in on February 24, 2015 requesting an order to continue physical therapy. Petitioner called in on March 13, 2015, stating that Dr. Shitut said he had a bulging disc in his cervical spine and did not want to do surgery at that time. Petitioner stated that he was released by Dr. Shitut and that he had one week left of physical therapy. It was noted that Petitioner had an appointment scheduled on May 5, 2015. Petitioner asked whether he needed to come in sooner and should he remain off work. It was noted that it was ok for Petitioner to follow up sooner. He also requested a Hydrocodone refill, and it was noted that he needed a urine drug screen. (PX3).

The records of Dr. Manju Ramchandani reflect that Petitioner was seen on April 2, 2015, at which time it was noted that he stated he was doing better and was released by Dr. Shitut. Petitioner stated that he had an MRI that showed a bulging disc. Petitioner stated that he was not at 100% and had finished physical therapy. Petitioner denied any numbness or tingling in any extremity and denied any weakness with any extremity, but did state that he continued to have some headaches on the top of his head where he was struck by the bucket. Petitioner stated he still had some neck pain associated with this. Petitioner stated that Dr. Shitut okayed him to go back to work, but it was noted the medical records would be obtained prior to doing this. Petitioner stated that he continued to take Hydrocodone, which helped his pain. The assessment was that of cervicalgia with cervical strain. It was noted that Petitioner would not be released to work without restrictions until further records were available, and that Petitioner was instructed to return in one week and have regularly scheduled routine labs done. A letter was issued on that date, excusing Petitioner from work until May 30, 2015. (PX3).

The medical records of Orthopedic and Spine Surgeons/Dr. Shitut were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Petitioner was seen on March 5, 2015, at which time he was seen for evaluation of neck issues. It was noted that Petitioner had been treated with medications and

had had physical therapy but no injections. Petitioner stated that soon after the emergency room visit he was "told" not to go back to work. It was noted that most of the pain that he referred to was in the back of the neck, mostly on the left side, was almost in the mastoid area and went across the occipitocervical junction to the mid-cervical area onto the left trapezius area. It was noted that it did not go below the shoulders. Petitioner denied tingling, numbness, or weakness of the upper extremities and denied any lower extremity signs or symptoms. It was noted that the pain was constant and aggravated with mechanical activities. Petitioner denied any neck problems before, and described himself to be in excellent health with no major medical problems such as diabetes, hypertension or heart disease. It was noted that Dr. Shitut thought that Petitioner had a myofascial type of neck strain, and that there was a significant phobia about returning to work with the injury he had. Petitioner was recommended to return to work and it was noted that that an MRI would be obtained. The current working diagnosis was that of resolving neck sprain, arising from industrial injury 2.5 months ago. (PX4).

The records of Dr. Shitut reflect that Petitioner was seen on March 12, 2015, at which time he was seen for follow-up of his cervical MRI. It was noted that the MRI showed fairly minor degenerative bulging of his C5-6 disc, which was not compromising any neural structures. It was noted that the clinical examination suggested that he had a neck sprain related to an industrial injury, and that he was "pretty much over it right now." Petitioner had minimal, if any, symptoms. Petitioner was allowed to return to work, and the diagnosis was that of resolved neck sprain, minor underlying spondylosis, no follow-up necessary. A Work/School Status Note was issued, allowing Petitioner to return to work on March 16, 2015. (PX4).

Interpretive reports for imaging studies at Christian Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The report for an MRI of the cervical spine performed on March 9, 2015 indicated that the films were interpreted as revealing (1) small broad C5-6 disc osteophyte complex asymmetric right with mild right foraminal stenosis; (2) small right paracentral disc osteophyte at C4-5 without canal stenosis; (3) minute right paracentral protrusion at C3-4; (4) mild C7-T1 facet arthropathy otherwise unremarkable; (5) medial deviated common carotid with contour bulge at posterior wall of pharynx and larynx. (PX5).

The medical records of Quest Diagnostics were entered into evidence at the time of arbitration as Petitioner's Exhibit 6.

The medical records of Orthopedic Center of St. Louis were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. Petitioner was seen on May 6, 2015 at the referral of Dr. Ramchandani and Dr. Kramer. Petitioner presented with a chief complaint of neck pain with headaches to both sides, bilateral trapezius, both shoulders, upper back and pain between his shoulder blades with intermittent shooting pain in his left arm and tingling in his fingertips on the left side. Petitioner stated his current problem began on December 19, 2014 when he was doing seasonal work for the State of Illinois. Petitioner stated that he was instructed to take a truck back to one of the facilities, and that he went behind the truck to inspect it before pulling away and a gentleman struck his head with the backhoe as he began to stand up. Petitioner stated that initially he felt okay, but that night his symptoms became significantly worse. It was noted that Petitioner did not recall any previous problems of significance with his neck or back, although he admitted to a history of what he felt was a potential right labral tear in his hip as well as potential right shoulder injections. Petitioner's symptoms were constant with really neck greater than any low back issues, and it was noted that he had mild low back pain. Petitioner's pain was worse with fixed head positions or arm activity and better with a neutral position. Petitioner was noted to have left arm shooting pain and numbness on occasion, but he denied right arm shooting pain. It was noted that Dr. Gornet felt that Petitioner suffered from discogenic neck pain secondary to a disc injury at C5-6, but that he did not have significant nerve or cord compression. It was noted that for the most part, his neurologic exam was non-focal. Petitioner was recommended to undergo injections at C5-6 and C3-4. It was noted that Dr. Gornet believed that Petitioner was capable of light duty work with no lifting greater

than 15 pounds, no overhead work, alternating between sitting and standing. It was noted that Petitioner understood that Dr. Gornet had "placed his low back on hold." (PX7).

The records of Dr. Gornet reflect that Petitioner was seen on July 9, 2015, at which time it was noted that the injections gave him some temporary relief. Petitioner was to continue on light duty and a new MRI scan was ordered. It was noted that Petitioner may require disc replacement surgery at C5-6. It was also noted that another option would be a trial of work full duty with no restrictions, but should not be construed as a release from care or being placed at maximum medical improvement. (PX7).

The records of Dr. Gornet reflect that Petitioner was seen on September 24, 2015, at which time it was noted that he continued to have pain which affected his quality of life. It was noted that a new MRI was requested but denied. It was noted that there was some question that he went to the emergency room the day before the accident, but according to Petitioner it was his son. It was noted that Dr. Gornet believed that if Petitioner's drug test was negative, he continued to believe that his symptoms were causally connected to his work-related accident. It was noted that his exam was unchanged and that he was somewhat miserable. Petitioner indicated that he would like a trial of full duty, and that he felt like he may be able to sign in for work and at least collect unemployment if no work was offered to him. Dr. Gornet did not believe that Petitioner was at maximum medical improvement and noted that he continued to believe that Petitioner may require further treatment. A new MRI was again recommended. (PX7).

The records of Dr. Gornet reflect that Petitioner was seen on November 30, 2015, at which time it was noted that the MRI was approved and revealed a disc herniation significantly at C5-6, which correlated with his neck pain, headaches and bilateral trapezial pain, particularly his bilateral shoulder pain, left greater than right. It was noted that Petitioner was trying to tolerate his symptoms, and that the injection helped. Medications were dispensed, and Petitioner was recommended to continue working full duty. (PX7).

The records of Dr. Gornet reflect that Petitioner was seen on February 1, 2016, at which time it was noted that he had one injection which had significantly improved his symptoms. It was noted that his symptoms were slowly returning, particularly in the trapezial region. Petitioner was recommended to continue with conservative care, and medications were dispensed. It was noted that he may require another injection and that he may require surgery. (PX7).

The interpretive report for an EMG/Nerve Conduction Study performed at St. Anthony's Health Center on May 11, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The clinical history noted that Petitioner presented with numbness, tingling and pain in the bilateral upper extremities. The study was interpreted as being abnormal consistent with peripheral motor polyneuropathy of the bilateral upper extremities, and that evaluation be considered for diabetes, nutritional deficiency, thyroid dysfunction, gammopathies and autoimmune conditions. (PX8).

The Pain Management Procedure Note of May 20, 2015 at the St. Louis Spine and Orthopedic Surgery Center was entered into evidence at the time of arbitration as Petitioner's Exhibit 9. Petitioner underwent a C5/6 epidural steroid injection for a diagnosis of cervical disc disease. (PX9).

The Pain Management Procedure Note of June 1, 2015 at the St. Louis Spine and Orthopedic Surgery Center was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. Petitioner underwent a C3/4 epidural steroid injection for a diagnosis of bilateral cervical radiculopathy. (PX10).

The medical records of MRI Partners of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 11. Petitioner underwent an MRI of the cervical spine on November 30, 2015, which was interpreted as revealing (1) central annular tear at the apex of a broad based central herniation at C5-6, which extends into the foramina greater on the right than the left; there is ventral cord

flattening, mild central canal stenosis and moderate right greater than left foraminal stenosis; (2) C4-5 broad based right paracentral and C3-4 focal right paracentral herniations with associated annular tears; there is dural displacement and cord contact at both levels, but no central canal stenosis; mild right greater than left foraminal stenosis are present at C4-5. (PX11).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 12. The Petition for Penalties and Attorney's Fees was entered into evidence at the time of arbitration as Petitioner's Exhibit 13. A group of backhoe pictures were entered into evidence at the time of arbitration as Petitioner's Exhibit 14. A group of ditch pictures were entered into evidence at the time of arbitration as Petitioner's Exhibit 15.

The Workers' Compensation Employee's Notice of Injury was entered into evidence at the time of arbitration as Petitioner's Exhibit 16. The form was completed on December 23, 2014 and was signed by Petitioner. The date of injury or illness was noted to be December 19, 2014 at 2:15 p.m. It was noted that the accident was reported on December 19, 2014 at 3:20 p.m. to Lonnie Pruett/Tom Moore. It was noted that Petitioner was checking the tailgate of a truck for safety, that he was walking to the rear of the truck to inspect the tailgate and that the backhoe bucket struck him on the top of his head. Petitioner indicated that the top of his head and neck hurt. Witnesses to the injury were noted to be Robert Jarzombek, Duane Beiser and Victor Spurgeon. (PX16).

The IDOT Daily Yard Attendance logs were entered into evidence at the time of arbitration as Respondent's Exhibit 1. The logs reflect that Petitioner worked from 7:00 a.m. to 3:30 p.m. on both December 22, 2014 and December 23, 2014. (RX1).

Multiple incident reports were entered into evidence at the time of arbitration as Respondent's Exhibit 2. The Illinois Form 45: Employer's First Report of Injury was dated December 22, 2014 and referenced a date of accident of December 19, 2014 at 2:15 p.m. The report was prepared by Jennifer Boisselle and indicated that Petitioner was "checking the pin" at the time of the accident and that Petitioner got out of the driver's side and walked to the back of the truck, he was dumping sand, when they were done they could not get the pin in, and when Petitioner went back to check he was looking down and the bucket came down on his head. Petitioner was reported to have sustained a contusion to the skull. (RX2).

The IDOT Employee Accident/Incident Report was prepared on December 23, 2014. The date of accident was noted to be December 19, 2014 at 2:15 p.m. Petitioner was noted to have sustained a head injury. It was noted that after getting out of the truck on the driver's side Petitioner went to the rear of the truck to inspect the tailgate condition before driving back to the yard and that the backhoe bucket struck him on the top of the head. It was also noted that the crew had been trying to replace a pin on the tailgate. (RX2).

The Workers' Compensation Employee's Notice of Injury was completed on December 23, 2014. The date of accident was noted to be that of December 19, 2014 at 2:15 p.m. Petitioner indicated that he was checking the tailgate of the truck for safety, that he was walking to the rear of the truck to inspect the tailgate and that the backhoe bucket struck him on the top of the head. Petitioner indicated that the top of his head and his neck hurt. (RX2).

Various Witness Reports were entered into evidence at the time of arbitration as Respondent's Exhibit 3. The Workers' Compensation Witness Report completed by Robert Jarzombek on December 23, 2014 indicated that he saw Petitioner walk under the backhoe and stood straight up, and that it did not look like he hit it hard. (RX3).

The Workers' Compensation Witness Report completed by Victor Spurgeon on December 23, 2014 indicated that they had to swing the backhoe out of the way to reposition the chain while the backhoe bucket was hanging over the side of the truck, and that Petitioner walked under it and when he backed up he stood up and hit his head. The report also indicated that with the view he had, it was obstructed from the rear of the truck. (RX3).

The Workers' Compensation Witness Report completed by Duane Beiser on December 23, 2014 indicated that he was in the back of the truck attempting to relatch the gate, and that Petitioner was going to leave the site and go back to the Hamel Operations Yard. Mr. Beiser indicated that he disembarked from the passenger side of the truck and that Petitioner left. He indicated that he was told by Victor Spurgeon that Petitioner had run into the backhoe bucket with his head, and that as Petitioner had left, he could not ask him what happened until approximately 30 minutes later when they rode back to the Hamel yard from the work site. Petitioner stated to Mr. Beiser that he was hit with the backhoe bucket by "Vic" and that he did not have a headache but felt tightness in his neck. (RX3).

The Supervisor's Report of Injury or Illness completed by Tom Moore on December 23, 2014 indicated that Petitioner was walking around to the rear of his truck to check the tailgate and was struck on the top of his head with the backhoe bucket. The body part(s) injured included the top of the head and it was noted that that Petitioner stated that his neck hurt. (RX3).

The Memorandum prepared by Don Sonnenberg on March 20, 2015 indicated that Bob Jarzombek was present at the time of the alleged accident and was asked to describe who and what kind of equipment was at the work site on or about the time of the alleged incident. It was noted that Jarzombek indicated that Vic Spurgeon was in the backhoe but was not at the controls as he had just moved the bucket away from the tailgate to the rear of the driver's side bed, that Duane Beiser was out of the 3-ton examining and assisting how to get the tailgate reattached and that Petitioner was on the driver's side of the 3-ton when he started walking back towards the tailgate and backhoe. It was noted that the backhoe was being used to attempt to get the tailgate fully attached but was not working as well as they would have like, and that safety issues were a concern and that they had it secured enough to head back to the yard. It was noted that Jarzombek indicated that Beiser was climbing out of the bed of the 3-ton on the passenger side while Petitioner was approaching the tailgate/backhoe from the driver's side. As Spurgeon was still in the backhoe but not on the controls and the backhoe was stationary just off the driver's side of the bed, Petitioner walked under the bucket to see what was going on the tailgate and lifted his head up striking the top of his head with the stationary bucket. It was noted that Sonnenberg asked Jarzombek if he actually witnessed Petitioner striking the top of his head to the bottom of the stationary bucket and he replied that he did. It was noted that Jarzombek went on to state that he asked Petitioner if he was okay and Petitioner replied that he was alright. It was further noted that they joked briefly about hitting his head and Petitioner went back to the truck as Beiser had earlier asked him to do. It was also noted that at no time did Petitioner fall to the ground or indicate that he had any type of injury. (RX3).

The Memorandum prepared by Don Sonnenberg on March 19, 2015 indicated that there appeared to be conflicting accounts of what took place on a culvert replacement job, and that Petitioner stated that he was "struck by a backhoe bucket" while checking the tailgate of a 3-ton dump, while witness statements indicated that no one saw the bucket strike the employee including the operator. Duane Beiser was noted to have been told by Vic Spurgeon that Petitioner ran into the bucket. It was noted that when Beiser got into the truck at the yard, he stated that Spurgeon hit him in the head with the bucket. It was noted that Beiser stated that there were no open wounds, no bleeding and no other signs of trauma. It was further noted that Beiser stated that if someone was struck by a moving bucket that "folks don't just jump up from that." (RX3).

The Memorandum prepared by Don Sonnenberg on March 23, 2015 indicated that Vic Spurgeon was the operator of the backhoe on the day of the alleged injury, and that he was able to confirm the equipment that was on the work site as well as the personnel. It was noted that according to Spurgeon, he left the bucket about 6 feet off the ground near the rear of the truck when he saw Petitioner exit the driver's side of the truck and began to walk back to the rear of the dump. It was noted that Spurgeon was off the controls and the bucket was stationary when he observed Petitioner bent over and walk under the bucket to the tailgate after Beiser told Petitioner to stay in the truck. It was noted that Spurgeon did not see Petitioner strike his bucket but stated that anytime a bucket is free hanging you can feel a jolt in the cab, and that Spurgeon felt that jolt, looked toward the bucket and saw Petitioner coming out from under the bucket rubbing the top of his head. It was noted that Spurgeon asked Petitioner if he was alright and Petitioner responded that he was fine. It was noted that Spurgeon was asked if he saw any bleeding or other signs of a head wound, and that he stated that all he saw was Petitioner rubbing the top of his head. (RX3).

The IDOT Termination Letter was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The letter was dated April 23, 2015 and noted that Petitioner was terminated for cause to a fraudulent worker's compensation claim which was submitted on or around December 23, 2014. (RX4).

The IDCW regarding 93 WC 5700 was entered into evidence at the time of arbitration as Respondent's Exhibit 5. The document referenced a prior settlement for 1.5% MAW. (RX5).

Documentation from Prescription Monitoring Program was entered into evidence at the time of arbitration as Respondent's Exhibit 6. The documentation referenced multiple Hydrocodone and Tramadol prescriptions having been filled throughout the timeframe of October 1, 2013 through August 13, 2015. (RX6).

The medical records of St. Anthony's Health Center for the date of service of December 19, 2014 pertaining to Petitioner were entered into evidence at the time of arbitration as Respondent's Exhibit 7A. The records were duplicative of those as contained in Petitioner's Exhibit 1. (RX7A).

The medical records of St. Anthony's Health Center for the date of service of December 19, 2014 pertaining to Petitioner's son were entered into evidence at the time of arbitration as Respondent's Exhibit 7B. Petitioner's son was seen with a chief complaint of low back and leg pain. It was noted that he was hit in the back with a pallet 12 days ago and was having pain to his lower back and pain to his legs that started at the time of the accident. Petitioner's son was given a prescription for Tramadol and was assessed with a lumbosacral strain. (RX7B).

The medical records of St. Anthony's Physician's Group/Dr. Ramchandani were entered into evidence at the time of arbitration as Respondent's Exhibit 8. Petitioner was seen on May 5, 2015, at which time it was noted that he wanted to discuss his left parietal head injury suffered on December 19, 2014. It was noted that since the injury, Petitioner had posterior neck pain that radiated through the upper back down his bilateral shoulders with left greater than right arm. It was noted that Petitioner mentioned a weaker left arm and leg, and that another issue he was having was with intermittent "stingers" in the left thigh down through his toes. Petitioner also noted that he was having numbness in his bilateral fingers and a persistent headache. It was noted that regarding his post-traumatic headaches, pain and numbness, Petitioner requested a referral to Dr. Gornet and that an EMG/nerve conduction study was ordered. (RX8).

The records of Dr. Ramchandani reflect that Petitioner was receiving prescriptions for various prescription pain medications including Hydrocodone, Norco, and/or Vicodin as far back as June of 2013, and that a prescription for Hydrocodone was issued on December 10, 2014. It was noted at the time of

the April 4, 2014 office visit that Petitioner was assessed with chronic pain, and that he continued to see Dr. Vest. (RX8).

The medical records of Orthopedic & Sports Medicine Clinic were entered into evidence at the time of arbitration as Respondent's Exhibit 9. Petitioner was seen by Dr. Vest on August 23, 2013 for issues related to his right hip, he was seen on December 12, 2013 reporting a new complaint of right shoulder pain for 6 months, and at the time of the visit on March 18, 2014 Petitioner was assessed with (1) right hip pain; (2) possible labral tears, right hip; (3) mild DJD right hip; (4) right shoulder pain; and (5) impingement syndrome, right shoulder. (RX9).

The medical records of Christian Hospital Orthopedic & Spine Surgeon/Dr. Shitut were entered into evidence at the time of arbitration as Respondent's Exhibit 10. The records were duplicative of those as contained in Petitioner's Exhibit 4.

The medical records of The Orthopedic Center of St. Louis/Dr. Gornet were entered into evidence at the time of arbitration as Respondent's Exhibit 11. The records were effectively duplicative of those as contained in Petitioner's Exhibit 7.

Documentation pertaining to unemployment benefits was entered into evidence at the time of arbitration as Respondent's Exhibit 12. The 2013 and 2014 IDOT applications were entered into evidence at the time of arbitration as Respondent's Exhibit 13. The application received on September 24, 2014 noted that Petitioner was taking Vicodin. (RX13).

CONCLUSIONS OF LAW

With respect to disputed issue (C) pertaining to accident, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of his employment with Respondent on December 19, 2014. The Arbitrator finds that Petitioner's job reasonably required him to be under the bucket of the backhoe when he was checking the tailgate. The Arbitrator finds that this is a risk to which the general public is not generally subjected. As a result thereof, the Arbitrator finds that Petitioner sustained injury when he stood up after inspecting the tailgate and struck his head on the bottom of the backhoe bucket. The Arbitrator notes, however, that Petitioner's testimony concerning the events of the date of December 19, 2014 was significantly contrary to the testimony of the various witnesses called by Respondent at the time of arbitration, and does not find Petitioner's version of events of the accident to have been credible.

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that, based upon the testimony of the various witnesses and the evidence submitted at the time of arbitration, Petitioner has failed to prove that his current condition of ill-being is causally related to the work injury of December 19, 2014.

In finding that Petitioner's accident did not occur as described by Petitioner at the time of arbitration, the Arbitrator necessarily questions the veracity of the history of accident as described by Petitioner to the various physicians and medical personnel in this matter. That said, the Arbitrator does not find it credible that Petitioner sustained more than a myofascial neck strain as diagnosed by Dr. Shitut for which he opined that Petitioner had attained maximum medical improvement as of March 12, 2015. The Arbitrator places great weight upon the opinions of Dr. Shitut, who noted at the time of the March 12, 2015 visit that the cervical MRI showed fairly minor degenerative bulging of his C5-6 disc which was not compromising any neural structures, and who opined that the clinical examination suggested that Petitioner had a neck sprain related to an industrial injury and was "pretty much over it right now."

(PX4). As a result of the foregoing, the Arbitrator finds that Petitioner has failed to prove that his current condition of ill-being is causally related to the work injury of December 19, 2014.

With respect to disputed issue (J) pertaining to medical services, in accordance with the Arbitrator's decision regarding the issue of causation, the Arbitrator finds that Petitioner's treatment for the timeframe of December 19, 2014 through March 12, 2015 is reasonable, necessary and related to the accident of December 19, 2014, bur that any treatment rendered to Petitioner subsequent to March 12, 2015 is not reasonable, necessary or causally related to the accident of December 19, 2014.

With respect to disputed issue (K) pertaining to prospective medical care, as the Arbitrator finds that Petitioner attained maximum medical improvement for his myofascial neck strain as of March 12, 2015 and that his current condition of ill-being is not related to the accident of December 19, 2014, Petitioner's request for prospective medical treatment is hereby denied.

With respect to disputed issue (L) pertaining to temporary total disability benefits, the Arbitrator notes that Petitioner seeks temporary total disability benefits for the timeframe of April 2, 2015 through March 17, 2016. (AX1). Given the Arbitrator's finding that Petitioner attained maximum medical improvement for his myofascial neck strain as of March 12, 2015, that his current condition of ill-being is not related to the accident of December 19, 2014, and that Petitioner was released to return to work without any restrictions by Dr. Shitut, the Arbitrator finds that Petitioner is not entitled to any temporary total disability benefits after March 12, 2015.

With respect to disputed issue (M) pertaining to penalties or fees, the Arbitrator notes that Petitioner filed a Petition for Penalties on November 18, 2015, seeking penalties against Respondent for failure to pay temporary total disability benefits and medical benefits under Sections 19(k) and 16 of the Act. (PX13). The Arbitrator further notes that, per the Request for Hearing form, Petitioner is seeking payment of temporary total disability benefits from April 2, 2015 through March 17, 2016, which is a period of time subsequent to when Petitioner was placed at maximum medical improvement by Dr. Shitut. (AX1). In viewing the record as a whole in this case, the Arbitrator finds that Respondent reasonably relied on the medical opinion of one of Petitioner's treating physicians, Dr. Shitut, in denying further benefits to Petitioner subsequent to March 12, 2015. As such, the Arbitrator denies Petitioner's request for penalties and fees.

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

William Cervac,
Petitioner,
vs.

NO: 15WC 19275

State of Illinois,
Respondent,

17IWCC0147

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, 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 8, 2016 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.

MAR 8 - 2017

DATED:
MJB/bm
o-2/28/2017
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CERVAC, WILLIAM
Employee/Petitioner

Case# **15WC019275**

STATE OF ILLINOIS
Employer/Respondent

17IWCC0147

On 2/8/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0152 LINN CAMPE & RIZZO LTD
JOHN J RIZZO
215 N MARTIN L KING JR AVE
WAUKEGAN, IL 60085

5472 ASSISTANT ATTORNEY GENERAL
BETSY R FERGUSON
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

FEB 8 - 2016

RONALD A. SARDIN, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF Lake)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
XXXXX ☐ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

William Cervac
Employee/Petitioner

v.

State of Illinois
Employer/Respondent

Case # **15** WC **19275**

Consolidated cases: ~~17 IWCC 0147~~

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **Rockford**, on **December 15, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☐ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Prospective Medical Treatment**

17 IWCC0147

FINDINGS

On **October 5, 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 $16,703.96 under Section 10 plus the average weekly wage under section 10 was **$321.23**.

On the date of accident, Petitioner was **54** years of age, ***married*** with **0** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$6,397.31** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of **$6,397.31**.

Respondent is entitled to a credit of **$0.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $253.00 per week for 60 1/7 weeks, commencing October 21, 2014 through December 15, 2015 (date of the hearing), provided in Section 8(b) of the Act.

Respondent shall pay to the Petitioner the amount of $15,268.91 for reasonable and necessary medical services as determined and contained in Petitioner's Exhibits 2 through 5 as provided in Section 8(a) and 8.2 of the Act.

Respondent shall authorize and pay the reasonable and necessary costs associated with the lumbar spinal fusion surgery prescribed for the Petitioner by Dr. Erickson on July 28, 2015, as provided in Section 8(a) and 8.2 of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for 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.

#0001 ARBITRATOR GEORGE J. ANDROS
Signature of Arbitrator – George Andros

February 5th, 2016
Date

FEB 8 - 2016

17IWCC0147

FINDINGS OF FACT 15 WC 019275:

The Petitioner is fifty four (54) years old and was employed by the Respondent as a Conservation Worker at the Chain O'Lakes State Park. His various duties included all types of janitorial/cleaning work, cutting grass, wood repairs, painting, and asphalt repairs as well as any other maintenance task assigned by his supervisor. By pattern of speech, voice inflection and actual testimony he takes his work of conservation very seriously and with dedication.

Petitioner sustained an undisputed work injury on October 5, 2014 while painting picnic tables. Petitioner testified that while painting picnic tables he had to flip them over to paint various sides, then wait for them to dry and flip them back over to paint the remaining sides. He needed to obtain additional paint from the facility building approximately a mile away from where he was painting. He drove the work truck back to the storage facility. The paint was stored in a loft area of the building up several stairs inside a locked cage. He pulled a five (5) gallon bucket from the shelf to the ground. While moving the heavy bucket from one hand to the other, he ducked underneath a metal beam of the locked cage. Petitioner testified that he felt an extreme pain and a pop or snap in his lower back. After waiting for the shock of the pain to subside, he descended the stairs with the paint by moving only one step at a time. Once out at the work truck, Petitioner was leaning up against his truck in pain. He advised his supervisor when he arrived to see Petitioner leaning on his truck. After being told to take it easy, Petitioner ultimately went home early that day. He could not complete his work duties the following day and needed to seek medical attention.

Petitioner initially presented to the emergency department of Advocate Condell Medical Center on October 9, 2014. (Px 6) A history of his injury, consistent with the undisputed work injury from lifting the five gallon paint bucket, is noted by the emergency room. He described lower back pain and tingling radiating down his left lower extremity. (Px 6) He was advised to follow-up with his family doctor, Dr. Shevlyagin, or Dr. Robert Erickson, neurosurgeon, upon discharge from the ER. (Px 6)

He was evaluated by Dr. Shevlyagin on October 17, 2014 with complaints of pain in his lower back and numbness in his left toes which resulted from lifting a 5 gallon buck of paint. (Px 7). Dr. Shevlyagin prescribed medication and recommended his be off work pending an evaluation with Dr. Erickson. (Px 7)

He began treatment with Dr. Erickson on November 25, 2014. Dr. Erickson noted the undisputed work injury history and documented pain with radiation to the left foot and toes. Dr. Erickson recommended he begin physical therapy, remain off work and obtain a lumber MRI. (Px 8)

Dr. Erickson reviewed the MRI conducted on December 11, 2014 (Px 8) and opined that Petitioner demonstrated an annular tear with lateral recess stenosis at L4/5. (Px 8 – 12/16/15 note) He noted that Petitioner was feeling worse with increased numbness into his toes and pain in the left leg and back. Prescription ensued for physical therapy and an epidural injection.

Petitioner underwent a Lumber Epidural Steroid Injection with Dr. Anatoly Arber on February 9, 2015. (Px 9) He also continued his physical therapy with Colletti Physical therapy. (Px 12)

On February 17, 2015, Dr. Erickson indicated that the epidural steroid injection did not provide the anticipated pain relief. Dr. Erickson decided to obtain a diagnostic discography CT to assess the lumbar back pain and recommended a sacroiliac injection. (Px 8)

Dr. Shayle Patzik performed a lumbar discogram L2-L3, L3-L4, L4-L5 at Advocate Condell MC on April 2, 2015. (Px 6) Dr. Patzik noted a specific positive discogram at L3-L4 with re-creation of the patient's normal chief complaint discomfort.

Upon review of the positive discogram, Dr. Erickson recommended he undergo minimally invasive fusion at L3/L4 and attempt a sacroiliac injection to rule out any dysfunction. (Px 8 – 4/28/15 note) Petitioner was evaluated by Dr. Hurh regarding the sacroiliac injection on June 18, 2015. (Px 11)

Dr. Erickson reiterated his recommendation of an instrumented lumbar fusion at L3/L4 via a minimally invasive approach on July 28, 2015. (Px 8)

Respondent requested Petitioner submit to an evaluation by Dr. Tack in March 25, 2015. (Rx 2) Dr. Tack stated that Petitioner did not demonstrate any objective findings and opined that Petitioner sustained a thoracolumbar stain. He indicated that Petitioner's condition was resolved and he could return to work. In comparing the reports of Dr.Tack to the clinical records of Dr. Erickson plus tests, Dr. Tack's opinion in this specific case becomes very suspect.

CONCLUSIONS OF LAW:

(F) Causal Connection & (O) Prospective Medical Treatment:

It is undisputed that Petitioner sustained an injury to his lumbar spine on October 5, 2014 while moving a five gallon bucket of paint while working for the Respondent.

Petitioner's consistent complaints and treatment are noted by Advocate Condell MC, Dr. Shevlyagin, Dr. Erickson, Dr. Arber, and Dr. Patzik. Dr. Tack, Respondent's Section 12 evaluation, is the only record that demonstrates finding that contradicts the treatment records, evaluation notes and diagnostic testing.

At issue is Dr. Erickson's July 28, 2015 recommendation of an instrumented lumbar fusion at L3/L4 via a minimally invasive approach. (Px 8) Dr. Erickson noted Petitioner's complaints of pain and numbness/tingling in the left lower extremity and toes. These complaints and findings were similarly noted by the ER physicians and Dr. Shevlyagin. After attempting conservative treatment with physical therapy at Colletti PT and an epidural injection with Dr. Arber, Dr. Erickson requested a confirmatory, diagnostic lumbar discogram.

That discogram was found to be specifically positive at L3-L4 with re-creation of the patient's normal chief complaint discomfort.

The Arbitrator makes the finding of fact that all medical documentation in the record supports those findings and notes of Dr. Erickson and the discogram provides corroboration that a fusion is necessary at L3/L4.

The Respondent's reliance on Dr. Tack's opinion lacks much foundation in any other medical evidence or reference in the hearing evidence.

The Arbitrator notes that Dr. Tack's report discussion makes no mention of Petitioner's pain and tingling radiating down his left lower extremity noted by the ER at Advocate Condell MC. Nor does Dr. Tack take into account the numbness in the left toes documented by Dr. Shevlyagin or Colletti PT's notation that Petitioner complained of numbness in the midfoot to the toes. Moreover, Dr. Tack fails to appreciate the increased numbness and positive straight leg raising test detailed by Dr. Erickson. Dr. Tack's opinion is not supported by other medical findings and is specifically contradicted by them.

In his subsequent report, Dr. Tack dismisses the positive, provocative lumber discogram performed by Dr. Patzik and documented by Dr. Erickson. (Rx 3) Dr. Tack's statements that lumbar discography is not an accepted diagnostic procedure and is not considered a reasonable procedure is not adopted given the plethora of IWCC precedent showing idespread use in medical practice. The lumbar discography is only used for diagnostic purposes. Dr. Erickson's recommendation of the lumbar discography to determine to need for lumbar fusion contradicts Dr. Tack's indication that it is a not an accepted procedure. Dr. Patzik's performance of the discography is evidence that such a test is used and performed at a significant medical facility such as Advocate Condell MC. More importantly, the lumbar discography was noted to be specifically positive at L3-L4 with re-creation of the patient's normal chief complaint discomfort.

The Arbitrator finds in this specific case that Dr. Erickson is very much more persuasive than Dr. Tack. Dr. Erickson's opinion and surgical recommendation is supported by the complete medical record and testimony of the worker. His recommendation for a minimally invasion lumbar fusion at L3/L4 is supported by the record and confirmed by a positive finding on discography performed by Dr. Patzik. Thus, based upon the totality of the evidence the Arbitrator adopts the opinion of Dr. Erickson.

Based upon the totality of the evidence, the Arbitrator finds that Petitioner's current condition of ill being in his lumbar spine is causally related to the undisputed work injury of October 5, 2014. In addition, the Arbitrator finds that the recommended lumbar spine surgery recommended by Dr. Erickson is causally related and sequel to the undisputed work injury of October 5, 2014.

17IWCC0147

(K) Temporary Total Disability Benefits:

The Arbitrator's findings with regarding to (F) Causal Connection and the stipulation to an undisputed work accident noted above are incorporated herein.

The Respondent disputed its obligation to pay temporary total disability benefits based upon their reliance on Dr. Tack's opinion as stated in his March 25, 2015 evaluation report and October 5, 2015 addendum report. (Rx 2, 3) Respondent stipulated to Petitioner's temporary total disability from October 21, 2014 through April 15, 2015.

Petitioner was initially restricted from working by the Advocate Condell MC and Dr. Shevlyagin. Dr. Erickson provided a total work restriction while under his care and treatment. Furthermore, Dr. Erickson stated that Petitioner was restricted from working until further notice pending surgery as recommended.

The Arbitrator, having found that Petitioner's condition to be causally related to the undisputed work injury, finds as a matter of fact and a matter of law that Petitioner is entitled to temporary total disability benefits. In addition, the Arbitrator, having found Dr. Erickson's recommendations to be supported by the record and Dr. Tack's opinion to be not persuasive in this particular case , finds Petitioner was temporarily and total disabled for the timeframe as indicated by Dr. Erickson and remains disabled as of the date of the hearing pending surgery.

Accordingly, the Arbitrator based upon the totality of the evidence as a matter of law orders Respondent l pay the Petitioner and his attorney temporary total disability benefits of $253 per week for 60 1/7 weeks, from October 21, 2014 through December 15, 2015, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the Petitioner, the disabling condition was temporary and had not reached a permanent condition, pursuant to Section 19(b) of the Act.

(J) Medical Benefits:

The Arbitrator's findings with regarding to (F) Causal Connection and the stipulation to an undisputed work accident noted above are incorporated herein.

Petitioner submitted medical expenses totaling $15,268.91 in Petitioner's exhibits 2 through 5. Respondent objected to its liability for payment of medical benefits based upon their contention that Petitioner's condition of ill-being was not causally related to the undisputed, October 5, 2014 work injury.

The Arbitrator, having found that Petitioner's condition to be causally related to the undisputed work injury, finds that Petitioner is entitled to payment of the submitted medical expenses.

Petitioner's exhibits included (2) Advocate Condell Medical Center - $1,645.00, (3) Dr. Erickson/American Center for Spine - $1,100.00, (4) Advocate Condell MC - $ 12,031.91, and (5) Dr. Hurh/Advocate Medical Group - $492.00.

The Respondent shall pay to the Petitioner and his attorney the reasonable and necessary medical services of $15,268.91, as provided in Sections 8(a) and 8.2 of the Act.

STATE OF ILLINOIS)	☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF KANE)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Lloyd,

Petitioner,

vs.

NO: 15 WC 19838

Good Call Plumbing,

17IWCC0144

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, temporary total disability, permanent partial disability, medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 1, 2016 is hereby affirmed and adopted.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1.00. 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: MAR 3 - 2017

MB/mas
o: 2/23/17
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LLOYD, MICHAEL
Employee/Petitioner

Case# **15WC019838**

17IWCC0144

GOOD CALL PLUMBING
Employer/Respondent

On 7/1/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0222 GOLDBERG WEISMAN CARIO
JAMES B HARDY
ONE E WACKER DR 38TH FL
CHICAGO, IL 60601

0210 GANAN & SHAPIRO PC
JOHN A MORRIS
210 W ILLINOIS ST
CHICAGO, IL 60654

17IWCC0144

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Michael Lloyd
Employee/Petitioner

v.

Good Call Plumbing
Employer/Respondent

Case # **15** WC **19838**

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 **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Geneva**, on **June 13, 2016**. After reviewing all of the evidence presented, the undersigned Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the 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 14, 2015, Respondent *was* operating under and subject to the provisions of the Act conferring jurisdiction in Illinois.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did not* sustain an accident that arose out of and in the course of employment as explained *infra*.

Timely notice of this accident *was not* given to Respondent as explained *infra*.

Petitioner's current condition of ill-being *is not* causally related to the accident as explained *infra*.

In the year preceding the injury, Petitioner earned $59,335.64; the average weekly wage was $1,141.07.

On the date of accident, Petitioner was 57 years of age, *married* with no dependent child.

Petitioner *has* received all reasonable and necessary medical services as explained *infra*.

Respondent *has* paid all appropriate charges for all reasonable and necessary medical services as explained *infra*.

Respondent shall be given a credit of $0 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits (i.e., mileage expenses), for a total credit of $0.

Respondent is entitled to a credit of $0 under Section 8(j) of the Act.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner has failed to establish that he sustained a compensable accident as claimed. Thus, all remaining issues are rendered moot and Petitioner's claim for benefits is denied.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

June 30, 2016
Date

JUL 1 - 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Michael Lloyd
Employee/Petitioner

v.

Good Call Plumbing
Employer/Respondent

Case # **15** WC **19838**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute at this hearing include accident, notice, causal connection, Respondent's liability for certain unpaid medical bills, Petitioner's entitlement to a period of temporary total disability benefits commencing on June 12, 2015 through July 20, 2015 as well as the nature and extent of the injury. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background

Michael Lloyd (Petitioner) testified that on May 14, 2015 he was employed by Good Call Plumbing (Respondent) and had been so employed for approximately 2-2 ½ months when he alleges that he was injured at work. Petitioner testified that he had no abdominal injuries or hernias before date of accident and he has no subsequent injuries.

May 14, 2015

Petitioner testified that on May 14, 2015, he was doing kitchen remodeling and mainline rodding work for Respondent at a particular residential project. Earlier in the week, Petitioner testified that he performed rodding jobs, mainline rodding jobs (including at least one in a basement), kitchen remodels, and some service calls to homes. He explained that mainline rodding involves rodding a sewer line with a big machine and there was always an apprentice with him. Petitioner testified that they would carry the machine that weighs roughly 200-300 pounds downstairs, although sometimes he lifted this machine on his own.

Petitioner testified that he did not lift the machine himself on May 14, 2015; he lifted it with Dan Ristau (Mr. Ristau). He explained that he noticed some discomfort in his lower right side groin area and noted the pain at the end of his shift. Petitioner testified that he had difficulty walking around 2:00 p.m., and he did not know why. On cross examination, Petitioner testified that two days prior to his injury he was lifting a sewer rodding machine. He also testified that on cross examination that he did not tell anyone on May 14, 2015 that he was injured because no one was available.

The following day, on May 15, 2015, Petitioner testified that he noticed slightly more discomfort while walking. Petitioner testified that he did not work on this day because he was not needed at work. Then on Saturday, Petitioner testified that he felt more pain in the groin area and he noticed a bulge or protrusion. Petitioner then sought medical treatment on Sunday, May 17, 2015.

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party.

Medical Treatment

Petitioner testified that he sought medical care at Rush Copley Medical Center on Sunday, May 17, 2015. He explained that he gave a history to a nurse and doctor that he was injured at work when he lifted a machine while doing some kitchen work. Petitioner added that he wanted this history documented so that there was no dispute.

The Rush Copley records reflect that he presented to the "emergency department complaining of a bulge to the right groin. He states it is not painful. He noticed it only last night for the first time. He also reports the last 2 days he was lifting a 200 pound machine out of someone [sic]. Patient denies any nausea or vomiting, diarrhea, urinary incontinence or any fevers or chills. He denies any similar problems in the past." PX1. The nursing notes reflect Petitioner's report that "patient noticed a soft lump in the right groin area. states he noticed the lump 2 days ago. states it is only painful when he walks a lot or presses on it. Will defer assessment to Dr. Parkes. Patient denies other complaints." *Id.* The triage notes reflect Petitioner's report that he noticed the lump in his right groin area yesterday. *Id.* The emergency room physician diagnosed Petitioner with a right inguinal hernia and imposed work restrictions including no straining or lifting until the hernia was surgically repaired. *Id.*

Conversation with Mr. Mendel & Application for Adjustment of Claim

Petitioner testified that he was scheduled to work on Monday, May 18, 2015. He explained that he went to work that morning and started at 7:30 a.m. Petitioner testified that he went to see the owner, Steve Mendel (Mr. Mendel), and Mr. Ristau was also present. According to Petitioner, he told Mr. Mendel that he was injured, but that it was not "real bad" so he did not know if it was something that he needed to address. Petitioner also testified that he did not know at that point whether his hernia was something that he needed to address at the time of the accident, but that his pain got progressively worse over the weekend. Petitioner testified that he told Mr. Mendel that he was at the emergency room the day prior and that he had been hurt the previous Thursday lifting a machine, although he was not sure exactly what time of day it occurred. Petitioner testified that he also gave Mr. Mendel a copy of the emergency room work restrictions. Petitioner testified that Mr. Mendel told him that they would be able to accommodate him. Petitioner explained that he told Mr. Mendel about the accident so that there was no problem going forward.

Petitioner filed his original Application for Adjustment of Claim on June 24, 2015. RX2. The date of accident is listed as May 21, 2015. *Id.* When asked about the accident date on cross examination, Petitioner testified that he did not see that this was the identified accident date, but acknowledged that he signed the form. Petitioner later filed an Amended Application for Adjustment of Claim on September 18, 2015 noting May 14, 2015 as the accident date. PX6.

Continued Medical Treatment

Petitioner then followed up with a general surgeon a week later, Allen Bloom, M.D. (Dr. Bloom) on June 1, 2015. Petitioner testified that he gave a history and told Dr. Bloom that his hernia happened at work. Specifically, Petitioner testified that he told Dr. Bloom that he was hurt at work while lifting a machine and he knew that he had a hernia because he was told as much at the emergency room. Petitioner testified that he told Dr. Bloom that he was injured the previous Thursday[2]. On cross examination, Petitioner denied that he told Dr.

[2] May 28, 2015.

Bloom that he was injured on May 21, 2015. Petitioner also testified that Dr. Bloom also asked him how he was going to get paid. On cross examination, Petitioner also disagreed with the notes reflected in Dr. Bloom's records. He testified that if he was not in pain, he would not have gone to the emergency room.

Dr. Bloom's medical records reflect Petitioner's report "that he injured himself at work on May 21. He had the next day, Friday, off and went to the Copley urgent care in Yorkville complaining of pain. He was diagnosed with a right inguinal hernia. The patient is a plumber and does heavy lifting. He has had no previous hernia repairs. He has had no previous abdominal surgery. His only surgery is a benign tumor removed from his scalp." PX2. After an examination, Dr. Bloom diagnosed Petitioner with a right inguinal hernia and recommended a right inguinal hernia repair. *Id.* Petitioner testified that Dr. Bloom imposed work restrictions and they were accommodated by Respondent.

Employment Termination

Petitioner testified that he is no longer working for Respondent. On his last day of work, Petitioner testified that he was called into the office and spoke with Mr. Mendel. He testified that he asked the "office lady" about medical insurance, but Mr. Mendel acted like he did not know about it. Petitioner testified that this conversation took place on a Monday or Tuesday before his surgery. He explained that Mr. Mendel addressed his work performance, which had nothing to do with his insurance question. Thereafter, Petitioner did not continue to work with Respondent although he was still working in an accommodated job at this point.

Continued Medical Treatment

On June 25, 2015, Petitioner underwent the recommended hernia surgery at Rush Copley Medical Center. PX1. Post-operatively, Dr. Bloom imposed the same work restrictions. Petitioner testified that he had two post-operative visits with Dr. Bloom and that he was released back to full duty work on June 30, 2015.

Steven Mendel

Steven Eric Mendel (Mr. Mendel) testified that he is Respondent's president and owner, and has been in such a position since the spring of 2007. Mr. Mendel testified that he performs plumbing, does bidding, oversees jobs, and delegates work. He explained that he has also performed every type of plumbing job required of Petitioner.

Mr. Mendel testified that Petitioner worked for him for a short time. He applied for a job and Mr. Mendel went over all job duties with Petitioner including those required in kitchen remodels, bathroom remodels, and occasional commercial remodels. Mr. Mendel testified that Petitioner told him that he would be able to teach an apprentice, etc.

Petitioner began working for Respondent on April 22, 2015. Mr. Mendel testified that Petitioner wore an older brace for back support about which he inquired within Petitioner's first week of work. Mr. Mendel testified that he believed that Petitioner had a hernia before he started working for him because he wore this old brace. Not much longer after noticing it, Mr. Ristau told Mr. Mendel that Petitioner told him (Mr. Ristau) that he was wearing a brace because he had a hernia.

Respondent offered into evidence daily time cards completed by his employees and identifying material lists on work orders. RX1. On May 14, 2015, Petitioner was working on a bath remodel and he installed a fiberglass sink and cabinet in a garage and put a small outside faucet in the garage. Mr. Mendel testified that they had to

move pipes around to accomplish these tasks and that the "rough-in" stage of the bathroom remodel would only require Petitioner to carry tools, PVC and copper piping—items that could be carried in a bag. Mr. Mendel explained that Petitioner would only have to lift 10-20 pounds to perform these tasks on that day. In addition, Mr. Mendel testified that Petitioner would not have lifted 200 pounds at any point during the week of May 14, 2015. See RX1.

Mr. Mendel also testified that Petitioner did not do main rodding. He explained that the main rodding machine weighed about 200 pounds and it took hours of training to run it. Mr. Mendel testified that only he and his son are would run the machine and Petitioner would never have been sent to a job to run that machine or lift it. Moreover, Mr. Mendel testified that Petitioner never rodded any drains for his company.

Petitioner's last date of work was June 12, 2015. Mr. Mendel testified that Petitioner's employment was terminated. Mr. Mendel explained that he called Petitioner into the office to go over Petitioner's work duties and told him that he was unable to handle the work given to him to Respondent's standards. At the end of the conversation, Mr. Mendel testified that he told Petitioner that it had nothing to do with his hernia, but Petitioner should have told him about it when he started. Mr. Mendel also testified that there are a lot of plumbing jobs that can be done for less than 30 pounds of lifting and he felt betrayed by Petitioner's actions.

Mr. Mendel could not recall the exact date of the conversation, but he explained that he spoke with Petitioner on one occasion and told him to go to the doctor. Petitioner took a Friday off, which he believed would have been Friday, May 15, 2015. Mr. Mendel testified that Petitioner did not tell him how his hernia happened. Mr. Mendel testified that he asked Petitioner about the hernia and how it happened to which Petitioner replied that he did not know and that one day he got out of the shower and his wife noticed a bump.

Mr. Mendel testified that he had conversations with Petitioner about the hernia after Petitioner saw the doctor. One week later, Mr. Mendel testified that Petitioner told him that he was not undergoing the surgery, but he did tell him that he was placed on work restrictions. According to Mr. Mendel, Petitioner said that he could not afford to do the surgery. Mr. Mendel testified that never once during any of the conversations and going through the process did Petitioner tell Mr. Mendel that the hernia happened while working until the day that Mr. Mendel called Petitioner in to tell Petitioner that his work was sub-par.

Dan Ristau

Dan Ristau (Mr. Ristau) is an apprentice plumber. He testified that he has been employed by Respondent for about four years. Mr. Ristau testified that his duties include performing daily tasks related to bathroom and kitchen remodels, etc. As an apprentice, Mr. Ristau is supervised in all of his work.

Mr. Ristau testified that he worked with Petitioner when he was employed by Respondent almost every day. He also worked with Petitioner on May 14, 2015 as reflected in Mr. Ristau's time sheet, which he wrote each day. RX3. According to Mr. Ristau and his May 14, 2015, he and Petitioner were working on a bathroom remodel preparing the area to perform the work they needed to do later including capping waterlines. Mr. Ristau explained that capping waterlines and engaging in this prep work does not involve much other than hand tools and a solder box. Mr. Ristau explained that during the other jobs performed with Petitioner during the week of May 14, 2015, he would not have had to lift 200 pounds or use a mainline sewage rodder. According to Mr. Ristau, he never used this machine with Petitioner. On cross examination, Mr. Ristau testified that carrying a rodding machine was a two-man job.

Mr. Ristau also testified that Petitioner did not tell him that he hurt himself on May 14, 2015 and Petitioner was able to complete all of his work.

Additional Information

With regard to his medical bills, Petitioner testified that either Blue Cross/Blue Shield paid his bills or he paid for services out-of-pocket. The Blue Cross/Blue Shield insurance was his own, and not provided by Respondent. Petitioner also testified that he had no short term disability or State of Illinois benefits.

Regarding his current condition, Petitioner testified that they did a pelvic mesh implant and he has discomfort in the right side groin area. He described pain and discomfort when he stretches or moves.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at the hearing as follows:

In support of the Arbitrator's decision relating to Issue (O), whether Petitioner's claim for benefits related to , the Arbitrator finds the following:

After careful consideration of the record as a whole, the Arbitrator finds that Petitioner failed to establish that he sustained a compensable injury at work on May 14, 2015 as claimed. In so concluding, the Arbitrator notes that the evidence simply does not corroborate Petitioner's contention that he injured himself at work.

An employee's injury is compensable under the Act only if it arises out of and in the course of the employment. 820 ILCS 305/2 (LEXIS 2011). The "in the course of employment" element refers to "[i]njuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work...." *Metropolitan Water Reclamation District of Greater Chicago v. IWCC*, 407 Ill. App. 3d 1010, 1013-14 (1st Dist. 2011). Additionally, Petitioner must establish the "'arising out of' component [which] refers to the origin or cause of the claimant's injury and requires that the risk be connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Metropolitan Water Reclamation District*, 407 Ill. App. 3d at 1013-14 (*citing Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58 (1989)). A claimant must prove both elements were present (i.e., that an injury arose out of and occurred in the course of his employment) to establish that her injury is compensable. *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 910 (1st Dist. 2006).

Petitioner testified that he was assigned to a job requiring him to use a large rodding machine on May 14, 2015. He explained that there was always an apprentice with him, Mr. Ristau, while working for Respondent and that both he and Mr. Ristau lifted the machine on the alleged date of accident. According to Petitioner, it was after lifting the machine that he noticed some discomfort in his lower right side groin area, but he did not know why and there was no one to whom to report the injury. However, the medical records of Dr. Bloom controvert Petitioner's testimony that he was injured on May 14, 2015, the medical records of Rush Copley Medical Center controvert Petitioner's testimony that he was injured while working for Respondent or that he was in significant pain, and the testimony of Mr. Mendel and Mr. Ristau controvert Petitioner's testimony that he lifted or used a 200 pound rodding machine on May 14, 2015 or at any other time during his employment with Respondent.

The emergency room records reflect a nurse noting Petitioner's report that he "noticed a soft lump in the right groin area....2 days ago[, which was] only painful when he walks a lot or presses on it." *Id.* By contrast, a triage note, and the history from the emergency room physician, reflect Petitioner's report that he had a bulge in the right groin area that was "not painful" and that he "noticed it *only last night for the first time*." PX1 (*emphasis* added). At the hearing, Petitioner disputed the accuracy of the emergency room records as a whole and maintained that he was in significant pain when he sought emergency treatment explaining on cross examination that he would not have gone if he was not in significant pain.

Petitioner also took issue with the history noted by his physician, Dr. Bloom. On cross examination, Petitioner denied telling Dr. Bloom that he was injured on May 21, 2015 as reflected in his medical records and maintained that he reported that he was hurt on May 14, 2015. Interestingly, Dr. Bloom's June 1, 2015 progress note also documents Petitioner's report that he was injured the previous Thursday, which would have been May 28, 2015, two weeks after May 14, 2015. Regardless, Petitioner made an unusual effort to underscore his memory of events. He testified that he reported an injury occurring on May 14, 2015 to his medical providers and he knew that he did so because he wanted that fact documented. Petitioner explained that he did not want any dispute (presumably from Respondent) in the future and added that Dr. Bloom asked him how he was going to get paid. Petitioner's notation of the foregoing is not unusual taken alone, but taken in light of the various documented dates of accident (i.e., two days before the emergency room visit, the night before the emergency room visit, on May 21, 2015, or on the Thursday before seeing Dr. Bloom on May 28, 2015) it becomes suspect.

In addition, both Mr. Mendel and Mr. Ristau testified that only Mr. Mendel and his son were allowed to use the rodding machine and that use of the machine required two people. Respondent produced records reflecting the specific jobs to which Petitioner was assigned on May 14, 2015 as well as during that week. Contrary to Petitioner's testimony that he was working with a 200 pound rodding machine on May 14, 2015 or at any time during his employment, Mr. Mendel and Mr. Ristau testified that none of these jobs required Petitioner to lift more than 50 pounds of tools and materials, much less use or lift a 200 pound rodding machine.

Finally, Mr. Mendel's testimony about the conversations he had with Petitioner explains the lack of reference to an injury at work in the emergency room records (which reflect Petitioner's own Blue Cross/Blue Shield insurance as a source of payment), the unusual testimony offered by Petitioner that he consistently reported an injury at work on May 14, 2015 so that it was "documented" as well as Dr. Bloom's concerns about payment for the recommended surgery. Mr. Mendel testified that he spoke with Petitioner after he saw the doctor. According to Mr. Mendel, Petitioner told him that he was not undergoing the surgery because he could not afford it. Mr. Mendel also testified that Petitioner never told him that his hernia occurred at work until the day that he spoke to Petitioner about sub-par work.

After careful consideration of Petitioner's testimony as well as the testimony of Mr. Mendel and Mr. Ristau, and in light of the record as a whole, the Arbitrator finds little credibility in Petitioner's testimony. Based on all of the foregoing, the Arbitrator finds that Petitioner failed to establish that he sustained a compensable injury at work as claimed. Thus, all remaining issues are rendered moot and Petitioner's claim for benefits is denied.

STATE OF ILLINOIS)	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☒ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF)	☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
CHAMPAIGN		☐ PTD/Fatal denied
	☐ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Omar Castro-Ibarra,

Petitioner,

vs. NO: 15 WC 21663

El Torro,

Respondent.

17IWCC0177

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of nature and extent, and being advised of the facts and law, affirms the Decision of the Arbitrator with changes as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission corrects a clerical error at p.5 of the Arbitrator's decision to show that Petitioner sustained permanent partial disability to the extent of 15% (not 20%) loss of use of the right hand pursuant to §8(e)9 of the Act. The Commission notes that this reference appears to be in error given that in the Order of the decision (p.2), the Arbitrator found that Petitioner was entitled to 30.75 weeks (15% x 205 weeks) pursuant to §8(e)9 because the injuries caused 15% loss of use of the right hand.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed 9/7/16, with corrections, 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.

17IWCC0177

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 $11,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 3 2017
o: 1/24/17
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CASTRO-IBARRA, OMAR
Employee/Petitioner

Case# **15WC021663**

EL TORO
Employer/Respondent

17IWCC0177

On 9/7/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.47% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0874 FREDERICK & HAGLE
PHILLIP W PEAK
129 W MAIN ST
URBANA, IL 61801

2871 LAW OFFICES STEVEN PILAND
MARY FLANAGAN-DEAN
1010 MARKET ST SUITE 1510
ST LOUIS, MO 63101

STATE OF ILLINOIS)
)SS.
COUNTY OF Champaign)

17IWCC0177

☐ Injured 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

Omar Castro-Ibarra
Employee/Petitioner

v.

El Toro
Employer/Respondent

Case # **15** WC **21663**

Consolidated cases: **none**

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Urbana, IL**, on **August 11, 2016**. By stipulation, the parties agree:

On the date of accident, **2/19/15**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

On this date, Petitioner sustained an accident that arose out of and in the course of employment.

Timely notice of this accident was given to Respondent.

Petitioner's current condition of ill-being is causally related to the accident.

In the year preceding the injury, Petitioner earned **$31,544.76**, and the average weekly wage was **$606.63**.

At the time of injury, Petitioner was **31** 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 **$4,275.30** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$4,275.30**.

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 $**363.98**/week for a further period of 30.75 weeks, as provided in Section **8(e)9** of the Act, because the injuries sustained caused15 % loss of use of the right hand..

Respondent shall pay Petitioner compensation that has accrued from **2/19/15** through **8/11/16**, 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.

D. Douglas McCarthy

8/31/2016

Signature of Arbitrator

Date

ICArbDecN&E p.2

SEP - 7 2016

Findings of fact

Petitioner, Omar Castro-Ibarra, was employed as a cook for the Respondent, El Toro. The Petitioner's job duties include preparing food, cutting food, and grilling food. He is still employed by the Respondent.

On February 19, 2015, the Petitioner cut his right hand while taking out the trash. He is right hand dominant. The Petitioner was seen in the emergency room at Carle Hospital after the occurrence (PX A). He was treated for a right hand laceration which was cleaned and sutured (PX A, p. 5). He was advised to follow up with a hand specialist due to the possibility of tendon involvement (PX A, p. 5).

The Petitioner followed up with Dr. Clifford Johnson on February 20, 2015 in the Carle Hand Surgery Clinic (PX D, p. 1). Dr. Johnson diagnosed a right hand laceration with zone 3 laceration of the flexor digitorum superficialis (FDS) and flexor digitorum profundus (FDP) to the index finger and possible nerve injury (PX D, p. 3). He recommended surgical exploration and repair (PX D, p. 3).

Surgery took place on February 25, 2015 (PX B & C). The operative note reveals that Dr. Johnson removed a deep foreign body (glass) from the palm of the Petitioner's right hand (PX C, p. 1). Dr. Johnson was also able to retrieve the stumps of the lacerated FDP and FDS tendons, and reattached the ends of the FDP tendon achieving excellent coaptation of the tendon ends (PX C, pp. 2-3). He then performed an identical repair for the FDS tendon (PX C, p. 3). No nerve injury was identified (PX C, p. 2).

The Petitioner completed physical therapy from March 3, 2015 through his discharge from care on July 2, 2015 (PX E). At the time of discharge, the Petitioner still had reduced grip strength in the right hand as compared to the left hand (PX E, p. 54). He also had not yet gotten to full range of motion (PX E, p. 54). In terms of grip strength, the Petitioner was able to increase his grip strength in his right hand to 36.6 pounds, but this was far short of the goal to increase the grip strength to 65 pounds (PX E, p. 54). In terms of range of motion, the Petitioner had gotten up to 231 degrees, which was 9 degrees short of the goal of 240 degrees of total active motion of the right index finger (PX E, p. 54).

The Petitioner followed up with Dr. Johnson on May 21, 2015 (PX D, pp. 23-24). At that point, her reported doing well and had no pain (PX D, p. 23). He was released to normal work and instructed to work aggressively on scar massage (PX D, p. 24). He returned for his final visit with Dr. Johnson on July 2, 2015 (PX D, pp. 25-26). Petitioner reported to Dr. Johnson that he had no pain and near full function (PX D, p. 25). He was able to do all of his normal work activities (PX D, p. 25). On examination, Dr. Johnson found that the Petitioner was able to make a full fist, but still had tightness in terminal flexion (PX D, p. 25). He was released to full activity without restriction (PX D, p. 26).

Petitioner was seen for an AMA impairment rating on March 10, 2016. The AMA impairment rating was performed by Dr. Robert Gordon (RX 1). On examination, the Petitioner was found to have diminished grip strength of the right as compared to the left hand (RX 1, p. 5). Dr. Gordon also noted three scars about the Petitioner's right palm between the second and fourth metacarpals (RX 1, p. 4). The length of the scars were 5.5 cm, 2.5 cm, and 3 cm (RX 1, p. 4). The Arbitrator notes that such scarring was visible on observation at trial, and that these scars are accurately represented in Petitioner's Exhibit F. Dr. Gordon's examination of the Petitioner was otherwise normal (RX 1).

As part of the AMA impairment rating process, the Petitioner also filled out a *Quick*DASH form (RX 1, p. 11). The Petitioner testified that this form is still accurate. The form reveals that the Petitioner has mild difficulty in doing heavy household chores and recreational activities, and has moderate difficulty in carrying a shopping bag or briefcase and using a knife to cut food (RX 1, p. 11). The Petitioner also indicated on the form that he generally has no pain or tingling, but does have moderate symptoms of both when cramping occurs while working and grasping.

Dr. Gordon gave a final total impairment rating of 6% of the right index finger, which equates to 1% of the right hand, which equates to 1% of the right upper extremity, which equates to 1% of the whole person (RX 1, p. 7).

The Petitioner testified that he returned to work without restrictions on May 28, 2015. He testified that his right hand cramps at work with carrying heavy objects and gripping a knife or spoon to cut and flip food. He still has the visible scarring on the palm of his right hand and described feeling a "little ball" on his tendon that he has to massage. When his hand cramps, he can feel this lump more. He described needing to massage his hand from 30 seconds to one minute when it cramps. The hand will sometimes cramp one or two times in a shift, although he can go a full shift without the hand cramping at all, depending upon his activities at work. He has a hand intensive job, and when he is not at work, he does not normally have pain in the hand.

The Petitioner further described having some limitation in his ability to extend the fingers of his right hand compared to his left hand, and that his right hand grip strength is weaker than his left hand, so he tries to do heavy tasks with his left hand instead.

Conclusions of Law

The only issue in this case is the nature and extent of the Petitioner's right hand injury. In terms of permanent partial disability, the Arbitrator notes that the Petitioner testified that he has some ongoing issues with his right hand, including reduced grip strength, slightly limited range of motion, permanent scarring, cramping, and occasional pain. He normally does not experience pain, but does experience cramping and pain with certain work activities and will stop to massage a knot in his right hand.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of 1% of right hand as determined by Dr. Robert Gordon, pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. (RX 1). 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 substantially diminished grip strength in the right hand as compared to the left hand, along with three scars in the palm of the right hand. Despite this deficiency, the rating system used by Dr. Gordon did not consider the grip strength as part of the computation. The Arbitrator gives lesser weight to this factor, as it does not appear the Guides have a section which could adequately consider the Petitioner's grip loss.

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 cook at the time of the accident and that he was able to return to work in his prior capacity as a result of said injury. The Arbitrator notes that the Petitioner's job requires frequent use of his hands, and occasionally causes his hands to cramp requiring the Petitioner to periodically massage a knot in his right hand. Because of the ongoing effect of the Petitioner's job duties on his hand symptoms, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 31 years old at the time of the accident. Because of the length of time that the Petitioner is expected to experience symptoms in his right hand as a result of his job duties, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that no evidence was presented as to any impact on the Petitioner's future earnings capacity as a result of this injury. Because of this, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the operative report revealed two lacerated tendons in the right hand requiring surgical

reattachment and coaptation. The records also reveal that the Petitioner still has three distinct scars in the right hand of substantial size. The records further reveal that the Petitioner has slightly diminished total range of motion and significantly limited right hand grip strength. The Petitioner's ongoing complaints of cramping and pain in the hand with certain grasping activities, and needing to occasionally massage the scar on his hand, makes sense in light of these findings. Indeed, the medical records reveal that one of the purposes of physical therapy was to work on scar massage (PX D, p. 24). As stated above, both his physical therapist, upon completion of his formal therapy on July 2, 2015 and Dr. Gordon, on March 10, 2016 found significant decreased grip strength when compared to his non-dominant left hand. Because of evidence of ongoing disability 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 right hand pursuant to §8(e)9 of the Act.

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

JAY E. MCCULLOUGH,

Petitioner,

vs. NO: 15 WC 29904

SPACE AGE CONSTRUCTION,

17IWCC0183

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 employment, accident, medical expenses, prospective medical, and temporary total disability benefits, and being advised of the facts and applicable law, clarifies but otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all of the testimony, exhibits, pleadings, and arguments submitted by the parties.

Petitioner filed timely review and a Statement of Exceptions wherein he argued the applicability of the Employee Classification Act. 820 ILCS 185. His argument was subsequently raised during oral arguments on March 14, 2017. Accordingly, the Commission writes to address the argument raised. Specifically, the Commission writes to clarify the Arbitrator's Decision as the Arbitrator did not specifically comment on Petitioner's claim that he was an employee and not an independent contractor pursuant to the Employee Classification Act.

17IWCC0183

The purpose of the Employee Classification Act is "to address the practice of misclassifying employees as independent contractors." 820 ILCS 185/3. Section 10 of said Act pertains to applicability, and provides two subsections that define when an individual performing services would not be considered an employee of the contractor:

> (b) An individual performing services for a contractor is deemed to be an employee of the contractor unless it is shown that:
>
> 1. the individual has been and will continue to be free from control or direction over the performance of the service for the contractor, both under the individual's contract of service and in fact;
>
> 2. the service performed by the individual is outside the usual course of services performed by the contractor; and
>
> 3. the individual is engaged in an independently established trade, occupation, profession or business; or
>
> 4. the individual is deemed a legitimate sole proprietor or partnership under subsection (c) of this Section.

820 ILCS 185/10(b).

The Commission will address the preceding factors in order. First, the Commission finds no evidence that Respondent controlled the manner in which Petitioner performed his work on August 19, 2015. Petitioner stated he did work as "directed and told by Space Age." (T.8). He testified that Respondent (through its job superintendent, John Park) asked him to assist his co-workers in various tasks; Mr. Park told him what needed to be done. (T11; T.13-14). However, although Respondent directed or instructed Petitioner on what needed to be accomplished, there was no evidence as to Respondent directing the performance or manner by which the work was to be accomplished.

Second, as to the service performed by Petitioner in relation to the general business of Respondent, the Commission finds Respondent hired Petitioner because he was a skilled excavator. He was needed for this particular contract at Walmart. Respondent's projects did not always require an excavator, and Petitioner was not always hired for its excavation work. (T.51-52). Petitioner also testified that his relationship was not exclusive to Respondent because he was free to bid on any job for any employer or company. (T.26). In this regard, the nature of Petitioner's work did constitute a separate business, not an integral part of Respondent's business nor was it intimately related. Ware v. Indus. Comm'n, 318 Ill. App. 3d 1117, 1125 (1st Dist. 2000).

17IWCC0183

Subsections 10(b)(3) and 10(b)(4) of the Employee Classification Act relate to Petitioner's engagement as an independently established trade or acting as a legitimate sole proprietor. Petitioner testified he owned and operated JM Excavating on his own and had no employees. (T.24-25; T.32-33). The Commission finds Petitioner submitted a worker verification certification to Respondent, in which he indicated that he was a subcontractor and his employer was JM Excavating. (T.27-28; RX2). Petitioner was not required to and did not complete a formal employment application. (T.29). Petitioner's Exhibit 8 details the bids he submitted to Respondent for excavation and storm sewer work in the Walmart project. Petitioner's Exhibit 9 is a set of invoices for work completed by Petitioner on an hourly basis.

Petitioner was paid hourly and sometimes a flat fee depending on the work completed. Instead of weekly timesheets, as required for Respondent's employees, Petitioner submitted invoices on JM Excavating letterhead. (T.31; T.34; PX8; PX9). These invoices included itemizations for labor, reimbursements for material and hotel stays, as well as per diem costs. Petitioner also earned more than Respondent's employees. For example, Petitioner earned $40.00 per hour for his labor, compared to Respondent's employees who earned $12.00 to $25.00 per hour. (T.38; T.48). Additionally, and unlike Respondent's employees, Petitioner received a 1099 tax form at the end of the year from Respondent. (T.30; RX5).

The Commission finds no evidence as to Respondent's ability to discharge Petitioner at will. Their relationship was not exclusive to one another and in fact, Petitioner was free to bid on any job for any employer or company. (T.26).

In addition, the tools or machinery Petitioner utilized on the job were either rented by Respondent (the bobcat) or Petitioner's own equipment, including a track hoe and various hand and power tools. (T.13; T.15; T.35). The Commission notes that a track hoe is a large and heavy piece of equipment used in excavation and construction work.

Section 10(c) of the Employee Classification Act enumerates additional factors to determine whether an individual is a legitimate sole proprietor performing services for a contractor as a subcontractor:

1. the sole proprietor or partnership is performing the service free from the direction or control over the means and manner of providing the service, subject only to the right of the contractor for whom the service is provided to specify the desired result;

2. the sole proprietor or partnership is not subject to cancellation or destruction upon severance of the relationship with the contractor;

3. the sole proprietor or partnership has a substantial investment of capital in the sole proprietorship or partnership beyond ordinary tools and equipment and a personal vehicle;

4. the sole proprietor or partnership owns the capital goods and gains the profits and bears the losses of the sole proprietorship or partnership;

5. the sole proprietor or partnership makes its services available to the general public or the business community on a continuing basis;

6. the sole proprietor or partnership includes services rendered on a Federal Income Tax Schedule as an independent business or profession;

7. the sole proprietor or partnership performs services for the contractor under the sole proprietorship's or partnership's name;

8. when the services being provided require a license or permit, the sole proprietor or partnership obtains and pays for the license or permit in the sole proprietorship's or partnership's name;

9. the sole proprietor or partnership furnishes the tools and equipment necessary to provide the service;

10. if necessary, the sole proprietor or partnership hires its own employees without contractor approval, pays the employees without reimbursement from the contractor and reports the employees' income to the Internal Revenue Service;

11. the contractor does not represent the sole proprietorship or partnership as an employee of the contractor to its customers; and

12. the sole proprietor or partnership has the right to perform similar services for others on whatever basis and whenever it chooses.

820 ILCS 185/10(c).

17IWCC0183

The Commission finds sufficient evidence, as stated above, to conclude that Petitioner was a sole proprietor pursuant to subsections (c)(1), (c)(5) through (c)(7), (c)(9), and (c)(12). The Commissions finds no evidence in the record as to the remaining subsections, namely, (c)(2) through (c)(4), (c)(8), and (c)(10) through (c)(11).

Therefore, this Commission finds Petitioner was not misclassified as an independent contractor. As such, Petitioner failed to establish that he was an employee of Respondent, and the Commission finds no employer-employee relationship existed on August 19, 2015.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed January 26, 2016, is hereby affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

No bond is required for removal of this cause to the Circuit Court by Respondent. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 28 2017

MJB/pm
O: 3/14/17
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

McCULLOUGH, JAY E
Employee/Petitioner

Case# **15WC029904**

17IWCC0183

SPACE AGE CONSTRUCTION
Employer/Respondent

On 1/26/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1157 DELANO LAW OFFICES LLC
CHARLES H DELANO
1 S E OLD STATE CAPITOL PLZ
SPRINGFIELD, IL 62705

0264 HEYL ROYSTER VOELKER & ALLEN
BRADFORD B INGRAM
300 HAMILTON SQ PO BOX 6199
PEORIA, IL 61601-6199

STATE OF ILLINOIS)
)SS.
COUNTY OF ROCK ISLAND)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Jay E. McCullough
Employee/Petitioner
v.
Space Age Construction
Employer/Respondent

Case # **15** WC **29904**

17IWCC0183

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Rock Island**, on **December 21, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☒ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☐ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other

FINDINGS

On the date of accident, **August 19, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent.

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

The Parties stipulated that Petitioner's earnings place him at the maximum rates for permanency and temporary total disability rates.

On the date of accident, Petitioner was **43** years of age, ***single*** with **2** dependent children.

ORDER

The Petitioner failed to prove an employee-employer relationship existed with the Respondent. The Petitioner's claim for benefits is, therefore, denied.

No benefits are awarded herein.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Arbitrator Anthony C. Erbacci

January 19, 2016
Date

JAN 26 2016

FACTS:

The Petitioner testified that he was injured on August 19, 2015 while he was performing work for the Respondent on a job-site at a Wal-Mart in Geneseo, Illinois. The Petitioner testified that he had been performing work at that site for a couple of months prior to his injury and that his injury occurred when he slipped and fell while getting into his track hoe. The Petitioner testified that he had gotten off of a bobcat he was operating and was going to move the track hoe out of the way when he tripped and fell, striking his face on the track hoe blade. The Petitioner testified that he sustained injuries to his face, lip, jaw, teeth and his left knee as a result of the trip and fall. It is not disputed that the incident occurred or that the Petitioner provided timely notice of the injury to the Respondent.

Following the incident, the Petitioner received medical treatment at Hammond Henry Hospital and then St. Francis Medical Center. The Petitioner testified that he received conservative medical treatment for his lip and knee injuries, but underwent surgery to repair his jaw and teeth. The Petitioner testified that he treated with Dr. Hillard-Sembell for his knee and with Dr. Merheb, an oral surgeon for his jaw.

The Petitioner testified that he owns and operates his own business, JM Excavating, and that he has owned and operated this business for approximately 15 years He testified that the nature of his business is mostly excavating and that he owns the track hoe that he was using at the Wal-Mart job-site. The Petitioner testified that the bobcat he was using at that job-site was rented by the Respondent for use at that job site. The Petitioner testified that his business is mostly excavating work and that he gets calls for work from contractors as well as submitting bids for work to contractors. He testified that approximately 50 percent of his work is bid work for contractors and that he does not exclusively do work for the Respondent. The Petitioner testified that he was free to bid on other jobs for other contractors and that he did not have any exclusive relationship with the Respondent.

With regard to his working relationship with the Respondent, the Petitioner testified that he began performing work for the Respondent 2 or 3 years prior to the injury. The Petitioner testified that this work included bid work and that, as part of the bid process, he submitted a Worker Verification Certification which identified himself as the "owner" of JM Excavating and a "subcontractor". He also submitted an Employment Eligibility Verification Application, which also identified him as an employee of JM Excavating. The Petitioner testified that, as part of the bid process, he also completed a Request for Taxpayer Identification Number and provided proof of Liability Insurance for his business, JM Excavating which was a requirement for every Wal-Mart job.

The Petitioner testified that on the jobsite, he received instructions from the Respondent's employees regarding "Just simple things" such as getting the bobcat and bringing rock around and that the Respondent's employees "asked for assistance" in breaking out concrete, saw cutting concrete and taking concrete to the dumpster. The Petitioner testified that he took directions from the Respondent's job superintendent, John Park, and that John Park told him what needed to be done and where it needed to be done at the jobsite. The Petitioner testified that he brought his own track hoe to the jobsite as well as some various hand tools and power tools.

With regard to payment, the Petitioner testified that some of the work he performed for the Respondent would be paid at a negotiated flat fee, and other work was paid at an hourly rate. Regardless of whether the work was hourly or from a bid job, the Petitioner testified that he always submitted invoices on JM Excavating letterhead. He testified that he never filled out a time card, even for the hourly work. The Petitioner also testified that if he was required to purchases materials or rent equipment, he would sometimes charge the materials or fees directly to the Respondent's account or pay them out of his pocket and then submit the charges to the Respondent for reimbursement. The Petitioner testified that his hourly rate was dependent on the type of work being performed. He testified that, for straight labor, he would charge about $40 per hour but if he was using his own equipment, he charged more to compensate him for the use of his equipment. The Petitioner testified that he was always paid by check from the Respondent and that the Respondent made no deductions from his payments for taxes or benefits. The Petitioner testified that the Respondent was always provided him with a Form 1099 at the end of the year.

With regard to the work that was being done on the date of his injury, the Petitioner testified that this work was not part of the original bid for the Geneseo Wal-Mart job. He testified that at the time of his injury, he had substantially completed the work that he had bid on and that he was assisting others with breaking up a concrete ramp in the rear of the building. The Petitioner described the work he was performing as being "another extra on the job" consistent with a change order. The Petitioner further testified that on the date of accident, he was initially utilizing his own track hoe to assist with breaking up the concrete ramp, but the concrete was too thick, so they had to rent a bobcat. The Petitioner testified that he rented the bobcat from Sunbelt Rentals and he charged the rental fees directly to the Respondent's account. He further testified he likely picked up the bobcat and drove it back from the rental center to the job-site utilizing his own truck.

Mike Singleton, the Respondent's owner, testified that he has owned the business for 16 years and acts as a general contractor. He testified that approximately 80 percent of the Respondent's work is managing projects and hiring subcontractors to do the work, and about 20 percent is completed by the Respondent and its employees. He testified that the Respondent has approximately 10 employees at the present time. Mr. Singleton testified that some of the Respondent's employees are paid hourly and others are salaried employees and that the hourly employees are paid anywhere from $12 to $25 per hour.

Mr. Singleton testified that all of the Respondent's employees are subject to a hiring process, which includes filling out an application and completing some training regarding an employee handbook. He testified that the Respondent's hourly employees are paid by check or direct deposit, that their hours are tracked on a timesheet which is required to be completed each week, and that taxes and other deductions are made from the employees' paychecks. Mr. Singleton testified the Petitioner did not go through the employee hiring process and would submit invoices for all of the work that he did, whether it was the result of a bid, a smaller project, or a change order. This was consistent with the Petitioner's testimony that he was not paid on a regular basis, but only after submitting an invoice to the Respondent.

With regard to the Petitioner's work at the Geneseo Wal-Mart project, Mr. Singleton testified that he needed some excavating work done on the project and he asked the Petitioner to provide a bid. The initial bid was for removing dirt, digging for footings, relocating a storm drain and setting

devices in place for erosion control. Mr. Singleton testified that his company does not own any excavating equipment and that for the Geneseo Wal-Mart project they utilized the Petitioner's equipment or rented equipment. Mr. Singleton testified that he does not exclusively use JM Excavating for all of its excavating work but that the Petitioner is a friend, so he usually offers work to him. Mr. Singleton testified that the Respondent did use two other excavators in 2015 which were lined up through bids.

With regard to overseeing the job sites, Mr. Singleton testified that he has superintendents that manage each job. John Parks and Brandon Fanning were the superintendents assigned to the Geneseo Wal-Mart job. Mr. Singleton testified that the Superintendents' job is to make sure everyone is doing their job and to ensure the quality of the work. With regard to the Wal-Mart job site specifically, Mr. Singleton testified that it was a controlled-access sites so, pursuant to Wal-Mart's directive, everyone on the site was required to have a badge to monitor who was on the site.

Mr. Singleton testified that the concrete work that was being done by the Petitioner on the date of his injury was not part of the original bid, but was the result of a change order, which he indicated was not unusual. Mr. Singleton further testified that he does not customarily bid the change orders out if he already has someone on the job that is capable of doing what is requested. Mr. Singleton testified that, in this case, the project owner asked him to tear out additional concrete in the garden center which was not part of the original project. Mr. Singleton testified he spoke with the Petitioner who provided him a verbal price of what he thought it was going to cost to complete the additional work and that he had the Petitioner do this work since it was an additional excavating project. Mr. Singleton further testified that while the work that was being done on the date of accident was part of the change order and outside the scope of the original bid, the original bid work and not yet been completed. He testified that the Petitioner still had some clean-up work that had not been completed.

Mr. Singleton testified that once the Geneseo Wal-Mart project was complete, the Respondent had additional jobs lined up, but there was no further work for the Petitioner. He testified that the Petitioner was not contracted to work on any of those subsequent projects.

The Petitioner testified that he was released by Dr. Hillard-Sembel with regard to his knee but that he continues to treat with Dr. Merheb for his jaw. He testified that he was released to return to work by Dr. Hillard-Sembel on September 30, 2015. The Petitioner testified that he is currently self-employed and that he continues to own and operates his own business, JM Excavating.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (B.), Was there an employee-employer relationship, the Arbitrator finds and concludes as follows:

It is axiomatic that the Petitioner bears the burden of proving all of the elements of his claim by a preponderance of the credible evidence and that the existence of an employee-employer relationship at the time of the injury is an essential element of an award under the Workers' Compensation Act. Based on the testimony and records submitted into evidence, the Arbitrator finds

that the Petitioner has failed to satisfy his burden of proof in the instant matter.

In determining whether an employee-employer relationship exists several factors must be considered. Those factors include the right to control the manner in which the work is done, the method of payment, the right to discharge, the skills required in the work to be done, the ownership/furnishing of tools, materials or equipment used in the work, the relationship of the work performed to the employer's purpose, and the deduction of withholding taxes. No single factor is determinative, but the right to control the manner in which the work is being performed is considered to be the most important factor.

In the instant matter, there is no evidence that the Respondent undertook to control the manner in which the Petitioner performed his work on the date of the accident. The Petitioner merely testified that on the jobsite, he received instructions from the Respondent's employees regarding "Just simple things" such as getting the bobcat and bringing rock around and that the Respondent's employees "asked for assistance" in breaking out concrete, saw cutting concrete and taking concrete to the dumpster. The Petitioner testified that he took directions from the Respondent's job superintendent, John Park as to what needed to be done and where it needed to be done at the jobsite, but he gave no testimony that he was directed or instructed as to how to perform the work. No other evidence was introduced from which it could be concluded that the Respondent controlled the manner in which the Petitioner performed his work.

Further, while the right to control the work is the most important factor in determining an employer-employee relationship, the Arbitrator cannot ignore the other factors:

With regard to the method of payment, the Petitioner was not paid like the Respondent's employees and was paid at a rate far beyond that of the hourly employees. The Petitioner testified to an hourly rate of approximately $40.00 per hour for work without his equipment and a greater amount when he used his equipment. The Respondent's employees were paid between $12 and $25 per hour. Both the Petitioner and Mr. Singleton testified that payment was prompted by the submission of invoices on JM Excavating letterhead, which were not submitted on a regular basis. The Respondent's employees were required to fill out and submit a weekly timesheet and were paid on a specific day each week. Further, both the Petitioner and Mr. Singleton agreed that no taxes were withheld from his payment. The Petitioner was paid in check and was issued a 1099 at the end of each year, unlike the Respondent's employees.

With regard to the right to discharge, both the Petitioner and the Respondent agreed that their work relationship was not an exclusive working relationship. The Petitioner was free to bid for and perform other work and the Respondent had other excavators with which it contracted for work. Further, both the Petitioner and the Respondent agreed that once the job was completed, there was no guarantee for additional work. Each party was free to work with other contractors and/or excavators and there was no evidence of any continued or ongoing business relationship.

With regard to the skills required in the work to be done, the Respondent hired the Petitioner, a skilled excavator, to perform a task wholly within his expertise and within the scope of his business. Mr. Singleton testified that he is a general contractor and bids out all of his excavating projects to contractors skilled in the trade of excavating.

With regard to the ownership/furnishing of tools, materials or equipment used in the work, the Petitioner owned and furnished his own excavating equipment. The Petitioner testified that on the date of accident, he was initially utilizing his own track hoe to assist with breaking up the concrete ramp, but the concrete was too thick, so they had to rent a bobcat. The Petitioner testified that he rented the bobcat from Sunbelt Rentals and he charged the rental fees directly to the Respondent's account. He further testified he likely picked up the bobcat and drove it back from the rental center to the job-site utilizing his own truck. The Petitioner further testified to purchasing other materials as needed, such as rock and seed, and submitting invoices for those expenses for reimbursement.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner failed to prove that an employee-employer relationship existed between the Petitioner and the Respondent.

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds and concludes as follows:

While it is not disputed that an accident occurred on August 19, 2015 while the Petitioner was performing work for the Respondent, the Arbitrator has found that the Petitioner failed to prove that an employee-employer relationship existed between the Petitioner and the Respondent on that date. Thus, the Arbitrator finds that the Petitioner failed to prove that a compensable accident occurred. The determination of the remaining disputed issues is, therefore, moot.

The Petitioner's claim for compensation is denied and no benefits are awarded herein.

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

Andrew Reid,
Petitioner,
vs.

NO: 15 WC 31610

Barton's Staffing,
Respondent,

17IWCC0186

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical care, causal connection, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 15, 2016, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent 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 $5,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 28 2017
o032317
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

REID, ANDREW
Employee/Petitioner

Case# **15WC031610**

BARTON'S STAFFING
Employer/Respondent

17IWCC0186

On 8/15/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1315 DWORKIN AND MACIARIELLO
GERALD F CONNOR
134 N LASALLE ST SUITE 1515
CHICAGO, IL 60602

1505 SLAVIN & SLAVIN LLC
KATHARINE J BARNES
100 N LASALLE ST 25TH FL
CHICAGO, IL 60602

17IWCC0186

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

Andrew Reid
Employee/Petitioner

v.

Barton's Staffing
Employer/Respondent

Case # 15 WC 031610

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **2/19/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **9/2/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$17,994.60**; the average weekly wage was **$346.05**.

On the date of accident, Petitioner was **41** years of age, ***single*** with **1** dependent child.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$0.00**.

Respondent is entitled to a credit of **$0.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner an amount equal to the outstanding medical bills for all reasonable, necessary and related medical services, **$3,283.00**, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$253.00**/week for **20** weeks, because the injuries sustained caused a **4%** loss of use, person as a whole, pursuant to Section 8(d)2 of the Act.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

8/15/2016
Date

AUG 15 2016

Andrew Reid
v.
Barton Staffing

Case #15 WC 31610

Findings of Fact

Petitioner, Andrew Reid, testified that he was employed by Respondent, Barton Staffing, on September 2, 2015. (TX) As of September 2, 2015, Petitioner had been employed in such a capacity for approximately 2 years. (TX)

Petitioner testified that on September 2, 2015, he was moving two machines on a dolly with a co-worker from the sales floor to the back warehouse when the machine he was moving hit the wall and it shook back and smacked him under his right eye causing a laceration. (TX) Petitioner testified his co-worker let the machine hit the wall. (TX)

Petitioner notified Respondent and was directed to speak to the triage nurse at Physicians Immediate Care. (TX) Petitioner testified that he spoke to the nurse for about an hour until 1:30 PM. (TX) Petitioner testified that the nurse told him to come to Physicians Immediate Care so that a doctor could inspect the facial laceration. (TX)

Petitioner testified that after he spoke with the nurse, he left work. (TX) Later that day, Petitioner presented to Physicians Immediate Care and reported to Dr. Kristin Baier that he was moving a machine on a dolly with a co-worker when the coworker went through the door and the machine jerked back and hit him in the face. (RX 1) Petitioner testified that he was truthful and accurate in describing how the injury occurred. (TX)

Petitioner testified that on September 2, 2015, drug and alcohol tests were administered. (TX) Petitioner testified that the alcohol test was administered through the

use of a breathalyzer. (TX) The alcohol test revealed positive results that Petitioner was under the influence of alcohol. (RX 1) Petitioner signed a statement acknowledging the positive results and that he understood he must not drive, perform safety-sensitive duties, or operate heavy equipment. (RX 1) Petitioner was then asked to give a urine sample for the drug test. (RX 1) The drug test also revealed positive results that the Petitioner was under the influence of marijuana. (RX 1) Petitioner testified that the use of alcohol and drugs impairs your movement and balance. (TX) However, Petitioner testified the positive results were due to his stopping at home and smoking a "joint" as well as stopping at a liquor store to purchase and consume a 22-ounce can of beer prior to presenting to Physicians Immediate Care. (TX) Petitioner further testified that smoking marijuana and drinking alcohol was his daily routine. (TX)

Dr. Baier diagnosed Petitioner with an open wound of the face without complications and sprains/strains of neck and back. Petitioner was released to full duty work and directed to follow up on September 4, 2015. (RX 1)

Petitioner followed up at Physicians Immediate Care on September 4, 2015. At that time, it was noted that Petitioner's facial wound was better and his neck was somewhat improved. Petitioner was again released to full-duty work and directed to follow up on September 11, 2015. (RX 1)

Petitioner did not return to Physicians Immediate Care as scheduled, and sought no treatment between September 4, 2015 and September 25, 2015 when he was directed to AMCI-Oak Park Medical Center by his attorney. (TX)

At that time, Petitioner reported he was pushing a 300 pound work out machine on a dolly with another employee when it hit a door frame and caused the machine to

shift backward striking him in the face. (PX 2) Petitioner testified that he was again truthful and accurate in describing how the injury occurred at this visit. (TX) Petitioner also reported that his supervisor had notified him that he had been terminated from his position. (PX 2) Petitioner was taken off work until a follow up evaluation. (PX 2)

Petitioner returned to AMCI-Oak Park Medical Center on October 7, 2015. At that time, Petitioner reported he had started a new job through a temporary agency. Divya Agrawal, M.D., released Petitioner to work to continue his temporary job. (PX 2)

Petitioner initially testified that he did not work from the time he was terminated by Respondent until November 11, 2015 and that he was not working as of October 7, 2015. (TX) On cross-examination, Petitioner testified that he worked on and off at temporary agencies after September 25, 2015 and throughout his treatment. (TX) On re-direct examination, Petitioner testified again that he did not work between September 25, 2015 and November 11, 2015. (TX)

Petitioner treated conservatively at AMCI-Oak Park Medical Center until November 11, 2015. (PX 2) Petitioner testified he has sought no further treatment and is currently working full time. (TX)

Conclusions of Law

C. In support of the Arbitrator's decision regarding whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds as follows:

The burden is on Respondent to show that Petitioner was intoxicated at the time of the accident. Paganelis v. Industrial Comm'n, 548 N.E.2d 1033 (1989).

Pursuant to Section 11 of the Illinois Worker's Compensation Act, "no compensation shall be payable if (1) the employee's intoxication is the proximate cause of the employee's accidental injury or (2) at that time the employee incurred the accidental injury, the employee was so intoxicated that the intoxication constituted a departure from the employment." 820 ILCS 305/11 "Admissible evidence of the concentration of (1) alcohol, (2) cannabis as defined in the Cannabis Control Act, (3) a controlled substance listed in the Illinois Controlled Substances Act, or (4) an intoxicating compound listed in the Use of Intoxicating Compounds Act in the employee's blood, breath, or urine at the time the employee incurred the accidental injury shall be considered in any hearing under this Act to determine whether the employee was intoxicated at the time the employee incurred the accidental injuries." 820 ILCS 305/11

"If at the time of the accidental injuries, there was 0.08% or more by weight of alcohol in the employee's blood, breath, or urine or if there is any evidence of impairment due to the unlawful or unauthorized use of (1) cannabis as defined in the Cannabis Control Act, (2) a controlled substance listed in the Illinois Controlled Substances Act, or (3) an intoxicating compound listed in the Use of Intoxicating Compounds Act or if the employee refuses to submit to testing of blood, breath, or urine,

then there shall be a rebuttable presumption that the employee was intoxicated and that the intoxication was the proximate cause of the employee's injury." 820 ILCS 305/11

In the case at bar, the drug and alcohol testing was conducted at 5:18 p.m., which was nearly nine hours after the piece of machinery struck Petitioner in the face. Respondent presented no witnesses or evidence that indicated Petitioner was intoxicated at work prior to accident. Petitioner's testimony that he consumed marijuana and alcohol after he left the jobsite at 11:30 a.m. stands unrebutted.

Therefore, the Arbitrator finds that Respondent failed to show that Petitioner was intoxicated at the time of the injury. Consequently, the Arbitrator finds that on September 2, 2015, Petitioner sustained an accident that arose out of and in the course of his employment by Respondent.

F. In support of the Arbitrator's decision regarding whether the Petitioner's current condition of ill-being is causally related to a work injury, the Arbitrator finds as follows:

The Arbitrator's findings and conclusions with regard to issue (C) is adopted and incorporated herein.

The Arbitrator finds that Petitioner's current condition of ill-being with regard to his facial laceration and cervical sprain are causally related to the accident. (PX 1, PX 2)

On the date of the accident, Petitioner went to an occupational clinic named Physicians Immediate Care, where the record states:

"The patient presents with a chief complaint of constant laceration of the right cheek since Wed, Sep 02, 2015 at 8:30 AM ... The patient reports it was the result of an injury that occurred on 9/2/15, which was work related ... Patient reports he was moving a machine on a dolly with a coworker, when the coworker went through the door pulling the dolly, and the machine jerked back and hit the patient in the face. This happened

around 8:30 a.m. … Now having tenderness over the cut and some neck stiffness." (PX 1)

Moreover, Petitioner's initial examination at AMCI-Oak Park Medical Center states:

"The patient is a 41 year old right-handed male who presents to my office on September 25, 2015, with primary complaints of right facial pain and neck pain following a work-related incident on September 2, 2015. Mr. Reid was on duty as a Special Projects employee for Body Solid when while he was pushing a 300 lbs. workout machine on a dolly with another employee, it hit a door frame. This caused the workout machine to shift backward, and it struck patient on the right side of his face causing a laceration . . ." Petitioner was diagnosed with contusion of face, scalp and neck excepts eyes, facial laceration, cervical sprain and cervical radiculitis. (PX 2)

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 at 63-64, 442 N.E.2d at 911 (1982)

Therefore, the Arbitrator finds that Petitioner's current condition of ill-being with regard to his facial laceration and his cervical sprain/cervical radiculitis is causally related to the accident of September 2, 2015.

J. In support of the Arbitrator's decision regarding whether the medical services that were provided to Petitioner were reasonable and necessary, and has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

The Arbitrator's findings and conclusions with regard to issues (C) and (F) are adopted and incorporated herein.

At AMCI-Oak Park Medical Center, in addition to evaluation, Petitioner received various modalities including neurostimulation electrodes, therapeutic exercises, hot wet packs, mechanical traction and interferential. (PX 2)

Therefore, the Arbitrator finds, pursuant to Section 8(a) and subject to Section 8.2 of the Act, that Respondent is liable for the following outstanding medical bills for the reasonable, necessary and related medical care that Petitioner received as a result of the September 2, 2015 accident:

Provider	Balance
1. Physicians Immediate Care	$64.00
2. AMCI-Oak Park Med. Ctr.	$3,219.00
TOTAL:	**$3,283.00**

K. In support of the Arbitrator's decision regarding whether the Petitioner is entitled to TTD benefits, the Arbitrator finds as follows:

The Arbitrator's findings and conclusions with regard to issues (C), (F) and (J) are adopted and incorporated herein.

On September 2, 2015 and September 4, 2015, the physicians at Physicians Immediate Care found that Petitioner was fit for duty without restriction.

The records of Dr. Agrawal at AMCI-Oak Park Medical Center (PX 2) show that Petitioner was unable to work from September 25, 2015 to October 28, 2015. From October 28, 2015 to November 11, 2015, Petitioner was placed on light-duty work.

The Arbitrator notes that Petitioner's testimony regarding the time he was unemployed was confusing and contradictory internally as well as with the medical

records. Petitioner initially testified that he was not able to find employment prior to November 11, 2015 when he was finished with treatment. On cross-examination, Petitioner then changed his testimony and admitted he was employed at two temporary agencies after September 25, 2015, and that he worked a week each for the 2 agencies. This testimony is supported by the treatment record from AMCI-Oak Park Medical Center dated October 7, 2015, which states that Petitioner reported being employed at a temporary agency. However, on redirect examination, Petitioner changed his testimony again and testified he was not working between September 25, 2015 and November 11, 2015, but that after November 11, 2015, he worked 3 days for one temp agency, 9 days for another temp agency and 4 days for another temp agency.

As there is documentary evidence that Petitioner was employed at another temp agency after September 25, 2015, and as Petitioner's testimony was confusing and contradictory as to this matter, the Arbitrator finds that Petitioner failed to prove his entitlement to TTD benefits.

L. In support of the Arbitrator's decision regarding the nature and extent of Petitioner's injury, the Arbitrator finds as follows:

The Arbitrator's findings and conclusions with regard to issues (C), (F), (J) and (K) are adopted and incorporated herein.

Section 8.1b of the Illinois Workers' Compensation Act states that for accidental injuries occurring on or after September 1, 2011, permanent partial disability shall be established using the following criteria:

i) The reported level of impairment pursuant to subsection (a);

ii) The occupation of the injured employee;

iii) The age of the employee at the time of the injury;

iv) The employee's future earning capacity;

v) Evidence of disability corroborated by the treating medical records.

No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to factor (i): There was no AMA impairment report entered into evidence by Petitioner or Respondent. Therefore, the Arbitrator gives no weight to this factor.

With regard to factor (ii): Petitioner's unrebutted testimony that the Petitioner is a laborer. The Arbitrator gives moderate weight to this factor.

With regard to factor (iii): The Request for Hearing indicates that the parties agreed Petitioner was 41 years old at the time of the injury. The Arbitrator gives moderate weight to this factor.

With regard to factor (iv): There is no evidence that Petitioner will sustain an increase or decrease in earnings subsequent to the September 2, 2015 accident. The Arbitrator gives no weight to this factor.

With regard to factor (v): As a result of the September 2, 2015 accidental injury, Petitioner was diagnosed with contusion of face, scalp and neck excepts eyes, facial

laceration, cervical sprain and cervical radiculitis. The laceration to Petitioner's right cheek was 2 cm. in length, linear in shape with clean margins and superficial depth.

Petitioner last received treatment for these injuries on November 11, 2015 at AMCI-Oak Park Medical Center. At this visit, on a scale of 0-10, Petitioner reported facial pain of 1 and neck pain of 2. The pain frequency "is better." He also reported stiffness/tightness in his cervical spine. The stiffness "is better." He also reported shooting pain in his left shoulder, which is about the same. Petitioner testified that, presently, he sometimes gets a crook in his neck and pain down the shoulder. The Arbitrator gives major weight to this factor.

Determination of permanent partial disability ("PPD") is not simply a calculation, but is an evaluation of the 5 factors. The Arbitrator has carefully considered all 5 factors. By applying §8.1b and by considering the relevance and weight of all 5 factors, the Arbitrator finds that as a result of the September 2, 2015, accident, Petitioner has sustained a loss of use, person as a whole, of 4%, under Section 8(d)(2), for the cervical sprain and radiculitis.

Brian T. Cronin 8-15-2016

Brian Cronin
Arbitrator

Date

STATE OF ILLINOIS)
) SS.
COUNTY OF LASALLE)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☒ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Diane Brokaw, as mother and next of friend
Zachery Brokaw,

Petitioner,

vs.

NO: 15 WC 33815

Blackhawk Area Council of Boys Scouts,

17IWCC0132

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, burial 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 July 22, 2016 is hereby affirmed and adopted.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1.00. 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: MAR 3 - 2017

Mario Basurto

David L. Gore

Stephen Mathis

MB/mas
o:2/9/17
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
FATAL

BROKAW, DIANE AS MOTHER AND NEXT FRIEND BROKAW, ZACHERY
Employee/Petitioner

Case# **15WC033815**

17IWCC0132

BLACKHAWK AREA COUNCIL OF BOYS SCOUTS
Employer/Respondent

On 7/22/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0202 FRANKS GERKINS & McKENNA PC
HERBERT H FRANKS
19333 E GRANT HWY PO BOX 5
MARENGO, IL 60152

2461 NYHAN BAMBRICK KINZIE & LOWRY
WILLIAM A LOWRY
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

17IWCC0132

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSalle)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
X None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
FATAL

Diane Brokaw, as mother and next of friend Zachery Brokaw Case # **15** WC **33815**
Employee/Petitioner

v.

Consolidated cases: _____

Blackhawk Area Council of Boys Scouts
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 **Christine Ory**, Arbitrator of the Commission, in the city of **Ottawa** on **March 23, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. X 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. X 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. X Other **Burial benefits**

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Diane Brokaw, as Mother and Next Best Friend of Zachery Brokaw Petitioner,	)	**17IWCC0132**
vs.	)	**No. 15 WC 29946**
Blackhawk Council of Boy Scouts Respondent.	)	

ADDENDUM TO ARBITRATOR'S DECISION

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing in Ottawa on March 23, 2016. The parties agree that on June 20, 2005, 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. Whether decedent's death was caused by an accident that arose out of and in the course of his employment with respondent.
2. Whether respondent is liable for funeral expenses in the amount of $8,000.00 limit of the $8,400.75 funeral expenses incurred.

STATEMENT OF FACTS

The parties agree petitioner left no dependents and the claim is limited to the burial expenses to the full amount allowed under §7 (f) of the Act in the amount of $8,000.00.

Parker Bradshaw was called as a witness in behalf of petitioner. Parker, age 16, had been an employee of respondent's camp for one year. Previous to his employment at respondent's camp Parker was a camp counselor at Rainbow Scout Reservation. As camp counselor for respondent, Parker's duties included robotics and merit badges class teacher.

On the day of the occurrence, Parker had gone to his boss, Bruce Small, and asked him for a ride to get some things for himself and the camp. Parker wanted to go to Walmart and the laundromat. As Small was too busy, he suggested Parker go ask someone else. Parker Bradshaw wanted to get prizes at Walmart for the merit badges class. Bradshaw asked the decedent who agree to give him a ride.

Parker could not recall when he and decedent left the camp. He confirmed they went to the laundromat, then went for lunch and then returned to the laundromat to dry the clothes. After that, they went to the Dollar Store. Bradshaw and decedent both made purchases at the Dollar Store; Parker Bradshaw got two prizes, but was not aware of decedent's purchases at the Dollar Store. Parker and decedent left the Dollar Store for Walmart. Parker testified he and decedent did not speak much as Parker slept most of the time he was in decedent's car.

FINDINGS

On the date of accident, **June 20, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Decedent and Respondent.

On this date, Decedent ***did*** 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*** causally related to the accident.

In the year preceding the injury, Decedent earned **$17,160**; the average weekly wage was **$330**.

On the date of accident, Decedent was **20** 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 $ for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

Respondent is entitled to a credit of $ under Section 8(j) of the Act.

The Arbitrator finds that Decedent died on **June 20, 2015**, leaving **No** survivor(s), as provided in Section 7(a) of the Act, including **D/N/A.**

ORDER

The decedent left no dependents, therefore only funeral expenses are awarded.

Burial Expense

Respondent shall pay the funeral expense limit of $8,000.00 to petitioner, Diane Brokaw, for funeral expenses of the decedent.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Christine M Ory
Signature of Arbitrator

07/12/2016
Date

JUL 22 2016

On the way to Walmart, they crashed into another driver. Parker was severely injured; he broke his arm, leg and ankle. Parker was hospitalized for two to three days at Rockford Memorial Hospital. Parker testified he signed out from the camp and to his knowledge so did the decedent.

On cross examination Parker testified he was told by Bruce Small to find someone else to take him. Parker Bradshaw does not recall giving a statement to Officer Patrick Bodmer on June 21, 2015. Parker Bradshaw remembered leaving the camp about 10:00 A.M., but does not recall returning to the camp at 11:10 A.M. after going to the laundromat. Parker did not wake up until after the accident occurred. Parker never saw decedent's [buy/find] list (PX.4).

Joy Bradshaw, mother of witness, Parker Bradshaw, testified in behalf of petitioner. Joy Bradshaw has been a Cook County Deputy Sheriff for 19 years. While Joy Bradshaw was with her son at the Rockford hospital, Don Kinney, scout executive CEO handed Joy Bradshaw his card. Kinney told Joy Bradshaw he was glad Parker Bradshaw had signed out so they knew where he was. Joy Bradshaw does recall a State Trooper coming to her son's room on June 21, 2015.

Petitioner, Diane Brokaw, testified in her own behalf. Petitioner read her son, the decedent's, obituary. Petitioner confirmed her son had been a counselor at Lowden for four years. The petitioner described the decedent as one who liked to make lists of almost anything, including birds he had seen, people he met, money he earned and spent.

On the day after the accident, friends of the petitioner picked up the decedent's personal affects. With the affects, was a list of things decedent had to buy/find and also a list of things to do for June 18 and 19, as well as June 20 and June 21 (PX.4). On the day of the accident, his list included shop for materials. Petitioner testified she often drove her son, the decedent to and from the camp as she did not like to leave her vehicle at the camp and also because decedent often slept as he was worked as much as 90 hours a week and was very tried.

Bruce Small was called as a witness for respondent. He is a retired teacher. He has been respondent's the camp director for 35 years. He knows Parker Bradshaw as he was hired as handicraft instructor for the summer 2015. Parker came to Small looking for a ride to get some personal items. Small advised Parker that he was not able to do take him until later in the evening as he was very busy. To Small's knowledge, Parker had not signed out before the accident occurred.

Small testified that decedent was employed as the nature ecology director for the camp. By contract, a counselor was off as of noon on Saturday and remained off work until Sunday at noon. Small believed this is noted in the Camp Lowden Staff Notebook. According to Small, the decedent had not signed out before he left.

Small did not authorize decedent to leave the camp and did not ask the decedent to leave the camp. Small heard about the accident when he received a phone call from the petitioner. Small did not believe that it was possible that he decedent was dead as Small believe the decedent was still in the camp. Small checked the sign out sheet and saw Parker's and decedent's name on the sheet which would indicate they were still in camp. A few days after the accident, when another counselor went to the laundromat, she retrieved laundry that belonged to decedent and Parker.

Small identified the buy/find list purportedly made by the decedent which contained various items as a list he had seen when decedent approached him at Small's counter. Small agreed to reimburse decedent for the items; with the requisite that decedent obtain a separate receipt and told the decedent "just don't bankrupt me".

To the best of Small's knowledge, decedent was on his own time at the time of the accident as decedent did not have to be on the clock until Sunday at noon. Small identified the camp staff handbook which provided the period of sessions which included the period from June 14 through June 19 as staff week and then from June 21 through June 27 as Session #1 (RX.1).

Small identified a document which provides information regarding the [counselors] contract. It explains what a counselor is to wear and when, and confirming the counselors are to wear their uniform until all troops have left camp on Saturday. The document states the check in time for counselors are at noon on Sunday and provides counselors are to be in uniform and ready to meet the troops by 1:30 on Sunday afternoon. (RX.2)

On cross-examination Small agreed respondent's exhibit number 2 was in effect when the campers had arrived and did not apply the week before they are getting ready for the campers. Small agreed decedent was an excellent employee. Small agreed decedent was his own boss in the area of the camp decedent was responsible as he was the nature ecology director. Small agreed that a few items on decedent's list were some things decedent needed to buy that were not at the camp already.

Small agreed that by contract counselors are not required to work from Saturday at noon until Sunday the counselors live there so are available and do work from Saturdays and Sundays. Small agreed decedent had to do everything to get his area ready for the campers even if it was during the period decedent was not obligated to work. Small agreed he most likely reimbursed decedent for items decedent had purchased for the camp in the past.

Small further testified that usually respondent lets the counselors go the Friday night before the camp starts, but as they were behind all counselors voted to stay and work on Saturday as they had a huge first week attendance. According to Small decedent would be on his own as of 11:00 A.M. on Saturday. Small confirmed the time of death per the autopsy report was 1:55 P.M. on [Saturday] June 20, 2015. Small agreed decedent would not knowingly avoid following the policies of respondent's camp.

Small confirmed respondent did not start taking in campers until Sunday, June 21, 2015. The week before was a preparation week.

CONCLUSIONS OF LAW

C. Did an accident occur, which resulted in decedent's death, arise out of and in the course of Decedent's employment by Respondent.

The undisputed facts are that the decedent was killed in accident on June 20, 2015 at 1:55 P.M. The decedent, as the camp's nature ecology director, had the permission of camp director,

Bruce Small, to purchase necessary items to set up his area for the camp which was to start on June 21, 2015. Small confirmed the decedent was an excellent employee, was his own boss in his responsible area, which was the nature and ecology center, and decedent had to do everything to get his area ready for campers even if it was during the period decedent was not obligated to work. The decedent, as a list maker, had completed a buy/find list which included some items that Small agreed was not available at respondent's camp (PX.4). Also, the decedent indicated on his "to do" list for Saturday, June 20 he was to shop for materials (PX.4).

Small also confirmed that although the counselors were usually done the Friday night before camp starts, all counselors agreed to work on Saturday as there was a lot of work to be completed due to a huge first week camp attendance. Small also agreed that the handbook applied when the camp started and not the week before (PX.2).

Also, not in dispute, co-worker, Parker Bradshaw was a passenger in decedent's vehicle at the time of the accident and suffered severe injuries. Parker and Small agreed that Parker had approached Small to ask for a ride to get some things for himself and for the camp. Specifically, Parker was looking for prizes for merit badges. It is also agreed that decedent and Parker first went to the laundromat before going to the Dollar Store and then on to Walmart. On the way to Walmart, the accident occurred.

The conflicting evidence is whether Small advised Parker to find someone else to take him to Walmart and the laundromat or whether Small advised he would drive Parker later. The evidence is also not clear as to when Small and decedent had the conversation about the necessary purchases on decedent's list.

Also, in conflict is when the decedent was officially "off the clock" on June 20, 2015. Small agreed they were behind in preparing the camp for the official start of the first session which was to start the day after the accident. Small did not explain why he believed decedent was on his own as of 11:00 the day of the accident. Small also agreed that the handbook, which called for departure of the counselors by noon on Saturday, only applied when camp was in session.

The evidence supports a finding the decedent and Parker were on their way to Walmart to purchase items that were to be used for respondent's camp. Tacitly, the trip was at Small's direction as Small testified decedent had to do everything to get his area ready for the camp, which was to start the next day, even if it was at a time decedent was not obligated to work. Furthermore, Small's testimony that he advised Parker he was too busy that day to take him to the laundromat and Walmart and would take him that evening conflicts with Small's testimony that Parker [and decedent] should be on their own as of 11:00 A.M.

It is not clear from the evidence whether the decedent and Parker were obligated to sign out, or whether they signed out, when they departed for the laundromat, Dollar Store and Walmart. The sign out sheet was not submitted into evidence. Regardless, whether the decedent or Parker signed out does not appear to be relevant as to whether both were in the course of their employment with respondent. Only the purpose of the trip and whether the trip to Walmart was a foreseeable risk. The Arbitrator finds the risk was foreseeable, based upon Small's testimony, that decedent was to do what is necessary to get his area ready for the camp that was to start the next day, which would include a trip to Walmart to purchase the required items.

For the aforementioned reasons, the Arbitrator finds the decedent was killed in an accident which arose out of and in the course of his employment with respondent.

O. Is respondent liable for the burial expenses pursuant to the limit of $8,000.00, pursuant to §7 (f) of the Act?

The Arbitrator awards the funeral expense to the limit of $8,000 in accordance with §7 (f) of the Act.

STATE OF ILLINOIS)	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
C0OUNTY OF LAKE)	☒ Reverse Accident	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kevin Lowy,

Petitioner,

vs. NO: 15 WC 38451

Lake Cook Plumbing Services,

17IWCC0151

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, temporary total disability and penalties, reverses the Decision of the Arbitrator, for the reasons stated below.

Petitioner, a 27 year old service technician plumber, testified that he began working for Respondent on 10/5/15. (T.11). He indicated that on 11/23/15 he was "... working under the kitchen sink [of a customer] and [he] was on [his] knees. [He] got up once or twice to go to the truck. [He] came back and [he] continued working on [his] knees. [He] was underneath the kitchen sink and [he] got up and [he] went to turn to go get another part out of the truck. As [he] got up [he] turned and [he] felt, like, this pop in [his] [right] knee. And from that point [his] knee has been not the same and reportedly it has a torn meniscus. [He] ha[s] not been able to walk the same since." (T.12-13). He noted that following the incident he "... really had a sharp pain. [He] wasn't able to walk right. [He] had to keep [his] knee bent at pretty much 90 degrees the whole time. [He] was not able to extend it." (T.13). He stated that he continued to work through the pain for another hour or so and completed the job. (T.13). He noted that after he left the residence he pulled down the street and called the service manager and then returned to the shop and informed his boss, Steve. (T.14).

Petitioner testified that before the above incident he had "... had a little stiffness over the weekend from working two days on [his] knees, but that was just a day or two after the Friday,

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which may have been the 21st, [he] believe[d], was the Friday beforehand. So around the 22nd it was pretty much gone. Just stiffness and soreness." (T.15). When asked whether he reported this stiffness and soreness to his employer, Petitioner responded: "[n]ot at that time. On the 23rd when I came back my boss asked me, Steve asked me what – how did this happen, and I told him I wasn't really sure, but I kind of told him that maybe it was because I had been working on my knees for two days straight that Thursday and Friday before, and that could have been the reason for it, but I wasn't sure." (T.15).

When asked to explain the difference between the stiffness he felt on the 21st and the pain in his knee after he felt the pop, Petitioner testified that "[t]he stiffness was just a day and it was just when [he] went – when [he] got home that night [he] just – [he] laid down on [his] bed and walking was a little stiff and [he] just laid down on [his] bed and [he] kind of had that little – not numbness, but just a stiffness. And when [his] knee popped on the 23rd it was – it was one of the worse pains [he] ever felt. It was just sharp. [He] couldn't walk. Throbbing. And just that pop. And [he] ha[s] not been able to walk since." (T.15-16). He also noted that "[i]f [he] step[s] a certain way [he] get[s] a sharp pain in the inside of [his] right knee…" (T.16). Petitioner denied having any difficulty walking prior to the 11/23/15 event. (T.17).

Petitioner estimated that when he goes to a private residence "[a]t least 85 percent of the calls you have to get down on your knees and look under the kitchen sink or any sinks. A lot of plumbing is down low", and that "[a] good majority [of the work at private residences] are kitchen sink calls." (T.17-18).

Petitioner testified that he had gone into his employer's shop prior to the incident and was not having any problems with his right knee at that time. (T.18). He denied reporting any difficulty walking on the right knee at that time, and indicated that if he had had difficulty walking or straightening his right knee that morning he would not have gone to the residence to work. (T.19).

Petitioner indicated that following the incident, and after he returned to his employer's shop, he sought treatment with Dr. John Stamelos at Buffalo Grove Orthopedic Associates who recommended an MRI of the right knee and that he remain off of work. (T.19). Petitioner underwent an MRI, as well as x-rays, of his right knee on 11/23/15. (T.19-20).

In an office note dated 11/23/15, Dr. Stamelos recorded that Petitioner's chief complaint was "[a]cute injury right knee resulting in pain and difficulty with extension since Friday, November 21, 2015." (PX1). Dr. Stamelos noted that Petitioner was a new patient who "… works as a plumber. He just started a new job. He is on a probationary period. He was doing a lot of kneeling for industrial plumbing. He did not have knee pads but was working long hours on Friday and then today and felt immediate discomfort. In fact he could not extend his knee fully. There is difficulty putting pressure on the area… Denies any direct injury otherwise. Past medical history is remarkable as four years ago had a motor vehicle accident where he was a passenger and had hit the dashboard with his knee and he had a significant traumatic pre-patellar hematoma requiring multiple aspirations. At that point he had an MRI scan which showed no injury and then according to patient he then could not explain this recurrent pre-patellar hematoma. He now presents with an acute onset of pain with difficulty extending the knee

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following a kneeling episode..." (PX1). Dr. Stamelos' impression was patella tendonitis traumatic pressure versus possible incomplete old patellar tendon tear near the infrapatellar region. (PX1). Dr. Stamelos took Petitioner off work for the next 10 days, advised him to get knee sleeves without a patella buttress and ordered an MRI scan. (PX1).

An MRI of the right knee dated 11/23/15 was interpreted by Dr. Resham R. Mendi as revealing a "[c]omplex, bucket-handle type medial meniscal tear with an oblique flap component involving the posterior horn and body. There is associated joint effusion and synovitis." (PX1). In an Addendum to the MRI dated 11/24/15, Dr. Mendi noted that "[t]he patellar tendon is normal in contour without evidence of tendinosis or tear. The quadriceps tendon is also intact." (PX1).

Petitioner returned to Dr. Stamelos on 11/25/15 at which time it was noted that "...for further clarification of his history, his previous injury from a motor vehicle accident occurred to his left knee and that was four years ago, so it was not his right knee. As for the right knee, even though he was doing a lot of kneeling and squatting at work and worked ten hours in one day on Thursday and Friday, it was Monday, November 23, 2015 when he was at a customer's home doing plumbing work when he was squatting and then when he came up, he felt a pain. He could not straighten his knee out. It was witnessed by the owner of the home and he went back to the office and then reported it to his employer at that time..." (PX1). Dr. Stamelos noted that the MRI confirmed that Petitioner had a large bucket handle tear of the medial meniscus, which he noted "... is consistent with a meniscal tear that was probably aggravated by his Thursday/Friday work activity and then when he got up and squatted on Monday it tore completely and he had a buckle handle extrusion that completely locked his knee..." (PX1). Dr. Stamelos concluded that "[a]t this point, this is consistent with his work related injury. Advised him to get back to his employer to obtain an authorization to proceed with arthroscopic meniscectomy. In the meantime, he can work with restrictive duties with sedentary office work. He cannot do squatting, kneeling and no more than 10 pounds of carrying or lifting..." (PX1).

Petitioner testified that he returned to Dr. Stamelos on 11/25/15 at which time the latter recommended surgical repair of his right knee and gave him light-duty work restrictions. (T.20). However, he noted that after notifying his employer about those restrictions his employer did not accommodate same. (T.20).

Petitioner indicated that he also visited Dr. Marc Breslow at Illinois Bone & Joint on 11/25/15 for a second opinion. (T.21). He noted that Dr. Breslow likewise recommended that he undergo surgery for his right knee. (T.21).

In a Progress Note dated 11/25/15, Dr. Breslow recorded that Petitioner "...works as a plumber. He had complaints related to his right knee prior to the date of incident on 11/23/15, he was working kneeling fixing plumbing at a client's house and then when he got up he felt a sudden onset of pain in his right knee, felt a sharp pain and pop. Now, he cannot straighten his knee all the way. It has not been the same since. No prior or new complaints... Saw another physician who ordered x-rays and MRI and was found to have a meniscus tear. There has been a discussion about surgical treatment. He is here for a second opinion." (PX2). Following his examination and review of the medical record, Dr. Breslow recommended an arthroscopic

meniscectomy, possible meniscus repair. (PX2).

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Petitioner returned to Dr. Breslow in follow up on 1/13/16. (T.21). In a letter dated 1/13/16, Dr. Breslow noted that Petitioner injured his knee at work, suffered a displaced buckle-handle tear of his meniscus and recommended a right knee arthroscopic partial medial meniscectomy, possible meniscus repair. (PX2).

Petitioner testified that since 1/13/16 he has not had any further treatment for his right knee, including the right knee surgery recommended by both Drs. Stamelos and Breslow. (T.21-22). Petitioner indicated that he would still like to have this surgery. (T.22).

Currently, Petitioner notices that his right knee is weak and that he "... still can't extend it. With it being winter, if [he] step[s] on a piece of ice wrong and [his] foot kind of turns, [he] get[s] a terrible sharp pain on the inside. Walking up stairs is difficult. Pretty much your daily routine, without having your right knee or with it disabled, is affected." (T.22). He also noted that he has difficulty with "[w]orking, sports, exercise" and that he does not "... risk shoveling the driveway in case [he] slip[s]. [He] can clean dishes. Anything standing with light, you know, light weight [he] can pretty much do. [He] can't get on [his] knee to look under [his] bed to find something." (T.22-23).

Petitioner testified that he has been off work completely from 11/24/15 through arbitration, 1/21/16, and that he has not received any workers' compensation payments during that time. (T.23). Petitioner also testified with respect to the out-of-pocket expenses he has paid for, the receipts for which were later admitted at PX4A-C. (T.24-25).

On cross, Petitioner indicated that the alleged accident occurred on 11/23/15 at a customer's house in Lake Zurich. (T.26). He agreed that he was at the residence to fix the sink, and that he saw the customer at the hearing site on the date of arbitration. (T.27). He noted that when his knee popped it happened in the kitchen and that the customer was "... in the kitchen with [Petitioner] the whole time. He was on the phone a lot of the time, on a conference call." (T.27). Petitioner indicated that he told the customer about his knee, stating that "... I told [the customer] as I was walking, I was limping, and he was looking at me, and I told him, 'I don't know what happened, but my knee is messed up. I can't walk anymore.' And he said, 'Yeah, I can tell.' And then he handed me over two pillows to kneel on to see if that would help. I ended up not using the pillows because it really didn't help my pain." (T.28). When asked whether his knee soreness from the previous week had pretty much gone away, Petitioner corrected counsel and said "[t]he weekend." (T.28). Petitioner also denied having any problems with his right knee in the past, only "... a left-knee drain problem." (T.29).

Along these lines, a review of the medical record shows that on 6/3/11 Petitioner presented with complaints of left knee swelling following a motor vehicle accident one month earlier, that he was diagnosed with prepatellar bursitis of the left knee and treated conservatively, including the drainage of fluid, and released PRN by Dr. Breslow on 11/9/11. (PX2).

Furthermore, the record shows that on 1/17/02, as a high school freshman, Petitioner visited Dr. Robert Patek with complaints of anterior right knee pain worse with kneeling, running

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and jumping-type motions for approximately five to seven weeks. (PX2). It was noted that there was no specific injury to the knee either now or in the past. (PX2). The diagnosis was Sinding-Larsen-Johansson syndrome, which the Commission notes is a form of juvenile osteochondrosis or inflammation of the bone at the bottom of the patella due to overuse and not trauma. (PX2). Petitioner was prescribed conservative treatment including non-steroidal anti-inflammatory medication, home stretching exercises and icing, as well as possible formal physical therapy. (PX2).

Petitioner returned to Dr. Patek on 2/24/04, as a high school sophomore, reporting that he was in good health until approximately two weeks ago when he fell a few times while playing basketball, injuring the anterior aspect of his right knee. (PX2). X-rays showed that his growth plates were still open, but there was no fracture or dislocation, and were otherwise unremarkable. (PX2). Dr. Patek's impression was 1) bilateral anterior knee pain, patellofemoral in nature, and 2) patellar tendinitis. (PX2). Petitioner was prescribed formal physical therapy for quadriceps strengthening, told to avoid "... squatting, kneeling, bench presses, etc., for the next three to four weeks" and instructed to "... follow up with Dr. Patek in in six to eight weeks' time if he is no better." (PX2). There is no evidence that Petitioner followed up with Dr. Patek thereafter for this condition.

When asked whether he currently played sports, Petitioner responded: "[b]asketball, softball. Now. I played more in the past. I played multiple sports growing up. But as of today, this year, last year, just basketball and softball." (T.29). Petitioner acknowledged that he was playing in a men's basketball league and that "[i]t is going on right now. It's in the fall and winter for basketball." (T.30). However, Petitioner claimed that "[i]f the league was going on [and having games the weekend before his incident on 11/23/15], [he] was not playing." (T.30). He noted that "[i]t's a Thursday night basketball league, and right before [his] injury [he] had recently joined a night class for a plumbing class for extra help and that was Thursday nights, so I wasn't able to continue this session of this season." (T.30-31). In fact, Petitioner denied playing any sports at all over the weekend before 11/23/15. (T.31).

Petitioner denied that when he saw Dr. Stamelos on the day he felt his knee pop, and had an MRI, that the MRI had already been scheduled before then. (T.31). Petitioner also agreed that he was not eligible for group health insurance at the time of the accident, but noted that he is active now. (T.31). However, he has not submitted any of the bills to his group insurance carrier. (T.32). He indicated that he believed his employer paid half of the premium on his group health insurance with Land of Lincoln. (T.32).

On re-direct, Petitioner testified that he has not played any sports or worked since he heard the pop in his right knee on 11/23/15. (T.32).

At the request of Respondent, Craig Herriges was called to testify. (T.33). Mr. Herriges noted that he lives at the residence in question and that in November [2015] he hired Respondent to fix some bad pipes. (T.35). He indicated that before he contacted Respondent he did not know anyone who worked there or any of the owners. (T.36). Instead, he noted that he had used them one time before, and agreed that he did not have a personal relationship with anyone at Lake Cook Plumbing. (T.36).

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Mr. Herriges testified that he had a plumber come out to his house during the week of Thanksgiving and that that individual was Petitioner. (T.36-37). He noted that "[i]t might have been [a] Wednesday", but he could not remember. (T.37). When asked whether he noticed anything unusual about Petitioner when he got to his house, Mr. Herriges testified "[n]ot at first." (T.37). Instead, he noted that "[w]hen [Petitioner] came to the door he made his introduction and came into the house." (T.37). He noted Petitioner "... was putting on his booties" and that he did not notice him limping "... right away." (T.38). However, Mr. Herriges indicated that he noticed Petitioner limping "[a]s he walked into my kitchen." (T.38). Mr. Herriges testified that "[a]t some point" Petitioner "... said that his knees were in pain" and that "[h]e said he had been hurt playing basketball." (T.38). Mr. Herriges agreed that he gave Petitioner a pillow or two and that the latter finished the job. (T.38-39).

Mr. Herriges testified that he did not observe anything occur in the kitchen while Petitioner was working on the sink that would indicate he had some kind of accident, and that he did not believe Petitioner mentioned anything about his knee popping at that time. (T.39). When asked whether anything happened while Petitioner was at his house, Mr. Herriges responded: "[n]o." (T.39). Mr. Herriges agreed that at some point he received a call from an insurance company, and that "[t]hey wanted to know if [Petitioner] had been hurt at [Mr. Herriges'] house." (T.39). He indicated that he gave a statement to the insurance company, and that someone from Respondent, possibly the owner, contacted him before the insurance company and asked if anything happened at his house. (T.40).

On cross, Mr. Herriges agreed that when Petitioner was working on the pipes in the kitchen he was squatting or kneeling under the sink. (T.40-41). He indicated that he was not staring at Petitioner the entire time that he was squatting and kneeling. (T.41). Mr. Herriges also agreed that he was actually on the phone, making a conference call, during the time Petitioner was working. (T.41). Thus, he agreed that it was fair to say that he was paying more attention to what he was saying on the phone than what Petitioner was specifically doing. (T.41). He also indicated that while he did not observe anything that would be an accident, he did not know for sure whether or not Petitioner popped his knee. (T.41-42).

When asked whether Petitioner specifically mentioned when he was playing basketball, Mr. Herriges replied: "I thought he said the night before. I don't know...", but that he did not remember "... if it was the night before or when." (T.43). He also indicated that "[i]t was pretty much right away" that Petitioner told him about the pain in his knee. (T.43). Mr. Herriges agreed that Petitioner went back and forth between his truck and the kitchen to get parts. (T.44). He noted as well that Petitioner was able to put booties on his feet when he first arrived and "[e]very time he went in and out." (T.44).

Mr. Herriges denied that defense counsel told him how to testify when they met prior to the hearing. (T.44). Instead, he noted that they talked about "[h]ow long it was going to take" and "[t]he meter that [Mr. Herriges] had to fill." (T.45). He also indicated that the only check he received was in relation to the subpoena. (T.45). In addition, Mr. Herriges denied that he has a financial stake in the case, noting that he had no idea whether Petitioner could sue him "for premises liability" if the accident was not work related and stating that he has renter's insurance.

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(T.45-47).

On rebuttal, when asked whether he would be able to put booties on his feet today with his knee condition, Petitioner testified that "[i]t's a lot more difficult to bend over than normal." (T.50). He also denied playing any basketball the night before the accident, on 11/22/15. (T.50). When asked when was the last time he played, Petitioner replied: "I believe it was last winter the year before, because as the new session started it was right when my new plumbing class had started, which was on the same day, so I wasn't able to join that session." (T.51). He noted that the winter session ended in March, and that he did not join the session starting up around October; thus, "[n]o basketball" from March 2015 until the date of the alleged accident on 11/23/15. (T.51). He also denied ever having any surgery on his right knee. (T.52).

On surrebuttal, Petitioner denied that he played basketball that wasn't part of a league, such as pick-up games. (T.53). Instead, he indicated that his basketball playing [before March of 2015] was limited to "... [o]nce a week on Thursday nights. Two sessions [a year]." (T.53-54). He testified that as far as exercise is concerned, he goes to the gym to work out when he can. (T.53). When asked what he does at the gym when he works out, Petitioner testified "[l]ift weights. I don't do any treadmill or cardio. I just lift weights." (T.53).

On further rebuttal, Petitioner denied that he was participating in a basketball league at the time of the accident. (T.54). He also noted that since he felt the popping in his knee on 11/23/15 he has not performed any exercises, including lifting weights. (T.54).

Based on the above, and the record taken as a whole, the Commission reverses the decision of the Arbitrator and finds that Petitioner failed to prove by a preponderance of the credible evidence that he sustained accidental injuries arising out of and in the course of his employment on 11/23/15. The Commission finds Petitioner's testimony as to the circumstances surrounding the alleged accident not to be credible based on the testimony of Mr. Herriges, the customer who was present at the time of the alleged incident. Mr. Herriges credibly testified that he did not observe anything occur in the kitchen while Petitioner was working on the sink that would indicate he had some kind of accident, and that he did not believe Petitioner mentioned anything about his knee popping at that time. (T.39). Mr. Herriges also testified that he noticed Petitioner limping "[a]s he walked into [his] kitchen" and that at some point Petitioner "... said he had been hurt playing basketball." (T.38). The Commission notes that Mr. Herriges would appear to have no discernible reason to provide misleading or incorrect testimony in this case, given that he has no known interest, either personal or financial, in its outcome or any obvious ties to the Respondent, and in light of the fact that he apparently rented the property in question and had renter's insurance.

The Commission further finds, in light of the above finding, that Petitioner failed to prove that a causal relationship exists between the alleged accident on 11/23/15 and Petitioner's current condition of ill-being.

Therefore, the Commission finds that Petitioner's claim for compensation and penalties is denied, and the Arbitrator's award for temporary total disability, medical expenses and prospective medical treatment is hereby vacated.

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IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 3/7/16 is hereby reversed and compensation is denied.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 10 2017
o:1/10/17
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

LOWY, KEVIN
Employee/Petitioner

Case# **15WC038451**

17IWCC0151

LAKE COOK PLUMBING SERVICES INC
Employer/Respondent

On 3/7/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0154 KROL BONGIORNO & GIVEN LTD
MICHAEL BRANDENBERG
120 N LASALLE ST SUITE 1150
CHICAGO, IL 60602

2837 LAW OFFICES JOSEPH MARCINIAK
ROBERT P SABETTO
2 N LASALLE ST SUITE 2510
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

17IWCC0151

☐ Injured 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)

Kevin Lowy
Employee/Petitioner

v.

Lake Cook Plumbing Services, Inc.
Employer/Respondent

Case # **15** WC **38451**

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 **Gregory Dollison**, Arbitrator of the Commission, in the city of **Waukegan, Illinois**, on **January 21, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **November 23, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$6,357.12**; the average weekly wage was **$963.20**.

On the date of accident, Petitioner was **27** years of age, ***single*** with **0** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $642.13/week for 8 & 3/7 weeks, representing the period commencing November 24, 2015 through January 21, 2016, as provided in Section 8(b) of the Act.

Respondent shall pay to Petitioner reasonable and necessary medical services of $2,120.00 under Sections 8(a) and 8.2 of the Act for the following unpaid medical bills: Buffalo Grove Orthopedic Associates - $225.00, Bright Light Radiology -$1,655.00, and Illinois Bone & Joint Institute - $240.00.

Respondent shall pay to Petitioner $830.00 reimbursement from the sum of the awarded bills for out-of-pocket payment for medical treatment related to this accident.

Respondent shall authorize the prospective medical treatment recommended by Dr. Stamelos on November 25, 2015 and Dr. Breslow on January 13, 2016. Specifically, Petitioner is awarded an arthroscopic meniscectomy with possible meniscal repair, and all incidental care thereto.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

3/1/16
Date

ICArbDec19(b)

MAR 7 - 2016

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FINDING OF FACTS:

At the time of the alleged accident, Kevin Lowy ("Petitioner") was a 27-year-old service technician plumber with Lake Cook Plumbing Services, Inc. ("Respondent"). He began working for Respondent on October 5, 2015. His job duties as a service tech plumber included maintaining a work truck and going from home to home and fixing any leaking pipes, water heaters, or any other plumbing issues. He testified that over 85% of the work he performed at homes requires him to kneel down or squat. A good majority of the work he does takes place under kitchen sinks.

Petitioner testified that on November 23, 2015, he was sent by Respondent to a private residence at 47 Caroyln Court in Lake Zurich, Illinois, where he was asked to work underneath a kitchen sink. Petitioner testified that he was able to put "booties" on his feet right when he arrived at the residence. Petitioner testified that he had to work on his knees underneath the sink and made several trips to get parts from his truck. Petitioner stated that after working for approximately one hour or more, he arose from his kneeling position under the sink to go get a part from his truck. As he did so, he turned his right knee and felt a pop, followed by immediate sharp pain. Petitioner indicated he immediately had difficulty walking and was unable to fully extend his right knee.

Petitioner testified that the customer was present in the kitchen the entire time he worked on the sink and that said customer "...was on the phone a lot." Petitioner testified that at the time of the occurrence he informed the customer that he hurt his knee. Petitioner provided that the customer offered him two pillows for his knees which he did not use because the "pillows didn't help my pain." Petitioner indicated that he continued to work through the pain and after completing the job, he called his supervisor Ben and reported the pop in his knee. Thereafter, he returned to Respondent's shop within five minutes and reported the accident to his boss, Steve.

On the same day of the alleged accident, Petitioner was examined by Dr. John Stamelos at Buffalo Grove Orthopedic Associates. Dr. Stamelos records indicate Petitioner reported an acute right knee injury resulting in pain and difficulty since Friday, November 21, 2015. In the history portion Dr. Stamelos noted Petitioner "...was doing a lot of kneeling for industrial plumbing. He did not have knee pads but was working long hours on Friday and then today and felt immediate discomfort. In fact he could not extend his knee fully..." Dr. Stamelos noted a prior injury to his knee from a motor vehicle accident and "...he now presents with an acute onset of pain with difficulty extending the knee following a kneeling episode." Upon examination, the right knee was tender in the infrapatellar region of the right patella tendon and there seemed to be an incomplete attachment of the medial aspect of the patellar tendon. There was no pitting edema or effusion. X-rays revealed no fracture. Active extension was limited above -10 degrees with pain. Dr. Stamelos's impression was patella tendonitis traumatic pressure versus possible incomplete old patellar tendon tear near the infrapatellar region. The doctor ordered a right knee MRI and took Petitioner off work. (PX 1)

Petitioner underwent an MRI of his right leg at Bright Light Radiology on November 23, 2015. The exam revealed a complex, bucket-handle type medial meniscal tear with an oblique flap component involving the posterior horn and body. There was associated joint effusion and synovitis. The patellar tendon was normal without evidence of tendinosis or tear. The quadriceps tendon was intact. (PX 1)

Petitioner followed up with Dr. Stamelos on November 25, 2015. Dr. Stamelos clarified that Petitioner's previous injury from a motor vehicle accident was to his left knee. He further clarified that Petitioner's right knee injury occurred on November 23, 2015 when Petitioner was getting up from doing plumbing work in a squatting position. Upon examination, the right knee could not fully extend and there was a slight flexed knee

gait. Dr. Stamelos diagnosed Petitioner with a complex tear of the posterior body and posterior horn of the right medial meniscus with radial component and large flipped fragment in the intercondylar notch consistent with a bucket handle type tear. Dr. Stamelos opined that Petitioner's condition is consistent with his work-related injury. He opined that Petitioner's knee was probably aggravated by work activity on Thursday and Friday, and the meniscus tore completely when he got up from working under the kitchen sink on Monday, November 23, 2015. Dr. Stamelos recommended that Petitioner undergo an arthroscopic meniscectomy and restricted him to sedentary office work with no squatting, kneeling, and no lifting over ten pounds. (PX 1)

On November 25, 2015, Petitioner was examined by Dr. Marc Breslow with Illinois Bone and Joint Institute for a second opinion. Petitioner reported a sudden onset of right knee pain while getting up from kneeling to fix plumbing on November 23, 2015. The doctor noted Petitioner had some right knee complaints prior to that date, but reported a sharp pain and pop occurring on November 23, 2015. He noted Petitioner has not been able to fully straighten his right knee since and has trouble with walking, running, and climbing stairs. Upon examination, the right knee had a 5-degree lack of extension with pain. Flexion of the right knee was to 120 degrees, with pain beyond that. Dr. Breslow reviewed the MRI and diagnosed Petitioner with a right knee displaced bucket handle tear of the medical meniscus. He recommended that Petitioner undergo an arthroscopic meniscectomy with possible meniscus repair. (PX 2)

Petitioner followed up with Dr. Breslow on January 13, 2016. Upon examination, the right knee showed minimal effusion, medial joint line tenderness, and a 5-degree lack of extension. Dr. Breslow again diagnosed Petitioner with a displaced bucket-handle tear of the right meniscus at work. He recommended that Petitioner undergo a right knee arthroscopic partial medial meniscectomy with possible meniscus repair. (PX 2)

Petitioner testified that prior to feeling the pop in his right knee on November 23, 2015 he had felt some stiffness in his right knee from working long hours while kneeling. He reported that stiffness to his employer the week prior to the accident. Petitioner testified that the stiffness had subsided by November 22, 2015. He further testified that the stiffness he felt was completely different from the sharp pain he felt after his knee popped on November 23, 2015. Petitioner stated that he reported to Respondent's shop the morning of November 23, 2015 for a meeting, and was not having any problems with his right knee or difficulty walking at that time. He testified that he would not have gone to work at the residence if he was having difficulty walking on his right knee or straightening it. He has never had any surgery performed on his right knee.

Petitioner testified that he currently has difficulty walking and cannot fully extend his right knee. He gets sharp pains on the inside of his right knee if he steps on ice and his foot slides. He has difficulty walking up stairs and has to take one step at a time with both feet, leading with the left foot. He does not shovel the driveway at home in order to avoid slipping. He is limited to performing standing chores, but cannot perform tasks such as bending down to look for items underneath his bed. Petitioner testified that he has been unable to work, play basketball or softball, or lift weights since the accident on November 23, 2015.

Petitioner testified that he had not played basketball of any kind since March of 2015. He stated that he only plays in organized leagues that meet on Thursday nights from the Fall through the Winter. He testified that he had been unable to play in the current league because he takes a plumbing class on Thursday nights. He has not played any "pick-up" or non-organized basketball outside of the league. He was not playing basketball or any sports the weekend before the accident occurred.

Respondent called Craig Herreges ("Herreges") as a witness at the hearing. He testified that he lives at 47 Carolyn Court in Lake Zurich, Illinois. He identified Petitioner as a plumber who came to work on his kitchen sink in November, just prior to Thanksgiving. He had used Respondent's plumbing service once before. Herreges testified that he did not notice anything when Petitioner first came to his door, other than he put "booties" on his shoes right away. Herreges later testified that he noticed a limp when Petitioner arrived to start

the job. He testified that at some point after Petitioner began working, Petitioner informed him that he had pain in his knees. Herreges then testified that Petitioner reported the pain right away. He testified that Petitioner told him his knee was hurt playing basketball, possibly the night before, but he did not know for sure when Petitioner had last played basketball. Herreges gave Petitioner pillows to work on, and Petitioner finished the job.

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Herreges testified that, other than Petitioner moving from the truck to the kitchen sink, nothing else happened to Petitioner. He agreed that Petitioner had to be in a squatting or kneeling position to work under his kitchen sink. He testified that he did not observe anything that would be an accident. He agreed that he was not looking at Petitioner the entire time he worked. He testified that he was on the phone in a conference call while Petitioner was working in the kitchen and that he was paying more attention to the phone call than to what Petitioner was doing. He agreed that he did not know for sure whether an accident had occurred. Herreges further testified that Respondent's business owner spoke to him and he later gave a statement to Respondent's workers' compensation insurance carrier. Respondent did not present a copy of the statement made by Herreges to the insurer.

With respect to (C.) DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT, the Arbitrator finds as follows:

Petitioner testified that, on November 23, 2015, he was sent by Respondent to work on the kitchen sink at a residence located at 47 Carolyn Court, Lake Zurich, Illinois. As he worked on the sink, he moved several times from a kneeling position under the sink to his truck to get parts. After over approximately one hour of working, Petitioner moved to get up from kneeling under the sink to go to his truck for a part when he turned his right knee and felt a pop. Immediately after feeling the pop, he felt a sharp pain in the right knee, had difficulty walking on that leg, and could not fully extend the right leg. He informed Herreges that he had pain in his right knee and Herreges went to get him pillows to kneel on. Per Petitioner's uncontradicted testimony, after finishing the job he immediately reported the accident to his supervisor, Ben. He then drove straight back to Respondent's shop and reported the accident to his boss, Steve.

The medical records are consistent with this history. Specifically, Petitioner was examined by Dr. Stamelos and underwent an MRI of his right knee the same day of the accident. He gave a history of an acute onset of right knee pain while fixing plumbing on November 23, 2015. Petitioner gave the same history to Dr. Breslow two days later. Both doctors found that Petitioner suffered a work-related meniscus tear when he came up from working under the sink.

Petitioner acknowledged, in both his testimony and his treating medical records, that he had felt some general stiffness in his knees from extended kneeling while working a few days prior to November 23, 2015. However, he testified that the stiffness had mostly resolved by November 22, 2015 and that the pain he felt after his right knee popped was completely different stating, the pain was "one of the worst pain I felt."

Respondent's witness, Herreges, gave inconsistent testimony with regard to Petitioner's accident. He testified that he did not notice anything about Petitioner when he showed up to his house, but also testified that Petitioner was limping when he arrived. Herreges testified that Petitioner complained of knee pain "at some point" after working, but then testified that Petitioner complained of pain right when he arrived. He also confirmed that Petitioner was able to put on "booties" when he first arrived. Herreges testified that he did not observe anything that would be considered an accident, but then admitted that he was not observing Petitioner the entire time he was working and he was paying more attention to his conference call at that time. Herreges testified that he could not say for sure whether or not Petitioner had an accident while working.

Herreges claimed that Petitioner told him he hurt his right knee playing basketball, possibly the night before. However, Petitioner gave very specific testimony that he only played league basketball, and the last league he played in ended in March of 2015. He testified that he has not played any basketball since March of 2015. Petitioner testified that he was not playing in the league when the accident occurred on November 23, 2015 because the games only took place on Thursday nights and he took plumbing classes on Thursday nights. Petitioner testified that he was not playing any sports the weekend prior to November 23, 2015.

Per Petitioner's uncontradicted testimony, his job duties included traveling to private residences to fix any plumbing issues. The majority of the work he performed involved working under kitchen sinks. Respondent's dispatcher instructed Petitioner to work at 47 Carolyn Court, Lake Zurich, Illinois on November 23, 2105. Both Petitioner and Herreges testified that Petitioner had to work in a squatting or kneeling position to reach the kitchen sink plumbing on November 23, 2015. Petitioner's right knee turned and popped as he was getting up from under the sink to get a part from his work truck.

The Arbitrator has reviewed the evidence and the testimony of the witnesses. The Arbitrator finds Petitioner's testimony to be more persuasive than Herreges's testimony. The Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of Petitioner's employment with Respondent on November 23, 2015.

With respect to (F.) IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, the Arbitrator finds as follows:

Petitioner testified that, prior to the accident on November 23, 2015, he was not having any problems with his right knee other than some stiffness which had resolved by November 22, 2015. Immediately after he turned his right knee and felt a pop while getting up from working under a kitchen sink, he felt sharp pain, difficulty walking, and inability to fully extend his right knee. Petitioner testified that the pain in his right knee after feeling the pop was different and worse than the stiffness he had felt prior. Petitioner testified that he had never had surgery on his right knee before.

The medical records are all consistent with this history. On the same day of the accident, Petitioner's reported an acute right knee injury to Dr. Stamelos. On November 25, 2015, Petitioner was diagnosed by Dr. Stamelos with a complex tear of the posterior body and posterior horn of the medial meniscus with radial component and large flipped fragment in the intercondylar notch consistent with a bucket handle type tear. Dr. Stamelos opined that the diagnosis was consistent with Petitioner's work-related injury. Dr. Stamelos clarified that Petitioner's prior injury from a motor vehicle accident was to his left knee. He further clarified that, while Petitioner's right knee was aggravated by work activity the week before, his right meniscus tore completely when he was getting up from squatting on November 23, 2015. On November 25, 2015, Petitioner was also diagnosed by Dr. Breslow with a right knee displaced bucket handle tear of the medial meniscus. Respondent offered no medical opinion indicating that Petitioner's reported mechanism of injury is not consistent with his symptoms or that the meniscal tear is not related to his work accident.

The Arbitrator has had the opportunity to review the medical evidence and the testimony of the witnesses. The Arbitrator finds that a causal relationship exists between Petitioner's present right knee condition of ill-being and the work accident of November 23, 2015.

With respect to (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 as follows:

The medical records reflect that Petitioner treated with Dr. Stamelos at Buffalo Grove Orthopedic Associates the day of the accident. An MRI and X-rays were performed on his right knee that day. On November 25, 2015, Petitioner followed up with Dr. Stamelos and sought a second opinion from Dr. Breslow at Illinois Bone & Joint Institute. The Arbitrator finds all of 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. Buffalo Grove Orthopedic Assoc. – DOS 11/23/15-11/25/15, $225.00
2. Bright Light Radiology – DOS 11/23/15, $1655.00
3. Illinois Bone & Joint Institute – DOS 11/25/15, $240.00

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Petitioner testified that, as of the date of hearing, he had not received an itemized bill for treatment with Illinois Bone and Joint Institute on January 13, 2016.

The Arbitrator notes that Petitioner paid $830.00 out-of-pocket for his medical treatment related to the accident. That amount is reimbursed to him out of the sum of the awarded bills.

Pursuant to the stipulation of the parties, Respondent is entitled to a credit for all payment made pursuant to Section 8(j) of the Act.

With respect to (K.) IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, the Arbitrator finds as follows:

Based on the Arbitrator's findings in Section "F" above, Petitioner's current medical condition is related to his work accident. The treating physicians have not found Petitioner to be at maximum medical improvement. On November 25, 2015, Dr. Stamelos recommended that Petitioner undergo an arthroscopic meniscectomy of the right knee. On November 25, 2015, Dr. Breslow also recommended that Petitioner undergo an arthroscopic meniscectomy, and possible meniscus repair. On January 13, 2016, Dr. Breslow again recommended that Petitioner undergo an arthroscopic medial meniscectomy with possible meniscus repair.

Having found the requisite causal relationship, the Arbitrator finds the treatment recommendations of Dr. Stamelos and Dr. Breslow to be reasonable and necessary and orders the same. Respondent shall pay for the prospective medical treatment recommended by Dr. Stamelos on November 25, 2015 and Dr. Breslow on January 13, 2016.

With respect (L.) WHAT TEMPORARY BENEFITS (TTD) ARE IN DISPUTE, the Arbitrator finds as follows:

Petitioner claims that he is entitled to TTD benefits for the period between November 24, 2015 and January 21, 2016, a period representing 8 and 3/7 weeks. Respondent disputes liability for any TTD benefits. On November 23, 2015, Dr. Stamelos restricted Petitioner from returning to work. On November 25, 2015, Dr. Stamelos restricted Petitioner to sedentary office work with no squatting, kneeling, and no lifting over ten pounds. (PX 1) No physician has released Petitioner to work full duty. Since the date of accident, Respondent has not accommodated any of his restrictions and Petitioner has not worked in any capacity.

The Arbitrator has reviewed the evidence and finds Petitioner is entitled to TTD benefits for 8 and 3/7 weeks, representing the period between November 24, 2015 and January 21, 2016.

With respect to (M.) SHOULD PENALTIES OR FEES BE IMPOSED UPON RESPONDENT, the Arbitrator finds as follows:

The Arbitrator finds that a legitimate dispute existed with respect to whether Petitioner sustained a compensable accident within the meaning of the Act. As such, Petitioner's request for penalties and fees is hereby denied.