STATE OF ILLINOIS)
) SS.
COUNTY OF ST. CLAIR)

☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Causal Connection	☐ Second Injury Fund (§8(e)18)
☐ Modify	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TYLER REAKA,

Petitioner,

17IWCC0203

vs.

NO: 03 WC 62174

CAPTAIN D'S LLC,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission pursuant the September 9, 2015, Order of Judge Robert LeChien of the Circuit Court of St. Clair County, Illinois. Judge LeChien found the Commission erred in failing to find a causal connection between Petitioner's undisputed January 3, 2011, accident and the condition of his cervical spine. After finding that such a causal connection existed, he then found that the medical expenses Petitioner incurred treating his cervical spine after said accident were also causally connected to the accident. He determined the injury to Petitioner's cervical spine resulted in a permanent disability that merited an award under Section 8(d)2 of 40% loss of the person as a whole and also determined that Respondent's handling of Petitioner's claim with respect to his cervical spine was unreasonable and vexatious and merited the imposition of penalties and attorney fees. Finally, Judge LeChien ordered the Commission to find for Petitioner on the issue of causation and award Petitioner all benefits as well as penalties and fees. The Commission complies with Judge LeChien's Order.

IT IS THEREFORE FOUND BY THE COMMISSION that the current condition of Petitioner's cervical spine and the medical expenses incurred treating said spine are causally connected to Petitioner's January 3, 2011, workplace accident, though the Commission finds no basis in law or fact for the Circuit Court's award of benefits.

IT IS THEREFORE ORDERED that Respondent pay to Petitioner the sum of $516.15 per week for a period of 200 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 40% loss of use of the person as a whole.

17IWCC0203

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $516.15 per week for a period of 100 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 50% loss of use of the left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $147,961.17 for medical expenses under §8(a) of the Act.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $125,595.58 as a penalty under Section 19(k) of the Act, the sum of $10,000.00 as a penalty under Section 19(l) of the Act, and $50,238.23 for attorney's fees under Section 16 of the Act

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: APR 4 - 2017
KWL/mav
O: 10/25/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

JAMES KAO,
Petitioner,

vs. NO: 06 WC 6270

INSIGHT ENTERPRISES,
Respondent.

ORDER

This matter comes before Commissioner Lamborn, pursuant to the Motion for Disposition of Case that was filed by Respondent on June 24, 2016. Respondent's motion was filed in response to the September 11, 2014, Order of Judge Robert Lopez Cepero of the Circuit Court of Cook County that remanded the matter to the Commission for the purpose of reopening and presenting all proofs. With both parties represented by counsel, Commissioner Kevin W. Lamborn presided over the November 17, 2016, hearing that was prompted by Respondent's Motion.

The Commission finds allowing the parties to present proofs without limitation is akin to litigating the arbitration hearing anew. The Order, as written, could allow evidence that was available at the time of the arbitration hearing but not offered and accepted into evidence to now be offered, accepted and considered. It is further found that allowing all proofs, including those previously entered, provides the parties the opportunity to refine the arguments that were already made and considered by both the presiding arbitrator and the Commission on review. The Commission finds the prohibition against introducing additional evidence, as articulated in Section 19(e) of the Act, sought to prevent this from occurring. This notwithstanding, the Commission is required to follow the directions of the Circuit Court. *Noonan v. Illinois Workers' Compensation Commission*, 2016 IL App (1st) 152300WC.

The plain reading of the Order could be interpreted as indicating that the same proofs that had previously been presented to the Commission are to be again presented to the Commission as the Order does not indicate what proofs are to be tendered. The Commission recognizes the absurdity of such an interpretation.

Made part of the November 17, 2016, hearing before Commissioner Lamborn was the transcript of the proceedings presided over by Judge Lopez Cepero. Within the transcript, Judge Lopez Cepero indicated that proofs were to be reopened from the beginning but more specifically indicates later that the parties "need to open the proofs from the beginning as it relates to these vocational matters." He reiterated the proofs that were to address questions concerning vocational matters, stating, "Reopen the proofs as far as what the job requires."

On the basis of the Order, Petitioner's counsel, appearing before Commissioner Lamborn, expressed his wish to depose the therapist who conducted the FCE, Petitioner's coworkers so that they could testify as to what Petitioner's actual job requirements entailed, and the videographer who provided a video representation of Petitioner's job activities. Petitioner gave no indication that any of these parties were unable to be deposed prior to closing of proofs by the presiding arbitrator. The Commission is of the belief that any deposition taken subsequent to the original hearing is patently inadmissible but for the order Judge Lopez-Cepero. The Commission reluctantly will allow proofs to be re-opened solely for the admission of evidence that pertains to the FCE. The Commission further believes that it is compelled to accept this evidence in light of the Circuit Court's order.

The Commission believes its limiting proofs to evidence only involving the FCE is consistent with Judge Lopez Cepero's Order as he sought to "make sure that the FCE is complete and consistent with the job descriptions." To that end, the Commission will permit into evidence a copy of a job description that purports to represent Petitioner's then-job activities, testimony from Petitioner limited to only acknowledging the accuracy of the job description, and the taking of a deposition of the therapist who conducted the FCE. Testimony from Petitioner would make the deposition of both Petitioner's coworkers and the videographer superfluous.

IT IS THEREFORE ORDERED BY THE COMMISSION that proofs are to be reopened for the limited purpose of reconciling the evidence with Petitioner's then-job activities. The proofs will be limited to the admission into evidence of the job description of Petitioner's then-job activities, the deposition of the therapist who conducted the FCE, and the live testimony of Petitioner before Commissioner Lamborn.

The party commencing 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: APR 4 - 2017
KWL/mav
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Patricia Burrola,

Petitioner,

vs. NO: 08 WC 16484

Sam's Club,

Respondent.

17IWCC0200

DECISION AND OPINION ON REMAND

This matter comes before the Commission pursuant to the Remand Order of the Circuit Court of Cook County, Judge Kay Hanlon presiding, reversing the Commission Decision and Opinion on Review dated 9/1/15 (15 IWCC 700), and remanding for further consideration. Pursuant to the Remand Order and having considered the entire record, the Commission modifies the decision of the Arbitrator as to the issues of causation, medical expenses and permanency, for the reasons set forth below.

I. HISTORY OF THE CASE

A) Arbitration Decision

The Arbitrator found that Petitioner "...established a causal connection between her work fall of April 9, 2008 and her current cervical spine condition of ill-being. The Arbitrator further [found] that the accident led to the need for the cervical spine surgery of Dr. Malek performed in December of 2009." (Arb.Dec., p.29). In addition, the Arbitrator determined that "...the work fall resulted in a non-surgical lumbar spine condition that merited an initial course of therapy and an MRI scan." (Id.) The Arbitrator also found that Petitioner "...established a causal connection between the work fall and right hand and bilateral shoulder contusions or strains..." (Id.). However, the Arbitrator determined that Petitioner "...failed to establish causation as to the bilateral shoulder surgery that Drs. Morgenstern and Giannoulias recommended and that Dr. Silver ultimately performed." (Id.).

17IWCC0200

Based on the aforementioned causation findings, the Arbitrator awarded reasonable and necessary medical expenses totaling $240,084.89, and subject to the fee schedule, cutting off conservative care after 7/31/08, or the date of Dr. Bernstein's first §12 examination. (Id., pp.30-32). The Arbitrator noted that while she "... disagree[d] with Dr. Bernstein's assessment of the video, ... [she] [found] the date of the doctor's first examination to be an appropriate cut-off point for the initial course of conservative care. The records show that Petitioner derived little lasting benefit from this care." (Id., p.32).

In addition, the Arbitrator found that Petitioner was temporarily totally disabled from 4/10/08 through 8/31/08, for a total of 61-3/7 weeks. (Id., p.33). The Commission notes a clerical error along these lines in that the period in question is actually 65-6/7 weeks. In support of this determination, the Arbitrator found that Petitioner had reached maximum medical improvement ("MMI") "...with respect to her causally related surgical spine condition of ill-being on September 3, 2010." (Id.). Finally, the Arbitrator declined to award permanent total disability benefits, but instead awarded 40% person-as-a-whole pursuant to §8(d)2 of the Act. (Id., pp.33-34).

B) Commission Decision and Opinion on Review

The Commission affirmed and adopted the Arbitrator's decision in a Decision and Opinion on Review dated 9/10/15 (15 IWCC 700).

C) Circuit Court Order

In an Order dated 4/19/16, Judge Hanlon found that "[t]hough the Commission failed to properly address and analyze the issue [of PTD], any finding that Plaintiff failed to meet her burden of establishing entitlement to PTD under the odd-lot category is against the manifest weight of the evidence" and the "[t]he issue is remanded to the Commission for it to complete the analysis of Plaintiff's entitlement to PTD. Importantly, whether Petitioner conducted a diligent job search is irrelevant to the question of whether she is employable in a stable labor market and [whether] such a market exists." (Circuit Court Order, p.27).

In addition, Judge Hanlon determined that "the Commission's decision as it relates to causal connection of Plaintiff's condition of ill-being with respect to her shoulders is against the manifest weight of the evidence", noting that "[t]he record is wholly devoid of any evidence supporting the Commission's determination" in this regard and that "...the 'clearly evident, plain and indisputable weight of the evidence compels an apparent, opposite conclusion.'" (Id., p.30).

Furthermore, Judge Hanlon found that the Commission's decision to terminate conservative care on 7/31/08 was against the manifest weight of the evidence, noting that "[t]he record is devoid of any support for the Commission's determination to cut off conservative care on July 31, 2008. Nor does the Commission provide any explanation for its decision. The Commission seemingly made the decision on a whim, ignoring the medical records showing various treatments performed for pain relief, such as trigger point injections, medication, and therapy, which followed the July 31, 2008 date." (Id.).

17IWCC0200

Finally, Judge Hanlon affirmed the Commission's decision as it relates to temporary total disability ("TTD") benefits, noting that it was "...reasonable for the Commission to infer Plaintiff reached MMI as of September 3, 2010." (Id., p.29).

II. FINDINGS OF FACT

The Commission hereby incorporates by reference herein the same statement of facts set forth in both the Arbitrator's Decision as well as the Circuit Court Opinion and Order.

III. CONCLUSIONS OF LAW

The issues on remand are a) PTD, b) MMI, c) causation regarding the bilateral shoulder condition, and d) the termination of conservative care on 7/31/08.

A) PTD

In support of her determination that Petitioner failed to prove that she was PTD, the Arbitrator found that "[w]hile Susan Entenberg viewed Petitioner as essentially unemployable, she conceded that the 2012 functional capacity evaluation showed Petitioner to be capable of sedentary duty, that Petitioner never looked for work and that Petitioner is a very poor historian and communicator. It appears to the Arbitrator that Petitioner long ago gave up any notion of returning to the workplace." (Arb.Dec., p.34).

On appeal, Judge Hanlon referenced "an apparent misunderstanding" by the Commission as to what is required to obtain PTD benefits, and noted that the fact that "...Plaintiff never looked for work and may have given up any notion of returning to the workplace does not end the analysis." (Circuit Court Order, p.26). The judge indicated that the Commission "... must still analyze whether, because of Petitioner's age, training, education, experience, and condition, there are no available jobs for a person in her circumstances." (Id., p.27).

Judge Hanlon concluded that "[t]hough the Commission failed to properly address and analyze the issue, any finding that Plaintiff failed to meet her burden of establishing entitlement to PTD under the odd-lot category is against the manifest weight of the evidence. The issue is remanded to the Commission for it to complete the analysis of Plaintiff's entitlement to PTD. Importantly, whether Petitioner conducted a diligent job search is irrelevant to the question of whether she is employable in a stable labor market and [whether] such a market exists." (Circuit Court Order, p.27).

Thus, while remanding the decision to the Commission in order to "complete" its analysis, Judge Hanlon has already essentially determined that Petitioner is entitled to permanent total disability benefits under an "odd-lot" theory, and that any finding to the contrary would be against the manifest weight of the evidence.

In light of this directive, the Commission provides the following analysis.

In order to prove entitlement to permanent total disability benefits for life pursuant to

17IWCC0200

§8(f) of the Act, a claimant must prove such a claim either (a) by a preponderance of the medical evidence, (b) by showing a diligent but unsuccessful job search, or (c) by demonstrating that because of his age, training, education, experience and condition no jobs are available to a person in like circumstances. See *ABB C-E Services v. Industrial Commission*, 250 Ill.Dec. 60, 737 N.E.2d 682, 316 Ill.App. 3d 745 (5th Dist. 2000).

In the present case, since that the record does not support a finding of PTD based on either a) a preponderance of the medical record or b) a diligent but unsuccessful job search, the question becomes whether Petitioner has shown by a preponderance of the credible evidence that no jobs are available to a person in like circumstance based upon her age, training, education, experience and condition.

A review of the record shows that Petitioner is 5'2" tall and was 49 years old at the time of the accident. She indicated that she began working for Respondent in Florida in September of 2003, first as a cashier and then in the meat department, before transferring to the Chicago area where she continued to work in the meat department during the period leading up to the date of the injury on 4/9/08.

Petitioner testified that she attended two years of college, studying early childhood education, but that she did not receive an associate's degree. However, Susan Entenberg's vocational rehabilitation report noted that Petitioner received an A.A. degree in Liberal Arts from St. Augustine College in 1988 and took classes in early childhood education, business and computers in 1991-1992 but did not complete a degree. In addition, Ms. Entenberg noted that Petitioner reported that she also took about six months of business classes at ITT in the 1980s but never received a certificate or degree. Ms. Entenberg recorded that Petitioner has no further education or training, never served in the Armed Forces and speaks both English and Spanish. (Entenberg Dep.Ex.2).

Prior to her employment with Respondent, Petitioner worked in the records department of a medical clinic where she took calls, did filing, delivered and picked up charts and made appointments for the doctors and nurses. Petitioner also noted that she worked as a teacher aide in a head start program at some point in her career, but could not recall when that was.

Petitioner's job with Respondent involved rotisserie work in the deli, including poultry skewering, racking, seasoning chickens, filling counters, wrapping and preparing trays. She would also have to lift 50 pound boxes of chicken from a pallet to a flatbed. She noted that she worked five days/40 hours a week and that she was on her feet seven hours per day.

A valid FCE performed on 4/10/12 noted that Petitioner "... demonstrated the physical capabilities to function **at the SEDENTARY category of work, which is indicative of a maximum/occasional 2-hand lift/carry of 10# from knee to chest level**. However, it must be distinguished that this is a general category and Ms. Perola (Burrola) exhibited severe functional limitations above and beyond this category description ..." (Emphasis in report) (PX15). As a result, it was recommended that Petitioner "... attempt to return to work only in a modified duty position respectful of the physical capabilities and tolerances outlined in this report, per the approval of her treating doctor." (PX15). This report also noted that Petitioner's "...current

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functional abilities and musculoskeletal findings demonstrate that she **cannot return to her previous full duty work activities**. She exhibited decreased tolerance primarily with the repetitive walking, stooping/bending, twisting, reaching and lifting tolerances required to perform her previous regular duty job demand." (Emphasis in report) (PX15).

Following her interview and review of the record, Ms. Entenberg opined that Petitioner "...is not capable of performing her past work as a deli processor. It is further my opinion that Ms. Burrola is a very poor candidate for vocational rehabilitation with no stable labor market available to her." (Entenberg Dep.Ex.2, p.3). Ms. Entenberg noted that this opinion was based on restrictions per the FCE of "... occasional sitting, standing, walking, stair climbing, stooping/bending, twisting, knee to chest lift of 10 pounds, push/pull of 15 pounds for 25 feet, reaching and no squatting, kneeling or below knee or above shoulder lifting. This is less than sedentary work, due to the need for only occasional sitting. Her work as a deli processor requires medium lifting with standing and walking throughout the day as well as bending and stooping. Her past work is therefore precluded based on all restrictions. Even assuming Dr. Bernstein's report of 7/31/08 and restrictions of 20 pound lifting and avoid repetitive bending, lifting and twisting, Ms. Burrola is precluded from her work as a deli processor." (Id.).

In addition, Ms. Entenberg noted that Petitioner "...has a work history that does not have transferable skills to sedentary work, very limited computer skills, very limited tolerances and is restricted to less than sedentary work, based on a valid FCE. She has extremely limited lifting, none on a frequent basis, and only occasional sitting, standing and walking ability. I would conclude that no stable labor market exists for Ms. Burrola given her education, work history and these restrictions." (Entenberg Dep.Ex.2, pp.3-4). Likewise, Ms. Entenberg did not feel that Petitioner was an appropriate vocational rehabilitation candidate. (Id., p.4).

Contrasting this viewpoint is the opinion offered by Respondent's §12 examining physician, Dr. Avi Bernstein. Dr. Bernstein felt that as of his initial examination on 7/31/08 Petitioner was "...capable of performing light duty work activity with a 20 lb. lifting restriction and avoidance of repetitive bending, lifting or twisting." (RX2). In a subsequent report, following a second examination on 9/27/12, Dr. Bernstein opined that Petitioner was "at maximum medical improvement" and "capable of functioning at the sedentary duty level based on her FCE, and if she was motivated, she could certainly function at the light duty physical demand level. I would not consider this injurious or dangerous to her." (RX3).

In addition, Respondent offered into evidence a labor market survey performed by Workfinders USA. (RX4). This survey located seven (7) potential employment opportunities for Petitioner in Chicago and the surrounding suburbs paying between $8.25 and $13.75 per hour. (RX4).

Based on the above, and in light of the Circuit Court Order, the Commission vacates its previous award and finds that Petitioner is permanently and totally disabled for life pursuant to §8(f) of the Act commencing 9/4/10, or the date she reached maximum medical improvement (See "MMI" discussion below). Specifically, the Commission finds that Petitioner proved by a preponderance of the credible evidence that no jobs are available to a person in like circumstance based upon her age, training, education, experience and physical limitations. In support of this

17IWCC0200

ruling, the Commission finds the opinion of Ms. Entenberg regarding Petitioner's employability to be more persuasive than that offered by Respondent's §12 examining physician, Dr. Bernstein. Along these lines, the Commission notes that it has viewed the surveillance video submitted at PX18, and on which Dr. Bernstein based much of his opinion, and finds absolutely no basis for Dr. Bernstein's belief that Petitioner somehow manipulated or staged her fall.

B) MMI

Judge Hanlon noted that "...the Commission found Plaintiff reached MMI on September 3, 2010, the day Dr. Malek recommended another lumbar spine MRI and found Plaintiff was 'doing a lot better' with respect to her neck." (Circuit Court Order, p.29). The judge went on to state that "[t]he record does not indicate any change in Plaintiff's medical condition between September 3 and 10, 2010. It is therefore reasonable for the Commission to infer Plaintiff reached MMI as of September 3, 2010." (Id.). As a result, Judge Hanlon affirmed the Commission's decision as it relates to MMI and TTD benefits. (Id., pp.28-29).

Therefore, based on the above, the Commission reiterates its prior finding that Petitioner reached maximum medical improvement as of 9/3/10 and that Petitioner was temporarily totally disabled from 4/10/08 through 8/31/08 and from 10/22/09 through 9/3/10. Furthermore, the Commission corrects a previously overlooked clerical error and finds that this period equals 65-6/7 weeks (not 61-3/7).

C) Causation re: bilateral shoulder condition

Judge Hanlon ruled that "[t]he Commission's decision as it relates to causal connection of Plaintiff's condition of ill-being with respect to her shoulders is against the manifest weight of the evidence" given that "[t]he record is wholly devoid of any evidence supporting the Commission's determination" in this regard. (Circuit Court Order, p.30).

Therefore, based on the clear language of the above Circuit Court Order, the Commission finds that Petitioner's current condition of ill-being with respect to her bilateral shoulder condition is causally related to the accident on 4/9/08. In support of this finding, the Commission chooses to place greater weight on the opinions of Drs. Coe and Morganstern and the records of Drs. Giannoulias and Silver over the opinions offered by Dr. Bernstein with respect to this issue. Once again, the Commission notes Dr. Bernstein's interpretation of what is seen in the video is not substantiated upon viewing, and that it is entirely possible, and indeed likely, based on the fall depicted that Petitioner injured both her shoulders as she fell backwards onto the floor.

As a result, the Commission finds that Petitioner is entitled to the reasonable and necessary medical expenses associated with her bilateral shoulder condition, in addition to the medical expenses already awarded by the Arbitrator, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

D) Termination of conservative care on 7/31/08

17IWCC0200

The Arbitrator found that while she "... disagree[d] with Dr. Bernstein's assessment of the video, ... [she] [found] the date of the doctor's first examination to be an appropriate cut-off point for the initial course of conservative care. The records show that Petitioner derived little lasting benefit from this care." (Arb.Dec., p.32).

Judge Hanlon ruled that "[t]here is no support in the record for the Commission's decision to terminate conservative care on July 31, 2008. Therefore, its decision is against the manifest weight of the evidence." (Circuit Court Order, p.30). In addition, the judge noted that "[t]he record is devoid of any support for the Commission's determination to cut off conservative care on July 31, 2008. Nor does the Commission provide any explanation for its decision. The Commission seemingly made the decision on a whim, ignoring the medical records showing various treatments performed for pain relief, such as trigger point injections, medication, and therapy, which followed the July 31, 2008 date." (Circuit Court Order, p.30).

While the Commission does not agree that its prior decision was made "on a whim", the above Circuit Court Order clearly requires reversal of the Arbitrator's original decision to terminate conservative care on July 31, 2008, or the date of Dr. Bernstein's initial evaluation. Once again, the Commission finds Dr. Bernstein's opinions along these lines to be unpersuasive. As a result, the Commission finds that Petitioner is entitled to the reasonable and necessary medical expenses rendered by Drs. Slusarenko, Osman and Hassan (a/k/a Abdellitif) prior to and subsequent to 7/31/08, in addition to the medical expenses already awarded by the Arbitrator, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

Therefore, based on the above, and in light of the Circuit Court Order, the Commission vacates its prior decision and modifies the decision of the Arbitrator to find that Petitioner proved by a preponderance of the credible evidence that a causal relationship exists between the accident on 4/9/08 and her bilateral shoulder condition, that Petitioner's was entitled to the reasonable and necessary medical expenses relating to her bilateral shoulder condition as set forth in the record, in addition to the medical expenses previously awarded by the Arbitrator, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act, including conservative care offered by Drs. Slusarenko, Osman and Hassan (a/k/a Abdellitif) subsequent to 7/31/08, and that Petitioner was entitled to permanent total disability benefits commencing 9/4/10 in the amount of $413.28 per week (the AWW, since the minimum PTD rate [$441.93] is greater) for life pursuant to §8(f) of the Act. As a result, the Commission's previous award of 40% person-as-a-whole pursuant to §8(d)2 is hereby vacated. Furthermore, the Commission corrects a clerical in its prior decision and finds that Petitioner was temporarily totally disabled from 4/10/08 through 8/31/08 (20-4/7 weeks) and from 10/22/09 through 9/3/10 (45-2/7 weeks), for a total of 65-6/7 weeks (not 61-3/7 weeks).

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Commission's prior decision is hereby vacated and the Arbitrator's decision dated 11/13/13 is modified as stated herein.

17IWCC0200

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $275.52 per week from 4/10/08 through 8/31/08 and from 10/22/09 through 9/3/10, for a period of 65-6/7 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 shall pay to Petitioner medical expenses as set forth above and admitted at PX17 under §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $413.28 pursuant per week for life under §8(f) of the Act for the reason that the injuries sustained caused the total permanent disability of the Petitioner.

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: APR 4 - 2017

o: 1/24/17
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

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

17IWCC0195

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.

IT IS FURTHER ORDERED BY THE COMMISSION that 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 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.

17IWCC0195

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 3 1 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)
) 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

Randy Russell,
Petitioner,

17IWCC0247

vs.

NO: 09 WC 36449

City of Fairview Heights,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 19, 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: APR 21 2017
o4/6/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0247

RUSSELL, RANDY
Employee/Petitioner

Case# **09WC036449**

09WC039491
10WC018033

CITY OF FAIRVIEW HEIGHTS
Employer/Respondent

On 6/19/2015, 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 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

3067 KIRKPATRICK LAW OFFICES PC
ERIC KIRKPATRICK
3 EXECUTIVE WOODS CT
BELLEVILLE, IL 62226

0810 BECKER PAULSON & HOERNER PC
RODNEY THOMPSON
5111 W MAIN ST
BELLEVILLE, IL 62226

17IWCC0247

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

Randy Russell
Employee/Petitioner

v.

City of Fairview Heights
Employer/Respondent

Case # **09 WC 36449**

Consolidated cases: **09WC36491;10 WC 18033**

An *Application for Adjustment 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 **Collinsville**, on **April 23, 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 **Whether Petitioner exceeded his choice of two physicians under the Act.**

17IWCC0247

FINDINGS

On **7/20/09**, 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 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 **$44,665.34**; the average weekly wage was **$858.95**.

On the date of accident, Petitioner was **49** years of age, ***single*** with **1** child 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 **$0.00** 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 general credit for any medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove he sustained an accident on 7/20/09 that arose out of and in the course of his employment. Petitioner's claim is denied and no benefits are awarded.

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

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

Signature of Arbitrator

June 18, 2015
Date

JUN 19 2015

Randy Russell v. City of Fairview Heights
Case Number: 09 WC 36449

Findings of Fact and Conclusions of Law

Three cases were consolidated for purposes of trial and the parties agreed that only one proposed decision covering all three cases would be prepared. There were two claims filed with a date of accident of 7/20/09. Case number 09 WC 36449 alleged a single, specific event with a date of 7/20/09 wherein Petitioner alleged that he injured his right shoulder and neck while lifting concrete forms. Case number 10 WC 18033 was an Application wherein Petitioner alleged that he sustained neck and both shoulder injuries as a result of repetitive trauma activities through 7/20/09. Case number 09 WC 39491 was for a date of accident of 8/19/09 wherein Petitioner alleged that his right arm was caught in a wood chipper.

With regard to case number 09 WC 36449 (the single, specific event on 7/20/09), the issues included whether the Petitioner sustained an accident on that date, whether notice was given of said accident, whether his condition of ill-being was related to the accident, whether Respondent was liable for any medical bills, whether Petitioner exceeded his choice of two physicians under the Act, temporary total disability and permanent disability benefits. With regard to case number 09 WC 39491, date of accident 8/19/09, the issues were identical to the issues in 09 WC 36449. Further, the issues were identical with regard to claim number 10 WC 18033, a repetitive trauma claim through 7/20/09.

While the parties requested that one decision issue, the Commission has requested that separate decisions issue. Accordingly, the Arbitrator is doing so. Chris Volkman was present throughout the hearing as Respondent's representative.

The Arbitrator finds:

The medical evidence supplied by the parties was quite extensive.

Petitioner underwent trauma to his right hand in May of 2008. He also reported some right shoulder pain. Petitioner had been handling some furniture. (RX 8) Petitioner continued treating for the right shoulder pain indicating that a heavy piece of furniture fell onto his right forearm at work five months earlier. He also reported performing physical work at his job, including shoveling and lifting and "thinks" he exacerbated his right shoulder pain while trying to lift a heavy pipe off the ground. Petitioner's shoulder hurt with most movements but he was on probation and didn't want to miss any work. An MRI was ordered. (RX 8)

On 2/17/09 Petitioner presented to Memorial Hospital for right arm pain that began on 2/9/09 while moving a refrigerator for a friend. He noted an original injury to the same arm while working with pipe in 2008. No radiating pain was noted. (RX 8)

Petitioner saw Dr. Khan on 5/21/09 complaining of right shoulder and left knee pain of three weeks duration. (PX 3)

On 5/21/09 Petitioner went to St. Elizabeth's Hospital because Dr. Jawad Khan had referred him for x-rays of his left knee and cervical spine. The diagnosis was paresthesias of the distal upper extremities, rule out carpal tunnel syndrome and left leg pain. On a radiology patient history form Petitioner noted that he had the symptoms for about 3-4 weeks. X-rays of the cervical spine revealed interspace narrowing at C5-6 and mild posterior foraminal narrowing at C5-6 on the right side.

On 5/27/09 Petitioner saw Dr. Hafiz Khattak. His impression was neck pain and degenerative joint disease of the knees. Petitioner was given a Hyalgan injection into the left knee and was prescribed Vicodin. (RX 4)

Petitioner was seen by Dr. Kahn on 6/15/09 for knee and shoulder pain. (PX 3)

On 6/17/09 Petitioner returned to Dr. Khattak. He said that his pain level in his right shoulder and left knee was 3-4/10. He was given another injection into his knee. (RX 4)

Petitioner returned to Dr. Khattak on 6/24/09. His pain level was 8/10. Diagnosis was chronic degenerative joint disease of the knees. He was given another Hyalgan injection. (RX 4)

Petitioner returned to Dr. Khattak on 7/13/09. His pain level was 5/10. He was still having problems with his left knee and with his neck. His knee was once again injected and he was prescribed Robaxin. (RX 4)

The first medical care provided to Petitioner after 7/20/09 was on 7/22/09 when he saw Dr. Khattak and stated his pain level was 9/10. Diagnosis was chronic neck pain. He was told to get an MRI of his cervical spine and was taken off work. He was given trigger point injections and another Hyalgan injection into the left knee. There was no history of any work-related event occurring on 7/20/09. (RX 4)

Petitioner returned on 7/27/09 to Dr. Khattak. He listed his pain level as 8-9/10 and noted that his pain was in his right shoulder area. Diagnoses were chronic neck pain and degenerative joint disease of the right knee. He was given a Hyalgan injection into the right knee and a Dilaudid injection. On his pain drawing, Petitioner noted right shoulder pain. (RX 4)

On 7/29/09 Petitioner presented to St. Elizabeth's Hospital for an MRI of the cervical spine. He was asked if his symptoms were "due to an accident". He answered both "yes" and "no". He said that he had a work injury from lifting. He said that he had injured his neck before. He said he had the symptoms for six months. He said that he had surgery on his neck in 2000. The MRI revealed a broad-based central to right-sided foraminal disc protrusion at C5-6 causing significant foraminal narrowing on the right side and mild to moderate foraminal narrowing on the left side. At C6-7 there was a mild, central bulging disc touching the thecal sac. (RX 6)

Petitioner returned to Dr. Khattak on 8/3/09. He complained that his pain level was 5-7/10. He listed the right side of his neck and his right shoulder as his problematic areas. Impressions were cervical herniated disc and degenerative joint disease of the knees. He was given an injection into his left knee. He was prescribed physical therapy for three weeks. Again, his pain drawing showed right shoulder pain and he listed his problems as sleeping and fatigue. (RX 4)

Petitioner returned to Dr. Khattak on 8/10/09. Impressions were cervicalgia with radiculopathy and myofascial pain syndrome. He listed his pain level at this time as 10/10. He was given some medication and told to follow up. His pain drawing remained unchanged. (RX 4)

Petitioner returned to Dr. Khattak on 8/14/09. His pain level was listed as 3/10. Impression was chronic degenerative joint disease of the knees. He was given an injection of Hyalgan into the right knee. However, he was also given an off work slip with regard to his neck. (RX 4)

On 8/19/09 Petitioner presented at Memorial Hospital. He complained of right forearm pain. He said a 75 pound door fell onto his arm at 1:20 that afternoon. He also had chronic right-sided neck pain that would radiate down the right shoulder. He said that was due to an old injury. He said that his employer had just purchased a new chipper and a bar came down, striking his arm and pushing it into a metal plate. He said that he forced the door back up. The door struck his upper forearm to the level of the elbow. He complained that his pain level was 6/10. Examination revealed no swelling and no obvious bruising. He gave a history of chronic right shoulder pain and neck pain. He said he was taking Vicodin but had run out of that. X-ray examination of the right forearm revealed no fracture, dislocation or unusual soft tissue calcification. Diagnosis was contusion and he was given Ibuprofen. (RX 9)

Petitioner was examined by Dr. Jawad Khan on 8/21/09. Petitioner gave a history of his 8/19/09 accident at work and complained of right forearm pain. He was given medication and taken off work through 8/25/09. Physical therapy was recommended. (RX 7; PX 3, p. 2)

Petitioner was seen by Dr. Khattak on 8/24/09. His pain complaints included his right shoulder and right forearm (pain drawing). He reported fatigue and lack of energy. He did not mark that he had any swelling in his hands or ankles. Petitioner was given a left knee injection. (RX 4)

Petitioner signed his Application for Adjustment of Claim in "09 WC 36449" (d/a: 7/20/09 - picking up forms when he felt pain in his shoulder) on 8/24/09. (AX 2)

Petitioner returned to Dr. Jawad Kahn on 8/25/09 with regard to his right forearm. He said he had been performing physical therapy. He was still tender and there was some mild swelling and bruising in the mid-forearm. He was given a Medrol Dose pak and prescribed Oxycontin and Percocet. He was to continue with his physical therapy. (RX 7)

On 8/25/09 Petitioner underwent his initial evaluation at physical therapy at St. Elizabeth's Hospital. He gave a history of right forearm pain with a crushing type of injury. He was to begin physical therapy for that. He gave a history at physical therapy of having right forearm pain, right shoulder pain and right side neck pain. He said that he had pain in the right shoulder down in the arm to the finger from C5-6. He was asked "how did it start". His answer was: "while picking up cover pipe/shovel, forearm was pinned in machine". When he was asked to state when his problem began, he said 5/20/09. He also said 8/17/09. He said it was a work-related injury. He said that he returned to work on 8/17/09 and was cutting trees when his right forearm was pinned. He said that he is a skilled laborer who repairs roads, pours concrete and performs grass care. He said that his pain was worse whenever he would sleep or walk. He was taking Vicodin and Ibuprofen. (RX 10)

On 8/28/09 Petitioner presented to the physical therapy department at St. Elizabeth's Hospital and was complaining of pain in his neck. He said that it began in September 2008 and was a work-related event. He said it was made worse by shoveling and picking up equipment. On 8/28/09 it was noted that with regard to his right forearm, he was wearing a "tubigrip" five hours a day without any ill effect. He said there was some decrease in the swelling of his right forearm. (RX 10)

Petitioner was seen by Dr. Khattak on 8/28/09. His pain drawing only noted right shoulder pain. (RX 4)

Petitioner returned to Dr. Khattak on 8/31/09. Impressions were chronic neck pain and herniated disc at C5-6. He was told to continue with his physical therapy. However, he also underwent another injection into his right knee. His pain drawing had markings on his right shoulder and forearm. (RX 4)

In a slip dated 9/1/09 Dr. Jawad Khan kept Petitioner off of work for his right forearm injury/strain. At that visit Petitioner received a trigger point injection. (RX 7)(PX 3)

On 9/9/09 Petitioner returned to Dr. Jawad Khan. He said he was taking Hydrocodone throughout the day. He had shooting pain up and down the right side of the neck. His right arm was not as strong as his left. The doctor reviewed some x-rays and found that Petitioner had mild secondary degenerative changes with narrowing at C5-6. Diagnosis was forearm injury on the right. He was given Feldene, Ibuprofen and Hydrocodone and kept off work through 9/22/09. (RX 7; PX 3)

In a slip dated 9/11/09 Dr. Khattak listed Petitioner's diagnoses as a herniated disc at C5-6 and right forearm pain. He recommended physical therapy. (RX 4)

Petitioner signed his Application for Adjustment of Claim in "09 WC 39491" on 9/17/09 (d/a - 8/19/09) (AX 4)

Dr. Khattak re-examined Petitioner on 9/21/09. Petitioner did not complete a pain drawing. Dr. Khattak took Petitioner off work through 10/2/09 for both Petitioner's neck and right forearm. (RX 4)

Petitioner returned to see the doctor (Khan) at Gateway Healthcare on 9/22/09. An appointment with the surgeon, Dr. Schultz, was pending. There is a note "Referred by Dr. Khattak." Petitioner didn't think the hydrocodone was helping. Petitioner complained of pain radiating from his neck down his right arm. Petitioner reported discussing Percocet with Dr. Khattak but didn't ask for meds. He requested medication for heart burn he noted after therapy. On examination the doctor noted tightness and spasticity of his right forearm and trapezius. Petitioner had decreased lateral rotation bilaterally, the left greater than the right. He was diagnosed with chronic neck/right forearm pain. Percocet was prescribed. (RX 7; PX 3)

Dr. Khattak examined Petitioner on 9/30/09. Petitioner's pain drawing noted complaints in his right shoulder, right forearm and the right side of his head. He was complaining of fatigue, headaches, weight loss/gain, ringing in his ears, and sleep difficulties. Petitioner was diagnosed with chronic neck pain, myofascial pain syndrome, and cervicalgia. (RX 4)

In a slip dated 10/2/09, Dr. Khattak kept Petitioner off work through October 20, 2009. He did not indicate the condition for which Petitioner was being kept off of work. (RX 7)

On 10/7/09 Petitioner saw Dr. Robert Schultz. He gave a history to Dr. Schultz that he had been injured "sometime around the end of June". He said that he was pulling on some rebar and using a jack hammer and had the onset of some pain in his shoulder.

He said that because he did not have any sick leave available, he saw his family doctor who gave him some medication and told him to continue to work. He said he did so until 8/19/09 when he was using a chipper. He said that his arm got caught in the chipper and he had some significant arm pain, shoulder pain and neck pain since that time. He noted that he had undergone trigger point injections in his neck. He said that he had been on Robaxin. He noted he underwent an MRI scan. He thought that he was getting worse. The doctor reviewed the MRI scan that was brought with the petitioner and he thought that it showed a degenerated, herniated disc at C5-6 with some narrowing of the foramen on the right. Physical examination revealed some loss of range of motion and some other minor irregularities. The doctor thought that he had some equivocal weakness of the biceps on the left as compared to the right and a sensory loss in the ulnar distribution of the right hand. The right triceps was apparently absent. Diagnoses were neck pain, degenerative disc disease at C5-6 with a herniated disc at the same level, spondylolysis of the neck and thoracic outlet syndrome on the right. He recommended that the petitioner undergo a couple of cervical epidural blocks, undergo some nerve studies of the upper extremities, obtain some additional x-rays and prescribed him Norco and Flexeril. He was taken off work through November 10, 2009. (RX 6)

On 10/9/09 Petitioner returned to Dr. Khattak. Diagnoses were chronic neck pain and right forearm pain. He was told to obtain an EMG/NCV of both arms. Petitioner's pain drawing again reflected right shoulder and forearm pain (extending into his right pinky finger). (RX 4)

On 10/19/09 Petitioner returned to Dr. Khattak. The diagnosis was chronic neck pain and radiculopathy. He was referred to Dr. Chris Heffner. His pain drawing was unchanged from the previous visit except that he didn't indicate right pinky finger pain. (RX 4)

On 11/2/09 Dr. Schultz notified Petitioner he was being discharged from further care due to problems with medication abuse. (RX 6)

On 11/9/09 Petitioner presented to the emergency room at St. Elizabeth's Hospital. He complained of neck pain. He said it started on 5/19/09 after a work injury. He was out of his Vicodin. Diagnosis was chronic neck pain. He was given an injection and prescribed Oxycodone.

On 11/9/09 Petitioner also returned to see Dr. Khattak. Diagnoses were chronic neck pain and myofasciitis pain. He was given trigger point injections and Voltaren gel. The pain drawing revealed bilateral neck complaints, right shoulder complaints, and right forearm/pinky finger complaints. He also complained of ringing in the ears. (RX 4)

On 11/11/09 Petitioner presented to the emergency room at St. Elizabeth's Hospital. He complained of pain in the right side of his neck. He was out of Vicodin. He was told to follow up with his doctors.

Petitioner saw Dr. Luke Hall on 11/12/09. He said he was being seen for back pain. He said that he had severe back pain for several months and an MRI showed a disc protrusion and that Dr. Heffner was recommending surgery (it should be noted that Petitioner did not see Dr. Heffner until 2/5/2010). He also said he saw Dr. Khattak for pain management. He said that his pain was not controlled with medication with Dr. Khattak and therefore he was told to see his personal medical doctor for management. At the time, he was taking a number of medications including Flexeril, Ibuprofen, Vicodin, Oxycontin and Percocet. Neurological examination revealed that his motor and sensory functions were intact and equal, his reflexes were normal and equal and his gait was normal. Dr. Hall contacted Dr. Khattak's office and they confirmed that Dr. Khattak wanted his private physician to handle the pain medications. Oxycontin and Percocet were given. (RX 8)

On 11/13/09 Petitioner was seen at Gateway Healthcare to follow up on lab work. He complained of elevated blood pressure and had been seen at the ER for high blood pressure and a right-sided headache. (RX 7)

On 11/18/09 Petitioner saw Dr. Khattak. Diagnoses were chronic neck pain, stenosis at C5-6 and right upper extremity pain. His medications were refilled. Petitioner's pain drawing noted right shoulder pain and less right forearm pain/complaints. (RX 4)

On 12/14/09 Petitioner saw Dr. Khattak and complained of chronic neck pain, right upper extremity pain and spinal stenosis at C5-6. His pain level was 5/10. He was given an injection of Depo Medrol. Petitioner's pain drawing again noted right shoulder and right forearm complaints. (RX 4)

On 1/8/10 Petitioner returned to see Dr. Hall. He was continuing to have back/neck pain, shoulder pain and shooting pains down his arms. He was taking Flexeril, Ibuprofen and Vicodin. Assessment was back/neck pain with disc protrusion from a work accident in May 2009. He was given exercises for his neck and back. He was to continue with the Oxycontin, Percocet and Ibuprofen. (RX 8)

On 1/15/10 Petitioner saw Dr. Khattak and complained of chronic neck pain, degenerative disc disease. His medications were refilled. No right forearm complaints were noted. (RX 4)

Petitioner returned to Gateway Healthcare on 1/19/10 for a review of his labwork. He had "no complaints other than neck and shoulder pain." He was also reporting poor sleeping. According to a note of Dr. Jawad Khan that same day Petitioner was waking

up from sleep at 3 a.m. with a feeling of pins and needles in his right forearm which would shoot up to his axilla and then the right side of his neck. He reported taking a lot of pain medications and noted a visit with Dr. Haefener who planned to do a nerve block. Petitioner reported his right hand would develop blanching on exposure to the cold. Petitioner was referred by Dr. J. Khan to a rheumatologist. (RX 7)

Petitioner was again seen at Gateway Healthcare on 1/25/10 primarily for his blood pressure. Dr. Jawad Khan noted that Petitioner was continuing to have right-sided posterolateral neck pain and headaches that Petitioner attributed to his neck pain. No right forearm complaints were noted. (RX 7)

In a note dated 1/27/10 Dr. J. Khan took Petitioner off work from 1/18/10 to 2/5/10 for forearm and neck pain. (RX 7)

On 1/28/10 the Petitioner saw Dr. David Lange at Respondent's request. Dr. Lange took a history from the patient indicating that his shoulder problems began back in "2008". He said that he saw a Dr. Hall at St. Elizabeth's Hospital for one or two months. He said that he thought that his shoulder was the issue. He continued to have symptoms about the right shoulder, but continued to work. He said that his work activities were quite heavy. They included the shoveling of asphalt and using a post-hole driver. He said that those activities consistently worsened in right shoulder pain. Further, Petitioner said that he lifted a "covert pipe" in July 2009 and that increased his right shoulder pain. He said that he had seen Dr. Hall, Dr. Khan and Dr. Khattak for his problem and had been treated with injections. He said that he had pain in the right side of his neck that would go into the right suprascapular area and then somewhat down the right arm and forearm. He complained of numbness in the ulnar aspect of the right forearm and proximal hand. Petitioner spoke to Dr. Lange about the event of 8/19/09 with the wood chipper. He said that a heavy door fell down onto his right forearm. Examination revealed a mildly positive Hoffman sign on the right. He complained of neck pain with forward motion. He had discomfort in the right trapezius. The doctor reviewed the cervical spine MRI and it was interpreted to show degenerative disc disease at C5-6 with some posterior spurs. He said that there was a soft, disc herniation centrally and to the right at that level. Dr. Lange then reviewed a multitude of records and reports. Diagnosis was degenerative disc disease at C5-6 with a herniation causing the right upper extremity complaints. He said that he could not substantiate a relationship between the disc herniation and his work activities. The doctor noted that he had seen physicians before July 20, 2009 for his neck problems. The doctor thought that because his cervical disc was degenerative in nature, it would be "impossible to state with any certainty his work activities were a factor with respect to his current condition". The doctor thought that he did need more treatment, including the possibility of surgery with a fusion. He said that since his symptoms seemed to go back to year 2008, even though certain activities at work and at home tended to aggravate that condition, "such increase of symptoms on a day to day basis is not to suggest that

having increased symptoms with any particular activity in some fashion aggravated, accelerated or made to become symptomatic the underlying disc pathology". Some residual aching in Petitioner's right forearm was noted. (RX 1, Dep. Ex. 3)

On 2/4/10 Petitioner returned to Dr. Hall. He continued to have the same complaints. Dr. Hall continued his Oxycontin and Percocet. (RX 8)

Petitioner saw Dr. Christopher Heffner on 2/5/10. He was referred to Dr. Heffner by Dr. Khattak. He said that about nine or ten months ago he was doing his regular job without a specific injury. He said he did a lot of heavy lifting and noticed some pain in his neck and right upper extremity along with some shoulder pain. He did say that he had a work injury to his right arm in September. Petitioner made it clear that the neck injury was not related to any specific work event. Examination revealed weakness in the right biceps and triceps. He had mild weakness in the right hand intrinsic function. He said that an MRI scan showed a sizable central, and somewhat right-sided, disc herniation at C5-6. Dr. Heffner said that he did not have "any specific injury to bring this on". The doctor recommended a C5-6 discectomy and interbody fusion. Petitioner agreed and was taken off work. He was taken off work for approximately 6 -12 weeks. (RX 5)

On 2/5/10 the petitioner returned to Dr. Khan. He was complaining of his neck. Diagnoses were chronic neck pain with radiculopathy, cervicalgia, spinal stenosis and degenerative disc disease. He was to follow up in one week for a neck injection and said that Dr. Heffner told him he needed surgery. Petitioner was given Hydrocodone and Ibuprofen.

On 2/5/10 the petitioner also saw Dr. Khattak. His diagnoses were the same and he was continued with his medications. No right forearm complaints were noted. (RX 4)
Dr. Lange issued another report on 2/5/10 addressing some transcription problems from his initial report. He indicated Petitioner's prognosis was excellent with a 1-level fusion and Petitioner should be able to resume full duty work approximately three months thereafter. He added that he did not think Petitioner's repetitive work activities would be associated with the herniation or any treatment for it. (RX 1 – Dep. Ex. 4,5)

On 2/8/10 Dr. J. Khan took Petitioner off work from 2/5/10 "until further notice" for "medical reasons." (RX 7)

Dr. Khattak re-examined Petitioner on 2/12/10. Petitioner didn't mark the pain drawing. His diagnoses remained unchanged and no right forearm complaints were noted. (RX 4)

In notes dated 2/16/10 Dr. Heffner thanked both Dr. A. Khan and Dr. Hafiz Khattak for the referral and noted Petitioner was scheduled for surgery on 2/16/10. (RX 5)

Petitioner was seen at Gateway Healthcare on 2/22/10 and reported no more headaches but ongoing neck pain. He wished to quit smoking. Dr. J. Khan recorded the visit as related to a follow-up for sinusitis. Petitioner denied any further headache but reported chronic neck pain ("4-5/10") and upcoming neck surgery with Dr. Heiffer. No right forearm complaints were noted. This is the last office visit with Gateway Healthcare/Dr. J. Khan. (RX 7)

Petitioner underwent a rheumatology exam on 2/23/10. He was noted to have an isolated positive ANA without any symptoms or signs of inflammatory disease. Petitioner reported some persistent discomfort in his proximal right forearm too. The doctor noted a burn on Petitioner's right arm a number of years earlier for which Petitioner required skin grafting. (RX 5)

Petitioner was seen at Dr. Heffner's office on 3/8/10. The Nurse's Notes indicate continued complaints of posterior neck pain radiating into his right shoulder, down the right arm to just below his elbow and constant tingling and numbness of the right ring and pinky finger. Petitioner was getting ready for surgery. (RX 5)

On 3/11/10 Petitioner returned to see Dr. Hall. Medications included Flexeril, Ibuprofen and Vicodin. He was to continue with his Oxycontin and Percocet until he underwent surgery. (RX 8)

On 3/15/10 he returned to Dr. Khattak. His medication was refilled. His pain drawing noted right shoulder and forearm pain. No diagnosis was made regarding the forearm pain. The doctor noted radiculopathy in conjunction with Petitioner's neck pain. (RX 4)

On 3/17/10 Petitioner was admitted to Memorial Hospital by Dr. Heffner. He was taken to surgery by Dr. Heffner that day for the removal of the disc between C5 and C6. An interbody spacer was filled with material and sunk between C5 and C6. He was told to remain off work, given a soft cervical collar, antibiotics and Lortab. (RX 5)

On 3/24/10 Petitioner returned to Dr. Heffner and said that he had no "real pain" since surgery until that morning when he had some right shoulder and arm pain. His collar was removed and the dressings were changed. He was told to return in three weeks, x-rays were taken and he was given a softer collar. Medication usage was also discussed. (RX 5)

In a letter dated 3/24/10 and addressed to whom it may concern, Dr. J. Khan wrote that Petitioner had been under the care of Dr. Khan and Dr. Khattak and was being treated from 9/20/09 for arm pain until further notice. (PX 3)

On 4/5/10 Petitioner called the Dr. Heffner's office and complained of right-sided neck pain. He was prescribed Robaxin and Ibuprofen. (RX 5)

On 4/14/10 Petitioner returned to Dr. Hall. He had the same complaints as before. It was noted that he had surgery two weeks ago. He said that Dr. Heffner deferred pain management to his personal physician. Dr. Hall prescribed Vicodin. (RX 8)

On 4/16/10 Petitioner returned to Dr. Khan for neck pain. He said that his medications needed to be refilled and he would need a physician's statement with regard to his ability to remain off work. He said he had surgery on his neck on 3/17/10. He was prescribed Vicodin and Robaxin. No right forearm complaints were noted. He was diagnosed with neck pain, cervical radiculitis, myalgias, and neuralgia. (RX 4)

Petitioner returned to Dr. Heffner on 4/23/10 and said that he had improved significantly with his neck and arm pain. He was to begin physical therapy. (RX 5)

On 5/6/10 Petitioner called Dr. Heffner's office and requested a note stating that his surgery was work-related. The nurse told Petitioner that the doctor could not state that his neck problem was work-related. (RX 5)

Petitioner's claim in "10 WC 18033" (d/a: 7/20/09 – repetitive trauma) was filed with the Commission on 5/11/10. (AX 6)[1]

On 5/14/10 Petitioner returned to Dr. Hall. He said that his pain was somewhat less. He was wearing a soft collar at night and started a rehab program. He was taking Flexeril, Ibuprofen and Vicodin. He thought that his pain had increased with his physical therapy and therefore his Vicodin amount was increased. He was also prescribed Ambien. (RX 8)

On 5/19/10 Petitioner returned to Dr. Khan. He was complaining of neck pain, right arm pain, numbness and tingling in the arm. He said his current pain level was 4/10. Diagnoses were neck pain, right shoulder and arm pain "status post trauma." His medications were refilled. (RX 4) That same day Dr. Khattak wrote an off work slip for the dated 5/19/10 to 5/24 or 29/10 for Petitioner's right forearm and referenced an accident date of 8/19/10. (RX 4)

Petitioner was seen at Memorial Hospital on 5/22/10 with right arm radicular pain complaints. (PX 22)

On 5/25/10 Petitioner called Dr. Heffner's office and stated that he had to go to the emergency room over the weekend because he was hurting very badly. There he was

[1] According to IWCC Case Status information

given a couple of shots and some pain pills. He asked for a different pain medication. (RX 5)

On 6/11/10 Petitioner saw Dr. Heffner who concluded that he had made outstanding progress. He said that he could return to work, but not to his regular job and needed additional therapy. He was kept off work. (RX 5)

On 6/14/10 Petitioner returned to Dr. Jawad Khan. He said that his pain level was 3-4/10. The doctor noted that they had received "information from the Illinois Department of Human Services prescription monitoring program". The information from IDHS stated that Petitioner was receiving narcotic medications from multiple physicians. This was placed in his chart. The doctor asked him as to whether or not he was getting medications from other doctors and he said that he was. He also agreed that he had violated the doctor's narcotic agreement. He was discharged from Dr. Khan's care. No right forearm complaints were noted. (RX 4) That same date Dr. Khattak discharged Petitioner from his care due to his knowingly violating the Narcotics Agreement. (RX 4; RX 5)

On 6/15/10 a representative from St. Elizabeth's physical therapy department called Dr. Heffner's office. He stated that Petitioner filed a complaint with the hospital's administration because he had been dropped from the physical therapy program because he missed 7 out of 12 scheduled visits. Petitioner also told the therapist that Dr. Heffner had only ordered him to undergo massage at physical therapy. However, the therapist told Petitioner that Dr. Heffner had ordered massage, strengthening and stretching exercises, other modalities and a home exercise program. Dr. Heffner's office said that Petitioner had called them, stating that therapy was aggravating him and that he was supposed to talk to the therapist. Petitioner then called Dr. Heffner's office and asked one of his assistants to make changes in his notes and that he didn't like the therapist because he stated that he had been non-compliant with therapy. Petitioner said that the therapist would "hurt his case" and wanted what he stated to be changed to something else. (RX 5)

On 6/15/10 Petitioner called Dr. Heffner's office and requested a referral to Barnes Pain Management Center. The doctor's office called Petitioner back and wanted to know why he was requesting a pain management referral when he had been doing well at his last office visit. The doctor then stated that he should be referred to another facility for therapy and that he would benefit from work conditioning or work hardening, but that there was no reason for a referral to pain management. (RX 5)

On 6/17/10 Dr. Heffner's office called Petitioner and wanted to know why he wanted a referral to pain management. Petitioner said that he was having arm pain and that therapy was making it worse. He said that he had been to the emergency room several times and they told him to call his doctor. The patient was told that Dr. Khattak was a

pain management specialist. Petitioner told the doctor's office that he would not go back to him as he was not "doing anything for him". Dr. Heffner's office asked if he was taking any pain medication. He said that he had some medication from Dr. Hall. The doctor's office did not know who Dr. Hall was. He said that he saw him for a second opinion. He told the doctor's office that he was going to therapy at St. Elizabeth's Hospital on Green Mount Road. A prescription for Lortab was called in for Petitioner. (RX 5)

On 6/18/10 Dr. Heffner's office prepared a note stating they had received a fax from Dr. Khattak stating that the employee had been discharged from his care for violating the narcotic agreement. (RX 5)

On 6/23/10 there was a physical therapy certification form from St. Elizabeth's Hospital indicating that Petitioner had been once again evaluated for therapy. Part of this included a patient history. He said that he was lifting heavy equipment on 5/20/09 and noticed pain in his neck and right arm. (RX 5)

On 6/30/10 Petitioner told Dr. Hall that he was seeking a pain management referral. He was taking Flexeril, Ibuprofen and Vicodin. Petitioner agreed to go to pain management and he was reminded that Dr. Hall would no longer give him any medications. (RX 8)

On 7/7/10 Petitioner went to Memorial Hospital emergency room and was given some Tramadol and Tylenol. He was told to follow up with Dr. Heffner. (PX 23)

On 7/19/10 he called Dr. Heffner's office and asked for pain medications stronger than Tramadol. He said that he went to the emergency room and was given Tramadol but it was not working. He also said that he has an appointment with BJC West on 8/18 and also was supposed to have an appointment at St. Elizabeth's Pain Management on 8/28. It was noted that Dr. Heffner had received a letter from Dr. Khattak stating that they had fired Petitioner for a violation of his pain contract. Dr. Heffner denied narcotic pain medication. (RX 5)

On 7/19/10 Petitioner called Memorial Hospital (Dr. Wilson) requesting stronger pain medication and discussing a new family doctor referral which could not be given. (RX 8)

On 7/21/10 Petitioner went to the emergency room of Memorial Hospital. He said he had been in physical therapy since March 2010 and was having pain from the right side of his neck down to his hand with tingling. He said he was taking Tylenol with no relief. He was given an injection of Morphine and Zofran. A pain drawing revealed right shoulder/neck complaints. (RX 3; PX 24)

On 7/27/10 he saw Dr. Mazhar Lakho with Southern Illinois Internal Medicine. He said that he was having pain in the right side of his neck down to his fingertips, causing numbness in his fingers. He said he could not go back to physical therapy until his pain was controlled. He said that Dr. Heffner was going to release him to return to work, but that his pain was severe. He was prescribed Vicodin, Flexeril and Neurontin. Petitioner was noted to have skin grafts on both arms. (RX 3)

He returned to Dr. Lakho on 8/10/10. He said his pain pills were helping and that he was sleeping through the night while taking Tylenol. He said his pain was on a scale of 7-8 out of 10. He said he wanted to talk to the doctor about being released to return to work. Diagnosis was cervical pain. Pettioner was to see Dr. Heffner on 8/13/10. He was told to continue with his medications. (RX 3)

On 8/13/10 there is a note from Dr. Hefner's nurse that physical therapy was stopped because of pain. Petitioner said that he had seen Dr. Lakho, who referred him to St. Louis University Pain Management and had an appointment on 8/16/10. He was taking Lortab and Tylenol. Dr. Heffner also saw the employee that day and said that he could be released to full duty work when that was acceptable to any pain management service that he attended. Petitioner was noted to be doing well and any chronic neck and shoulder pain wasn't overly severe. Dr. lakho was now Petitioner's primary care doctor. (RX 5)

On 8/16/10 Petitioner saw Dr. Eugene Pereira, a pain management physician. He was referred by Dr. Lakho. He complained of neck pain and right arm pain. He told the doctor that he was a skilled laborer for the City of Fairview Heights and was having right-sided neck pain, right arm pain, and right shoulder pain that started after a work injury and had progressively gotten worse with repetitive stress at work. He had been off work for nine months on a medical leave. He was having complaints of pain down his right arm. He said that he had a couple of steroid injections which had provided some good relief. He also had surgery that provided some relief. He had gone to the emergency room three times in July 2010. He was taking Vicodin, Ibuprofen and Gabapentin. Examination revealed full range of motion with exacerbation of pain upon cervical flexion. He also reported tenderness upon touching of the right side of the neck and the trapezius muscle. Diagnoses included chronic cervical pain, chronic right shoulder pain and chronic right arm pain. Trigger point injection treatment was suggested. No mention of the wood chipper event was noted. (RX 3)

On 8/31/10 Petitioner went to St. Elizabeth's emergency room. He was complaining of chronic pain. He related it to a work injury in 2009. At that time he was taking Tramadol, Ibuprofen and Hydrocodone. He rated his pain level as 9/10. He was given Zofran and Dilaudid. A prescription was written for 10 tablets of Ibuprofen and 15 tablets of Oxycontin.

On 9/8/10 Petitioner returned to Dr. Lakho and stated that he had been to the emergency room for evaluation of neck pain. He said he tried to go without medication but it was just too severe. He was taking Flexeril, Gabapentin and Neurontin. Diagnosis was cervical pain. He was to continue with the Vicodin and his regular medications. Dr. Lakho took Petitioner off work until Petitioner's FCE on 9/10/10. (RX 3; PX 25)

On 9/10/10 Petitioner underwent a functional capacity evaluation at Memorial Hospital. He described his job requirements as being able to lift 100 pounds from the ground to the waist, pour concrete, load trucks, operate a jack hammer, weed eater, drive tractors, oil and chip, shovel asphalt, lay culverts and operate multiple hand and power tools. The testing put him in the medium physical demand level. He was to undergo work hardening at four hours every shift for a while. Petitioner was noted to be eager to return to work. (RX 3)

On 9/13/10 Petitioner returned to Dr. Lakho. He stated that he was willing to go back to light duty work four hours a day. He was concerned about his pain medications which included Flexeril, Gabapentin, Ibuprofen, Neurontin and Vicodin. He was told to discontinue the Neurontin and Vicodin. (RX 3)

On 9/14/10 Petitioner called Dr. Lakho's office and said that pursuant to the functional capacity evaluation he could have a work hardening class and return to work four hours a day. Dr. Lakho said he could return to work four hours a day, light duty. The Petitioner said that was alright but if he was "reinjured" that it was "on us (Dr. Lakho)". (RX 3)

On 10/6/10 Petitioner underwent an injection of the trapezius muscles by Dr. Pereira. Afterwards, the employee told the doctor that he sought the advice of an attorney to have his case opened and decided in his favor. The doctor said he wished him well. (RX 3)

X-rays of Petitioner's right forearm were taken on 1/18/10 and revealed no fracture, no dislocation, or radiographically significant soft tissue swelling. (PX 18)

On 10/8/10 Petitioner called Dr. Lakho's office again regarding a work hardening class. (RX 3)

On 10/11/10 Petitioner returned to Dr. Lakho. He said his job would not return him to work. He said he needed a referral of Dr. David Brown for nerve testing. He said he needed a stronger medication due to a colonoscopy. Examination was negative. He was told to continue with the Ibuprofen. (RX 3)

On 10/12/10 apparently Dr. Lakho spoke with Dr. Pereira and was notified that Petitioner had been non-compliant with office visits. (RX 3)

Petitioner underwent trigger point injections on 11/1/10 for myofascial pain, cervical radiculopathy, cervical laminectomy syndrome, cervicalgia, and right arm pain. (RX 3)

On 11/8/10 Petitioner returned to Dr. Lakho and said that he was considering obtaining a spinal cord stimulator. He wanted a refill of his Vicodin. Examination was negative. Assessment included chronic neck pain and shoulder pain. He was given Vicodin, Motrin and told to see a psychiatrist as advised by Dr. Pereira. (RX 3)

On 12/20/10 Petitioner returned to Dr. Lakho. He said that his pain medications were not handling his pain. He said that the spinal cord stimulator was still pending. He was given Gabapentin and was told to continue with the rest of his medications. (RX 3)

On 1/10/11 Petitioner returned to Dr. Lakho. He once again said that his medications were not taking care of his pain and he ran out of his pain medications early. He asked for a prescription for Vicodin. He requested an MRI to determine why he was in such pain. The examination was negative. Diagnosis was the same. He was given Hydrocodone and told to see a psychiatrist. (RX 3)

On 1/31/11 Petitioner was seen regarding a refill on medications. (RX 3)

On 2/3/11 Petitioner returned to Dr. Lakho and said that his pain medication was not enough to control his pain. He was told that he could no longer get early refills. He was given Motrin and was told to get a psychiatric examination. (RX 3)

On 2/11/11 Petitioner returned to Dr. Lakho and said that he needed a letter stating that he could not lift with his right arm due to pain. Examination was normal. He was given Tylenol and Motrin. (RX 3; RX 8)

On 2/15/11 Petitioner saw Dr. Hermann Witte, a psychologist. He gave a history that his physical problems began with two accidents at work. The first was in May 2008 involving an injury to his right shoulder when engaged in heavy lifting. He said he had intermittent pain thereafter and finally was diagnosed with a herniated disc. He said that "a few days later" he reinjured the same area, subsequently developing pain that went down from his neck into his fingers on the right arm. He said he last worked in the mid-August 2009. He said that virtually any type of physical activity or movement worsened his pain. The doctor said that the findings of his evaluation showed significant inconsistencies between his self-presentation in the interview and the test data and even between differing tests. The most prominent inconsistencies concerned the existence in the degree of his emotional stress (depression) and his level of pain and related functional disability. He said that his overall life satisfaction was 8/10 which

was inconsistent with his admitted chronic pain, depression and severe frustrations. The doctor said that his personal impression was that he was depressed and angry and that his pain was not as severe as he reported, at least when he was properly medicated. He seemed to be lacking self-motivation as well. (RX 3; RX 8)

Dr. Lakho saw Petitioner on 2/18/11 for right ear pain. (RX 3; RX 8)

On 2/22/11 Petitioner was seen by Dr. Adams/Pereira for right shoulder pain that radiated down his right arm. Petitioner has had "pain quite sometime following a work injury." Petitioner desired to get off pain medications and wished to try a cervical spinal cord stimulator trial. Petitioner's diagnoses were post cervical laminectomy syndrome and cervical radiculopathy of the right upper extremity. (RX 3; RX 8)

Dr. Lakho saw Petitioner again on 3/8/11 for really sharp pain in his right neck which he experienced while putting on his shirt. Petitioner "states never had this pain before." (RX 3; RX 8)

On 3/29/11 Petitioner saw Dr. William Richardson. He complained of neck and right arm pain and said that it began after an accident at work which occurred on 5/20/09. He said that he picked up a piece of pipe at work and it caused an injury to his right shoulder. He said that it started out as tightness and that it became very painful the next day. Eventually, he underwent surgery. He complained of numbness and tingling in his right hand. He said he was taking Oxycontin, Oxycodone, Gabapentin, Vicodin and Ibuprofen. Assessment was chronic pain of the neck and right arm. Recommendations were to prescribe Vicodin, Oxycontin, Soma, Gabapentin, physical therapy and to see a pain psychologist. He concluded that the employee could return to work provided that he not lift over 20 pounds or work with a jack hammer. He was not supposed to use his right arm 8 hours a day as well.

Dr. Lakho again saw Petitioner on 5/25/11 for back, shoulder, forearm and neck pain. He was getting injections through pain management. He wished to undergo a colonoscopy. (RX 3 RX 8)

Petitioner returned to see Dr. Richardson on 6/7/11. He complained of right shoulder pain on a scale of 7/10. He had slight weakness in the right hand and aching in the right arm. He had a decreased range of motion of the neck and shoulder. Diagnoses included chronic neck and right arm pain. He was given three trigger point injections in the right shoulder. He was told to continue with his medications.

On 7/15/11, 8/15/11 and 9/16/11 Dr. Richardson noted that Petitioner's condition was the same and he was to continue all of his medications and to return in a month.

Petitioner was seen in the emergency room on 8/14/11 for chronic neck pain. (RX 3; PX 18; PX 26)

Dr. Gornet examined Petitioner on 8/29/11, according to Petitioner, at the request of Dr. Kahn and Dr. Richardson. He presented with the chief complaint of neck pain, headaches, right shoulder pain, right arm pain, trapezial pain, and numbness and tingling of the right hand which he stated began on 5/20/09 while working for Respondent. Petitioner was unloading a truck with some pipes and tubes and developed "increasing pain" in his right shoulder. He was referred to Dr. Kahn who referred him to pain managements. Injections followed. He had tried physical therapy and was diagnosed with a herniated disc at C5-6 and referred to Dr. Schultz who referred him to Dr. Heffner who recommended surgery but at that point Petitioner returned to work and was trying to live with his symptoms. There was some dispute regarding whether it was covered by workers' compensation. Petitioner also reported a second accident on 8/19/09 when his arm was caught in a chipper and he developed increasing pain. Petitioner reported constant symptoms, worse with any type of arm activity, fixed head positions, and improvement when lying down. He has numbness, weakness and right arm pain. Dr. Gornet discussed the whole concept of structural spine problems with Petitioner and, based upon Petitioner's history, he felt Petitoner's current symptoms were related to the two work injuries. Petitioner remained unable to work. He requested a CT scan and a weaning off of medications. (PX 13)

On 10/17/11 Petitioner underwent a CT scan of the cervical spine at CT Partners of Chesterfield. The scan revealed some mild disc space narrowing at C3-4 and also at C4-5. At C5-6 there was evidence of a fusion with a metallic interbody device. The radiologist did not see any definite bridging bone. There was a small disc bulge at C6-7. (PX 13)

Dr. Gornet re-examined Petitioner on 10/17/11 and they reviewed his CT scan. Dr. Gornet still felt Petitioner's symptoms were due to the work injuries. While it was originally felt he had a shoulder and arm problem, Dr. Gornet believed Petitioner had a cervical spine issue. They decided to wait for approval for further treatment. (PX 13)

Petitioner was seen at St. Elizabeth's Hospital on 11/9/11 for neck pain. An injection was given. (PX 16)

On 11/9/11 Petitioner called the Dr. Heffner's office and stated that his fusion had come "loose". He said he saw another surgeon who told him it was "pretty bad". He said that this "needs to be rectified" and wanted to hear back from Dr. Heffner as soon as possible. Petitioner told the doctor's nurse that he would "hate for him to get a call from my attorney". (RX 5)

On 11/10/11 Dr. Heffner's office called Petitioner and told him that he wanted to schedule an appointment and that he was to bring x-rays, MRIs or any other test results with him. He was then asked why he did not call Dr. Heffner when he was having problems. He said it was because Dr. Heffner sent him to pain management and they sent him to Dr. Gornet.

On 11/11/11 Petitioner called Dr. Heffner's office and said that he had an appointment with the doctor the following week and wanted to "make sure we were aware of his injury when his arm got caught in the chipper". He said that his work injury is why he needed to see the doctor. They asked him when this occurred and he told them it was on 8/19/10. The doctor's office told him that he had been released from their care on 8/13/10 so they did not know about this injury. (RX 5)

Petitioner again went to St. Elizabeth's Hospital on 11/11/11 for his neck pain and given medication. (PX 16)

Dr. J. Khan examined Petitioner on 11/15/11 noting complaints of right forearm pain since his accident in 2009. He also reported his neck surgery and complained of numbness, tingling, and radicular symptoms in his arm. Petitioner was advised Dr. Heffner would order further studies as needed. (PX 3)

On 11/17/11 Petitioner returned to see Dr. Heffner. He said that he was in the emergency room a couple of months ago and had some x-rays taken and saw a surgeon who told him that he might not have adequate bone growth. However, he did not bring any records or x-rays. On examination he seemed to be nominal. The doctor said he would review any x-ray studies. (RX 3; RX 5)

Petitioner saw Dr. Heffner on 11/28/11 and brought in some x-rays. The doctor said that reviewing the x-rays and comparing them with the ones taken in April 2010 indicated that the metal spacer had not moved in position and that he had a sizable anterior traction spur on the vertebral body of C5 that had resorbed since April 2010 suggesting good limitation of motion at the C5-6 level. He said there was some mild amount of lucency around the superior portion of the metal graft suggesting inadequate bone growth. The doctor concluded that he did not believe that another surgery would be necessary and that he would have to stop smoking, if he did. He said that his original problem at C5-6 could relate to repetitive trauma, although he did not have a specific injury to his neck. He said that the employee told him he did a lot of heavy lifting with his job activity as well as running a jack hammer and these kinds of things could certainly lead to repetitive trauma in the cervical area. (RX 3; RX 5)

On 12/13/11, 1/13/12 and 2/10/12 Dr. Richardson prescribed Ambien, Vicodin and Oxycodone.

Dr. Gornet re-examined Petitioner on 12/15/11 noting Petitioner was being weaned off his OxyContin and now only sporadically taking hydrocodone. He was released to light duty and no lifting greater than 20 pounds and no driving while on narcotics. He still thought Petitioner's condition (a failed fusion) was work-related. Further treatment could proceed once Petitioner was off all narcotics. (PX 13)

Petitioner failed to show up for his 1/26/12 appointment with Dr. Hefner. (RX 5)

On 3/1/12 Petitioner saw Dr. Mahruhk Khan with Gateway Healthcare. He diagnosed his condition as chronic pain syndrome. (RX 2)

On 3/29/12 Petitioner saw Dr. Crystal Carmichael (Gateway Healthcare). He was receiving Oxycontin from Dr. Richardson. Diagnosis was chronic pain syndrome. He was prescribed Dilaudid 4 mg. every 4-6 hours as needed for severe pain and Amitryptiline for chronic pain. (RX 2; PX 3)

On 4/12/12 Petitioner returned to Gateway Healthcare. Petitioner was complaining of pain on his right arm, throbbing in nature. He rated the Pain in his right arm was 9/10. He wanted refill of Dilaudid and MRI. Diagnosis was right elbow/forearm pain. He was prescribed Cymbalta. A graft site on Petitioner's right forearm was noted. (RX 2; PX 3)

Petitioner saw Dr. Fox on 4/16/12. He said he was unable to tolerate Morphine Sulfate. He was taking Vicodin but ran out of Oxycodone. He noted that he tried to get some more Oxycodone but the pharmacist told him that he had to have a written prescription and could not be phoned in. She noted that the "patient has been very demanding with respect to his pain medications despite missing appointment 4/4/12." He still had right neck and arm pain, right hand and forearm pain and tingling and numbness. Diagnoses were as before. She wanted to schedule an MRI of the right forearm and schedule EMG/NCV of the right arm. She emphasized that he follow a narcotics agreement. His Oxycodone and Vicodin was refilled. She noted that he had been obtaining medications from two different pharmacies. She told him that in the future they would only be filled at one pharmacy. She also told him that any visits to the emergency room would have to be reported to her.

As of 4/26/12 Dr. Gornet believed Petitioner was still suffering from neck pain and headaches going into his right shoulder, arm, trapezius and hand with numbness and tingling all of which emanated initially from Petitioner's 5/20/09 accident. Due to Petitioner's narcotics problem, further treatment could not be given. He was referred to Dr. Boutwell for weaning. (PX 13)

Petitioner returned to Dr. Fox on 5/16/12. She noted that he had significant pain relief with his Oxycodone. He was told to restart his Gabapentin and was continued with his

Vicodin and Oxycodone. The other tests had not been performed. His Ambien was also renewed. He was told to see a Dr. Cowan for a psychiatric evaluation.

Petitioner returned to Dr. Fox on 6/18/12. He had undergone the nerve conduction studies and the MRI of the forearm. There were no significant indications for nerve damage. He had some mild carpal tunnel syndrome on the right. The MRI of the forearm was normal. He had decreased range of motion of the right shoulder. He had tenderness in the back of the shoulder. Range of motion of the elbow and wrist was intact. He had slightly decreased grip strength on the right. He had posterior neck tenderness without any trigger points. He was told to stop the Oxycodone. He was given Hydromorphone, Gabapentin, Ambien and Vicodin.

Petitioner called Dr. Hefner's office on 7/1/12 wishing to make an appointment. (RX 5)

Petitioner returned to Dr. Fox on 7/12/12. He said that his pain was not being controlled. He still had posterior neck tenderness. His arm examination was as before. She increased his Hydromorphone to 4mg 1-2 tablets every six hours. He was also to take Gabapentin, Ambien and Vicodin.

On 8/3/12 Petitioner saw Dr. Heffner for some component of chronic neck pain for which he needed medications. He had undergone no studies of his neck since 2011. He said that the employee told him that he was "reasonably comfortable with his situation", that he could tolerate it and that he was not "significantly interested" in having further surgery. Examination was nominal. X-rays were ordered. (RX 5)

Petitioner returned to Dr. Fox on 8/13/12. His complaints were the same. His examination was the same. His Hydromorphone was increased and the Gabapentin, Ambien and Vicodin remained the same.

On 9/26/12 Petitioner returned to Dr. Basga Bernard (Southern Illinois Healthcare Foundation) complaining that his hands and his feet would go numb. He was taking Hydromorphone 8mg every four hours. He also complained that his right hand got caught in a wood chipper. He complained of neck pain.

On 10/4/12 Petitioner returned to Dr. Fox. He was out of his Dilaudid. He also said he had a new primary physician, namely a Dr. Bernardi who was working with him to have his neck properly evaluated. Examination was as before. Diagnoses were as before. His medications were refilled.

Petitioner returned to see Dr. Fox on 11/7/12. He said he still had severe pain in the right side of his neck and his shoulder was "catching". Examination was as before. Diagnoses were as before. The Hydromorphone was stopped and he was to take Oxycodone IR, Gabapentin and Vicodin.

He returned to Dr. Fox on 12/6/12. The pain was the same as before. Examination was as before. His Oxycodone, Vicodin, Ambien and Gabapentin were refilled.

Petitioner underwent a CT of his abdomen and pelvis on 1/7/13 due to right lower quadrant pain and nausea. (RX 8)

On 3/29/13 Petitioner returned to Gateway Healthcare. He complained of pain and numbness in his legs. He was prescribed Gabapentin. No right forearm complaints were noted. (RX 2)

On 4/3/13 Dr. Fox wrote prescriptions for Vicodin and Oxycodone IR.

On 4/12/13 Petitioner presented to Memorial Hospital emergency room. He complained of chronic neck pain. He said that he would suffer from neck flares that were worse than usual. He complained of distal numbness and tingling in both upper extremities. He said that he rated his pain level at 7/10. Examination revealed tenderness to touch in the neck. There were no other neurological deficits. X-rays showed the fusion at C5-6. The employee said he felt much better after taking a dose of Dilaudid and was ready to go home. X-rays taken of that date at Memorial indicated a fusion device at C5-6 with a near complete fusion at that level. (RX 5; RX 8; PX 27)

4/18/13 x-rays showed a sold cervical spine fusion. (RX 5)

On 4/29/13 Petitioner returned to Dr. Fox. She said that his pain on the right side of his neck and shoulder had increased and he was requesting trigger point injections. He was given four trigger point injections. Diagnoses remained the same. Morphine Sulfate ER, Oxycodone IR, Vicodin and Gabapentin were refilled.

On 5/2/13 Petitioner was seen at SIFH in follow-up for pain medication. Petitioner complained of knee pain and tingling and coldness in his feet. Medication was given. (RX 8)

On 5/4/13 Dr. Bernard wrote a prescription for Ibuprofen 800mg.

On 5/29/13 Petitioner returned to Dr. Fox. Complaints and findings seem to be the same. He once again had to sign a drug policy agreement. The Morphine Sulfate ER was increased; Oxycodone, Vicodin and Gabapentin remained the same.

Petitioner saw Dr. Heffner on 5/31/13 and continued to complain of chronic neck pain and pain into his right shoulder. He said his neck pain was on a constant basis. He had difficulty in turning his head. He had difficulties with his knees and because of that he was using a cane. Examination revealed some tenderness over the right shoulder and

some tenderness over the knee joints. The doctor thought that x-rays showed the resorption of the anterior tractor spur indicative of elimination of motion at C5-6. He said there was some mild lucency around the metal spacer, but there was bone growth visible as well. The doctor said he thought he had partial bone growth and because of that it was very questionable whether additional surgery at that level would be a requirement. He was to follow up with the doctor in a few months. (RX 5) Petitioner did not return to Dr. Heffner. (RX 5)

Petitioner was seen at the emergency room on 6/1/13 for a stye in his eye. (RX 8) He returned again on 6/19/13 for an eye infection, noting he still could not work as he was disabled. (RX 8)

Petitioner returned to Dr. Fox on 6/27/13. He said he could not sleep. Examination was as before. He was taking Morphine Sulfate ER, Oxycodone, Vicodin and Gabapentin.

Petitioner returned to Dr. Fox on 7/25/13. He said that the increase in the Morphine Sulfate achieved a satisfactory level of pain control but that this left him sleepy. He said that he had tingling and numbness in the right arm. Assessment on this date was chronic right neck and right arm pain that was significantly decreased; history of disc compression at C5-6; right hand and forearm tingling and numbness-stable; persistent financial and social stressors and chronic depression and anxiety due to chronic pain. All medications remained the same and he was to return to see Dr. Fox in one month.

Petitioner was seen at SIFH on 11/6/13 for pain in his lower back. He also needed a dental referral for a broken tooth. Chronic pain syndrome was noted among other conditions. (RX 8) He returned again on 11/18/13 for abdominal pain but left before being examined. (RX 8) He returned again on 11/19/13 due to weakness and cellulitis in his toes. (RX 8)

Petitioner was under surveillance on 12/21/13 and 12/22/13. (RX 12)

At Respondent's request, Dr. Lange re-examined Petitioner on January 6, 2014 and a written report followed. Petitioner presented with residual symptoms he attributed to his work activities. While Petitioner initially suggested two work accidents, he was now claiming a third one as he felt his "symptoms initially began in '08'." (RX 1, Dep. Ex. 6) There was no single incident at that time; rather, he attributed his problems to repetitive heavy activities including the use of a jackhammer. Although he had right shoulder complaints, it was his belief that he also had a neck problem "even then." He then had the second issue in May of 2009 when lifting the culvert pipe and it significantly worsened his right shoulder discomfort. Petitioner then had a third accident on September 18, 2009 when his arm got stuck in a chipper and his neck, right shoulder and right upper extremity were aggravated by that incident. Subsequent to the wood

chipper event Petitioner reportedly underwent surgery "real quick." In actuality the surgery was March 11, 2010 after which Petitioner was better for three months and then they returned. Dr. Heffner reportedly had never released him and his care was transferred to other physicians. Petitioner's biggest problem was neck pain and diffuse discomfort about his right shoulder and parascapular region He also reported a persistent ache over the medial/proximal right forearm where he was hit by the chipper along with intermittent tingling in his right hand digits and a feeling of coldness. An exam was performed and medical records were reviewed. Dr. Lange's assessment was status post C5-6 anterior cervical fusion and chemical dependency. His causation opinion regarding Petitioner's neck remained unchanged. He did feel Petitioner was disabled for essentially all occupations at this point in time, in part due to his chemical dependency. While further treatment was necessary it would not be for a work-related issue. (RX 1 – Dep. Ex. 6)

Petitioner presented to SIHF on 3/18/14 for a routine check up on ongoing neck and right shoulder problems, bilateral knee pain, and dental caries. (RX 8)

On 3/24/14 Petitioner returned to Dr. Mary Fox for follow up. He told her his pain was better controlled with the current increase in the Morphine sulfate. He had decreased his use of Oxycodone to four every 24 hours and was using about six Hydrocodone per day. With regard to the physical examination she said that he was in no acute distress, he was using a cane in his right hand and that he had a mild antalgic gait. Assessment remained the same and she prescribed him Morphine Sulfate ER, Oxycodone, Hydrocodone and Gabapentin.

On 4/23/14 Petitioner returned to Dr. Fox. He said that his pain had "flared up". He ran out of Oxycodone about a week ago. He was taking 6-8 Hydrocodone per day. He was complaining of muscle cramps for two weeks and his personal physician had ordered lab tests. Physical exam was as before. Assessment was as before. He was prescribed the same medication as before.

Petitioner returned to Dr. Fox on 5/21/14. Examination was as before as was the assessment. Medications and amounts remained the same.

On 6/22/14 Petitioner went to Memorial Hospital complaining of neck pain. He gave a history of chronic neck pain that was due to an independent accident. He said that he sustained further injury to neck after he had a fusion. Later his right arm was caught in a wood chipper and he had pulled his arm out of the chipper, which later led to further damage to his neck. Diagnoses were dental caries and cervical radiculopathy. He was given Penicillin and Vicodin. (RX 8)

On 6/23/14 Petitioner returned to Dr. Fox. He said that he had overused his Morphine Sulfate due to severe tooth pain and a flare-up of neck and arm pain. He said he had

been only taking Hydrocodone since 6/12/14. He said he was seen in the emergency room at Belleville Memorial the day before and issued 30 Hydrocodone tablets. He said his average pain was 6/10 with a spike of up to 8/10. It was noted that he appeared to be in more pain and he was still using the cane. He also had tender right paracervical muscles with spasm extending into the right upper back. She added a diagnosis of acute-on-chronic right neck and arm pain and apparent overuse of opioid medications. She said that she had a lengthy and serious discussion with him concerning the use of the opioid medications. He wanted to see if he could find a pain management doctor in Illinois. Medications and amounts remained the same.

On 7/14/14 Petitioner returned to Dr. Fox. She said that this was an "early" visit. His average pain level was 4/10 and up to 7/10. Examination indicated that he was in no acute distress and he was ambulating with a cane in the right hand. She said that he had returned to his base line chronic right neck and right arm pain. Medications and amounts remained the same.

Petitioner again presented to SIHF on 7/22/14 regarding knee pain and low back pain. A psychiatric referral was recommended. (RX 8)

Dr. Lange was deposed on 8/5/14. (RX 1) He testified consistent with his earlier reports.

On 8/20/14 Petitioner returned to Dr. Fox. He said he wanted to see an orthopedic surgeon for his knee. He said he was on a new medication for his "nerves" from his personal physician. He said it was helping with irritability and anxiety. Examination revealed a mildly antalgic gait with a cane in his right hand. She said that he had chronic right neck and arm pain that fluctuated. Everything else remained the same. All the medications and their amounts remained the same.

On 9/8/14 Petitioner returned to Dr. Fox. His neck pain levels had remained stable since the last visit. Everything remained the same in terms of assessment and all the medications and the medication amounts remained the same.

Petitioner saw Dr. Fox again on 10/8/14. He said that his neck pain and right arm pain levels were fluctuating. He was complaining of more pain in his left arm, perhaps with the use of a cane. His average pain level was 4/10 and it was up to 7/10. Again the physical examination was the same as were the assessments of his conditions of ill-being. All the medications remained the same.

Petitioner returned to see Dr. Fox on 11/10/14. Neck and right arm pain levels increased lately due to his sister move out of their parents' home causing him to have more care tasks to perform. Physical examination was unchanged. Diagnoses were

unchanged. Medications prescribed included Morphine sulfate, Oxycodone IR, Hydrocodone and Medrol Dose Pak.

Petitioner was again under surveillance on 12/3/14 and 12/4/14.

Petitioner underwent bilateral knee x-rays, hip x-rays, and lumbar/thoracic spine x-rays at Dr. Mahrukh Khan's request on December 8, 2014. The latter revealed degenerative changes. (RX 2)

On 1/3/15 Petitioner underwent right foot x-rays due to right heel pain of six weeks duration. He denied any injury. (RX 8)

Petitioner continued to see Dr. Fox and his treatment remained the same.

Petitioner's case proceeded to arbitration on April 23, 2015. Petitioner testified that he was 59 years old at the time of hearing. He stated that he last worked for the City in 2009 and had worked about three years for them prior to that as a skilled laborer. He stated that he would perform a number of different activities, including lifting, shoveling, digging holes, weed eating, grass cutting, forming concrete, loading and unloading trucks, cleaning up, jack hammering, painting stripes and disposing of bulk trash. He stated that he started having symptoms in his right shoulder in 2008. He also had symptoms in his neck. He said that before 2009 he would take some medications and perform stretching exercises, but his shoulder was still bothering him in the spring of 2009. The pain seemed to be behind his right shoulder blade. He said that he was off work for 2-3 weeks in May 2009 and when he returned they were working with culvert pipes on driveways. He testified that he would have to get the pipe himself because they did not have any equipment.

He also testified that he did a lot of pot hole patching in April 2009. The culvert that he was lifting was aluminum in nature. He also did a lot of tree trimming where he would stand on the back of a truck and use a tree pole saw. Further, he was using a wood chipper to take care of the tree limbs that were removed. He stated that he also put in a lot of stop signs. He used a jackhammer maybe twice in the spring of 2009.

He said that on July 20, 2009 he was picking up pipes and used a jackhammer and his neck and shoulder started to bother him. He also testified that he was working with some concrete forms and that they were also using a device called a screed to level concrete. After that day he spoke to his supervisor and told him that he was in pain and he wanted to seek treatment. He filled out an incident report. He said that he underwent an MRI for his neck and that he reported that to his supervisor. He testified that he was off work for some time and then returned to work on 8/17/09. He said that he was still having some pain when he lifted or used his right arm.

He testified that on 8/19/09 they were trimming tree limbs and they were using a chipper after the limbs were cut. He said that he and a co-worker pulled a lever to start the chipper and something slammed on his right forearm. He said that he began screaming and was pulling and tugging on his arm. He said that his co-worker heard him, turned off the chipper, ran around to his side of the chipper and helped him pull his arm out of the chipper. He said that the plate that struck his arm on the chipper struck his right forearm about half way between his wrist and right elbow.

He testified that immediately after that event he experienced a lot of pain in the right forearm and up and down his right arm into his neck. He said that the pain was very bad. He stated that he had to go to the emergency room. He then started seeing a number of different physicians and went to a number of different facilities for treatment. Eventually, Dr. Heffner performed surgery on his neck. After that he saw a number of other physicians including a Dr. Pereira, Dr. Khan and Dr. Lakho. He was also referred to Dr. Robert Schultz for a second opinion. He saw a Dr. Bernard in 2012. He said that he had been referred there by Dr. Khan. He saw Dr. Matthew Gornet, who he also says he was referred to by Dr. Khan.

He was asked specifically about the types of difficulties he was having before the event of 8/19/09 and after the event of 8/19/09. He said that just before the event of 8/19/09 he testified to pain if he lifted or grabbed something. He said that he would have some throbbing, but it wouldn't last long. He said that if he lay down or took pain medication, it would normally go away. However, after the event of 8/19/09, he testified that his pain was "unbearable". He would have pain in his neck, down his right arm, with tingling of his fingers. After surgery he took a number of different pain medications prescribed by a number of different physicians.

At the hearing he testified that his pain level was a 4-5/10, provided he was taking his medication. He would experience numbness and tingling in the last three fingers of his right hand. He said he could not pick up anything over 5-10 pound. He could not raise his arm over his head except occasionally. He had difficulty moving his neck. He drives, although he is not supposed to drive given the medication that he is taking. He said that his medication would cause him to have a lot of anger, sadness and depression. He testified that he did very little during the course of a day because of his pain and the effects of his medication. He had not searched for any work since he last worked for Respondent. He testified that he was using a cane because the medication caused him to fall on one occasion while he was walking. He said that one of his treating doctors told him to use the cane at all times and that he used it because he was fearful of falling again.

On cross-examination he once again confirmed that he used the cane because of his medication, and denied that his knee problems had any role in the use of this device.

He admitted that Dr. Khattak had provided him with a number of injections in both of his knees.

He denied completing any information that was submitted with his time cards. He said that he never indicated what jobs he performed each day unless he was a lead person over the pot hole patch crew. He did say that he would write down what he did each day in a log book.

Petitioner was questioned regarding the activities that he believed he performed in a repetitive manner that caused problems with his neck or arm. He testified that it would have been pouring and pulling concrete. He thought that he would have to do this about ten times a month. He also stated that jack hammering, maybe twice a month, caused him problems. He stated that using a product called "cold patch" was difficult in that it would harden and would be difficult to shovel out of the back of the back of a truck. He said that he had to patch pot holes for Respondent every day for three months in a row.

Petitioner was questioned regarding his application for 7/20/09 wherein he alleged that he picked up some forms and felt pain in his right shoulder and neck. He admitted that his attorney had prepared that application, that had read it and signed it, and that he agreed that lifting concrete forms on 7/20/09 caused his right shoulder and neck pain. He said those forms weighed probably 50 to 60 pounds.

He once again stated that following the event of 7/20/09 he had pain in his neck and right arm and some tingling and numbness in his right hand. He said that the only similar symptom he had before that date was stiffness in the back of his right shoulder . He admitted that it was difficult for him to remember things because he was taking medication and it had been a number of years since some of the events took place.

Whenever he sought medical treatment he stated that he would try to give the doctor's as much information as possible and be as honest and straight forward with them as he could. He wanted to give them the proper information because he wanted proper care and treatment.

He testified that when he first saw Dr. Khattak on 7/22/09 he told him what had occurred at work. He also acknowledged going to St. Elizabeth's Hospital on 7/29/09 for the performance of an MRI, but could not recall what he might have told them about how his pain started in his neck. When asked if the records of St. Elizabeth's Hospital on 7/29/09 were correct in that it showed that he told them that he had neck symptoms for about six months prior to his visit, it was his belief that the history was incorrect..

He stated on cross-examination that the event of 8/19/09 made his prior symptoms in his neck and right arm worse and that they never returned to the same level as they

were before 8/19/09. He also reiterated that the event of 8/19/09 required the assistance of his co-worker to help him pull his arm out of the chipper, that he was screaming and that there was quite a bit of trauma to his right arm. He stated that when he went to the emergency room his arm was examined, and it was already swollen when he went there. He also complained of having a bruise already on his arm. He denied telling the staff at Memorial Hospital on that date that he had neck pain, but that it was due to an old injury.

He admitted seeing Dr. Khan following the event of 8/19/09 and being referred to St. Elizabeth's Hospital for physical therapy that began on 8/25/09. He was asked about the history that he provided to the medical providers at St. Elizabeth's Hospital on 8/28/09 when they recorded that he told them that his neck problems began in September 2008. He testified that he did not provide them with that history.

He was questioned regarding his Application for Adjustment of Claim concerning the event of 8/19/09. He admitted to reading over it after the attorney had completed it. He was asked why it merely listing his right arm when he was claiming that the event injured not only his right arm, but his neck (Id.). He had no explanation as to why his application merely said it was his right arm when he had always stated that the event aggravated his "C5-C6".

He was questioned about a second Application that he filed alleging a date of accident of 7/20/09 wherein he claimed injury through repetitive trauma. He was asked if he listed that the body parts injured were his neck and both shoulders. He said that he did not believe that he told his attorney that he hurt both shoulders. He stated that he did not say anything about both of his shoulders being hurt and that he was not making any claim for his left shoulder.

When asked whether it was repetitive trauma or the lifting of the forms on 7/20/09 that caused the injury to his right shoulder, right arm and neck, he said it was the repetitive activities.

Petitioner stated that he saw Dr. Robert Schultz in October 2009. He stated that he was referred there by Dr. Khattak. He said he could not recall what he told Dr. Schultz at that time and he would agree that his memory was probably better back then than it is now. When asked if the history recorded by Dr. Schultz stating that he had injured himself around the end of June when he was pulling on some rebar and using a jack hammer was correct, Petitioner stated that it was not correct. He insisted that he was there merely for a consultation and not for any treatment. He admitted that Dr. Schultz gave him medication after his first visit with him, but that he did not fill those prescriptions. He also admitted that Dr. Schultz wanted to see him again, but he did not return. He said that Dr. Khattak had something to do with his failure to return to Dr. Schultz. When he was asked whether the real reason for not seeing Dr. Schultz

again was because Dr. Schultz wrote him a letter stating that he did not want to see him again because he thought that Petitioner was abusing medications, he denied that was the reason, but did admit to receiving such a letter.

When he was confronted with the fact that he had seen five different medical providers in November 2009 and that all of them provided him with some medication, he denied that all of those medical providers gave him medications. However, he did recall that Dr. Khattak only gave him 20 Vicodin during that period of time and that Dr. Khattak told him that he could take all the medications that had been prescribed by Dr. Hall at that time. He was asked how he could remember those details in light of his previous testimony that he could not recall much of what occurred several years before the hearing, and he said it was because he had a dispute with Dr. Khattak and he was just following his orders.

Petitioner was then asked about records that showed that Dr. Khattak had referred him to Dr. Hall to take care of his pain medication, but that he continued to see Dr. Khattak and got medication from him. He once again testified that Dr. Khattak only gave him 20 pain pills and he thought he could continue to see Dr. Hall and get medications from his as well. He did admit that if Dr. Khattak's records showed that he was prescribed medication by him, he would have no reason to dispute that.

Petitioner agreed that he saw Dr. Lange on 1/28/10 and that Dr. Lange talked to him about how he got hurt. He agreed that he told Dr. Lange that he had been shoveling asphalt and using a post hole driver, that those activities worsened his shoulder pain, but that in July 2009 he was lifting a culvert pipe that increased his shoulder pain.

Petitioner stated that he could not recall what history he provided to Dr. Heffner on 2/5/10. After some dispute about what the records said on that date, he agreed that if Dr. Heffner's note of that date stated that he had been doing his regular job without a specific injury, that he did a lot of heavy lifting, that he had a work injury to his right arm in September 2009, but that he made it clear to the doctor that his neck injury was not related to any specific work event, then the records would be true. He also agreed that if Dr. Heffner stated a second time in his note that there was no specific injury that caused his problem, then that would be true.

Petitioner was asked why, if Dr. Hall had been requested to fill his pain medications by Dr. Khattak, did he still continued to see Dr. Khattak for medications, he testified that Dr. Hall was treating him for blood pressure and other things and that Dr. Khattak was giving him too many Vicodin. He also agreed that if the records showed that both Dr. Hall and Dr. Heffner had given him pain medication in April 2010, even though he told Dr. Hall that Dr. Heffner would not give him medication that would be true, but that he never took any medication from both of them as noted in the record. He also disputed the fact that the records indicated he was taking pain medication from Dr. Khan and Dr.

Hall in April 2010, although he stated that the prescriptions were only 5-8 days. However, he then admitted that he could not recall how many pills he was specifically given by those physicians at that time. He did agree that he was probably taking all medication that was prescribed to him by the doctors.

Petitioner denied calling Dr. Heffner's office to discuss what had caused him to have neck surgery. He was specifically asked if the doctor's records were accurate in stating that on 5/6/10 he had called in, requesting a note stating that the surgery was work-related. He said that that was a false statement by the doctor's office (Id.). He reiterated that the statement as contained in the doctor's records of 5/6/10 was something that he did not provide them. He said that it was the "machine's statement" not Dr. Heffner's own note on that date.

Petitioner was asked if he stopped seeing Dr. Khattak in June 2010 and he agreed, stating that he stopped seeing him because Dr. Khattak did not keep good records. However, he admitted that there was a note in his file from Dr. Khattak of 6/14/10 stating that Dr. Khattak had discharged him as a patient because he knowingly violated a narcotic agreement. He denied that Jawad Khan refused to see him after June 2010. He denied having a disagreement with the physical therapy department at St. Elizabeth's Hospital in June 2010 and said that if Dr. Heffner's records showed that he called his office, complained about the therapist, and wanted his records changed because he thought it would hurt his case, that would be another false statement by Dr. Heffner's office. He also testified that if Dr. Heffner's records from a visit of 6/11/10 said that he had made outstanding progress following his surgery, that would be an incorrect statement as far as he was concerned. He did agree that when Dr. Heffner's office wanted to return him back to Dr. Khattak, he told Dr. Heffner's office that he did not want to do so because Dr. Khattak wasn't doing anything for him. He did not tell Dr. Heffner that Dr. Khattak had discharged him for violating a narcotics agreement. He did agree that Dr. Hall told him in June 2010 that he would not give him any further medications. He stated that he would go to emergency rooms for treatment of his neck because the medication he was taking was not effective and it usually took an injection of Dilaudid or Morphine to ease his pain.

Petitioner stated that the records of Dr. Eugene Pereira on 8/16/10 were false in stating that the surgery had provided him with some relief. He recalled that Dr. Lakho did release him to return to work on a light duty basis in September 2010, but denied that he told the doctor's office that if he did return to work and got reinjured, that it was on Dr. Lakho. Even though he stated that he had been approved for a spinal cord stimulator as recommended by Dr. Pereira, he had no explanation as to why the records of the doctor did not mention a spinal cord stimulator. He said that he did not know why Dr. Richardson recorded that he got hurt at work on May 20, 2009 when he picked up a piece of pipe. He stated that Dr. Khan had referred him to Dr. Gornet in September or October 2011, even though Dr. Khan's office records ended in June 2010.. He agreed

that he wanted to go back and see Dr. Heffner after he saw Dr. Gornet, and probably told the doctor's office that he (Petitioner) would hate for Dr. Heffner's office to get a call from his attorney. He denied seeing a Dr. Mahrukh Khan and Dr. Crystal Carmichael with Gateway Healthcare beginning in March 2012. He started seeing Dr. Mary Fox in April 2012 who prescribed him Oxycodone, Vicodin, Gabapentin, Ambien and other drugs. He started seeing a Dr. Bernard in September 2012.

Although Petitioner recalled seeing Dr. Heffner in May 2003 about his neck pain, he denied telling Dr. Heffner that he was using a cane because of difficulties with his knees. He said that he told Dr. Fox about his leg collapsing because of his medication. However, she did not alter any of his medications as a result of that.

At the time of the hearing he was seeing both Dr. Fox and Dr. Bernard, but denied that Dr. Bernard was giving him any pain medication. He was taking Oxycodone, Vicodin, and Gabapentin. He said that he tried to wean off his medications one time but Dr. Fox told him not to do so and that he wanted to have surgery with Dr. Gornet.

Petitioner continues to have throbbing pain in the right side of his neck down his right shoulder, down the back of his right shoulder blade, and that the pain goes under his arm, down the side and all the way through his fingers. He continues to experience numbness and tingling in the last three fingers on his right hand and this occurs about two times a week. He is unable to pick up anything over 5-10lbs with his right arm and he cannot raise his arm over his head without a great deal of pain.

With regard to his neck, Petitioner testified he is unable to turn to his right and experiences less range of motion if he is without medication. He described that he is very limited in his ability to drive particularly considering the medication and his limited range of motion.

Petitioner's typical day is to get up, take his medicine and sit on the bed until the medicine starts providing relief about 30-45 minutes later. Sometimes the medicine makes him fall back to sleep. He is able to do some chores around the house such as sweep the floor or take out the trash but it limited due to pain. He takes his medication every six hours.

When asked again about driving Petitioner testified that he is not supposed to drive while taking Morphine but sometimes he does drive to get things that he needs such as making trips to Walmart.

Petitioner was observed to be carrying a cane and testified that he has fallen in the past when the medication (morphine) has hit him so he typically uses the cane wherever he goes.

Christopher Volkman testified for Respondent. He was the Director of Public Works/City Engineer. He held that position for about 5½ years and managed the street department. He was familiar with the work activities of his street crew. He testified that he normally did not have his workers lift more than 75 pounds. They had a number of machines to do lifting and moving of items. He said that it was not standard operating procedure for a worker to lift a culvert by himself as there was always a backhoe in the area to excavate ground to put the pipe in. He said that the material that was used to patch potholes would harden under compression and that the workers were able to shovel that material with a shovel holding about 20 pounds.

He testified to a form called the daily report form that was filled out by the lead laborers and would list all of the daily activities of the street crew, the employees who performed those activities and what equipment was used during the course of a day. That form was completed each day and it was maintained by the City of Fairview Heights. He brought the originals of those forms with him to the hearing. Mr. Volkman also testified to what was called a time sheet form. He said that each employee would have to fill out a time card at the end of each pay period (twice a month) and they would have to put down what activity they performed each day. This was supposed to contain what they did that day and how much time they spent doing it. He said that that would be how the employee would get paid and it would also be used in planning and budgeting for the street department. He provided a copy of the time sheet forms for 2008 and 2009 pertaining to Petitioner (RX 13)

Job logs are found in RX 12. Petitioner was working on 7.20.09 using a truck, roller, and John Deere equipment (small and large). They used cold patch and paint while "Cut R.O.W., painted streets, [?] prep." (RX 12)

Off work slips are found in PX 29.

Petitioner's medical bills are found in PX 30.

Photographs of equipment are found in PX 31.

The Arbitrator notes that many of the exhibits contain highlighting which was not done by her. The exhibits were tendered to her in that manner.

The Arbitrator concludes:

Issue (C) Accident

The Arbitrator acknowledges that the outline of the testimony of Petitioner, the testimony of Respondent's representative and an outline of the medical information in

these cases is quite extensive and detailed. However, this was necessary in order to develop a context in which Petitioner's testimony, and his allegations, are to be determined. Petitioner's credibility was tested on multiple occasions during his cross-examination. When his testimony, and the medical records mentioned above, are compared, it is apparent that Petitioner's testimony was not credible on a number of issues. Petitioner disagreed with many entries placed in the medical providers' notes concerning contact with him, and he went so far as to say that at least two physicians entered false entries in his medical records. However, he admitted that when those statements were made, his memory of the events that had occurred several years ago would be better than his memory of the events now. Even his comments about his recollection of events of several years ago caused the Arbitrator to question his credibility. Petitioner would freely admit that he was incapable of remembering things that he might have told medical providers many years ago, but testified quite clearly as to medications that he was given and even the number of pills that were prescribed 4-5 years ago. When confronted with this dichotomy, Petitioner admitted that he could not recall the specific number of pills given at any particular time.

The various histories that Petitioner provided to the medical providers near the time of the alleged events of 7/20/09 and at the time of the event of 8/19/09 were multiple and varied as well. In particular, the Arbitrator would note that when Petitioner saw Dr. Christopher Heffner, the operating neurosurgeon with regard to his cervical spine on 2/5/10, Dr. Heffner noted specifically in two sections of his record of that date that Petitioner denied any specific event as the cause for his neck and shoulder problems. However, Petitioner insisted during his testimony that not only did the 8/19/09 event injure his right forearm, but it made much worse his right shoulder and cervical spine complaints that he asserted began on 7/20/09. It should be noted that even his complaints of cervical spine issues and upper extremity issues preceded 7/20/09, according to the medical records offered into evidence. It seems that Petitioner would try to provide a history to a medical provider that might advance the cause of his pending Workers' Compensation claims. He gave multiple histories of events occurring in September 2008, May 2009, June 2009, July 2009 and August 2009, including histories of repetitive trauma. He described the alleged single specific event that occurred on 7/20/09 as lifting concrete forms, pulling rebar and using a jack hammer, lifting a culvert pipe or performing other heavy lifting on or about 7/20/09.

A review of the medical records on and after 7/20/09 up until the time of the 8/19/09 event do not reveal any indication of a single, specific event occurring on 7/20/09. Indeed, although the Petitioner alleged that he was lifting concrete forms on that date in his Application for Adjustment of Claim, the time card forms and the daily sheet forms provided by Respondent's witness (Mr. Volkman) do not indicate that Petitioner was handling or utilizing concrete forms at all on 7/20/09. Additionally, Petitioner's testimony that he had to lift a metal culvert by himself on or near 7/20/09 was undermined by Mr. Volkman's testimony that a backhoe was available to lift the culvert

because a backhoe had to be in the area so that it could dig the trenches into which the culvert was to be placed. He also said that it was the normal procedure of the department to use a machine to lift more than 75 pounds.

Further, with regard to Petitioner's credibility, the Arbitrator notes that Petitioner's care with three physicians was terminated for violating narcotic agreements or abusing prescription medications and that an additional physician stopped providing him medications (Dr. Hall). The records are also clear that on several occasions within two to four weeks, Petitioner would see three to five different medical providers and obtain prescription pain medications from all of them, including such narcotics as Oxycontin, Oxycodone, Percocet and Vicodin. Petitioner readily admitted that he did not advise the various physicians that he was receiving medication from more than one source nor did he advise the physicians that he was utilizing more than one pharmacy to obtain his medications. Petitioner admitted that he would go to various emergency rooms to receive injections of Dilaudid or other potent pain medications because his regular pain medication was not sufficient to control his pain, in spite of the fact that he was prescribed potent pain medications in pill form and his only surgical procedure was a single level disc fusion with hardware at C5-6. Indeed, most of Petitioner's physical examinations by the multiple medical providers were nominal in nature.

Although Petitioner may have performed heavy activities while working for Respondent as a skilled laborer, the Arbitrator finds that these activities were not repetitive enough in nature to constitute repetitive trauma under the Act. It is clear that Petitioner performed a number of duties every day (as he indicated during his testimony) and that his duties varied from day to day. Many of the activities were not heavy in nature. It was also apparent that Respondent had various pieces of machinery that could assist with the heavier duties that Petitioner might be required to perform. Further, the daily sheet forms and the payroll forms offered into evidence do not indicate that Petitioner patched pot holes for three months straight as he alleged in his testimony.

Therefore, with regard to the alleged date of 7/20/09 the Arbitrator concludes that Petitioner has 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 that date. In addition to the problems with Petitioner's credibility, Petitioner's testimony was not corroborated by any medical records generated contemporaneously with that date or recent dates thereafter. The early treatment records after 7/20/09 don't mention a work accident on 7/20/09. Petitioner's claim for compensation is denied and no benefits are awarded. All remaining issues are moot.

****

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

Delbert W. Black,

Petitioner,

vs.

NO: 09WC 37681

City of Rockford,

17IWCC0226

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, 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 11, 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.

17IWCC0226

The party commencing 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: APR 13 2017

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CJD/rlc
049

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BLACK, DELBERT W
Employee/Petitioner

Case# **09WC037681**

CITY OF ROCKFORD
Employer/Respondent

17IWCC0226

On 12/11/2015, 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 0.53% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2841 REESE & REESE
TODD REESE
200 W MARKET
TAYLORVILLE, IL 62568

1408 HEYL ROYSTER VOELKER & ALLEN
KEVIN J LUTHER
120 W STATE ST 2ND FL
ROCKFORD, IL 61105

FINDINGS

On **August 7, 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 **$52,270.40**; the average weekly wage was **$1005.20**.

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 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 under Section 8(j) of the Act for benefits documented.

ORDER

Respondent shall pay reasonable and necessary medical services of $48,767.75, as detailed in Petitioner's Exhibits 6-13, 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 pay Petitioner temporary total disability benefits of $670.13 /week for 5 weeks, commencing January 25, 2010 through February 28, 2010, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $603.12/week for 50 weeks, because the injuries sustained caused the 10% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

December 10, 2015
Date

DEC 11 2015

described the whiplash injury and that it continued to cause him some discomfort. "But about 10 days or so ago, which is about 2 weeks after the accident; he had the first onset of sharp left shoulder discomfort at home. Petitioner noted that he never had left shoulder discomfort before the accident. He notes that this is the shoulder that was bumped during the accident." Dr. Dorsey further noted that the neck and left shoulder complaints were absolutely two different symptoms and the shoulder symptom never was there prior to the accident. Dr. Dorsey's impression was that Petitioner had rotator cuff dysfunction on top of a whiplash injury. Petitioner's physical therapy was continued and he was told to follow up with Dr. Hahnel.

On September 21, 2009, Petitioner followed up with Dr. Hahnel. He had been attending physical therapy, but he has not had any attention to his left shoulder. He was to continue with physical therapy and give attention to the left shoulder. An MRI of the left shoulder was ordered (PX 2). The September 26, 2009 MRI of the left shoulder revealed a down sloping acromion impinging on the musculotendinous supraspinatus, hypertrophy of the acromioclavicular joint noted with osteoarthritic changes, focal high signal changes noted in the distal tendon of the supraspinatus with adjacent bony cystic changes in the humerus and suspect tendinosis of the supraspinatus tendon (PX 3). On October 26, 2009, Petitioner followed up with Dr. Hahnel. Dr. Hahnel reviewed the x-rays and MRI of left shoulder and referred Petitioner to Dr. Brian Bear (PX 2).

The October 27, 2009 unsigned Physician Consultation Request states, "Left shoulder pain, right side neck pain post MVA 5 years ago - fell last week reinjuring shoulder/neck" (PX 2). Petitioner testified that he did not have any falls that injured his left shoulder and/or neck and that he never told anyone that he had a fall. Dr. Bear testified that he was never given a history of any fall and injury to the left shoulder and/or neck (PX 18).

On November 12, 2009, Petitioner was seen by Dr. Brian Bear at Rockford Orthopedic Associates. The records of Rockford Orthopedic Associates were admitted as Petitioner's Exhibit 4. Petitioner provided a consistent history of accident noting that his airbag did not deploy. His complaints were left shoulder pain and recheck right shoulder. Dr. Bear records that Petitioner noted left shoulder pain three weeks after the accident. On examination of the left shoulder, Hawkins impingement test was mildly positive and Neer impingement test was positive. There was tenderness over the anterior lateral aspect of the left shoulder. Yergason test was positive and O'Brien's test was positive. The 9/26/09 MRI of the left shoulder was reviewed. Dr. Bear's assessment was impingement syndrome and capsulitis. Dr. Bear recommended an injection and to continue physical therapy and medication. Dr. Bear performed a left shoulder epidural steroid injection.

On December 22, 2009, Petitioner followed up with Dr. Bear for his left shoulder pain. He was doing slightly better in comparison to the last visit. The main complaint was pain in the anterior portion of the shoulder. The injection at last visit was beneficial but now it is starting to wear off. Range of motion had improved since physical therapy. Petitioner stated that when he does any lifting, his arm will start shaking. Dr. Bear gave an assessment of: impingement syndrome; rotator cuff partial thickness tear; and biceps tendonitis. Dr. Bear stated that Petitioner had failed conservative treatment and the symptoms were severely affecting his quality of life, and ability to perform activities of daily living and work. Dr. Bear recommended surgical treatment.

On January 25, 2010, Dr. Bear performed a left shoulder suprascapular nerve block, arthroscopic glenohumeral joint debridement, subacromial decompression and bursectomy (PX 5). Petitioner saw Dr. Bear for follow up care through June 29, 2010. On February 22, 2010, Dr. Bear continued Petitioner's treatment and gave work restrictions of one handed work with the right hand and return to work at six weeks post surgery with a five pound weight restriction. At ten weeks post-surgery, Petitioner would be allowed to return to unrestricted work (PX 4). Petitioner testified that he returned to work on March 1, 2010. Petitioner was seen

Conclusions of Law

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

Petitioner sustained an undisputed accident on August 7, 2009 when his van was rear ended. He sought immediate treatment for whiplash complaints in the neck. Petitioner was diagnosed with a cervical strain. On August 31, 2009, Petitioner added complaints in the left shoulder. Dr. Bear testified that the left shoulder condition which he treated was caused by the accidental injury sustained on August 7, 2009. Dr. Benson testified that the accident was aggravating factor, but that it was not significant. Both Dr. Bear and Dr. Benson agree that Petitioner had preexisting degenerative pathology in the left shoulder found on MRI and during surgery. There is no evidence that Petitioner had any prior complaints or treatment to the left shoulder. Dr. Bear testified that his examinations through August 14, 2007 while treating Petitioner's earlier right shoulder injury did not reveal any condition of ill being in the left shoulder

If the claimant had health problems prior to a work-related injury, he bears the burden of showing that the preexisting condition was aggravated by the employment and that the aggravation occurred as a result of an accident which arose out of and in the course of his employment. The accident need not be the sole or principal cause, as long as it was a causative factor in the Petitioner's condition of ill-being. Petitioner testified that he initially had a throbbing in the shoulder, but was more concerned with his neck. The initial records document that he was wearing his shoulder harness when he was rear ended. Dr. Bear opined that the Petitioner's left shoulder condition is causally connected to the accident on August 7, 2009. Dr. Bear testified that the pain began within a reasonable timeframe after the accident and explained the reasoning for his opinion based upon the mechanism of injury and biomechanics of the shoulder. While questioning the significance of the accident based upon his assessment of the forces shown by the photos of the vehicles, Dr. Benson agreed that the accident was aggravating factor. The Arbitrator finds the opinion of Dr. Bear persuasive and notes that Dr. Benson's opinion does not dispute a causal relationship based upon his admission that there was an aggravation of the shoulder condition as a result of the accident.

The Arbitrator notes that Petitioner did not submit any medical evidence with respect to the alleged condition of ill being in the neck or back other that the emergency room records and the records of Rockford Clinic through October 27, 2009. Petitioner testified to a preexisting condition with ongoing treatment to the neck and back. At the time of the August 7, 2009 accident, he was taking Vicodin several times per week. Dr. Benson provides the only opinion with respect to the low back, testifying that Petitioner's back condition was not caused by the accident.

Based upon the record as a whole, including the testimony of the Petitioner, the medical records admitted and the opinion of Dr. Bear, the Arbitrator finds that the Petitioner has proved by a preponderance of the evidence that, as a result of the accidental injuries sustained on August 7, 2009, Petitioner suffered the condition of ill being in the left shoulder as diagnosed, treated and testified to by Dr. Bear, and a cervical strain as diagnosed by St. Anthony Emergency department.

With respect to the left shoulder, Petitioner was diagnosed with impingement syndrome and underwent arthroscopic surgery consisting of a glenohumeral joint debridement, subacromial decompression and bursectomy. He returned to work on March 1, 2010 and was discharged from care on June 29, 2010. His main complaint at that point was pain at times in the anterior portion of the shoulder with certain activities. He notices when he lifts anything over 40lbs, then his arm will start to shake. The quality of pain was a throbbing type of pain intermittently. He rated pain at 1/10 at rest and 3-7/10 with certain activities. Petitioner was released with restrictions of no overhead work and no lifting greater than 25 pounds. He has sought no further medical treatment thereafter. Although he was given a 25 pound lifting restriction, he has testified that he already had been given that restriction before the accident. He has returned to his regular job.

Based upon the record as a whole, the Arbitrator finds that, as a result of the accidental injuries sustained on August 7, 2009, that the Petitioner has sustained a loss of 10% of the person as a whole pursuant to Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Randy Russell,
Petitioner,

17IWCC0248

vs.

NO: 09 WC 39491

City of Fairview Heights,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 19, 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: APR 21 2017
o4/6/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0248

RUSSELL, RANDY
Employee/Petitioner

Case# **09WC039491**

09WC036449
10WC018033

CITY OF FAIRVIEW HEIGHTS
Employer/Respondent

On 6/19/2015, 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 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

3067 KIRKPATRICK LAW OFFICES PC
ERIC KIRKPATRICK
3 EXECUTIVE WOODS CT
BELLEVILLE, IL 62226

0810 BECKER PAULSON & HOERNER PC
RODNEY THOMPSON
5111 W MAIN ST
BELLEVILLE, IL 62226

17IWCC0248

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

Randy Russell
Employee/Petitioner

v.

City of Fairview Heights
Employer/Respondent

Case # **09** WC **39491**

Consolidated cases: **10WC18033 & 09WC36449**

An *Application for Adjustment 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 **Collinsville**, on **April 23, 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 **Whether Petitioner exceeded his choice of two physicians under the Act.**

FINDINGS

On **8/19/09**, 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, in part,*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$44,665.34**; the average weekly wage was **$858.95**.

On the date of accident, Petitioner was **49** years of age, ***single*** with **1** child under 18.

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 general credit for any medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$572.63 per week** for **7-2/7 weeks** commencing **August 20, 2009** and ending **October 9, 2009**, as provided in Section 8(b) of the Act.

If not previously paid, Respondent shall pay for the reasonable and necessary medical services of the medical providers who treated Petitioner's right forearm injury following the event of 8/19/09. Specifically, Respondent shall be responsible for, and hold Petitioner harmless from, the emergency room visit at Memorial Hospital on 8/19/09; the office visits with Dr. Jawad Khan of 8/21/09, 8/25/09 and 9/1/09; the physical therapy services provided to Petitioner's right forearm area only with St. Elizabeth's Hospital beginning 8/25/09 and ending on 9/2/09 and from 9/10/09 through 10/9/09; and the office visits with Dr. Hafiz Khattak of 9/9/09 and 10/9/09.

Respondent shall pay Petitioner permanent partial disability benefits of **$515.37 per week** for **7.59 weeks** because Petitioner sustained **3% permanent partial disability of the right arm under Section 8(e)10 of the Act.**

Respondent shall pay Petitioner compensation that has accrued from **August 19, 2009** through **October 9, 2009** and shall pay the remainder of the award, if any, in weekly installments.

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

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

Signature of Arbitrator

June 19, 2015
Date

JUN 1 9 2015

Randy Russell v. City of Fairview Heights
Case Number: 09 WC 39491

Findings of Fact and Conclusions of Law

Three cases were consolidated for purposes of trial and the parties agreed that only one proposed decision covering all three cases would be prepared. There were two claims filed with a date of accident of 7/20/09. Case number 09 WC 36449 alleged a single, specific event with a date of 7/20/09 wherein Petitioner alleged that he injured his right shoulder and neck while lifting concrete forms. Case number 10 WC 18033 was an Application wherein Petitioner alleged that he sustained neck and both shoulder injuries as a result of repetitive trauma activities through 7/20/09. Case number 09 WC 39491 was for a date of accident of 8/19/09 wherein Petitioner alleged that his right arm was caught in a wood chipper.

With regard to case number 09 WC 36449 (the single, specific event on 7/20/09), the issues included whether the Petitioner sustained an accident on that date, whether notice was given of said accident, whether his condition of ill-being was related to the accident, whether Respondent was liable for any medical bills, whether Petitioner exceeded his choice of two physicians under the Act, temporary total disability and permanent disability benefits. With regard to case number 09 WC 39491, date of accident 8/19/09, the issues were identical to the issues in 09 WC 36449. Further, the issues were identical with regard to claim number 10 WC 18033, a repetitive trauma claim through 7/20/09.

While the parties requested that one decision issue, the Commission has requested that separate decisions issue. Accordingly, the Arbitrator is doing so. Chris Volkman was present throughout the hearing as Respondent's representative.

The Arbitrator finds:

The medical evidence supplied by the parties was quite extensive.

Petitioner underwent trauma to his right hand in May of 2008. He also reported some right shoulder pain. Petitioner had been handling some furniture. (RX 8) Petitioner continued treating for the right shoulder pain indicating that a heavy piece of furniture fell onto his right forearm at work five months earlier. He also reported performing physical work at his job, including shoveling and lifting and "thinks" he exacerbated his right shoulder pain while trying to lift a heavy pipe off the ground. Petitioner's shoulder hurt with most movements but he was on probation and didn't want to miss any work. An MRI was ordered. (RX 8)

On 2/17/09 Petitioner presented to Memorial Hospital for right arm pain that began on 2/9/09 while moving a refrigerator for a friend. He noted an original injury to the same arm while working with pipe in 2008. No radiating pain was noted. (RX 8)

Petitioner saw Dr. Khan on 5/21/09 complaining of right shoulder and left knee pain of three weeks duration. (PX 3)

On 5/21/09 Petitioner went to St. Elizabeth's Hospital because Dr. Jawad Khan had referred him for x-rays of his left knee and cervical spine. The diagnosis was paresthesias of the distal upper extremities, rule out carpal tunnel syndrome and left leg pain. On a radiology patient history form Petitioner noted that he had the symptoms for about 3-4 weeks. X-rays of the cervical spine revealed interspace narrowing at C5-6 and mild posterior foraminal narrowing at C5-6 on the right side.

On 5/27/09 Petitioner saw Dr. Hafiz Khattak. His impression was neck pain and degenerative joint disease of the knees. Petitioner was given a Hyalgan injection into the left knee and was prescribed Vicodin. (RX 4)

Petitioner was seen by Dr. Kahn on 6/15/09 for knee and shoulder pain. (PX 3)

On 6/17/09 Petitioner returned to Dr. Khattak. He said that his pain level in his right shoulder and left knee was 3-4/10. He was given another injection into his knee. (RX 4)

Petitioner returned to Dr. Khattak on 6/24/09. His pain level was 8/10. Diagnosis was chronic degenerative joint disease of the knees. He was given another Hyalgan injection. (RX 4)

Petitioner returned to Dr. Khattak on 7/13/09. His pain level was 5/10. He was still having problems with his left knee and with his neck. His knee was once again injected and he was prescribed Robaxin. (RX 4)

The first medical care provided to Petitioner after 7/20/09 was on 7/22/09 when he saw Dr. Khattak and stated his pain level was 9/10. Diagnosis was chronic neck pain. He was told to get an MRI of his cervical spine and was taken off work. He was given trigger point injections and another Hyalgan injection into the left knee. There was no history of any work-related event occurring on 7/20/09. (RX 4)

Petitioner returned on 7/27/09 to Dr. Khattak. He listed his pain level as 8-9/10 and noted that his pain was in his right shoulder area. Diagnoses were chronic neck pain and degenerative joint disease of the right knee. He was given a Hyalgan injection into the right knee and a Dilaudid injection. On his pain drawing, Petitioner noted right shoulder pain. (RX 4)

On 7/29/09 Petitioner presented to St. Elizabeth's Hospital for an MRI of the cervical spine. He was asked if his symptoms were "due to an accident". He answered both "yes" and "no". He said that he had a work injury from lifting. He said that he had injured his neck before. He said he had the symptoms for six months. He said that he had surgery on his neck in 2000. The MRI revealed a broad-based central to right-sided foraminal disc protrusion at C5-6 causing significant foraminal narrowing on the right side and mild to moderate foraminal narrowing on the left side. At C6-7 there was a mild, central bulging disc touching the thecal sac. (RX 6)

Petitioner returned to Dr. Khattak on 8/3/09. He complained that his pain level was 5-7/10. He listed the right side of his neck and his right shoulder as his problematic areas. Impressions were cervical herniated disc and degenerative joint disease of the knees. He was given an injection into his left knee. He was prescribed physical therapy for three weeks. Again, his pain drawing showed right shoulder pain and he listed his problems as sleeping and fatigue. (RX 4)

Petitioner returned to Dr. Khattak on 8/10/09. Impressions were cervicalgia with radiculopathy and myofascial pain syndrome. He listed his pain level at this time as 10/10. He was given some medication and told to follow up. His pain drawing remained unchanged. (RX 4)

Petitioner returned to Dr. Khattak on 8/14/09. His pain level was listed as 3/10. Impression was chronic degenerative joint disease of the knees. He was given an injection of Hyalgan into the right knee. However, he was also given an off work slip with regard to his neck. (RX 4)

On 8/19/09 Petitioner presented at Memorial Hospital. He complained of right forearm pain. He said a 75 pound door fell onto his arm at 1:20 that afternoon. He also had chronic right-sided neck pain that would radiate down the right shoulder. He said that was due to an old injury. He said that his employer had just purchased a new chipper and a bar came down, striking his arm and pushing it into a metal plate. He said that he forced the door back up. The door struck his upper forearm to the level of the elbow. He complained that his pain level was 6/10. Examination revealed no swelling and no obvious bruising. He gave a history of chronic right shoulder pain and neck pain. He said he was taking Vicodin but had run out of that. X-ray examination of the right forearm revealed no fracture, dislocation or unusual soft tissue calcification. Diagnosis was contusion and he was given Ibuprofen. (RX 9)

Petitioner was examined by Dr. Jawad Khan on 8/21/09. Petitioner gave a history of his 8/19/09 accident at work and complained of right forearm pain. He was given medication and taken off work through 8/25/09. Physical therapy was recommended. (RX 7; PX 3, p. 2)

Petitioner was seen by Dr. Khattak on 8/24/09. His pain complaints included his right shoulder and right forearm (pain drawing). He reported fatigue and lack of energy. He did not mark that he had any swelling in his hands or ankles. Petitioner was given a left knee injection. (RX 4)

Petitioner signed his Application for Adjustment of Claim in "09 WC 36449" (d/a: 7/20/09 – picking up forms when he felt pain in his shoulder) on 8/24/09. (AX 2)

Petitioner returned to Dr. Jawad Kahn on 8/25/09 with regard to his right forearm. He said he had been performing physical therapy. He was still tender and there was some mild swelling and bruising in the mid-forearm. He was given a Medrol Dose pak and prescribed Oxycontin and Percocet. He was to continue with his physical therapy. (RX 7)

On 8/25/09 Petitioner underwent his initial evaluation at physical therapy at St. Elizabeth's Hospital. He gave a history of right forearm pain with a crushing type of injury. He was to begin physical therapy for that. He gave a history at physical therapy of having right forearm pain, right shoulder pain and right side neck pain. He said that he had pain in the right shoulder down in the arm to the finger from C5-6. He was asked "how did it start". His answer was: "while picking up cover pipe/shovel, forearm was pinned in machine". When he was asked to state when his problem began, he said 5/20/09. He also said 8/17/09. He said it was a work-related injury. He said that he returned to work on 8/17/09 and was cutting trees when his right forearm was pinned. He said that he is a skilled laborer who repairs roads, pours concrete and performs grass care. He said that his pain was worse whenever he would sleep or walk. He was taking Vicodin and Ibuprofen. (RX 10)

On 8/28/09 Petitioner presented to the physical therapy department at St. Elizabeth's Hospital and was complaining of pain in his neck. He said that it began in September 2008 and was a work-related event. He said it was made worse by shoveling and picking up equipment. On 8/28/09 it was noted that with regard to his right forearm, he was wearing a "tubigrip" five hours a day without any ill effect. He said there was some decrease in the swelling of his right forearm. (RX 10)

Petitioner was seen by Dr. Khattak on 8/28/09. His pain drawing only noted right shoulder pain. (RX 4)

Petitioner returned to Dr. Khattak on 8/31/09. Impressions were chronic neck pain and herniated disc at C5-6. He was told to continue with his physical therapy. However, he also underwent another injection into his right knee. His pain drawing had markings on his right shoulder and forearm. (RX 4)

In a slip dated 9/1/09 Dr. Jawad Khan kept Petitioner off of work for his right forearm injury/strain. At that visit Petitioner received a trigger point injection. (RX 7)(PX 3)

On 9/9/09 Petitioner returned to Dr. Jawad Khan. He said he was taking Hydrocodone throughout the day. He had shooting pain up and down the right side of the neck. His right arm was not as strong as his left. The doctor reviewed some x-rays and found that Petitioner had mild secondary degenerative changes with narrowing at C5-6. Diagnosis was forearm injury on the right. He was given Feldene, Ibuprofen and Hydrocodone and kept off work through 9/22/09. (RX 7; PX 3)

In a slip dated 9/11/09 Dr. Khattak listed Petitioner's diagnoses as a herniated disc at C5-6 and right forearm pain. He recommended physical therapy. (RX 4)

Petitioner signed his Application for Adjustment of Claim in "09 WC 39491" on 9/17/09 (d/a - 8/19/09) (AX 4)

Dr. Khattak re-examined Petitioner on 9/21/09. Petitioner did not complete a pain drawing. Dr. Khattak took Petitioner off work through 10/2/09 for both Petitioner's neck and right forearm. (RX 4)

Petitioner returned to see the doctor (Khan) at Gateway Healthcare on 9/22/09. An appointment with the surgeon, Dr. Schultz, was pending. There is a note "Referred by Dr. Khattak." Petitioner didn't think the hydrocodone was helping. Petitioner complained of pain radiating from his neck down his right arm. Petitioner reported discussing Percocet with Dr. Khattak but didn't ask for meds. He requested medication for heart burn he noted after therapy. On examination the doctor noted tightness and spasticity of his right forearm and trapezius. Petitioner had decreased lateral rotation bilaterally, the left greater than the right. He was diagnosed with chronic neck/right forearm pain. Percocet was prescribed. (RX 7; PX 3)

Dr. Khattak examined Petitioner on 9/30/09. Petitioner's pain drawing noted complaints in his right shoulder, right forearm and the right side of his head. He was complaining of fatigue, headaches, weight loss/gain, ringing in his ears, and sleep difficulties. Petitioner was diagnosed with chronic neck pain, myofascial pain syndrome, and cervicalgia. (RX 4)

In a slip dated 10/2/09, Dr. Khattak kept Petitioner off work through October 20, 2009. He did not indicate the condition for which Petitioner was being kept off of work. (RX 7)

On 10/7/09 Petitioner saw Dr. Robert Schultz. He gave a history to Dr. Schultz that he had been injured "sometime around the end of June". He said that he was pulling on some rebar and using a jack hammer and had the onset of some pain in his shoulder.

He said that because he did not have any sick leave available, he saw his family doctor who gave him some medication and told him to continue to work. He said he did so until 8/19/09 when he was using a chipper. He said that his arm got caught in the chipper and he had some significant arm pain, shoulder pain and neck pain since that time. He noted that he had undergone trigger point injections in his neck. He said that he had been on Robaxin. He noted he underwent an MRI scan. He thought that he was getting worse. The doctor reviewed the MRI scan that was brought with the petitioner and he thought that it showed a degenerated, herniated disc at C5-6 with some narrowing of the foramen on the right. Physical examination revealed some loss of range of motion and some other minor irregularities. The doctor thought that he had some equivocal weakness of the biceps on the left as compared to the right and a sensory loss in the ulnar distribution of the right hand. The right triceps was apparently absent. Diagnoses were neck pain, degenerative disc disease at C5-6 with a herniated disc at the same level, spondylolysis of the neck and thoracic outlet syndrome on the right. He recommended that the petitioner undergo a couple of cervical epidural blocks, undergo some nerve studies of the upper extremities, obtain some additional x-rays and prescribed him Norco and Flexeril. He was taken off work through November 10, 2009. (RX 6)

On 10/9/09 Petitioner returned to Dr. Khattak. Diagnoses were chronic neck pain and right forearm pain. He was told to obtain an EMG/NCV of both arms. Petitioner's pain drawing again reflected right shoulder and forearm pain (extending into his right pinky finger). (RX 4)

On 10/19/09 Petitioner returned to Dr. Khattak. The diagnosis was chronic neck pain and radiculopathy. He was referred to Dr. Chris Heffner. His pain drawing was unchanged from the previous visit except that he didn't indicate right pinky finger pain. (RX 4)

On 11/2/09 Dr. Schultz notified Petitioner he was being discharged from further care due to problems with medication abuse. (RX 6)

On 11/9/09 Petitioner presented to the emergency room at St. Elizabeth's Hospital. He complained of neck pain. He said it started on 5/19/09 after a work injury. He was out of his Vicodin. Diagnosis was chronic neck pain. He was given an injection and prescribed Oxycodone.

On 11/9/09 Petitioner also returned to see Dr. Khattak. Diagnoses were chronic neck pain and myofasciitis pain. He was given trigger point injections and Voltaren gel. The pain drawing revealed bilateral neck complaints, right shoulder complaints, and right forearm/pinky finger complaints. He also complained of ringing in the ears. (RX 4)

On 11/11/09 Petitioner presented to the emergency room at St. Elizabeth's Hospital. He complained of pain in the right side of his neck. He was out of Vicodin. He was told to follow up with his doctors.

Petitioner saw Dr. Luke Hall on 11/12/09. He said he was being seen for back pain. He said that he had severe back pain for several months and an MRI showed a disc protrusion and that Dr. Heffner was recommending surgery (it should be noted that Petitioner did not see Dr. Heffner until 2/5/2010). He also said he saw Dr. Khattak for pain management. He said that his pain was not controlled with medication with Dr. Khattak and therefore he was told to see his personal medical doctor for management. At the time, he was taking a number of medications including Flexeril, Ibuprofen, Vicodin, Oxycontin and Percocet. Neurological examination revealed that his motor and sensory functions were intact and equal, his reflexes were normal and equal and his gait was normal. Dr. Hall contacted Dr. Khattak's office and they confirmed that Dr. Khattak wanted his private physician to handle the pain medications. Oxycontin and Percocet were given. (RX 8)

On 11/13/09 Petitioner was seen at Gateway Healthcare to follow up on lab work. He complained of elevated blood pressure and had been seen at the ER for high blood pressure and a right-sided headache. (RX 7)

On 11/18/09 Petitioner saw Dr. Khattak. Diagnoses were chronic neck pain, stenosis at C5-6 and right upper extremity pain. His medications were refilled. Petitioner's pain drawing noted right shoulder pain and less right forearm pain/complaints. (RX 4)

On 12/14/09 Petitioner saw Dr. Khattak and complained of chronic neck pain, right upper extremity pain and spinal stenosis at C5-6. His pain level was 5/10. He was given an injection of Depo Medrol. Petitioner's pain drawing again noted right shoulder and right forearm complaints. (RX 4)

On 1/8/10 Petitioner returned to see Dr. Hall. He was continuing to have back/neck pain, shoulder pain and shooting pains down his arms. He was taking Flexeril, Ibuprofen and Vicodin. Assessment was back/neck pain with disc protrusion from a work accident in May 2009. He was given exercises for his neck and back. He was to continue with the Oxycontin, Percocet and Ibuprofen. (RX 8)

On 1/15/10 Petitioner saw Dr. Khattak and complained of chronic neck pain, degenerative disc disease. His medications were refilled. No right forearm complaints were noted. (RX 4)

Petitioner returned to Gateway Healthcare on 1/19/10 for a review of his labwork. He had "no complaints other than neck and shoulder pain." He was also reporting poor sleeping. According to a note of Dr. Jawad Khan that same day Petitioner was waking

up from sleep at 3 a.m. with a feeling of pins and needles in his right forearm which would shoot up to his axilla and then the right side of his neck. He reported taking a lot of pain medications and noted a visit with Dr. Haefener who planned to do a nerve block. Petitioner reported his right hand would develop blanching on exposure to the cold. Petitioner was referred by Dr. J. Khan to a rheumatologist. (RX 7)

Petitioner was again seen at Gateway Healthcare on 1/25/10 primarily for his blood pressure. Dr. Jawad Khan noted that Petitioner was continuing to have right-sided posterolateral neck pain and headaches that Petitioner attributed to his neck pain. No right forearm complaints were noted. (RX 7)

In a note dated 1/27/10 Dr. J. Khan took Petitioner off work from 1/18/10 to 2/5/10 for forearm and neck pain. (RX 7)

On 1/28/10 the Petitioner saw Dr. David Lange at Respondent's request. Dr. Lange took a history from the patient indicating that his shoulder problems began back in "2008". He said that he saw a Dr. Hall at St. Elizabeth's Hospital for one or two months. He said that he thought that his shoulder was the issue. He continued to have symptoms about the right shoulder, but continued to work. He said that his work activities were quite heavy. They included the shoveling of asphalt and using a post-hole driver. He said that those activities consistently worsened in right shoulder pain. Further, Petitioner said that he lifted a "covert pipe" in July 2009 and that increased his right shoulder pain. He said that he had seen Dr. Hall, Dr. Khan and Dr. Khattak for his problem and had been treated with injections. He said that he had pain in the right side of his neck that would go into the right suprascapular area and then somewhat down the right arm and forearm. He complained of numbness in the ulnar aspect of the right forearm and proximal hand. Petitioner spoke to Dr. Lange about the event of 8/19/09 with the wood chipper. He said that a heavy door fell down onto his right forearm. Examination revealed a mildly positive Hoffman sign on the right. He complained of neck pain with forward motion. He had discomfort in the right trapezius. The doctor reviewed the cervical spine MRI and it was interpreted to show degenerative disc disease at C5-6 with some posterior spurs. He said that there was a soft, disc herniation centrally and to the right at that level. Dr. Lange then reviewed a multitude of records and reports. Diagnosis was degenerative disc disease at C5-6 with a herniation causing the right upper extremity complaints. He said that he could not substantiate a relationship between the disc herniation and his work activities. The doctor noted that he had seen physicians before July 20, 2009 for his neck problems. The doctor thought that because his cervical disc was degenerative in nature, it would be "impossible to state with any certainty his work activities were a factor with respect to his current condition". The doctor thought that he did need more treatment, including the possibility of surgery with a fusion. He said that since his symptoms seemed to go back to year 2008, even though certain activities at work and at home tended to aggravate that condition, "such increase of symptoms on a day to day basis is not to suggest that

having increased symptoms with any particular activity in some fashion aggravated, accelerated or made to become symptomatic the underlying disc pathology". Some residual aching in Petitioner's right forearm was noted. (RX 1, Dep. Ex. 3)

On 2/4/10 Petitioner returned to Dr. Hall. He continued to have the same complaints. Dr. Hall continued his Oxycontin and Percocet. (RX 8)

Petitioner saw Dr. Christopher Heffner on 2/5/10. He was referred to Dr. Heffner by Dr. Khattak. He said that about nine or ten months ago he was doing his regular job without a specific injury. He said he did a lot of heavy lifting and noticed some pain in his neck and right upper extremity along with some shoulder pain. He did say that he had a work injury to his right arm in September. Petitioner made it clear that the neck injury was not related to any specific work event. Examination revealed weakness in the right biceps and triceps. He had mild weakness in the right hand intrinsic function. He said that an MRI scan showed a sizable central, and somewhat right-sided, disc herniation at C5-6. Dr. Heffner said that he did not have "any specific injury to bring this on". The doctor recommended a C5-6 discectomy and interbody fusion. Petitioner agreed and was taken off work. He was taken off work for approximately 6 -12 weeks. (RX 5)

On 2/5/10 the petitioner returned to Dr. Khan. He was complaining of his neck. Diagnoses were chronic neck pain with radiculopathy, cervicalgia, spinal stenosis and degenerative disc disease. He was to follow up in one week for a neck injection and said that Dr. Heffner told him he needed surgery. Petitioner was given Hydrocodone and Ibuprofen.

On 2/5/10 the petitioner also saw Dr. Khattak. His diagnoses were the same and he was continued with his medications. No right forearm complaints were noted. (RX 4)
Dr. Lange issued another report on 2/5/10 addressing some transcription problems from his initial report. He indicated Petitioner's prognosis was excellent with a 1-level fusion and Petitioner should be able to resume full duty work approximately three months thereafter. He added that he did not think Petitioner's repetitive work activities would be associated with the herniation or any treatment for it. (RX 1 – Dep. Ex. 4,5)

On 2/8/10 Dr. J. Khan took Petitioner off work from 2/5/10 "until further notice" for "medical reasons." (RX 7)

Dr. Khattak re-examined Petitioner on 2/12/10. Petitioner didn't mark the pain drawing. His diagnoses remained unchanged and no right forearm complaints were noted. (RX 4)

In notes dated 2/16/10 Dr. Heffner thanked both Dr. A. Khan and Dr. Hafiz Khattak for the referral and noted Petitioner was scheduled for surgery on 2/16/10. (RX 5)

Petitioner was seen at Gateway Healthcare on 2/22/10 and reported no more headaches but ongoing neck pain. He wished to quit smoking. Dr. J. Khan recorded the visit as related to a follow-up for sinusitis. Petitioner denied any further headache but reported chronic neck pain ("4-5/10") and upcoming neck surgery with Dr. Heiffer. No right forearm complaints were noted. This is the last office visit with Gateway Healthcare/Dr. J. Khan. (RX 7)

Petitioner underwent a rheumatology exam on 2/23/10. He was noted to have an isolated positive ANA without any symptoms or signs of inflammatory disease. Petitioner reported some persistent discomfort in his proximal right forearm too. The doctor noted a burn on Petitioner's right arm a number of years earlier for which Petitioner required skin grafting. (RX 5)

Petitioner was seen at Dr. Heffner's office on 3/8/10. The Nurse's Notes indicate continued complaints of posterior neck pain radiating into his right shoulder, down the right arm to just below his elbow and constant tingling and numbness of the right ring and pinky finger. Petitioner was getting ready for surgery. (RX 5)

On 3/11/10 Petitioner returned to see Dr. Hall. Medications included Flexeril, Ibuprofen and Vicodin. He was to continue with his Oxycontin and Percocet until he underwent surgery. (RX 8)

On 3/15/10 he returned to Dr. Khattak. His medication was refilled. His pain drawing noted right shoulder and forearm pain. No diagnosis was made regarding the forearm pain. The doctor noted radiculopathy in conjunction with Petitioner's neck pain. (RX 4)

On 3/17/10 Petitioner was admitted to Memorial Hospital by Dr. Heffner. He was taken to surgery by Dr. Heffner that day for the removal of the disc between C5 and C6. An interbody spacer was filled with material and sunk between C5 and C6. He was told to remain off work, given a soft cervical collar, antibiotics and Lortab. (RX 5)

On 3/24/10 Petitioner returned to Dr. Heffner and said that he had no "real pain" since surgery until that morning when he had some right shoulder and arm pain. His collar was removed and the dressings were changed. He was told to return in three weeks, x-rays were taken and he was given a softer collar. Medication usage was also discussed. (RX 5)

In a letter dated 3/24/10 and addressed to whom it may concern, Dr. J. Khan wrote that Petitioner had been under the care of Dr. Khan and Dr. Khattak and was being treated from 9/20/09 for arm pain until further notice. (PX 3)

On 4/5/10 Petitioner called the Dr. Heffner's office and complained of right-sided neck pain. He was prescribed Robaxin and Ibuprofen. (RX 5)

On 4/14/10 Petitioner returned to Dr. Hall. He had the same complaints as before. It was noted that he had surgery two weeks ago. He said that Dr. Heffner deferred pain management to his personal physician. Dr. Hall prescribed Vicodin. (RX 8)

On 4/16/10 Petitioner returned to Dr. Khan for neck pain. He said that his medications needed to be refilled and he would need a physician's statement with regard to his ability to remain off work. He said he had surgery on his neck on 3/17/10. He was prescribed Vicodin and Robaxin. No right forearm complaints were noted. He was diagnosed with neck pain, cervical radiculitis, myalgias, and neuralgia. (RX 4)

Petitioner returned to Dr. Heffner on 4/23/10 and said that he had improved significantly with his neck and arm pain. He was to begin physical therapy. (RX 5)

On 5/6/10 Petitioner called Dr. Heffner's office and requested a note stating that his surgery was work-related. The nurse told Petitioner that the doctor could not state that his neck problem was work-related. (RX 5)

Petitioner's claim in "10 WC 18033" (d/a: 7/20/09 – repetitive trauma) was filed with the Commission on 5/11/10. (AX 6)[1]

On 5/14/10 Petitioner returned to Dr. Hall. He said that his pain was somewhat less. He was wearing a soft collar at night and started a rehab program. He was taking Flexeril, Ibuprofen and Vicodin. He thought that his pain had increased with his physical therapy and therefore his Vicodin amount was increased. He was also prescribed Ambien. (RX 8)

On 5/19/10 Petitioner returned to Dr. Khan. He was complaining of neck pain, right arm pain, numbness and tingling in the arm. He said his current pain level was 4/10. Diagnoses were neck pain, right shoulder and arm pain "status post trauma." His medications were refilled. (RX 4) That same day Dr. Khattak wrote an off work slip for the dated 5/19/10 to 5/24 or 29/10 for Petitioner's right forearm and referenced an accident date of 8/19/10. (RX 4)

Petitioner was seen at Memorial Hospital on 5/22/10 with right arm radicular pain complaints. (PX 22)

On 5/25/10 Petitioner called Dr. Heffner's office and stated that he had to go to the emergency room over the weekend because he was hurting very badly. There he was

[1] According to IWCC Case Status information

given a couple of shots and some pain pills. He asked for a different pain medication. (RX 5)

On 6/11/10 Petitioner saw Dr. Heffner who concluded that he had made outstanding progress. He said that he could return to work, but not to his regular job and needed additional therapy. He was kept off work. (RX 5)

On 6/14/10 Petitioner returned to Dr. Jawad Khan. He said that his pain level was 3-4/10. The doctor noted that they had received "information from the Illinois Department of Human Services prescription monitoring program". The information from IDHS stated that Petitioner was receiving narcotic medications from multiple physicians. This was placed in his chart. The doctor asked him as to whether or not he was getting medications from other doctors and he said that he was. He also agreed that he had violated the doctor's narcotic agreement. He was discharged from Dr. Khan's care. No right forearm complaints were noted. (RX 4) That same date Dr. Khattak discharged Petitioner from his care due to his knowingly violating the Narcotics Agreement. (RX 4; RX 5)

On 6/15/10 a representative from St. Elizabeth's physical therapy department called Dr. Heffner's office. He stated that Petitioner filed a complaint with the hospital's administration because he had been dropped from the physical therapy program because he missed 7 out of 12 scheduled visits. Petitioner also told the therapist that Dr. Heffner had only ordered him to undergo massage at physical therapy. However, the therapist told Petitioner that Dr. Heffner had ordered massage, strengthening and stretching exercises, other modalities and a home exercise program. Dr. Heffner's office said that Petitioner had called them, stating that therapy was aggravating him and that he was supposed to talk to the therapist. Petitioner then called Dr. Heffner's office and asked one of his assistants to make changes in his notes and that he didn't like the therapist because he stated that he had been non-compliant with therapy. Petitioner said that the therapist would "hurt his case" and wanted what he stated to be changed to something else. (RX 5)

On 6/15/10 Petitioner called Dr. Heffner's office and requested a referral to Barnes Pain Management Center. The doctor's office called Petitioner back and wanted to know why he was requesting a pain management referral when he had been doing well at his last office visit. The doctor then stated that he should be referred to another facility for therapy and that he would benefit from work conditioning or work hardening, but that there was no reason for a referral to pain management. (RX 5)

On 6/17/10 Dr. Heffner's office called Petitioner and wanted to know why he wanted a referral to pain management. Petitioner said that he was having arm pain and that therapy was making it worse. He said that he had been to the emergency room several times and they told him to call his doctor. The patient was told that Dr. Khattak was a

pain management specialist. Petitioner told the doctor's office that he would not go back to him as he was not "doing anything for him". Dr. Heffner's office asked if he was taking any pain medication. He said that he had some medication from Dr. Hall. The doctor's office did not know who Dr. Hall was. He said that he saw him for a second opinion. He told the doctor's office that he was going to therapy at St. Elizabeth's Hospital on Green Mount Road. A prescription for Lortab was called in for Petitioner. (RX 5)

On 6/18/10 Dr. Heffner's office prepared a note stating they had received a fax from Dr. Khattak stating that the employee had been discharged from his care for violating the narcotic agreement. (RX 5)

On 6/23/10 there was a physical therapy certification form from St. Elizabeth's Hospital indicating that Petitioner had been once again evaluated for therapy. Part of this included a patient history. He said that he was lifting heavy equipment on 5/20/09 and noticed pain in his neck and right arm. (RX 5)

On 6/30/10 Petitioner told Dr. Hall that he was seeking a pain management referral. He was taking Flexeril, Ibuprofen and Vicodin. Petitioner agreed to go to pain management and he was reminded that Dr. Hall would no longer give him any medications. (RX 8)

On 7/7/10 Petitioner went to Memorial Hospital emergency room and was given some Tramadol and Tylenol. He was told to follow up with Dr. Heffner. (PX 23)

On 7/19/10 he called Dr. Heffner's office and asked for pain medications stronger than Tramadol. He said that he went to the emergency room and was given Tramadol but it was not working. He also said that he has an appointment with BJC West on 8/18 and also was supposed to have an appointment at St. Elizabeth's Pain Management on 8/28. It was noted that Dr. Heffner had received a letter from Dr. Khattak stating that they had fired Petitioner for a violation of his pain contract. Dr. Heffner denied narcotic pain medication. (RX 5)

On 7/19/10 Petitioner called Memorial Hospital (Dr. Wilson) requesting stronger pain medication and discussing a new family doctor referral which could not be given. (RX 8)

On 7/21/10 Petitioner went to the emergency room of Memorial Hospital. He said he had been in physical therapy since March 2010 and was having pain from the right side of his neck down to his hand with tingling. He said he was taking Tylenol with no relief. He was given an injection of Morphine and Zofran. A pain drawing revealed right shoulder/neck complaints. (RX 3; PX 24)

On 7/27/10 he saw Dr. Mazhar Lakho with Southern Illinois Internal Medicine. He said that he was having pain in the right side of his neck down to his fingertips, causing numbness in his fingers. He said he could not go back to physical therapy until his pain was controlled. He said that Dr. Heffner was going to release him to return to work, but that his pain was severe. He was prescribed Vicodin, Flexeril and Neurontin. Petitioner was noted to have skin grafts on both arms. (RX 3)

He returned to Dr. Lakho on 8/10/10. He said his pain pills were helping and that he was sleeping through the night while taking Tylenol. He said his pain was on a scale of 7-8 out of 10. He said he wanted to talk to the doctor about being released to return to work. Diagnosis was cervical pain. Pettioner was to see Dr. Heffner on 8/13/10. He was told to continue with his medications. (RX 3)

On 8/13/10 there is a note from Dr. Hefner's nurse that physical therapy was stopped because of pain. Petitioner said that he had seen Dr. Lakho, who referred him to St. Louis University Pain Management and had an appointment on 8/16/10. He was taking Lortab and Tylenol. Dr. Heffner also saw the employee that day and said that he could be released to full duty work when that was acceptable to any pain management service that he attended. Petitioner was noted to be doing well and any chronic neck and shoulder pain wasn't overly severe. Dr. lakho was now Petitioner's primary care doctor. (RX 5)

On 8/16/10 Petitioner saw Dr. Eugene Pereira, a pain management physician. He was referred by Dr. Lakho. He complained of neck pain and right arm pain. He told the doctor that he was a skilled laborer for the City of Fairview Heights and was having right-sided neck pain, right arm pain, and right shoulder pain that started after a work injury and had progressively gotten worse with repetitive stress at work. He had been off work for nine months on a medical leave. He was having complaints of pain down his right arm. He said that he had a couple of steroid injections which had provided some good relief. He also had surgery that provided some relief. He had gone to the emergency room three times in July 2010. He was taking Vicodin, Ibuprofen and Gabapentin. Examination revealed full range of motion with exacerbation of pain upon cervical flexion. He also reported tenderness upon touching of the right side of the neck and the trapezius muscle. Diagnoses included chronic cervical pain, chronic right shoulder pain and chronic right arm pain. Trigger point injection treatment was suggested. No mention of the wood chipper event was noted. (RX 3)

On 8/31/10 Petitioner went to St. Elizabeth's emergency room. He was complaining of chronic pain. He related it to a work injury in 2009. At that time he was taking Tramadol, Ibuprofen and Hydrocodone. He rated his pain level as 9/10. He was given Zofran and Dilaudid. A prescription was written for 10 tablets of Ibuprofen and 15 tablets of Oxycontin.

On 9/8/10 Petitioner returned to Dr. Lakho and stated that he had been to the emergency room for evaluation of neck pain. He said he tried to go without medication but it was just too severe. He was taking Flexeril, Gabapentin and Neurontin. Diagnosis was cervical pain. He was to continue with the Vicodin and his regular medications. Dr. Lakho took Petitioner off work until Petitioner's FCE on 9/10/10. (RX 3; PX 25)

On 9/10/10 Petitioner underwent a functional capacity evaluation at Memorial Hospital. He described his job requirements as being able to lift 100 pounds from the ground to the waist, pour concrete, load trucks, operate a jack hammer, weed eater, drive tractors, oil and chip, shovel asphalt, lay culverts and operate multiple hand and power tools. The testing put him in the medium physical demand level. He was to undergo work hardening at four hours every shift for a while. Petitioner was noted to be eager to return to work. (RX 3)

On 9/13/10 Petitioner returned to Dr. Lakho. He stated that he was willing to go back to light duty work four hours a day. He was concerned about his pain medications which included Flexeril, Gabapentin, Ibuprofen, Neurontin and Vicodin. He was told to discontinue the Neurontin and Vicodin. (RX 3)

On 9/14/10 Petitioner called Dr. Lakho's office and said that pursuant to the functional capacity evaluation he could have a work hardening class and return to work four hours a day. Dr. Lakho said he could return to work four hours a day, light duty. The Petitioner said that was alright but if he was "reinjured" that it was "on us (Dr. Lakho)". (RX 3)

On 10/6/10 Petitioner underwent an injection of the trapezius muscles by Dr. Pereira. Afterwards, the employee told the doctor that he sought the advice of an attorney to have his case opened and decided in his favor. The doctor said he wished him well. (RX 3)

X-rays of Petitioner's right forearm were taken on 1/18/10 and revealed no fracture, no dislocation, or radiographically significant soft tissue swelling. (PX 18)

On 10/8/10 Petitioner called Dr. Lakho's office again regarding a work hardening class. (RX 3)

On 10/11/10 Petitioner returned to Dr. Lakho. He said his job would not return him to work. He said he needed a referral of Dr. David Brown for nerve testing. He said he needed a stronger medication due to a colonoscopy. Examination was negative. He was told to continue with the Ibuprofen. (RX 3)

On 10/12/10 apparently Dr. Lakho spoke with Dr. Pereira and was notified that Petitioner had been non-compliant with office visits. (RX 3)

Petitioner underwent trigger point injections on 11/1/10 for myofascial pain, cervical radiculopathy, cervical laminectomy syndrome, cervicalgia, and right arm pain. (RX 3)

On 11/8/10 Petitioner returned to Dr. Lakho and said that he was considering obtaining a spinal cord stimulator. He wanted a refill of his Vicodin. Examination was negative. Assessment included chronic neck pain and shoulder pain. He was given Vicodin, Motrin and told to see a psychiatrist as advised by Dr. Pereira. (RX 3)

On 12/20/10 Petitioner returned to Dr. Lakho. He said that his pain medications were not handling his pain. He said that the spinal cord stimulator was still pending. He was given Gabapentin and was told to continue with the rest of his medications. (RX 3)

On 1/10/11 Petitioner returned to Dr. Lakho. He once again said that his medications were not taking care of his pain and he ran out of his pain medications early. He asked for a prescription for Vicodin. He requested an MRI to determine why he was in such pain. The examination was negative. Diagnosis was the same. He was given Hydrocodone and told to see a psychiatrist. (RX 3)

On 1/31/11 Petitioner was seen regarding a refill on medications. (RX 3)

On 2/3/11 Petitioner returned to Dr. Lakho and said that his pain medication was not enough to control his pain. He was told that he could no longer get early refills. He was given Motrin and was told to get a psychiatric examination. (RX 3)

On 2/11/11 Petitioner returned to Dr. Lakho and said that he needed a letter stating that he could not lift with his right arm due to pain. Examination was normal. He was given Tylenol and Motrin. (RX 3; RX 8)

On 2/15/11 Petitioner saw Dr. Hermann Witte, a psychologist. He gave a history that his physical problems began with two accidents at work. The first was in May 2008 involving an injury to his right shoulder when engaged in heavy lifting. He said he had intermittent pain thereafter and finally was diagnosed with a herniated disc. He said that "a few days later" he reinjured the same area, subsequently developing pain that went down from his neck into his fingers on the right arm. He said he last worked in the mid-August 2009. He said that virtually any type of physical activity or movement worsened his pain. The doctor said that the findings of his evaluation showed significant inconsistencies between his self-presentation in the interview and the test data and even between differing tests. The most prominent inconsistencies concerned the existence in the degree of his emotional stress (depression) and his level of pain and related functional disability. He said that his overall life satisfaction was 8/10 which

was inconsistent with his admitted chronic pain, depression and severe frustrations. The doctor said that his personal impression was that he was depressed and angry and that his pain was not as severe as he reported, at least when he was properly medicated. He seemed to be lacking self-motivation as well. (RX 3; RX 8)

Dr. Lakho saw Petitioner on 2/18/11 for right ear pain. (RX 3; RX 8)

On 2/22/11 Petitioner was seen by Dr. Adams/Pereira for right shoulder pain that radiated down his right arm. Petitioner has had "pain quite sometime following a work injury." Petitioner desired to get off pain medications and wished to try a cervical spinal cord stimulator trial. Petitioner's diagnoses were post cervical laminectomy syndrome and cervical radiculopathy of the right upper extremity. (RX 3; RX 8)

Dr. Lakho saw Petitioner again on 3/8/11 for really sharp pain in his right neck which he experienced while putting on his shirt. Petitioner "states never had this pain before." (RX 3; RX 8)

On 3/29/11 Petitioner saw Dr. William Richardson. He complained of neck and right arm pain and said that it began after an accident at work which occurred on 5/20/09. He said that he picked up a piece of pipe at work and it caused an injury to his right shoulder. He said that it started out as tightness and that it became very painful the next day. Eventually, he underwent surgery. He complained of numbness and tingling in his right hand. He said he was taking Oxycontin, Oxycodone, Gabapentin, Vicodin and Ibuprofen. Assessment was chronic pain of the neck and right arm. Recommendations were to prescribe Vicodin, Oxycontin, Soma, Gabapentin, physical therapy and to see a pain psychologist. He concluded that the employee could return to work provided that he not lift over 20 pounds or work with a jack hammer. He was not supposed to use his right arm 8 hours a day as well.

Dr. Lakho again saw Petitioner on 5/25/11 for back, shoulder, forearm and neck pain. He was getting injections through pain management. He wished to undergo a colonoscopy. (RX 3 RX 8)

Petitioner returned to see Dr. Richardson on 6/7/11. He complained of right shoulder pain on a scale of 7/10. He had slight weakness in the right hand and aching in the right arm. He had a decreased range of motion of the neck and shoulder. Diagnoses included chronic neck and right arm pain. He was given three trigger point injections in the right shoulder. He was told to continue with his medications.

On 7/15/11, 8/15/11 and 9/16/11 Dr. Richardson noted that Petitioner's condition was the same and he was to continue all of his medications and to return in a month.

Petitioner was seen in the emergency room on 8/14/11 for chronic neck pain. (RX 3; PX 18; PX 26)

Dr. Gornet examined Petitioner on 8/29/11, according to Petitioner, at the request of Dr. Kahn and Dr. Richardson. He presented with the chief complaint of neck pain, headaches, right shoulder pain, right arm pain, trapezial pain, and numbness and tingling of the right hand which he stated began on 5/20/09 while working for Respondent. Petitioner was unloading a truck with some pipes and tubes and developed "increasing pain" in his right shoulder. He was referred to Dr. Kahn who referred him to pain managements. Injections followed. He had tried physical therapy and was diagnosed with a herniated disc at C5-6 and referred to Dr. Schultz who referred him to Dr. Heffner who recommended surgery but at that point Petitioner returned to work and was trying to live with his symptoms. There was some dispute regarding whether it was covered by workers' compensation. Petitioner also reported a second accident on 8/19/09 when his arm was caught in a chipper and he developed increasing pain. Petitioner reported constant symptoms, worse with any type of arm activity, fixed head positions, and improvement when lying down. He has numbness, weakness and right arm pain. Dr. Gornet discussed the whole concept of structural spine problems with Petitioner and, based upon Petitioner's history, he felt Petitoner's current symptoms were related to the two work injuries. Petitioner remained unable to work. He requested a CT scan and a weaning off of medications. (PX 13)

On 10/17/11 Petitioner underwent a CT scan of the cervical spine at CT Partners of Chesterfield. The scan revealed some mild disc space narrowing at C3-4 and also at C4-5. At C5-6 there was evidence of a fusion with a metallic interbody device. The radiologist did not see any definite bridging bone. There was a small disc bulge at C6-7. (PX 13)

Dr. Gornet re-examined Petitioner on 10/17/11 and they reviewed his CT scan. Dr. Gornet still felt Petitioner's symptoms were due to the work injuries. While it was originally felt he had a shoulder and arm problem, Dr. Gornet believed Petitioner had a cervical spine issue. They decided to wait for approval for further treatment. (PX 13)

Petitioner was seen at St. Elizabeth's Hospital on 11/9/11 for neck pain. An injection was given. (PX 16)

On 11/9/11 Petitioner called the Dr. Heffner's office and stated that his fusion had come "loose". He said he saw another surgeon who told him it was "pretty bad". He said that this "needs to be rectified" and wanted to hear back from Dr. Heffner as soon as possible. Petitioner told the doctor's nurse that he would "hate for him to get a call from my attorney". (RX 5)

On 11/10/11 Dr. Heffner's office called Petitioner and told him that he wanted to schedule an appointment and that he was to bring x-rays, MRIs or any other test results with him. He was then asked why he did not call Dr. Heffner when he was having problems. He said it was because Dr. Heffner sent him to pain management and they sent him to Dr. Gornet.

On 11/11/11 Petitioner called Dr. Heffner's office and said that he had an appointment with the doctor the following week and wanted to "make sure we were aware of his injury when his arm got caught in the chipper". He said that his work injury is why he needed to see the doctor. They asked him when this occurred and he told them it was on 8/19/10. The doctor's office told him that he had been released from their care on 8/13/10 so they did not know about this injury. (RX 5)

Petitioner again went to St. Elizabeth's Hospital on 11/11/11 for his neck pain and given medication. (PX 16)

Dr. J. Khan examined Petitioner on 11/15/11 noting complaints of right forearm pain since his accident in 2009. He also reported his neck surgery and complained of numbness, tingling, and radicular symptoms in his arm. Petitioner was advised Dr. Heffner would order further studies as needed. (PX 3)

On 11/17/11 Petitioner returned to see Dr. Heffner. He said that he was in the emergency room a couple of months ago and had some x-rays taken and saw a surgeon who told him that he might not have adequate bone growth. However, he did not bring any records or x-rays. On examination he seemed to be nominal. The doctor said he would review any x-ray studies. (RX 3; RX 5)

Petitioner saw Dr. Heffner on 11/28/11 and brought in some x-rays. The doctor said that reviewing the x-rays and comparing them with the ones taken in April 2010 indicated that the metal spacer had not moved in position and that he had a sizable anterior traction spur on the vertebral body of C5 that had resorbed since April 2010 suggesting good limitation of motion at the C5-6 level. He said there was some mild amount of lucency around the superior portion of the metal graft suggesting inadequate bone growth. The doctor concluded that he did not believe that another surgery would be necessary and that he would have to stop smoking, if he did. He said that his original problem at C5-6 could relate to repetitive trauma, although he did not have a specific injury to his neck. He said that the employee told him he did a lot of heavy lifting with his job activity as well as running a jack hammer and these kinds of things could certainly lead to repetitive trauma in the cervical area. (RX 3; RX 5)

On 12/13/11, 1/13/12 and 2/10/12 Dr. Richardson prescribed Ambien, Vicodin and Oxycodone.

Dr. Gornet re-examined Petitioner on 12/15/11 noting Petitioner was being weaned off his OxyContin and now only sporadically taking hydrocodone. He was released to light duty and no lifting greater than 20 pounds and no driving while on narcotics. He still thought Petitioner's condition (a failed fusion) was work-related. Further treatment could proceed once Petitioner was off all narcotics. (PX 13)

Petitioner failed to show up for his 1/26/12 appointment with Dr. Hefner. (RX 5)

On 3/1/12 Petitioner saw Dr. Mahruhk Khan with Gateway Healthcare. He diagnosed his condition as chronic pain syndrome. (RX 2)

On 3/29/12 Petitioner saw Dr. Crystal Carmichael (Gateway Healthcare). He was receiving Oxycontin from Dr. Richardson. Diagnosis was chronic pain syndrome. He was prescribed Dilaudid 4 mg. every 4-6 hours as needed for severe pain and Amitryptiline for chronic pain. (RX 2; PX 3)

On 4/12/12 Petitioner returned to Gateway Healthcare. Petitioner was complaining of pain on his right arm, throbbing in nature. He rated the Pain in his right arm was 9/10. He wanted refill of Dilaudid and MRI. Diagnosis was right elbow/forearm pain. He was prescribed Cymbalta. A graft site on Petitioner's right forearm was noted. (RX 2; PX 3)

Petitioner saw Dr. Fox on 4/16/12. He said he was unable to tolerate Morphine Sulfate. He was taking Vicodin but ran out of Oxycodone. He noted that he tried to get some more Oxycodone but the pharmacist told him that he had to have a written prescription and could not be phoned in. She noted that the "patient has been very demanding with respect to his pain medications despite missing appointment 4/4/12." He still had right neck and arm pain, right hand and forearm pain and tingling and numbness. Diagnoses were as before. She wanted to schedule an MRI of the right forearm and schedule EMG/NCV of the right arm. She emphasized that he follow a narcotics agreement. His Oxycodone and Vicodin was refilled. She noted that he had been obtaining medications from two different pharmacies. She told him that in the future they would only be filled at one pharmacy. She also told him that any visits to the emergency room would have to be reported to her.

As of 4/26/12 Dr. Gornet believed Petitioner was still suffering from neck pain and headaches going into his right shoulder, arm, trapezius and hand with numbness and tingling all of which emanated initially from Petitioner's 5/20/09 accident. Due to Petitioner's narcotics problem, further treatment could not be given. He was referred to Dr. Boutwell for weaning. (PX 13)

Petitioner returned to Dr. Fox on 5/16/12. She noted that he had significant pain relief with his Oxycodone. He was told to restart his Gabapentin and was continued with his

Vicodin and Oxycodone. The other tests had not been performed. His Ambien was also renewed. He was told to see a Dr. Cowan for a psychiatric evaluation.

Petitioner returned to Dr. Fox on 6/18/12. He had undergone the nerve conduction studies and the MRI of the forearm. There were no significant indications for nerve damage. He had some mild carpal tunnel syndrome on the right. The MRI of the forearm was normal. He had decreased range of motion of the right shoulder. He had tenderness in the back of the shoulder. Range of motion of the elbow and wrist was intact. He had slightly decreased grip strength on the right. He had posterior neck tenderness without any trigger points. He was told to stop the Oxycodone. He was given Hydromorphone, Gabapentin, Ambien and Vicodin.

Petitioner called Dr. Hefner's office on 7/1/12 wishing to make an appointment. (RX 5)

Petitioner returned to Dr. Fox on 7/12/12. He said that his pain was not being controlled. He still had posterior neck tenderness. His arm examination was as before. She increased his Hydromorphone to 4mg 1-2 tablets every six hours. He was also to take Gabapentin, Ambien and Vicodin.

On 8/3/12 Petitioner saw Dr. Heffner for some component of chronic neck pain for which he needed medications. He had undergone no studies of his neck since 2011. He said that the employee told him that he was "reasonably comfortable with his situation", that he could tolerate it and that he was not "significantly interested" in having further surgery. Examination was nominal. X-rays were ordered. (RX 5)

Petitioner returned to Dr. Fox on 8/13/12. His complaints were the same. His examination was the same. His Hydromorphone was increased and the Gabapentin, Ambien and Vicodin remained the same.

On 9/26/12 Petitioner returned to Dr. Basga Bernard (Southern Illinois Healthcare Foundation) complaining that his hands and his feet would go numb. He was taking Hydromorphone 8mg every four hours. He also complained that his right hand got caught in a wood chipper. He complained of neck pain.

On 10/4/12 Petitioner returned to Dr. Fox. He was out of his Dilaudid. He also said he had a new primary physician, namely a Dr. Bernardi who was working with him to have his neck properly evaluated. Examination was as before. Diagnoses were as before. His medications were refilled.

Petitioner returned to see Dr. Fox on 11/7/12. He said he still had severe pain in the right side of his neck and his shoulder was "catching". Examination was as before. Diagnoses were as before. The Hydromorphone was stopped and he was to take Oxycodone IR, Gabapentin and Vicodin.

He returned to Dr. Fox on 12/6/12. The pain was the same as before. Examination was as before. His Oxycodone, Vicodin, Ambien and Gabapentin were refilled.

Petitioner underwent a CT of his abdomen and pelvis on 1/7/13 due to right lower quadrant pain and nausea. (RX 8)

On 3/29/13 Petitioner returned to Gateway Healthcare. He complained of pain and numbness in his legs. He was prescribed Gabapentin. No right forearm complaints were noted. (RX 2)

On 4/3/13 Dr. Fox wrote prescriptions for Vicodin and Oxycodone IR.

On 4/12/13 Petitioner presented to Memorial Hospital emergency room. He complained of chronic neck pain. He said that he would suffer from neck flares that were worse than usual. He complained of distal numbness and tingling in both upper extremities. He said that he rated his pain level at 7/10. Examination revealed tenderness to touch in the neck. There were no other neurological deficits. X-rays showed the fusion at C5-6. The employee said he felt much better after taking a dose of Dilaudid and was ready to go home. X-rays taken of that date at Memorial indicated a fusion device at C5-6 with a near complete fusion at that level. (RX 5; RX 8; PX 27)

4/18/13 x-rays showed a sold cervical spine fusion. (RX 5)

On 4/29/13 Petitioner returned to Dr. Fox. She said that his pain on the right side of his neck and shoulder had increased and he was requesting trigger point injections. He was given four trigger point injections. Diagnoses remained the same. Morphine Sulfate ER, Oxycodone IR, Vicodin and Gabapentin were refilled.

On 5/2/13 Petitioner was seen at SIFH in follow-up for pain medication. Petitioner complained of knee pain and tingling and coldness in his feet. Medication was given. (RX 8)

On 5/4/13 Dr. Bernard wrote a prescription for Ibuprofen 800mg.

On 5/29/13 Petitioner returned to Dr. Fox. Complaints and findings seem to be the same. He once again had to sign a drug policy agreement. The Morphine Sulfate ER was increased; Oxycodone, Vicodin and Gabapentin remained the same.

Petitioner saw Dr. Heffner on 5/31/13 and continued to complain of chronic neck pain and pain into his right shoulder. He said his neck pain was on a constant basis. He had difficulty in turning his head. He had difficulties with his knees and because of that he was using a cane. Examination revealed some tenderness over the right shoulder and

some tenderness over the knee joints. The doctor thought that x-rays showed the resorption of the anterior tractor spur indicative of elimination of motion at C5-6. He said there was some mild lucency around the metal spacer, but there was bone growth visible as well. The doctor said he thought he had partial bone growth and because of that it was very questionable whether additional surgery at that level would be a requirement. He was to follow up with the doctor in a few months. (RX 5) Petitioner did not return to Dr. Heffner. (RX 5)

Petitioner was seen at the emergency room on 6/1/13 for a stye in his eye. (RX 8) He returned again on 6/19/13 for an eye infection, noting he still could not work as he was disabled. (RX 8)

Petitioner returned to Dr. Fox on 6/27/13. He said he could not sleep. Examination was as before. He was taking Morphine Sulfate ER, Oxycodone, Vicodin and Gabapentin.

Petitioner returned to Dr. Fox on 7/25/13. He said that the increase in the Morphine Sulfate achieved a satisfactory level of pain control but that this left him sleepy. He said that he had tingling and numbness in the right arm. Assessment on this date was chronic right neck and right arm pain that was significantly decreased; history of disc compression at C5-6; right hand and forearm tingling and numbness-stable; persistent financial and social stressors and chronic depression and anxiety due to chronic pain. All medications remained the same and he was to return to see Dr. Fox in one month.

Petitioner was seen at SIFH on 11/6/13 for pain in his lower back. He also needed a dental referral for a broken tooth. Chronic pain syndrome was noted among other conditions. (RX 8) He returned again on 11/18/13 for abdominal pain but left before being examined. (RX 8) He returned again on 11/19/13 due to weakness and cellulitis in his toes. (RX 8)

Petitioner was under surveillance on 12/21/13 and 12/22/13. (RX 12)

At Respondent's request, Dr. Lange re-examined Petitioner on January 6, 2014 and a written report followed. Petitioner presented with residual symptoms he attributed to his work activities. While Petitioner initially suggested two work accidents, he was now claiming a third one as he felt his "symptoms initially began in '08'." (RX 1, Dep. Ex. 6) There was no single incident at that time; rather, he attributed his problems to repetitive heavy activities including the use of a jackhammer. Although he had right shoulder complaints, it was his belief that he also had a neck problem "even then." He then had the second issue in May of 2009 when lifting the culvert pipe and it significantly worsened his right shoulder discomfort. Petitioner then had a third accident on September 18, 2009 when his arm got stuck in a chipper and his neck, right shoulder and right upper extremity were aggravated by that incident. Subsequent to the wood

chipper event Petitioner reportedly underwent surgery "real quick." In actuality the surgery was March 11, 2010 after which Petitioner was better for three months and then they returned. Dr. Heffner reportedly had never released him and his care was transferred to other physicians. Petitioner's biggest problem was neck pain and diffuse discomfort about his right shoulder and parascapular region He also reported a persistent ache over the medial/proximal right forearm where he was hit by the chipper along with intermittent tingling in his right hand digits and a feeling of coldness. An exam was performed and medical records were reviewed. Dr. Lange's assessment was status post C5-6 anterior cervical fusion and chemical dependency. His causation opinion regarding Petitioner's neck remained unchanged. He did feel Petitioner was disabled for essentially all occupations at this point in time, in part due to his chemical dependency. While further treatment was necessary it would not be for a work-related issue. (RX 1 - Dep. Ex. 6)

Petitioner presented to SIHF on 3/18/14 for a routine check up on ongoing neck and right shoulder problems, bilateral knee pain, and dental caries. (RX 8)

On 3/24/14 Petitioner returned to Dr. Mary Fox for follow up. He told her his pain was better controlled with the current increase in the Morphine sulfate. He had decreased his use of Oxycodone to four every 24 hours and was using about six Hydrocodone per day. With regard to the physical examination she said that he was in no acute distress, he was using a cane in his right hand and that he had a mild antalgic gait. Assessment remained the same and she prescribed him Morphine Sulfate ER, Oxycodone, Hydrocodone and Gabapentin.

On 4/23/14 Petitioner returned to Dr. Fox. He said that his pain had "flared up". He ran out of Oxycodone about a week ago. He was taking 6-8 Hydrocodone per day. He was complaining of muscle cramps for two weeks and his personal physician had ordered lab tests. Physical exam was as before. Assessment was as before. He was prescribed the same medication as before.

Petitioner returned to Dr. Fox on 5/21/14. Examination was as before as was the assessment. Medications and amounts remained the same.

On 6/22/14 Petitioner went to Memorial Hospital complaining of neck pain. He gave a history of chronic neck pain that was due to an independent accident. He said that he sustained further injury to neck after he had a fusion. Later his right arm was caught in a wood chipper and he had pulled his arm out of the chipper, which later led to further damage to his neck. Diagnoses were dental caries and cervical radiculopathy. He was given Penicillin and Vicodin. (RX 8)

On 6/23/14 Petitioner returned to Dr. Fox. He said that he had overused his Morphine Sulfate due to severe tooth pain and a flare-up of neck and arm pain. He said he had

been only taking Hydrocodone since 6/12/14. He said he was seen in the emergency room at Belleville Memorial the day before and issued 30 Hydrocodone tablets. He said his average pain was 6/10 with a spike of up to 8/10. It was noted that he appeared to be in more pain and he was still using the cane. He also had tender right paracervical muscles with spasm extending into the right upper back. She added a diagnosis of acute-on-chronic right neck and arm pain and apparent overuse of opioid medications. She said that she had a lengthy and serious discussion with him concerning the use of the opioid medications. He wanted to see if he could find a pain management doctor in Illinois. Medications and amounts remained the same.

On 7/14/14 Petitioner returned to Dr. Fox. She said that this was an "early" visit. His average pain level was 4/10 and up to 7/10. Examination indicated that he was in no acute distress and he was ambulating with a cane in the right hand. She said that he had returned to his base line chronic right neck and right arm pain. Medications and amounts remained the same.

Petitioner again presented to SIHF on 7/22/14 regarding knee pain and low back pain. A psychiatric referral was recommended. (RX 8)

Dr. Lange was deposed on 8/5/14. (RX 1) He testified consistent with his earlier reports.

On 8/20/14 Petitioner returned to Dr. Fox. He said he wanted to see an orthopedic surgeon for his knee. He said he was on a new medication for his "nerves" from his personal physician. He said it was helping with irritability and anxiety. Examination revealed a mildly antalgic gait with a cane in his right hand. She said that he had chronic right neck and arm pain that fluctuated. Everything else remained the same. All the medications and their amounts remained the same.

On 9/8/14 Petitioner returned to Dr. Fox. His neck pain levels had remained stable since the last visit. Everything remained the same in terms of assessment and all the medications and the medication amounts remained the same.

Petitioner saw Dr. Fox again on 10/8/14. He said that his neck pain and right arm pain levels were fluctuating. He was complaining of more pain in his left arm, perhaps with the use of a cane. His average pain level was 4/10 and it was up to 7/10. Again the physical examination was the same as were the assessments of his conditions of ill-being. All the medications remained the same.

Petitioner returned to see Dr. Fox on 11/10/14. Neck and right arm pain levels increased lately due to his sister move out of their parents' home causing him to have more care tasks to perform. Physical examination was unchanged. Diagnoses were

unchanged. Medications prescribed included Morphine sulfate, Oxycodone IR, Hydrocodone and Medrol Dose Pak.

Petitioner was again under surveillance on 12/3/14 and 12/4/14.

Petitioner underwent bilateral knee x-rays, hip x-rays, and lumbar/thoracic spine x-rays at Dr. Mahrukh Khan's request on December 8, 2014. The latter revealed degenerative changes. (RX 2)

On 1/3/15 Petitioner underwent right foot x-rays due to right heel pain of six weeks duration. He denied any injury. (RX 8)

Petitioner continued to see Dr. Fox and his treatment remained the same.

Petitioner's case proceeded to arbitration on April 23, 2015. Petitioner testified that he was 59 years old at the time of hearing. He stated that he last worked for the City in 2009 and had worked about three years for them prior to that as a skilled laborer. He stated that he would perform a number of different activities, including lifting, shoveling, digging holes, weed eating, grass cutting, forming concrete, loading and unloading trucks, cleaning up, jack hammering, painting stripes and disposing of bulk trash. He stated that he started having symptoms in his right shoulder in 2008. He also had symptoms in his neck. He said that before 2009 he would take some medications and perform stretching exercises, but his shoulder was still bothering him in the spring of 2009. The pain seemed to be behind his right shoulder blade. He said that he was off work for 2-3 weeks in May 2009 and when he returned they were working with culvert pipes on driveways. He testified that he would have to get the pipe himself because they did not have any equipment.

He also testified that he did a lot of pot hole patching in April 2009. The culvert that he was lifting was aluminum in nature. He also did a lot of tree trimming where he would stand on the back of a truck and use a tree pole saw. Further, he was using a wood chipper to take care of the tree limbs that were removed. He stated that he also put in a lot of stop signs. He used a jackhammer maybe twice in the spring of 2009.

He said that on July 20, 2009 he was picking up pipes and used a jackhammer and his neck and shoulder started to bother him. He also testified that he was working with some concrete forms and that they were also using a device called a screed to level concrete. After that day he spoke to his supervisor and told him that he was in pain and he wanted to seek treatment. He filled out an incident report. He said that he underwent an MRI for his neck and that he reported that to his supervisor. He testified that he was off work for some time and then returned to work on 8/17/09. He said that he was still having some pain when he lifted or used his right arm.

He testified that on 8/19/09 they were trimming tree limbs and they were using a chipper after the limbs were cut. He said that he and a co-worker pulled a lever to start the chipper and something slammed on his right forearm. He said that he began screaming and was pulling and tugging on his arm. He said that his co-worker heard him, turned off the chipper, ran around to his side of the chipper and helped him pull his arm out of the chipper. He said that the plate that struck his arm on the chipper struck his right forearm about half way between his wrist and right elbow.

He testified that immediately after that event he experienced a lot of pain in the right forearm and up and down his right arm into his neck. He said that the pain was very bad. He stated that he had to go to the emergency room. He then started seeing a number of different physicians and went to a number of different facilities for treatment. Eventually, Dr. Heffner performed surgery on his neck. After that he saw a number of other physicians including a Dr. Pereira, Dr. Khan and Dr. Lakho. He was also referred to Dr. Robert Schultz for a second opinion. He saw a Dr. Bernard in 2012. He said that he had been referred there by Dr. Khan. He saw Dr. Matthew Gornet, who he also says he was referred to by Dr. Khan.

He was asked specifically about the types of difficulties he was having before the event of 8/19/09 and after the event of 8/19/09. He said that just before the event of 8/19/09 he testified to pain if he lifted or grabbed something. He said that he would have some throbbing, but it wouldn't last long. He said that if he lay down or took pain medication, it would normally go away. However, after the event of 8/19/09, he testified that his pain was "unbearable". He would have pain in his neck, down his right arm, with tingling of his fingers. After surgery he took a number of different pain medications prescribed by a number of different physicians.

At the hearing he testified that his pain level was a 4-5/10, provided he was taking his medication. He would experience numbness and tingling in the last three fingers of his right hand. He said he could not pick up anything over 5-10 pound. He could not raise his arm over his head except occasionally. He had difficulty moving his neck. He drives, although he is not supposed to drive given the medication that he is taking. He said that his medication would cause him to have a lot of anger, sadness and depression. He testified that he did very little during the course of a day because of his pain and the effects of his medication. He had not searched for any work since he last worked for Respondent. He testified that he was using a cane because the medication caused him to fall on one occasion while he was walking. He said that one of his treating doctors told him to use the cane at all times and that he used it because he was fearful of falling again.

On cross-examination he once again confirmed that he used the cane because of his medication, and denied that his knee problems had any role in the use of this device.

He admitted that Dr. Khattak had provided him with a number of injections in both of his knees.

He denied completing any information that was submitted with his time cards. He said that he never indicated what jobs he performed each day unless he was a lead person over the pot hole patch crew. He did say that he would write down what he did each day in a log book.

Petitioner was questioned regarding the activities that he believed he performed in a repetitive manner that caused problems with his neck or arm. He testified that it would have been pouring and pulling concrete. He thought that he would have to do this about ten times a month. He also stated that jack hammering, maybe twice a month, caused him problems. He stated that using a product called "cold patch" was difficult in that it would harden and would be difficult to shovel out of the back of the back of a truck. He said that he had to patch pot holes for Respondent every day for three months in a row.

Petitioner was questioned regarding his application for 7/20/09 wherein he alleged that he picked up some forms and felt pain in his right shoulder and neck. He admitted that his attorney had prepared that application, that had read it and signed it, and that he agreed that lifting concrete forms on 7/20/09 caused his right shoulder and neck pain. He said those forms weighed probably 50 to 60 pounds.

He once again stated that following the event of 7/20/09 he had pain in his neck and right arm and some tingling and numbness in his right hand. He said that the only similar symptom he had before that date was stiffness in the back of his right shoulder . He admitted that it was difficult for him to remember things because he was taking medication and it had been a number of years since some of the events took place.

Whenever he sought medical treatment he stated that he would try to give the doctor's as much information as possible and be as honest and straight forward with them as he could. He wanted to give them the proper information because he wanted proper care and treatment.

He testified that when he first saw Dr. Khattak on 7/22/09 he told him what had occurred at work. He also acknowledged going to St. Elizabeth's Hospital on 7/29/09 for the performance of an MRI, but could not recall what he might have told them about how his pain started in his neck. When asked if the records of St. Elizabeth's Hospital on 7/29/09 were correct in that it showed that he told them that he had neck symptoms for about six months prior to his visit, it was his belief that the history was incorrect..

He stated on cross-examination that the event of 8/19/09 made his prior symptoms in his neck and right arm worse and that they never returned to the same level as they

were before 8/19/09. He also reiterated that the event of 8/19/09 required the assistance of his co-worker to help him pull his arm out of the chipper, that he was screaming and that there was quite a bit of trauma to his right arm. He stated that when he went to the emergency room his arm was examined, and it was already swollen when he went there. He also complained of having a bruise already on his arm. He denied telling the staff at Memorial Hospital on that date that he had neck pain, but that it was due to an old injury.

He admitted seeing Dr. Khan following the event of 8/19/09 and being referred to St. Elizabeth's Hospital for physical therapy that began on 8/25/09. He was asked about the history that he provided to the medical providers at St. Elizabeth's Hospital on 8/28/09 when they recorded that he told them that his neck problems began in September 2008. He testified that he did not provide them with that history.

He was questioned regarding his Application for Adjustment of Claim concerning the event of 8/19/09. He admitted to reading over it after the attorney had completed it. He was asked why it merely listing his right arm when he was claiming that the event injured not only his right arm, but his neck (Id.). He had no explanation as to why his application merely said it was his right arm when he had always stated that the event aggravated his "C5-C6".

He was questioned about a second Application that he filed alleging a date of accident of 7/20/09 wherein he claimed injury through repetitive trauma. He was asked if he listed that the body parts injured were his neck and both shoulders. He said that he did not believe that he told his attorney that he hurt both shoulders. He stated that he did not say anything about both of his shoulders being hurt and that he was not making any claim for his left shoulder.

When asked whether it was repetitive trauma or the lifting of the forms on 7/20/09 that caused the injury to his right shoulder, right arm and neck, he said it was the repetitive activities.

Petitioner stated that he saw Dr. Robert Schultz in October 2009. He stated that he was referred there by Dr. Khattak. He said he could not recall what he told Dr. Schultz at that time and he would agree that his memory was probably better back then than it is now. When asked if the history recorded by Dr. Schultz stating that he had injured himself around the end of June when he was pulling on some rebar and using a jack hammer was correct, Petitioner stated that it was not correct. He insisted that he was there merely for a consultation and not for any treatment. He admitted that Dr. Schultz gave him medication after his first visit with him, but that he did not fill those prescriptions. He also admitted that Dr. Schultz wanted to see him again, but he did not return. He said that Dr. Khattak had something to do with his failure to return to Dr. Schultz. When he was asked whether the real reason for not seeing Dr. Schultz

again was because Dr. Schultz wrote him a letter stating that he did not want to see him again because he thought that Petitioner was abusing medications, he denied that was the reason, but did admit to receiving such a letter.

When he was confronted with the fact that he had seen five different medical providers in November 2009 and that all of them provided him with some medication, he denied that all of those medical providers gave him medications. However, he did recall that Dr. Khattak only gave him 20 Vicodin during that period of time and that Dr. Khattak told him that he could take all the medications that had been prescribed by Dr. Hall at that time. He was asked how he could remember those details in light of his previous testimony that he could not recall much of what occurred several years before the hearing, and he said it was because he had a dispute with Dr. Khattak and he was just following his orders.

Petitioner was then asked about records that showed that Dr. Khattak had referred him to Dr. Hall to take care of his pain medication, but that he continued to see Dr. Khattak and got medication from him. He once again testified that Dr. Khattak only gave him 20 pain pills and he thought he could continue to see Dr. Hall and get medications from his as well. He did admit that if Dr. Khattak's records showed that he was prescribed medication by him, he would have no reason to dispute that.

Petitioner agreed that he saw Dr. Lange on 1/28/10 and that Dr. Lange talked to him about how he got hurt. He agreed that he told Dr. Lange that he had been shoveling asphalt and using a post hole driver, that those activities worsened his shoulder pain, but that in July 2009 he was lifting a culvert pipe that increased his shoulder pain.

Petitioner stated that he could not recall what history he provided to Dr. Heffner on 2/5/10. After some dispute about what the records said on that date, he agreed that if Dr. Heffner's note of that date stated that he had been doing his regular job without a specific injury, that he did a lot of heavy lifting, that he had a work injury to his right arm in September 2009, but that he made it clear to the doctor that his neck injury was not related to any specific work event, then the records would be true. He also agreed that if Dr. Heffner stated a second time in his note that there was no specific injury that caused his problem, then that would be true.

Petitioner was asked why, if Dr. Hall had been requested to fill his pain medications by Dr. Khattak, did he still continued to see Dr. Khattak for medications, he testified that Dr. Hall was treating him for blood pressure and other things and that Dr. Khattak was giving him too many Vicodin. He also agreed that if the records showed that both Dr. Hall and Dr. Heffner had given him pain medication in April 2010, even though he told Dr. Hall that Dr. Heffner would not give him medication that would be true, but that he never took any medication from both of them as noted in the record. He also disputed the fact that the records indicated he was taking pain medication from Dr. Khan and Dr.

Hall in April 2010, although he stated that the prescriptions were only 5-8 days. However, he then admitted that he could not recall how many pills he was specifically given by those physicians at that time. He did agree that he was probably taking all medication that was prescribed to him by the doctors.

Petitioner denied calling Dr. Heffner's office to discuss what had caused him to have neck surgery. He was specifically asked if the doctor's records were accurate in stating that on 5/6/10 he had called in, requesting a note stating that the surgery was work-related. He said that that was a false statement by the doctor's office (Id.). He reiterated that the statement as contained in the doctor's records of 5/6/10 was something that he did not provide them. He said that it was the "machine's statement" not Dr. Heffner's own note on that date.

Petitioner was asked if he stopped seeing Dr. Khattak in June 2010 and he agreed, stating that he stopped seeing him because Dr. Khattak did not keep good records. However, he admitted that there was a note in his file from Dr. Khattak of 6/14/10 stating that Dr. Khattak had discharged him as a patient because he knowingly violated a narcotic agreement. He denied that Jawad Khan refused to see him after June 2010. He denied having a disagreement with the physical therapy department at St. Elizabeth's Hospital in June 2010 and said that if Dr. Heffner's records showed that he called his office, complained about the therapist, and wanted his records changed because he thought it would hurt his case, that would be another false statement by Dr. Heffner's office. He also testified that if Dr. Heffner's records from a visit of 6/11/10 said that he had made outstanding progress following his surgery, that would be an incorrect statement as far as he was concerned. He did agree that when Dr. Heffner's office wanted to return him back to Dr. Khattak, he told Dr. Heffner's office that he did not want to do so because Dr. Khattak wasn't doing anything for him. He did not tell Dr. Heffner that Dr. Khattak had discharged him for violating a narcotics agreement. He did agree that Dr. Hall told him in June 2010 that he would not give him any further medications. He stated that he would go to emergency rooms for treatment of his neck because the medication he was taking was not effective and it usually took an injection of Dilaudid or Morphine to ease his pain.

Petitioner stated that the records of Dr. Eugene Pereira on 8/16/10 were false in stating that the surgery had provided him with some relief. He recalled that Dr. Lakho did release him to return to work on a light duty basis in September 2010, but denied that he told the doctor's office that if he did return to work and got reinjured, that it was on Dr. Lakho. Even though he stated that he had been approved for a spinal cord stimulator as recommended by Dr. Pereira, he had no explanation as to why the records of the doctor did not mention a spinal cord stimulator. He said that he did not know why Dr. Richardson recorded that he got hurt at work on May 20, 2009 when he picked up a piece of pipe. He stated that Dr. Khan had referred him to Dr. Gornet in September or October 2011, even though Dr. Khan's office records ended in June 2010.. He agreed

that he wanted to go back and see Dr. Heffner after he saw Dr. Gornet, and probably told the doctor's office that he (Petitioner) would hate for Dr. Heffner's office to get a call from his attorney. He denied seeing a Dr. Mahrukh Khan and Dr. Crystal Carmichael with Gateway Healthcare beginning in March 2012. He started seeing Dr. Mary Fox in April 2012 who prescribed him Oxycodone, Vicodin, Gabapentin, Ambien and other drugs. He started seeing a Dr. Bernard in September 2012.

Although Petitioner recalled seeing Dr. Heffner in May 2003 about his neck pain, he denied telling Dr. Heffner that he was using a cane because of difficulties with his knees. He said that he told Dr. Fox about his leg collapsing because of his medication. However, she did not alter any of his medications as a result of that.

At the time of the hearing he was seeing both Dr. Fox and Dr. Bernard, but denied that Dr. Bernard was giving him any pain medication. He was taking Oxycodone, Vicodin, and Gabapentin. He said that he tried to wean off his medications one time but Dr. Fox told him not to do so and that he wanted to have surgery with Dr. Gornet.

Petitioner continues to have throbbing pain in the right side of his neck down his right shoulder, down the back of his right shoulder blade, and that the pain goes under his arm, down the side and all the way through his fingers. He continues to experience numbness and tingling in the last three fingers on his right hand and this occurs about two times a week. He is unable to pick up anything over 5-10lbs with his right arm and he cannot raise his arm over his head without a great deal of pain.

With regard to his neck, Petitioner testified he is unable to turn to his right and experiences less range of motion if he is without medication. He described that he is very limited in his ability to drive particularly considering the medication and his limited range of motion.

Petitioner's typical day is to get up, take his medicine and sit on the bed until the medicine starts providing relief about 30-45 minutes later. Sometimes the medicine makes him fall back to sleep. He is able to do some chores around the house such as sweep the floor or take out the trash but it limited due to pain. He takes his medication every six hours.

When asked again about driving Petitioner testified that he is not supposed to drive while taking Morphine but sometimes he does drive to get things that he needs such as making trips to Walmart.

Petitioner was observed to be carrying a cane and testified that he has fallen in the past when the medication (morphine) has hit him so he typically uses the cane wherever he goes.

Christopher Volkman testified for Respondent. He was the Director of Public Works/City Engineer. He held that position for about 5½ years and managed the street department. He was familiar with the work activities of his street crew. He testified that he normally did not have his workers lift more than 75 pounds. They had a number of machines to do lifting and moving of items. He said that it was not standard operating procedure for a worker to lift a culvert by himself as there was always a backhoe in the area to excavate ground to put the pipe in. He said that the material that was used to patch potholes would harden under compression and that the workers were able to shovel that material with a shovel holding about 20 pounds.

He testified to a form called the daily report form that was filled out by the lead laborers and would list all of the daily activities of the street crew, the employees who performed those activities and what equipment was used during the course of a day. That form was completed each day and it was maintained by the City of Fairview Heights. He brought the originals of those forms with him to the hearing. Mr. Volkman also testified to what was called a time sheet form. He said that each employee would have to fill out a time card at the end of each pay period (twice a month) and they would have to put down what activity they performed each day. This was supposed to contain what they did that day and how much time they spent doing it. He said that that would be how the employee would get paid and it would also be used in planning and budgeting for the street department. He provided a copy of the time sheet forms for 2008 and 2009 pertaining to Petitioner (RX 13)

Job logs are found in RX 12. Petitioner was working on 7.20.09 using a truck, roller, and John Deere equipment (small and large). They used cold patch and paint while "Cut R.O.W., painted streets, [?] prep." (RX 12)

Off work slips are found in PX 29.

Petitioner's medical bills are found in PX 30.

Photographs of equipment are found in PX 31.

The Arbitrator notes that many of the exhibits contain highlighting which was not done by her. The exhibits were tendered to her in that manner.

The Arbitrator concludes:

Issue (C) Accident and Issue (E) Notice.

The Arbitrator acknowledges that the outline of the testimony of Petitioner, the testimony of Respondent's representative and an outline of the medical information in

these cases is quite extensive and detailed. However, this was necessary in order to develop a context in which Petitioner's testimony, and his allegations, are to be determined. Petitioner's credibility was tested on multiple occasions during his cross-examination. When his testimony, and the medical records mentioned above, are compared, it is apparent that Petitioner's testimony was not credible on a number of issues. Petitioner disagreed with many entries placed in the medical providers' notes concerning contact with him, and he went so far as to say that at least two physicians entered false entries in his medical records. However, he admitted that when those statements were made, his memory of the events that had occurred several years ago would be better than his memory of the events now. Even his comments about his recollection of events of several years ago caused the Arbitrator to question his credibility. Petitioner would freely admit that he was incapable of remembering things that he might have told medical providers many years ago, but testified quite clearly as to medications that he was given and even the number of pills that were prescribed 4-5 years ago. When confronted with this dichotomy, Petitioner admitted that he could not recall the specific number of pills given at any particular time.

The various histories that Petitioner provided to the medical providers near the time of the alleged events of 7/20/09 and at the time of the event of 8/19/09 were multiple and varied as well. In particular, the Arbitrator would note that when Petitioner saw Dr. Christopher Heffner, the operating neurosurgeon with regard to his cervical spine on 2/5/10, Dr. Heffner noted specifically in two sections of his record of that date that Petitioner denied any specific event as the cause for his neck and shoulder problems. However, Petitioner insisted during his testimony that not only did the 8/19/09 event injure his right forearm, but it made much worse his right shoulder and cervical spine complaints that he asserted began on 7/20/09. It should be noted that even his complaints of cervical spine issues and upper extremity issues preceded 7/20/09, according to the medical records offered into evidence. It seems that Petitioner would try to provide a history to a medical provider that might advance the cause of his pending Workers' Compensation claims. He gave multiple histories of events occurring in September 2008, May 2009, June 2009, July 2009 and August 2009, including histories of repetitive trauma. He described the alleged single specific event that occurred on 7/20/09 as lifting concrete forms, pulling rebar and using a jack hammer, lifting a culvert pipe or performing other heavy lifting on or about 7/20/09.

A review of the medical records on and after 7/20/09 up until the time of the 8/19/09 event do not reveal any indication of a single, specific event occurring on 7/20/09. Indeed, although the Petitioner alleged that he was lifting concrete forms on that date in his Application for Adjustment of Claim, the time card forms and the daily sheet forms provided by Respondent's witness (Mr. Volkman) do not indicate that Petitioner was handling or utilizing concrete forms at all on 7/20/09. Additionally, Petitioner's testimony that he had to lift a metal culvert by himself on or near 7/20/09 was undermined by Mr. Volkman's testimony that a backhoe was available to lift the culvert

because a backhoe had to be in the area so that it could dig the trenches into which the culvert was to be placed. He also said that it was the normal procedure of the department to use a machine to lift more than 75 pounds.

Further, with regard to Petitioner's credibility, the Arbitrator notes that Petitioner's care with three physicians was terminated for violating narcotic agreements or abusing prescription medications and that an additional physician stopped providing him medications (Dr. Hall). The records are also clear that on several occasions within two to four weeks, Petitioner would see three to five different medical providers and obtain prescription pain medications from all of them, including such narcotics as Oxycontin, Oxycodone, Percocet and Vicodin. Petitioner readily admitted that he did not advise the various physicians that he was receiving medication from more than one source nor did he advise the physicians that he was utilizing more than one pharmacy to obtain his medications. Petitioner admitted that he would go to various emergency rooms to receive injections of Dilaudid or other potent pain medications because his regular pain medication was not sufficient to control his pain, in spite of the fact that he was prescribed potent pain medications in pill form and his only surgical procedure was a single level disc fusion with hardware at C5-6. Indeed, most of Petitioner's physical examinations by the multiple medical providers were nominal in nature.

Although Petitioner may have performed heavy activities while working for Respondent as a skilled laborer, the Arbitrator finds that these activities were not repetitive enough in nature to constitute repetitive trauma under the Act. It is clear that Petitioner performed a number of duties every day (as he indicated during his testimony) and that his duties varied from day to day. Many of the activities were not heavy in nature. It was also apparent that Respondent had various pieces of machinery that could assist with the heavier duties that Petitioner might be required to perform. Further, the daily sheet forms and the payroll forms offered into evidence do not indicate that Petitioner patched pot holes for three months straight as he alleged in his testimony.

With regard to the event of 8/19/09 when Petitioner alleges that his right forearm was pinned in a word chipper, the Arbitrator finds that this event occurred and was reported properly. However, the Arbitrator finds that the only physical injury related to said event was a crushing injury to his right forearm/elbow area. Petitioner alleged that it required the assistance of his co-worker to dislodge his arm and that they had to pull his arm out of the chipper. Further, he stated that his arm was already swollen and bruised by the time he presented to Memorial Hospital on the same day of the event. This is not verified by the records of the hospital. Petitioner stated that he was able to free his arm (without mention of any assistance from his co-employee). Although he stated that he had neck pain, he related it to a prior accident. His arm was not swollen or bruised on examination. X-rays were negative. There was no examination of the

right shoulder or shoulder on that date. The diagnosis was a contusion to the forearm and he was prescribed Ibuprofen.

When Petitioner saw Dr. Jawad Khan on 8/21/09, he noted that Petitioner complained of forearm pain after his arm was pinned at work. Physical therapy was ordered for the forearm. He was given exercises to perform, told to elevate his arm and told to us ice on his arm. Again, there was no mention of his right shoulder or neck.

He saw Dr. Khan again on 8/25/09 and the complaints and findings were to the right forearm only.

Petitioner's physical therapy was directed to his forearm and there was no mention in the records of St. Elizabeth's physical therapy department about the 8/19/09 event having any impact on his right shoulder and neck.

When Petitioner saw Dr. Robert Schultz on 10/7/09, although he did related pain in his arm and neck to the event of 8/19/09, he stated that he also had an injury in June 2009 to his neck when he was pulling some rebar and using a jackhammer. Petitioner never filed an application concerning that alleged event nor did he testify to such an event at trial.

But most telling were the records of Dr. Heffner, the operating surgeon, who noted in his initial contact with Petitioner when the doctor recorded that Petitioner denied that any single, specific event played a role in his right shoulder and neck complaints. In addition, when Petitioner called Dr. Heffner's office on 5/16/10 asking for an opinion from the doctor that his neck condition was work-related, the doctor's office stated that he could not do so. This would have taken into account his repetitive trauma allegation and his event of 8/19/09.

The records indicate that the office visit of 10/9/09 with Dr. Khattak was the last mention of his right forearm until much later in the records. From that point forward, his care and treatment was focused on his right shoulder and neck complaints.

Issue (F) Causal Connection.

The Arbitrator incorporates her findings relating to accident herein. Petitioner failed to prove a causal connection between any further alleged right forearm complaints and symptoms after 10/9/09. Thereafter, no doctor provided a persuasive causation opinion between any ongoing right forearm symptoms and complaints and Petitioner's work accident of 8/19/09. Petitioner has treated for a myriad of neck, right shoulder and upper extremity complaints with various physicians contending the right upper extremity complaints could be associated with Petitioner's neck and/or shoulder complaints. Neither Petitioner's neck or right shoulder were injured on 8/19/09.

Issue (J) Medical Expenses.

On the basis of the above, and taking into account all of the testimony and medical information outlined above, the Arbitrator finds that Respondent shall pay for the medical treatment connected with the right forearm injury through 10/9/09. Specifically, the treatment that shall be the responsibility of Respondent shall be the emergency room visit at Memorial Hospital of 9/19/09: the office visits with Dr. Jawad Khan of 8/21/09, 8/25/09 and 9/1/09; the physical therapy services provided to Petitioner's right forearm area only at St. Elizabeth's Hospital beginning 8/25/09 and ending on 9/2/09 and from 9/10/09 through 10/9/09; and the office visits with Dr. Hafiz Khattak of 9/9/09 and 10/9/09.

Issue (K) Temporary Total Disability Benefits.

Respondent shall pay Petitioner temporary total disability benefits of $572.63 per week for 7-2/7 weeks commencing August 20, 2009 and ending October 9, 2009, as provided in Section 8(b) of the Act. Petitioner initially sought treatment for his right forearm on 8/19/09 and continued regular treatment for said forearm injury until October 9, 2009 when he saw Dr. Khattak. Thereafter, treatment was focused on his right shoulder and neck injury and additional lost time was attributable to those alleged conditions of ill being. Any further off work slips pertaining to Petitioner's right forearm injury were not based upon persuasive causation opinions and/or office visits (for ex. Dr. Khan's 3/24/10 to whom it may concern letter). Dr. Khan did not examine Petitioner on that date.

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

Respondent shall pay Petitioner permanent partial disability benefits of $515.37 per week for 7.59 weeks because Petitioner sustained 3 % permanent partial disability of the right arm under Section 8(e)10 of the Act. In so concluding the Arbitrator has given consideration to Petitioner's credibility issues as well as Dr. Lange's February of 2014 notation that indicated a persistent ache over Petitioner's medial/proximal right forearm.

Issue (O) Exceeding the Choice of Physicians

Petitioner did not exceed his choice of physicians. In so concluding the Arbitrator relies upon her causation determination above. Petitioner treated with Dr. Khan and Dr. Khattak.

****

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

Jeremiah Beutow,
Petitioner,

vs.

NO: 09 WC 50137

City of Bloomington
Respondent,

17IWCC0225

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that, other than as stated above, the Decision of the Arbitrator filed January 21, 2016 is hereby affirmed and adopted.

The party commencing 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: APR 13 2017

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

o-04/04/17
jdl-jl
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BEUTOW, JEREMIAH
Employee/Petitioner

Case# **09WC050137**

CITY OF BLOOMINGTON
Employer/Respondent

17IWCC0225

On 1/21/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.37% 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:

5757 MARTIN J HAXEL PC
2651 S 5TH ST
SPRINGFIELD, IL 62703

0000 RUSIN & MACIOROWSKI LTD
R MARK COSIMINI
2506 GALEN DR SUITE 108
CHAMPAIGN, IL 61821

STATE OF ILLINOIS)
)SS.
COUNTY OF MCLEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jeremiah Beutow
Employee/Petitioner

Case # 09 WC 50137

v.

Consolidated cases: N/A

City of Bloomington
Employer/Respondent

17IWCC0225

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Arbitrator Douglas McCarthy, Arbitrator of the Commission, in the city of Bloomington, on 12/21/15. 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 _____

ICArbDec 2/10 100 W. Randolph Street #8-200 Chicago, IL 60601 312/814-6611 Toll-free 866/352-3033 Web site: www.iwcc.il.gov
Downstate offices: Collinsville 618/346-3450 Peoria 309/671-3019 Rockford 815/987-7292 Springfield 217/785-7084
This form is a true and exact copy of the current IWCC form ICArbDec, as revised 2/10.

FINDINGS

On 9-17-09, 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 not* sustain an accident that arose out of and in the course of employment.

Timely notice of this alleged accident N/A given to Respondent.

Petitioner's current condition of ill-being N/A causally related to this alleged accident.

In the year preceding the injury, Petitioner earned $51,086.42; the average weekly wage was $982.43.

On the date of accident, Petitioner was 29 years of age, married, with 1 children under 18.

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

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

ORDER

Petitioner failed to prove he sustained accidental injuries which arose out of and in the course of his employment for Respondent.

All other issues become moot. Claim 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 of at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

D. Dglas McCarty

01/14/2016

Signature of arbitrator

Date

JAN 21 2016

STATEMENT OF FACTS

Petitioner testified he began working for the City of Bloomington in September 2009. He worked as a laborer in the street and sewer division. Petitioner explained his job duties included concrete work to repair streets and sidewalks after the water department repaired water mains. His job duties during the winter time consisted of plowing snow preparing trucks for plowing snow. Petitioner testified his job duties during the winter were easier than those during the summer.

Petitioner testified that prior to the alleged accident date of September 17, 2009, he had been experiencing some back pain, but he was still able to function. He testified that on September 17, 2009, his job duties required him to shovel 10 tons of hot asphalt from a dump truck. He testified another worker was with him at the time assisting with the shoveling duties. Petitioner testified his back hurt worse as a result of the job duties, and he was unable to continue working. Petitioner did finish his shift at work, but he testified he did not engage in any physical activities. Petitioner testified that he told one of his supervisors, Mr. Lampert, about the accident that afternoon.

Prior to the alleged accident date, Petitioner was evaluated by Dr. Lalana Babugowda. The evaluation was performed September 11, 2009. Dr. Babugowda's note indicates Petitioner was having low back pain with occasional muscle twitching for the previous two to three weeks. He denied having any radiating symptoms to his legs. Dr. Babugowda diagnosed Petitioner with musculoskeletal spasms and prescribed a muscle relaxant. She also recommended stretching exercises.

X-rays taken by Dr. Babugowda September 11, 2009 revealed there was no loss of vertebral body height, and the disc heights were maintained. No abnormalities were identified on the x-ray films.

Petitioner was next evaluated by Dr. Babugowda September 18, 2009 which was the day after the alleged accident date. Petitioner testified the visit with Dr. Babugowda was already scheduled prior to the alleged work accident. The subjective history in Dr. Babugowda's September 18, 2009 note indicates Petitioner was being seen for a follow-up on back pain. She noted Petitioner was continuing to have pain in his back with no radiating symptoms. She noted Petitioner works in a concrete job and does a lot of bending and lifting things. The physical exam appears identical to the exam one week earlier. The handwritten notes indicate Petitioner's condition was about the same as it was a week earlier. Dr. Babugowda ordered an MRI of the lumbar spine.

At trial, Petitioner testified he advised Dr. Babugowda of the alleged work accident, but she does not speak English very well. However, he also acknowledged that virtually all of the other information contained in Dr. Babugowda's notes was accurate.

An MRI of the lumbar spine was performed September 23, 2009. The clinical indication indicates Petitioner had low back pain radiating down the right leg with no known injury. This was the first mention of Petitioner having radiating symptoms down his leg.

The MRI report reflects mild disc bulges at multiple levels which were described as low-grade degenerative changes. No stenosis was identified at any level of the lumbar spine.

Petitioner was referred to Central Illinois Neurohealth Sciences were he was evaluated by Dr. Kattner October 5, 2009. The history form prepared by Petitioner indicates Petitioner's

symptoms began September 17, 2009 when shoveling hot asphalt. At trial, Petitioner admitted his symptoms actually began before that time.

On October 5, 2009, Dr. Kattner diagnosed Petitioner with mechanical low back pain from a muscle strain/sprain, and he referred Petitioner to Dr. Jhee for therapy. Dr. Kattner did not believe Petitioner was a surgical candidate.

On December 11, 2009, Dr. Jhee noted Petitioner had not felt any back pain over the previous few weeks. Petitioner denied any lower extremity symptoms including radiating pain, paresthesia or weakness.

Dr. Jhee noted Petitioner had resolved low back pain following a lumbosacral strain and lumbar disc disease. He advised Petitioner to continue with physical therapy for the next couple of weeks. Dr. Jhee also indicated Petitioner could return to his regular job duties beginning December 14, 2009.

Petitioner testified he did not recall advising Dr. Jhee that he was symptom-free during December 2009.

On March 11, 2010, Petitioner received chiropractic treatment from Dr. Rogge. The case history form indicates Petitioner's low back pain began September 17, 2009. As indicated above, Petitioner testified at trial that his symptoms actually began prior to that date.

The case history form indicates Petitioner engaged in moderate exercise including kickboxing.

Petitioner testified he was involved in kickboxing activities from approximately 2010 through approximately 2012. He testified he did not engage in any sparring activities, but his workouts generally lasted about 45 minutes and they included punching and kicking a heavy bag.

Dr. Rogge's note from April 7, 2010 indicates Petitioner had abnormalities in the cervical spine, thoracic spine, and lumbar spine, but Petitioner only testified to problems with his lower back.

Petitioner was evaluated by Dr. Babugowda October 13 following an emergency room visit for a laceration to Petitioner's toe. Dr. Babugowda noted Petitioner wears steel toe shoes at work. She also advised Petitioner not to engage in his kickboxing activities for at least two weeks.

Petitioner testified that currently, some days are better than others with respect to his low back discomfort. No particular activities make his back worse.

Petitioner also testified he has been performing his regular job duties for the City of Bloomington since December 2009. His job duties include heavy physical labor including concrete work and the use of a jackhammer.

Honor Coleman testified on behalf of Petitioner. He worked with Petitioner September 17, 2009. He had been working for the respondent since 2005. Mr. Coleman testified Petitioner injured his back while shoveling asphalt, and Petitioner was unable to continue working after that time.

Mr. Coleman was unable to recall any other details concerning the alleged accident date. However, he also testified Petitioner's back was just fine prior to the alleged accident date, and Petitioner never mentioned any problems with his back prior to that time. The Arbitrator notes Mr. Coleman's recollection is inconsistent with Petitioner's testimony and the medical records which indicate Petitioner was having problems with his lower back for three to four weeks prior to the alleged accident date.

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 makes the following findings:

It is well settled that a claimant has the burden of proving by a preponderance of the credible evidence all of the elements of his claim, including that the injury arose out of and in the course of his employment. *Parro v. Industrial Comm'n,* 260 Ill. App.3d 551, 630 N.E.2d 860 (1993). With that in mind, the case of *Shell Oil v. Industrial Comm'n,* 2 Ill.2d 590, 119 N.E.2d 224 (1954), is instructive. In that case, the Illinois Supreme Court found the declarations of an injured person to his treating physician as to his physical condition and the cause thereof are admitted in evidence for the reason that it is presumed a person will not falsify such statements to a physician from whom he expects and hopes to receive medical aid.

A claimant's testimony, standing alone, may support an award where all the facts and circumstances do not preponderate in favor of the opposite conclusion. *Seiber v. Industrial Comm'n,* 82 Ill.2d 87, 411 N.E.2d 249 (1980). However, there is no requirement to award compensation to a claimant merely because there is some testimony which, if it stood alone, might warrant such a finding. *Smith v. Industrial Comm'n,* 98 Ill.2d 20, 455 N.E.2d 86 (1983). The mere existence of testimony does not require its acceptance. *United States Steel v. Industrial Comm'n,* 8 Ill.2d 407, 134 N.E.2d 307 (1956).

The Workers' Compensation Commission has a duty to determine in each case whether the claimant has proven all the elements of his case, including accident, by a preponderance of credible evidence. Where the Commission has failed to reconcile the claimant's testimony with major contradictions and lack of corroboration, its Decisions have been reversed by the Appellate Court. See for example, *Orkin Exterminating Company v. Industrial Comm'n,* 172 Ill.

App.3d 753, 526 N.E.2d 826 (1988); *United States Steel v. Industrial Comm'n,* 8 Ill.2d 407, 134 N.E.2d 307 (1956).

Here, the testimony of Petitioner and his co-worker concerning the alleged accident is not supported by the medical evidence. At the time of the alleged accident, Petitioner was still receiving treatment for low back symptoms which began three to four weeks earlier. The testimony of Honor Coleman is suspect in that he did not recall any specifics of the alleged accident other than to say Petitioner injured his lower back while performing his job duties. He also had no knowledge that Petitioner was experiencing problems with his lower back for the previous three to four weeks.

Significantly, the medical note from the day after the alleged accident fails to document any type of work-related injury from the previous day. Also, the exam findings were virtually identical to those noted one week earlier. The Petitioner was found to have spasm of the paraspinal muscles with no radiation of pain. Similarly, the history portion of the MRI report expressly states there was no known injury. The findings of the MRI also fail to identify any type of acute pathology. The radiologist who interpreted the MRI films only identified low-grade degenerative changes.

Based upon the foregoing, the Arbitrator finds Petitioner failed to prove he sustained accidental injuries which arose out of and in the course of his employment for Respondent.

The claim is denied. All other issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Francisca Ramirez,
Petitioner,

vs.

NO: 10 WC 49189

Aspen Marketing Services,
Respondent.

ORDER

Motion for Rule to Show Cause and Dismissal of Petitioner's Review having been filed by Respondent herein, and due notice given, this matter came on for hearing before the Illinois Workers' Compensation Commission on December 21, 2016 in Chicago, Illinois.

PROCEDURAL HISTORY AND FACTS

On February 13, 2014, this matter appeared on the status call of Arbitrator Barbara Flores. In accordance with Section 9020.60 (b)(2)(D)(i) (formerly 7020.60) of the Rules of the Illinois Workers' Compensation Commission, the parties or their attorneys must be present at each status call on which the case appears. Petitioner and/or her representative did not appear at the February 13, 2014 status call. On February 14, 2014, the Arbitrator issued a Notice of Case Dismissal due to the party and/or her attorney's failure to appear.

On April 4, 2014, Petitioner's attorney filed a Petition to Reinstate without proper notice to Respondent's counsel and without a date certain for appearance/presentation before the Arbitrator. On November 18, 2015, Petitioner's attorney filed a second Petition to Reinstate with proper notice to Respondent's counsel and notice of hearing for December 5, 2015.

On December 8, 2015, Arbitrator Flores conducted a hearing as to Petitioner's Petition to Reinstate. At the conclusion of the hearing, Arbitrator Flores denied Petitioner's Petition to Reinstate.

On March 18, 2016, Petitioner's attorney filed a timely Petition for Review of the Arbitrator's Order. On June 2, 2016, the Commission issued a Notice of Return Date on Review setting the same for July 29, 2016 and establishing the briefing schedule. Respondent filed its Brief in support of Dismissal of the Appeal and Denial of Reinstatement on September 9, 2016.

The Petitioner failed to file the transcript by the established Return Date on Review. Petitioner subsequently filed the authenticated transcript on September 26, 2016 which was accepted by the Commission.

On September 6, 2016, Respondent filed a Motion for Rule to Show Cause and Dismissal of Review with a notice of hearing for September 28, 2016. The Motion was entered and continued and ultimately heard on December 21, 2016.

On December 21, 2016, arguments were heard relative to the Respondent's Motion to Dismiss the Review predicated on Petitioner's failure to timely file her Statement of Exceptions and Supporting Brief. The matter was taken under advisement. During the hearing Petitioner sought leave to file her Statement of Exceptions and Supporting Brief, *instanter*, which was granted. Petitioner's Statement of Exceptions was filed on December 21, 2016.

CONCLUSION OF LAW

Petitioner filed a timely Petition for Review on March 8, 2016, and a properly authenticated transcript on September 26, 2016 which was accepted by the Commission, albeit two months following the Return Date on Review. Pursuant to Section 19(e) of the Act, "If a petition for review and agreed statement of facts or transcript of evidence is filed, as provided herein, the Commission shall promptly review the decision of the Arbitrator and all questions of law or fact which appear from the statement of facts or transcript of evidence." *820 ILCS 305/19(e)* (West 2013). See *Klein Construction v. IWCC*, 384 Ill. App. 3d 233, 238 (2008) ("Although the claimant's failure to file a Statement of Exceptions acted as a waiver of his right to oral argument and an election not to advise the Commission of any reason to change the arbitrator's decision or grant his petition, the Commission was nevertheless required by statute to review all questions of law or fact which appeared from the transcript of evidence.").

Therefore based on Section 19(e) of the Act, the applicable case law as it applies to the above facts and the reasons set forth above, Respondent's Motion for Rule to Show Cause and Dismiss Review is hereby denied.

Section 9040.70(d) of the Rules of the Illinois Workers' Compensation Commission states, in pertinent part, "Failure of any party to timely file any Statement of Exceptions and Supporting Brief or Response Brief required by this Section, including an abstract when required under subsection (f), shall constitute a forfeiture of the right to oral argument by that party." Petitioner filed her Statement of Exceptions on December 21, 2016 well beyond the required

date of September 13, 2016. Given Petitioner's failure to timely file her Statement of Exceptions, oral arguments are hereby denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Motion for Rule to Show Cause and Dismiss Review is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that oral arguments are hereby denied for Petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION that this matter shall be set for oral argument with a decision to issue on its merits thereafter.

DATED: APR 6 - 2017

L. Elizabeth Coppoletti

EC/jm

R: 12/21/16

43

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

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

Randy Russell,
Petitioner,

vs.

City of Fairview Heights,
Respondent.

17IWCC0246

NO: 10 WC 18033

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 30, 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: APR 21 2017
o4/6/17
DLS/rm
046

Deborah L. Simpson

Deborah L. Simpson

David L. Gore

David L. Gore

Stephen J. Mathis

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0246

RUSSELL, RANDY
Employee/Petitioner

Case# **10WC018033**

09WC036491
09WC036449

CITY OF FAIRVIEW HTS
Employer/Respondent

On 6/30/2015, 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:

3067 KIRKPATRICK LAW OFFICES PC
ERIC KIRKPATRICK
3 EXECUTIVE WOODS CT
BELLEVILLE, IL 62226

0810 BECKER PAULSON & HOERNER PC
RODNEY THOMPSON
5111 W MAIN ST
BELLEVILLE, IL 62226

17IWCC0246

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

Randy Russell
Employee/Petitioner

v.

City of Fairview Heights
Employer/Respondent

Case # 10 WC 18033

Consolidated cases: 09WC36491;09 WC 36449

An *Application for Adjustment 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 **Collinsville**, on **April 23, 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 **Whether Petitioner exceeded his choice of two physicians under the Act.**

FINDINGS

On **7/20/09**, 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 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 **$44,665.34**; the average weekly wage was **$858.95**.

On the date of accident, Petitioner was **49** years of age, ***single*** with **1** child 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 **$0.00** 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 general credit for any medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove he sustained an accident on 7/20/09 that arose out of and in the course of his employment or that his current condition of ill-being is causally connected to that accident. Petitioner's claim is denied and no benefits are awarded.

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

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

Signature of Arbitrator

June 18, 2015
Date

JUN 19 2015

Randy Russell v. City of Fairview Heights
Case Number: 10 WC 18033

Findings of Fact and Conclusions of Law

Three cases were consolidated for purposes of trial and the parties agreed that only one proposed decision covering all three cases would be prepared. There were two claims filed with a date of accident of 7/20/09. Case number 09 WC 36449 alleged a single, specific event with a date of 7/20/09 wherein Petitioner alleged that he injured his right shoulder and neck while lifting concrete forms. Case number 10 WC 18033 was an Application wherein Petitioner alleged that he sustained neck and both shoulder injuries as a result of repetitive trauma activities through 7/20/09. Case number 09 WC 39491 was for a date of accident of 8/19/09 wherein Petitioner alleged that his right arm was caught in a wood chipper.

With regard to case number 09 WC 36449 (the single, specific event on 7/20/09), the issues included whether the Petitioner sustained an accident on that date, whether notice was given of said accident, whether his condition of ill-being was related to the accident, whether Respondent was liable for any medical bills, whether Petitioner exceeded his choice of two physicians under the Act, temporary total disability and permanent disability benefits. With regard to case number 09 WC 39491, date of accident 8/19/09, the issues were identical to the issues in 09 WC 36449. Further, the issues were identical with regard to claim number 10 WC 18033, a repetitive trauma claim through 7/20/09.

While the parties requested that one decision issue, the Commission has requested that separate decisions issue. Accordingly, the Arbitrator is doing so. Chris Volkman was present throughout the hearing as Respondent's representative.

The Arbitrator finds:

The medical evidence supplied by the parties was quite extensive.

Petitioner underwent trauma to his right hand in May of 2008. He also reported some right shoulder pain. Petitioner had been handling some furniture. (RX 8) Petitioner continued treating for the right shoulder pain indicating that a heavy piece of furniture fell onto his right forearm at work five months earlier. He also reported performing physical work at his job, including shoveling and lifting and "thinks" he exacerbated his right shoulder pain while trying to lift a heavy pipe off the ground. Petitioner's shoulder hurt with most movements but he was on probation and didn't want to miss any work. An MRI was ordered. (RX 8)

On 2/17/09 Petitioner presented to Memorial Hospital for right arm pain that began on 2/9/09 while moving a refrigerator for a friend. He noted an original injury to the same arm while working with pipe in 2008. No radiating pain was noted. (RX 8)

Petitioner saw Dr. Khan on 5/21/09 complaining of right shoulder and left knee pain of three weeks duration. (PX 3)

On 5/21/09 Petitioner went to St. Elizabeth's Hospital because Dr. Jawad Khan had referred him for x-rays of his left knee and cervical spine. The diagnosis was paresthesias of the distal upper extremities, rule out carpal tunnel syndrome and left leg pain. On a radiology patient history form Petitioner noted that he had the symptoms for about 3-4 weeks. X-rays of the cervical spine revealed interspace narrowing at C5-6 and mild posterior foraminal narrowing at C5-6 on the right side.

On 5/27/09 Petitioner saw Dr. Hafiz Khattak. His impression was neck pain and degenerative joint disease of the knees. Petitioner was given a Hyalgan injection into the left knee and was prescribed Vicodin. (RX 4)

Petitioner was seen by Dr. Kahn on 6/15/09 for knee and shoulder pain. (PX 3)

On 6/17/09 Petitioner returned to Dr. Khattak. He said that his pain level in his right shoulder and left knee was 3-4/10. He was given another injection into his knee. (RX 4)

Petitioner returned to Dr. Khattak on 6/24/09. His pain level was 8/10. Diagnosis was chronic degenerative joint disease of the knees. He was given another Hyalgan injection. (RX 4)

Petitioner returned to Dr. Khattak on 7/13/09. His pain level was 5/10. He was still having problems with his left knee and with his neck. His knee was once again injected and he was prescribed Robaxin. (RX 4)

The first medical care provided to Petitioner after 7/20/09 was on 7/22/09 when he saw Dr. Khattak and stated his pain level was 9/10. Diagnosis was chronic neck pain. He was told to get an MRI of his cervical spine and was taken off work. He was given trigger point injections and another Hyalgan injection into the left knee. There was no history of any work-related event occurring on 7/20/09. (RX 4)

Petitioner returned on 7/27/09 to Dr. Khattak. He listed his pain level as 8-9/10 and noted that his pain was in his right shoulder area. Diagnoses were chronic neck pain and degenerative joint disease of the right knee. He was given a Hyalgan injection into the right knee and a Dilaudid injection. On his pain drawing, Petitioner noted right shoulder pain. (RX 4)

On 7/29/09 Petitioner presented to St. Elizabeth's Hospital for an MRI of the cervical spine. He was asked if his symptoms were "due to an accident". He answered both "yes" and "no". He said that he had a work injury from lifting. He said that he had injured his neck before. He said he had the symptoms for six months. He said that he had surgery on his neck in 2000. The MRI revealed a broad-based central to right-sided foraminal disc protrusion at C5-6 causing significant foraminal narrowing on the right side and mild to moderate foraminal narrowing on the left side. At C6-7 there was a mild, central bulging disc touching the thecal sac. (RX 6)

Petitioner returned to Dr. Khattak on 8/3/09. He complained that his pain level was 5-7/10. He listed the right side of his neck and his right shoulder as his problematic areas. Impressions were cervical herniated disc and degenerative joint disease of the knees. He was given an injection into his left knee. He was prescribed physical therapy for three weeks. Again, his pain drawing showed right shoulder pain and he listed his problems as sleeping and fatigue. (RX 4)

Petitioner returned to Dr. Khattak on 8/10/09. Impressions were cervicalgia with radiculopathy and myofascial pain syndrome. He listed his pain level at this time as 10/10. He was given some medication and told to follow up. His pain drawing remained unchanged. (RX 4)

Petitioner returned to Dr. Khattak on 8/14/09. His pain level was listed as 3/10. Impression was chronic degenerative joint disease of the knees. He was given an injection of Hyalgan into the right knee. However, he was also given an off work slip with regard to his neck. (RX 4)

On 8/19/09 Petitioner presented at Memorial Hospital. He complained of right forearm pain. He said a 75 pound door fell onto his arm at 1:20 that afternoon. He also had chronic right-sided neck pain that would radiate down the right shoulder. He said that was due to an old injury. He said that his employer had just purchased a new chipper and a bar came down, striking his arm and pushing it into a metal plate. He said that he forced the door back up. The door struck his upper forearm to the level of the elbow. He complained that his pain level was 6/10. Examination revealed no swelling and no obvious bruising. He gave a history of chronic right shoulder pain and neck pain. He said he was taking Vicodin but had run out of that. X-ray examination of the right forearm revealed no fracture, dislocation or unusual soft tissue calcification. Diagnosis was contusion and he was given Ibuprofen. (RX 9)

Petitioner was examined by Dr. Jawad Khan on 8/21/09. Petitioner gave a history of his 8/19/09 accident at work and complained of right forearm pain. He was given medication and taken off work through 8/25/09. Physical therapy was recommended. (RX 7; PX 3, p. 2)

Petitioner was seen by Dr. Khattak on 8/24/09. His pain complaints included his right shoulder and right forearm (pain drawing). He reported fatigue and lack of energy. He did not mark that he had any swelling in his hands or ankles. Petitioner was given a left knee injection. (RX 4)

Petitioner signed his Application for Adjustment of Claim in "09 WC 36449" (d/a: 7/20/09 – picking up forms when he felt pain in his shoulder) on 8/24/09. (AX 2)

Petitioner returned to Dr. Jawad Kahn on 8/25/09 with regard to his right forearm. He said he had been performing physical therapy. He was still tender and there was some mild swelling and bruising in the mid-forearm. He was given a Medrol Dose pak and prescribed Oxycontin and Percocet. He was to continue with his physical therapy. (RX 7)

On 8/25/09 Petitioner underwent his initial evaluation at physical therapy at St. Elizabeth's Hospital. He gave a history of right forearm pain with a crushing type of injury. He was to begin physical therapy for that. He gave a history at physical therapy of having right forearm pain, right shoulder pain and right side neck pain. He said that he had pain in the right shoulder down in the arm to the finger from C5-6. He was asked "how did it start". His answer was: "while picking up cover pipe/shovel, forearm was pinned in machine". When he was asked to state when his problem began, he said 5/20/09. He also said 8/17/09. He said it was a work-related injury. He said that he returned to work on 8/17/09 and was cutting trees when his right forearm was pinned. He said that he is a skilled laborer who repairs roads, pours concrete and performs grass care. He said that his pain was worse whenever he would sleep or walk. He was taking Vicodin and Ibuprofen. (RX 10)

On 8/28/09 Petitioner presented to the physical therapy department at St. Elizabeth's Hospital and was complaining of pain in his neck. He said that it began in September 2008 and was a work-related event. He said it was made worse by shoveling and picking up equipment. On 8/28/09 it was noted that with regard to his right forearm, he was wearing a "tubigrip" five hours a day without any ill effect. He said there was some decrease in the swelling of his right forearm. (RX 10)

Petitioner was seen by Dr. Khattak on 8/28/09. His pain drawing only noted right shoulder pain. (RX 4)

Petitioner returned to Dr. Khattak on 8/31/09. Impressions were chronic neck pain and herniated disc at C5-6. He was told to continue with his physical therapy. However, he also underwent another injection into his right knee. His pain drawing had markings on his right shoulder and forearm. (RX 4)

In a slip dated 9/1/09 Dr. Jawad Khan kept Petitioner off of work for his right forearm injury/strain. At that visit Petitioner received a trigger point injection. (RX 7)(PX 3)

On 9/9/09 Petitioner returned to Dr. Jawad Khan. He said he was taking Hydrocodone throughout the day. He had shooting pain up and down the right side of the neck. His right arm was not as strong as his left. The doctor reviewed some x-rays and found that Petitioner had mild secondary degenerative changes with narrowing at C5-6. Diagnosis was forearm injury on the right. He was given Feldene, Ibuprofen and Hydrocodone and kept off work through 9/22/09. (RX 7; PX 3)

In a slip dated 9/11/09 Dr. Khattak listed Petitioner's diagnoses as a herniated disc at C5-6 and right forearm pain. He recommended physical therapy. (RX 4)

Petitioner signed his Application for Adjustment of Claim in "09 WC 39491" on 9/17/09 (d/a - 8/19/09) (AX 4)

Dr. Khattak re-examined Petitioner on 9/21/09. Petitioner did not complete a pain drawing. Dr. Khattak took Petitioner off work through 10/2/09 for both Petitioner's neck and right forearm. (RX 4)

Petitioner returned to see the doctor (Khan) at Gateway Healthcare on 9/22/09. An appointment with the surgeon, Dr. Schultz, was pending. There is a note "Referred by Dr. Khattak." Petitioner didn't think the hydrocodone was helping. Petitioner complained of pain radiating from his neck down his right arm. Petitioner reported discussing Percocet with Dr. Khattak but didn't ask for meds. He requested medication for heart burn he noted after therapy. On examination the doctor noted tightness and spasticity of his right forearm and trapezius. Petitioner had decreased lateral rotation bilaterally, the left greater than the right. He was diagnosed with chronic neck/right forearm pain. Percocet was prescribed. (RX 7; PX 3)

Dr. Khattak examined Petitioner on 9/30/09. Petitioner's pain drawing noted complaints in his right shoulder, right forearm and the right side of his head. He was complaining of fatigue, headaches, weight loss/gain, ringing in his ears, and sleep difficulties. Petitioner was diagnosed with chronic neck pain, myofascial pain syndrome, and cervicalgia. (RX 4)

In a slip dated 10/2/09, Dr. Khattak kept Petitioner off work through October 20, 2009. He did not indicate the condition for which Petitioner was being kept off of work. (RX 7)

On 10/7/09 Petitioner saw Dr. Robert Schultz. He gave a history to Dr. Schultz that he had been injured "sometime around the end of June". He said that he was pulling on some rebar and using a jack hammer and had the onset of some pain in his shoulder.

He said that because he did not have any sick leave available, he saw his family doctor who gave him some medication and told him to continue to work. He said he did so until 8/19/09 when he was using a chipper. He said that his arm got caught in the chipper and he had some significant arm pain, shoulder pain and neck pain since that time. He noted that he had undergone trigger point injections in his neck. He said that he had been on Robaxin. He noted he underwent an MRI scan. He thought that he was getting worse. The doctor reviewed the MRI scan that was brought with the petitioner and he thought that it showed a degenerated, herniated disc at C5-6 with some narrowing of the foramen on the right. Physical examination revealed some loss of range of motion and some other minor irregularities. The doctor thought that he had some equivocal weakness of the biceps on the left as compared to the right and a sensory loss in the ulnar distribution of the right hand. The right triceps was apparently absent. Diagnoses were neck pain, degenerative disc disease at C5-6 with a herniated disc at the same level, spondylolysis of the neck and thoracic outlet syndrome on the right. He recommended that the petitioner undergo a couple of cervical epidural blocks, undergo some nerve studies of the upper extremities, obtain some additional x-rays and prescribed him Norco and Flexeril. He was taken off work through November 10, 2009. (RX 6)

On 10/9/09 Petitioner returned to Dr. Khattak. Diagnoses were chronic neck pain and right forearm pain. He was told to obtain an EMG/NCV of both arms. Petitioner's pain drawing again reflected right shoulder and forearm pain (extending into his right pinky finger). (RX 4)

On 10/19/09 Petitioner returned to Dr. Khattak. The diagnosis was chronic neck pain and radiculopathy. He was referred to Dr. Chris Heffner. His pain drawing was unchanged from the previous visit except that he didn't indicate right pinky finger pain. (RX 4)

On 11/2/09 Dr. Schultz notified Petitioner he was being discharged from further care due to problems with medication abuse. (RX 6)

On 11/9/09 Petitioner presented to the emergency room at St. Elizabeth's Hospital. He complained of neck pain. He said it started on 5/19/09 after a work injury. He was out of his Vicodin. Diagnosis was chronic neck pain. He was given an injection and prescribed Oxycodone.

On 11/9/09 Petitioner also returned to see Dr. Khattak. Diagnoses were chronic neck pain and myofasciitis pain. He was given trigger point injections and Voltaren gel. The pain drawing revealed bilateral neck complaints, right shoulder complaints, and right forearm/pinky finger complaints. He also complained of ringing in the ears. (RX 4)

On 11/11/09 Petitioner presented to the emergency room at St. Elizabeth's Hospital. He complained of pain in the right side of his neck. He was out of Vicodin. He was told to follow up with his doctors.

Petitioner saw Dr. Luke Hall on 11/12/09. He said he was being seen for back pain. He said that he had severe back pain for several months and an MRI showed a disc protrusion and that Dr. Heffner was recommending surgery (it should be noted that Petitioner did not see Dr. Heffner until 2/5/2010). He also said he saw Dr. Khattak for pain management. He said that his pain was not controlled with medication with Dr. Khattak and therefore he was told to see his personal medical doctor for management. At the time, he was taking a number of medications including Flexeril, Ibuprofen, Vicodin, Oxycontin and Percocet. Neurological examination revealed that his motor and sensory functions were intact and equal, his reflexes were normal and equal and his gait was normal. Dr. Hall contacted Dr. Khattak's office and they confirmed that Dr. Khattak wanted his private physician to handle the pain medications. Oxycontin and Percocet were given. (RX 8)

On 11/13/09 Petitioner was seen at Gateway Healthcare to follow up on lab work. He complained of elevated blood pressure and had been seen at the ER for high blood pressure and a right-sided headache. (RX 7)

On 11/18/09 Petitioner saw Dr. Khattak. Diagnoses were chronic neck pain, stenosis at C5-6 and right upper extremity pain. His medications were refilled. Petitioner's pain drawing noted right shoulder pain and less right forearm pain/complaints. (RX 4)

On 12/14/09 Petitioner saw Dr. Khattak and complained of chronic neck pain, right upper extremity pain and spinal stenosis at C5-6. His pain level was 5/10. He was given an injection of Depo Medrol. Petitioner's pain drawing again noted right shoulder and right forearm complaints. (RX 4)

On 1/8/10 Petitioner returned to see Dr. Hall. He was continuing to have back/neck pain, shoulder pain and shooting pains down his arms. He was taking Flexeril, Ibuprofen and Vicodin. Assessment was back/neck pain with disc protrusion from a work accident in May 2009. He was given exercises for his neck and back. He was to continue with the Oxycontin, Percocet and Ibuprofen. (RX 8)

On 1/15/10 Petitioner saw Dr. Khattak and complained of chronic neck pain, degenerative disc disease. His medications were refilled. No right forearm complaints were noted. (RX 4)

Petitioner returned to Gateway Healthcare on 1/19/10 for a review of his labwork. He had "no complaints other than neck and shoulder pain." He was also reporting poor sleeping. According to a note of Dr. Jawad Khan that same day Petitioner was waking

up from sleep at 3 a.m. with a feeling of pins and needles in his right forearm which would shoot up to his axilla and then the right side of his neck. He reported taking a lot of pain medications and noted a visit with Dr. Haefener who planned to do a nerve block. Petitioner reported his right hand would develop blanching on exposure to the cold. Petitioner was referred by Dr. J. Khan to a rheumatologist. (RX 7)

Petitioner was again seen at Gateway Healthcare on 1/25/10 primarily for his blood pressure. Dr. Jawad Khan noted that Petitioner was continuing to have right-sided posterolateral neck pain and headaches that Petitioner attributed to his neck pain. No right forearm complaints were noted. (RX 7)

In a note dated 1/27/10 Dr. J. Khan took Petitioner off work from 1/18/10 to 2/5/10 for forearm and neck pain. (RX 7)

On 1/28/10 the Petitioner saw Dr. David Lange at Respondent's request. Dr. Lange took a history from the patient indicating that his shoulder problems began back in "2008". He said that he saw a Dr. Hall at St. Elizabeth's Hospital for one or two months. He said that he thought that his shoulder was the issue. He continued to have symptoms about the right shoulder, but continued to work. He said that his work activities were quite heavy. They included the shoveling of asphalt and using a post-hole driver. He said that those activities consistently worsened in right shoulder pain. Further, Petitioner said that he lifted a "covert pipe" in July 2009 and that increased his right shoulder pain. He said that he had seen Dr. Hall, Dr. Khan and Dr. Khattak for his problem and had been treated with injections. He said that he had pain in the right side of his neck that would go into the right suprascapular area and then somewhat down the right arm and forearm. He complained of numbness in the ulnar aspect of the right forearm and proximal hand. Petitioner spoke to Dr. Lange about the event of 8/19/09 with the wood chipper. He said that a heavy door fell down onto his right forearm. Examination revealed a mildly positive Hoffman sign on the right. He complained of neck pain with forward motion. He had discomfort in the right trapezius. The doctor reviewed the cervical spine MRI and it was interpreted to show degenerative disc disease at C5-6 with some posterior spurs. He said that there was a soft, disc herniation centrally and to the right at that level. Dr. Lange then reviewed a multitude of records and reports. Diagnosis was degenerative disc disease at C5-6 with a herniation causing the right upper extremity complaints. He said that he could not substantiate a relationship between the disc herniation and his work activities. The doctor noted that he had seen physicians before July 20, 2009 for his neck problems. The doctor thought that because his cervical disc was degenerative in nature, it would be "impossible to state with any certainty his work activities were a factor with respect to his current condition". The doctor thought that he did need more treatment, including the possibility of surgery with a fusion. He said that since his symptoms seemed to go back to year 2008, even though certain activities at work and at home tended to aggravate that condition, "such increase of symptoms on a day to day basis is not to suggest that

having increased symptoms with any particular activity in some fashion aggravated, accelerated or made to become symptomatic the underlying disc pathology". Some residual aching in Petitioner's right forearm was noted. (RX 1, Dep. Ex. 3)

On 2/4/10 Petitioner returned to Dr. Hall. He continued to have the same complaints. Dr. Hall continued his Oxycontin and Percocet. (RX 8)

Petitioner saw Dr. Christopher Heffner on 2/5/10. He was referred to Dr. Heffner by Dr. Khattak. He said that about nine or ten months ago he was doing his regular job without a specific injury. He said he did a lot of heavy lifting and noticed some pain in his neck and right upper extremity along with some shoulder pain. He did say that he had a work injury to his right arm in September. Petitioner made it clear that the neck injury was not related to any specific work event. Examination revealed weakness in the right biceps and triceps. He had mild weakness in the right hand intrinsic function. He said that an MRI scan showed a sizable central, and somewhat right-sided, disc herniation at C5-6. Dr. Heffner said that he did not have "any specific injury to bring this on". The doctor recommended a C5-6 discectomy and interbody fusion. Petitioner agreed and was taken off work. He was taken off work for approximately 6 -12 weeks. (RX 5)

On 2/5/10 the petitioner returned to Dr. Khan. He was complaining of his neck. Diagnoses were chronic neck pain with radiculopathy, cervicalgia, spinal stenosis and degenerative disc disease. He was to follow up in one week for a neck injection and said that Dr. Heffner told him he needed surgery. Petitioner was given Hydrocodone and Ibuprofen.

On 2/5/10 the petitioner also saw Dr. Khattak. His diagnoses were the same and he was continued with his medications. No right forearm complaints were noted. (RX 4)
Dr. Lange issued another report on 2/5/10 addressing some transcription problems from his initial report. He indicated Petitioner's prognosis was excellent with a 1-level fusion and Petitioner should be able to resume full duty work approximately three months thereafter. He added that he did not think Petitioner's repetitive work activities would be associated with the herniation or any treatment for it. (RX 1 – Dep. Ex. 4,5)

On 2/8/10 Dr. J. Khan took Petitioner off work from 2/5/10 "until further notice" for "medical reasons." (RX 7)

Dr. Khattak re-examined Petitioner on 2/12/10. Petitioner didn't mark the pain drawing. His diagnoses remained unchanged and no right forearm complaints were noted. (RX 4)

In notes dated 2/16/10 Dr. Heffner thanked both Dr. A. Khan and Dr. Hafiz Khattak for the referral and noted Petitioner was scheduled for surgery on 2/16/10. (RX 5)

Petitioner was seen at Gateway Healthcare on 2/22/10 and reported no more headaches but ongoing neck pain. He wished to quit smoking. Dr. J. Khan recorded the visit as related to a follow-up for sinusitis. Petitioner denied any further headache but reported chronic neck pain ("4-5/10") and upcoming neck surgery with Dr. Heiffer. No right forearm complaints were noted. This is the last office visit with Gateway Healthcare/Dr. J. Khan. (RX 7)

Petitioner underwent a rheumatology exam on 2/23/10. He was noted to have an isolated positive ANA without any symptoms or signs of inflammatory disease. Petitioner reported some persistent discomfort in his proximal right forearm too. The doctor noted a burn on Petitioner's right arm a number of years earlier for which Petitioner required skin grafting. (RX 5)

Petitioner was seen at Dr. Heffner's office on 3/8/10. The Nurse's Notes indicate continued complaints of posterior neck pain radiating into his right shoulder, down the right arm to just below his elbow and constant tingling and numbness of the right ring and pinky finger. Petitioner was getting ready for surgery. (RX 5)

On 3/11/10 Petitioner returned to see Dr. Hall. Medications included Flexeril, Ibuprofen and Vicodin. He was to continue with his Oxycontin and Percocet until he underwent surgery. (RX 8)

On 3/15/10 he returned to Dr. Khattak. His medication was refilled. His pain drawing noted right shoulder and forearm pain. No diagnosis was made regarding the forearm pain. The doctor noted radiculopathy in conjunction with Petitioner's neck pain. (RX 4)

On 3/17/10 Petitioner was admitted to Memorial Hospital by Dr. Heffner. He was taken to surgery by Dr. Heffner that day for the removal of the disc between C5 and C6. An interbody spacer was filled with material and sunk between C5 and C6. He was told to remain off work, given a soft cervical collar, antibiotics and Lortab. (RX 5)

On 3/24/10 Petitioner returned to Dr. Heffner and said that he had no "real pain" since surgery until that morning when he had some right shoulder and arm pain. His collar was removed and the dressings were changed. He was told to return in three weeks, x-rays were taken and he was given a softer collar. Medication usage was also discussed. (RX 5)

In a letter dated 3/24/10 and addressed to whom it may concern, Dr. J. Khan wrote that Petitioner had been under the care of Dr. Khan and Dr. Khattak and was being treated from 9/20/09 for arm pain until further notice. (PX 3)

On 4/5/10 Petitioner called the Dr. Heffner's office and complained of right-sided neck pain. He was prescribed Robaxin and Ibuprofen. (RX 5)

On 4/14/10 Petitioner returned to Dr. Hall. He had the same complaints as before. It was noted that he had surgery two weeks ago. He said that Dr. Heffner deferred pain management to his personal physician. Dr. Hall prescribed Vicodin. (RX 8)

On 4/16/10 Petitioner returned to Dr. Khan for neck pain. He said that his medications needed to be refilled and he would need a physician's statement with regard to his ability to remain off work. He said he had surgery on his neck on 3/17/10. He was prescribed Vicodin and Robaxin. No right forearm complaints were noted. He was diagnosed with neck pain, cervical radiculitis, myalgias, and neuralgia. (RX 4)

Petitioner returned to Dr. Heffner on 4/23/10 and said that he had improved significantly with his neck and arm pain. He was to begin physical therapy. (RX 5)

On 5/6/10 Petitioner called Dr. Heffner's office and requested a note stating that his surgery was work-related. The nurse told Petitioner that the doctor could not state that his neck problem was work-related. (RX 5)

Petitioner's claim in "10 WC 18033" (d/a: 7/20/09 - repetitive trauma) was filed with the Commission on 5/11/10. (AX 6)[1]

On 5/14/10 Petitioner returned to Dr. Hall. He said that his pain was somewhat less. He was wearing a soft collar at night and started a rehab program. He was taking Flexeril, Ibuprofen and Vicodin. He thought that his pain had increased with his physical therapy and therefore his Vicodin amount was increased. He was also prescribed Ambien. (RX 8)

On 5/19/10 Petitioner returned to Dr. Khan. He was complaining of neck pain, right arm pain, numbness and tingling in the arm. He said his current pain level was 4/10. Diagnoses were neck pain, right shoulder and arm pain "status post trauma." His medications were refilled. (RX 4) That same day Dr. Khattak wrote an off work slip for the dated 5/19/10 to 5/24 or 29/10 for Petitioner's right forearm and referenced an accident date of 8/19/10. (RX 4)

Petitioner was seen at Memorial Hospital on 5/22/10 with right arm radicular pain complaints. (PX 22)

On 5/25/10 Petitioner called Dr. Heffner's office and stated that he had to go to the emergency room over the weekend because he was hurting very badly. There he was

[1] According to IWCC Case Status information

given a couple of shots and some pain pills. He asked for a different pain medication. (RX 5)

On 6/11/10 Petitioner saw Dr. Heffner who concluded that he had made outstanding progress. He said that he could return to work, but not to his regular job and needed additional therapy. He was kept off work. (RX 5)

On 6/14/10 Petitioner returned to Dr. Jawad Khan. He said that his pain level was 3-4/10. The doctor noted that they had received "information from the Illinois Department of Human Services prescription monitoring program". The information from IDHS stated that Petitioner was receiving narcotic medications from multiple physicians. This was placed in his chart. The doctor asked him as to whether or not he was getting medications from other doctors and he said that he was. He also agreed that he had violated the doctor's narcotic agreement. He was discharged from Dr. Khan's care. No right forearm complaints were noted. (RX 4) That same date Dr. Khattak discharged Petitioner from his care due to his knowingly violating the Narcotics Agreement. (RX 4; RX 5)

On 6/15/10 a representative from St. Elizabeth's physical therapy department called Dr. Heffner's office. He stated that Petitioner filed a complaint with the hospital's administration because he had been dropped from the physical therapy program because he missed 7 out of 12 scheduled visits. Petitioner also told the therapist that Dr. Heffner had only ordered him to undergo massage at physical therapy. However, the therapist told Petitioner that Dr. Heffner had ordered massage, strengthening and stretching exercises, other modalities and a home exercise program. Dr. Heffner's office said that Petitioner had called them, stating that therapy was aggravating him and that he was supposed to talk to the therapist. Petitioner then called Dr. Heffner's office and asked one of his assistants to make changes in his notes and that he didn't like the therapist because he stated that he had been non-compliant with therapy. Petitioner said that the therapist would "hurt his case" and wanted what he stated to be changed to something else. (RX 5)

On 6/15/10 Petitioner called Dr. Heffner's office and requested a referral to Barnes Pain Management Center. The doctor's office called Petitioner back and wanted to know why he was requesting a pain management referral when he had been doing well at his last office visit. The doctor then stated that he should be referred to another facility for therapy and that he would benefit from work conditioning or work hardening, but that there was no reason for a referral to pain management. (RX 5)

On 6/17/10 Dr. Heffner's office called Petitioner and wanted to know why he wanted a referral to pain management. Petitioner said that he was having arm pain and that therapy was making it worse. He said that he had been to the emergency room several times and they told him to call his doctor. The patient was told that Dr. Khattak was a

pain management specialist. Petitioner told the doctor's office that he would not go back to him as he was not "doing anything for him". Dr. Heffner's office asked if he was taking any pain medication. He said that he had some medication from Dr. Hall. The doctor's office did not know who Dr. Hall was. He said that he saw him for a second opinion. He told the doctor's office that he was going to therapy at St. Elizabeth's Hospital on Green Mount Road. A prescription for Lortab was called in for Petitioner. (RX 5)

On 6/18/10 Dr. Heffner's office prepared a note stating they had received a fax from Dr. Khattak stating that the employee had been discharged from his care for violating the narcotic agreement. (RX 5)

On 6/23/10 there was a physical therapy certification form from St. Elizabeth's Hospital indicating that Petitioner had been once again evaluated for therapy. Part of this included a patient history. He said that he was lifting heavy equipment on 5/20/09 and noticed pain in his neck and right arm. (RX 5)

On 6/30/10 Petitioner told Dr. Hall that he was seeking a pain management referral. He was taking Flexeril, Ibuprofen and Vicodin. Petitioner agreed to go to pain management and he was reminded that Dr. Hall would no longer give him any medications. (RX 8)

On 7/7/10 Petitioner went to Memorial Hospital emergency room and was given some Tramadol and Tylenol. He was told to follow up with Dr. Heffner. (PX 23)

On 7/19/10 he called Dr. Heffner's office and asked for pain medications stronger than Tramadol. He said that he went to the emergency room and was given Tramadol but it was not working. He also said that he has an appointment with BJC West on 8/18 and also was supposed to have an appointment at St. Elizabeth's Pain Management on 8/28. It was noted that Dr. Heffner had received a letter from Dr. Khattak stating that they had fired Petitioner for a violation of his pain contract. Dr. Heffner denied narcotic pain medication. (RX 5)

On 7/19/10 Petitioner called Memorial Hospital (Dr. Wilson) requesting stronger pain medication and discussing a new family doctor referral which could not be given. (RX 8)

On 7/21/10 Petitioner went to the emergency room of Memorial Hospital. He said he had been in physical therapy since March 2010 and was having pain from the right side of his neck down to his hand with tingling. He said he was taking Tylenol with no relief. He was given an injection of Morphine and Zofran. A pain drawing revealed right shoulder/neck complaints. (RX 3; PX 24)

On 7/27/10 he saw Dr. Mazhar Lakho with Southern Illinois Internal Medicine. He said that he was having pain in the right side of his neck down to his fingertips, causing numbness in his fingers. He said he could not go back to physical therapy until his pain was controlled. He said that Dr. Heffner was going to release him to return to work, but that his pain was severe. He was prescribed Vicodin, Flexeril and Neurontin. Petitioner was noted to have skin grafts on both arms. (RX 3)

He returned to Dr. Lakho on 8/10/10. He said his pain pills were helping and that he was sleeping through the night while taking Tylenol. He said his pain was on a scale of 7-8 out of 10. He said he wanted to talk to the doctor about being released to return to work. Diagnosis was cervical pain. Pettioner was to see Dr. Heffner on 8/13/10. He was told to continue with his medications. (RX 3)

On 8/13/10 there is a note from Dr. Hefner's nurse that physical therapy was stopped because of pain. Petitioner said that he had seen Dr. Lakho, who referred him to St. Louis University Pain Management and had an appointment on 8/16/10. He was taking Lortab and Tylenol. Dr. Heffner also saw the employee that day and said that he could be released to full duty work when that was acceptable to any pain management service that he attended. Petitioner was noted to be doing well and any chronic neck and shoulder pain wasn't overly severe. Dr. lakho was now Petitioner's primary care doctor. (RX 5)

On 8/16/10 Petitioner saw Dr. Eugene Pereira, a pain management physician. He was referred by Dr. Lakho. He complained of neck pain and right arm pain. He told the doctor that he was a skilled laborer for the City of Fairview Heights and was having right-sided neck pain, right arm pain, and right shoulder pain that started after a work injury and had progressively gotten worse with repetitive stress at work. He had been off work for nine months on a medical leave. He was having complaints of pain down his right arm. He said that he had a couple of steroid injections which had provided some good relief. He also had surgery that provided some relief. He had gone to the emergency room three times in July 2010. He was taking Vicodin, Ibuprofen and Gabapentin. Examination revealed full range of motion with exacerbation of pain upon cervical flexion. He also reported tenderness upon touching of the right side of the neck and the trapezius muscle. Diagnoses included chronic cervical pain, chronic right shoulder pain and chronic right arm pain. Trigger point injection treatment was suggested. No mention of the wood chipper event was noted. (RX 3)

On 8/31/10 Petitioner went to St. Elizabeth's emergency room. He was complaining of chronic pain. He related it to a work injury in 2009. At that time he was taking Tramadol, Ibuprofen and Hydrocodone. He rated his pain level as 9/10. He was given Zofran and Dilaudid. A prescription was written for 10 tablets of Ibuprofen and 15 tablets of Oxycontin.

On 9/8/10 Petitioner returned to Dr. Lakho and stated that he had been to the emergency room for evaluation of neck pain. He said he tried to go without medication but it was just too severe. He was taking Flexeril, Gabapentin and Neurontin. Diagnosis was cervical pain. He was to continue with the Vicodin and his regular medications. Dr. Lakho took Petitioner off work until Petitioner's FCE on 9/10/10. (RX 3; PX 25)

On 9/10/10 Petitioner underwent a functional capacity evaluation at Memorial Hospital. He described his job requirements as being able to lift 100 pounds from the ground to the waist, pour concrete, load trucks, operate a jack hammer, weed eater, drive tractors, oil and chip, shovel asphalt, lay culverts and operate multiple hand and power tools. The testing put him in the medium physical demand level. He was to undergo work hardening at four hours every shift for a while. Petitioner was noted to be eager to return to work. (RX 3)

On 9/13/10 Petitioner returned to Dr. Lakho. He stated that he was willing to go back to light duty work four hours a day. He was concerned about his pain medications which included Flexeril, Gabapentin, Ibuprofen, Neurontin and Vicodin. He was told to discontinue the Neurontin and Vicodin. (RX 3)

On 9/14/10 Petitioner called Dr. Lakho's office and said that pursuant to the functional capacity evaluation he could have a work hardening class and return to work four hours a day. Dr. Lakho said he could return to work four hours a day, light duty. The Petitioner said that was alright but if he was "reinjured" that it was "on us (Dr. Lakho)". (RX 3)

On 10/6/10 Petitioner underwent an injection of the trapezius muscles by Dr. Pereira. Afterwards, the employee told the doctor that he sought the advice of an attorney to have his case opened and decided in his favor. The doctor said he wished him well. (RX 3)

X-rays of Petitioner's right forearm were taken on 1/18/10 and revealed no fracture, no dislocation, or radiographically significant soft tissue swelling. (PX 18)

On 10/8/10 Petitioner called Dr. Lakho's office again regarding a work hardening class. (RX 3)

On 10/11/10 Petitioner returned to Dr. Lakho. He said his job would not return him to work. He said he needed a referral of Dr. David Brown for nerve testing. He said he needed a stronger medication due to a colonoscopy. Examination was negative. He was told to continue with the Ibuprofen. (RX 3)

On 10/12/10 apparently Dr. Lakho spoke with Dr. Pereira and was notified that Petitioner had been non-compliant with office visits. (RX 3)

Petitioner underwent trigger point injections on 11/1/10 for myofascial pain, cervical radiculopathy, cervical laminectomy syndrome, cervicalgia, and right arm pain. (RX 3)

On 11/8/10 Petitioner returned to Dr. Lakho and said that he was considering obtaining a spinal cord stimulator. He wanted a refill of his Vicodin. Examination was negative. Assessment included chronic neck pain and shoulder pain. He was given Vicodin, Motrin and told to see a psychiatrist as advised by Dr. Pereira. (RX 3)

On 12/20/10 Petitioner returned to Dr. Lakho. He said that his pain medications were not handling his pain. He said that the spinal cord stimulator was still pending. He was given Gabapentin and was told to continue with the rest of his medications. (RX 3)

On 1/10/11 Petitioner returned to Dr. Lakho. He once again said that his medications were not taking care of his pain and he ran out of his pain medications early. He asked for a prescription for Vicodin. He requested an MRI to determine why he was in such pain. The examination was negative. Diagnosis was the same. He was given Hydrocodone and told to see a psychiatrist. (RX 3)

On 1/31/11 Petitioner was seen regarding a refill on medications. (RX 3)

On 2/3/11 Petitioner returned to Dr. Lakho and said that his pain medication was not enough to control his pain. He was told that he could no longer get early refills. He was given Motrin and was told to get a psychiatric examination. (RX 3)

On 2/11/11 Petitioner returned to Dr. Lakho and said that he needed a letter stating that he could not lift with his right arm due to pain. Examination was normal. He was given Tylenol and Motrin. (RX 3; RX 8)

On 2/15/11 Petitioner saw Dr. Hermann Witte, a psychologist. He gave a history that his physical problems began with two accidents at work. The first was in May 2008 involving an injury to his right shoulder when engaged in heavy lifting. He said he had intermittent pain thereafter and finally was diagnosed with a herniated disc. He said that "a few days later" he reinjured the same area, subsequently developing pain that went down from his neck into his fingers on the right arm. He said he last worked in the mid-August 2009. He said that virtually any type of physical activity or movement worsened his pain. The doctor said that the findings of his evaluation showed significant inconsistencies between his self-presentation in the interview and the test data and even between differing tests. The most prominent inconsistencies concerned the existence in the degree of his emotional stress (depression) and his level of pain and related functional disability. He said that his overall life satisfaction was 8/10 which

was inconsistent with his admitted chronic pain, depression and severe frustrations. The doctor said that his personal impression was that he was depressed and angry and that his pain was not as severe as he reported, at least when he was properly medicated. He seemed to be lacking self-motivation as well. (RX 3; RX 8)

Dr. Lakho saw Petitioner on 2/18/11 for right ear pain. (RX 3; RX 8)

On 2/22/11 Petitioner was seen by Dr. Adams/Pereira for right shoulder pain that radiated down his right arm. Petitioner has had "pain quite sometime following a work injury." Petitioner desired to get off pain medications and wished to try a cervical spinal cord stimulator trial. Petitioner's diagnoses were post cervical laminectomy syndrome and cervical radiculopathy of the right upper extremity. (RX 3; RX 8)

Dr. Lakho saw Petitioner again on 3/8/11 for really sharp pain in his right neck which he experienced while putting on his shirt. Petitioner "states never had this pain before." (RX 3; RX 8)

On 3/29/11 Petitioner saw Dr. William Richardson. He complained of neck and right arm pain and said that it began after an accident at work which occurred on 5/20/09. He said that he picked up a piece of pipe at work and it caused an injury to his right shoulder. He said that it started out as tightness and that it became very painful the next day. Eventually, he underwent surgery. He complained of numbness and tingling in his right hand. He said he was taking Oxycontin, Oxycodone, Gabapentin, Vicodin and Ibuprofen. Assessment was chronic pain of the neck and right arm. Recommendations were to prescribe Vicodin, Oxycontin, Soma, Gabapentin, physical therapy and to see a pain psychologist. He concluded that the employee could return to work provided that he not lift over 20 pounds or work with a jack hammer. He was not supposed to use his right arm 8 hours a day as well.

Dr. Lakho again saw Petitioner on 5/25/11 for back, shoulder, forearm and neck pain. He was getting injections through pain management. He wished to undergo a colonoscopy. (RX 3 RX 8)

Petitioner returned to see Dr. Richardson on 6/7/11. He complained of right shoulder pain on a scale of 7/10. He had slight weakness in the right hand and aching in the right arm. He had a decreased range of motion of the neck and shoulder. Diagnoses included chronic neck and right arm pain. He was given three trigger point injections in the right shoulder. He was told to continue with his medications.

On 7/15/11, 8/15/11 and 9/16/11 Dr. Richardson noted that Petitioner's condition was the same and he was to continue all of his medications and to return in a month.

Petitioner was seen in the emergency room on 8/14/11 for chronic neck pain. (RX 3; PX 18; PX 26)

Dr. Gornet examined Petitioner on 8/29/11, according to Petitioner, at the request of Dr. Kahn and Dr. Richardson. He presented with the chief complaint of neck pain, headaches, right shoulder pain, right arm pain, trapezial pain, and numbness and tingling of the right hand which he stated began on 5/20/09 while working for Respondent. Petitioner was unloading a truck with some pipes and tubes and developed "increasing pain" in his right shoulder. He was referred to Dr. Kahn who referred him to pain managements. Injections followed. He had tried physical therapy and was diagnosed with a herniated disc at C5-6 and referred to Dr. Schultz who referred him to Dr. Heffner who recommended surgery but at that point Petitioner returned to work and was trying to live with his symptoms. There was some dispute regarding whether it was covered by workers' compensation. Petitioner also reported a second accident on 8/19/09 when his arm was caught in a chipper and he developed increasing pain. Petitioner reported constant symptoms, worse with any type of arm activity, fixed head positions, and improvement when lying down. He has numbness, weakness and right arm pain. Dr. Gornet discussed the whole concept of structural spine problems with Petitioner and, based upon Petitioner's history, he felt Petitoner's current symptoms were related to the two work injuries. Petitioner remained unable to work. He requested a CT scan and a weaning off of medications. (PX 13)

On 10/17/11 Petitioner underwent a CT scan of the cervical spine at CT Partners of Chesterfield. The scan revealed some mild disc space narrowing at C3-4 and also at C4-5. At C5-6 there was evidence of a fusion with a metallic interbody device. The radiologist did not see any definite bridging bone. There was a small disc bulge at C6-7. (PX 13)

Dr. Gornet re-examined Petitioner on 10/17/11 and they reviewed his CT scan. Dr. Gornet still felt Petitioner's symptoms were due to the work injuries. While it was originally felt he had a shoulder and arm problem, Dr. Gornet believed Petitioner had a cervical spine issue. They decided to wait for approval for further treatment. (PX 13)

Petitioner was seen at St. Elizabeth's Hospital on 11/9/11 for neck pain. An injection was given. (PX 16)

On 11/9/11 Petitioner called the Dr. Heffner's office and stated that his fusion had come "loose". He said he saw another surgeon who told him it was "pretty bad". He said that this "needs to be rectified" and wanted to hear back from Dr. Heffner as soon as possible. Petitioner told the doctor's nurse that he would "hate for him to get a call from my attorney". (RX 5)

On 11/10/11 Dr. Heffner's office called Petitioner and told him that he wanted to schedule an appointment and that he was to bring x-rays, MRIs or any other test results with him. He was then asked why he did not call Dr. Heffner when he was having problems. He said it was because Dr. Heffner sent him to pain management and they sent him to Dr. Gornet.

On 11/11/11 Petitioner called Dr. Heffner's office and said that he had an appointment with the doctor the following week and wanted to "make sure we were aware of his injury when his arm got caught in the chipper". He said that his work injury is why he needed to see the doctor. They asked him when this occurred and he told them it was on 8/19/10. The doctor's office told him that he had been released from their care on 8/13/10 so they did not know about this injury. (RX 5)

Petitioner again went to St. Elizabeth's Hospital on 11/11/11 for his neck pain and given medication. (PX 16)

Dr. J. Khan examined Petitioner on 11/15/11 noting complaints of right forearm pain since his accident in 2009. He also reported his neck surgery and complained of numbness, tingling, and radicular symptoms in his arm. Petitioner was advised Dr. Heffner would order further studies as needed. (PX 3)

On 11/17/11 Petitioner returned to see Dr. Heffner. He said that he was in the emergency room a couple of months ago and had some x-rays taken and saw a surgeon who told him that he might not have adequate bone growth. However, he did not bring any records or x-rays. On examination he seemed to be nominal. The doctor said he would review any x-ray studies. (RX 3; RX 5)

Petitioner saw Dr. Heffner on 11/28/11 and brought in some x-rays. The doctor said that reviewing the x-rays and comparing them with the ones taken in April 2010 indicated that the metal spacer had not moved in position and that he had a sizable anterior traction spur on the vertebral body of C5 that had resorbed since April 2010 suggesting good limitation of motion at the C5-6 level. He said there was some mild amount of lucency around the superior portion of the metal graft suggesting inadequate bone growth. The doctor concluded that he did not believe that another surgery would be necessary and that he would have to stop smoking, if he did. He said that his original problem at C5-6 could relate to repetitive trauma, although he did not have a specific injury to his neck. He said that the employee told him he did a lot of heavy lifting with his job activity as well as running a jack hammer and these kinds of things could certainly lead to repetitive trauma in the cervical area. (RX 3; RX 5)

On 12/13/11, 1/13/12 and 2/10/12 Dr. Richardson prescribed Ambien, Vicodin and Oxycodone.

Dr. Gornet re-examined Petitioner on 12/15/11 noting Petitioner was being weaned off his OxyContin and now only sporadically taking hydrocodone. He was released to light duty and no lifting greater than 20 pounds and no driving while on narcotics. He still thought Petitioner's condition (a failed fusion) was work-related. Further treatment could proceed once Petitioner was off all narcotics. (PX 13)

Petitioner failed to show up for his 1/26/12 appointment with Dr. Hefner. (RX 5)

On 3/1/12 Petitioner saw Dr. Mahruhk Khan with Gateway Healthcare. He diagnosed his condition as chronic pain syndrome. (RX 2)

On 3/29/12 Petitioner saw Dr. Crystal Carmichael (Gateway Healthcare). He was receiving Oxycontin from Dr. Richardson. Diagnosis was chronic pain syndrome. He was prescribed Dilaudid 4 mg. every 4-6 hours as needed for severe pain and Amitryptiline for chronic pain. (RX 2; PX 3)

On 4/12/12 Petitioner returned to Gateway Healthcare. Petitioner was complaining of pain on his right arm, throbbing in nature. He rated the Pain in his right arm was 9/10. He wanted refill of Dilaudid and MRI. Diagnosis was right elbow/forearm pain. He was prescribed Cymbalta. A graft site on Petitioner's right forearm was noted. (RX 2; PX 3)

Petitioner saw Dr. Fox on 4/16/12. He said he was unable to tolerate Morphine Sulfate. He was taking Vicodin but ran out of Oxycodone. He noted that he tried to get some more Oxycodone but the pharmacist told him that he had to have a written prescription and could not be phoned in. She noted that the "patient has been very demanding with respect to his pain medications despite missing appointment 4/4/12." He still had right neck and arm pain, right hand and forearm pain and tingling and numbness. Diagnoses were as before. She wanted to schedule an MRI of the right forearm and schedule EMG/NCV of the right arm. She emphasized that he follow a narcotics agreement. His Oxycodone and Vicodin was refilled. She noted that he had been obtaining medications from two different pharmacies. She told him that in the future they would only be filled at one pharmacy. She also told him that any visits to the emergency room would have to be reported to her.

As of 4/26/12 Dr. Gornet believed Petitioner was still suffering from neck pain and headaches going into his right shoulder, arm, trapezius and hand with numbness and tingling all of which emanated initially from Petitioner's 5/20/09 accident. Due to Petitioner's narcotics problem, further treatment could not be given. He was referred to Dr. Boutwell for weaning. (PX 13)

Petitioner returned to Dr. Fox on 5/16/12. She noted that he had significant pain relief with his Oxycodone. He was told to restart his Gabapentin and was continued with his

Vicodin and Oxycodone. The other tests had not been performed. His Ambien was also renewed. He was told to see a Dr. Cowan for a psychiatric evaluation.

Petitioner returned to Dr. Fox on 6/18/12. He had undergone the nerve conduction studies and the MRI of the forearm. There were no significant indications for nerve damage. He had some mild carpal tunnel syndrome on the right. The MRI of the forearm was normal. He had decreased range of motion of the right shoulder. He had tenderness in the back of the shoulder. Range of motion of the elbow and wrist was intact. He had slightly decreased grip strength on the right. He had posterior neck tenderness without any trigger points. He was told to stop the Oxycodone. He was given Hydromorphone, Gabapentin, Ambien and Vicodin.

Petitioner called Dr. Hefner's office on 7/1/12 wishing to make an appointment. (RX 5)

Petitioner returned to Dr. Fox on 7/12/12. He said that his pain was not being controlled. He still had posterior neck tenderness. His arm examination was as before. She increased his Hydromorphone to 4mg 1-2 tablets every six hours. He was also to take Gabapentin, Ambien and Vicodin.

On 8/3/12 Petitioner saw Dr. Heffner for some component of chronic neck pain for which he needed medications. He had undergone no studies of his neck since 2011. He said that the employee told him that he was "reasonably comfortable with his situation", that he could tolerate it and that he was not "significantly interested" in having further surgery. Examination was nominal. X-rays were ordered. (RX 5)

Petitioner returned to Dr. Fox on 8/13/12. His complaints were the same. His examination was the same. His Hydromorphone was increased and the Gabapentin, Ambien and Vicodin remained the same.

On 9/26/12 Petitioner returned to Dr. Basga Bernard (Southern Illinois Healthcare Foundation) complaining that his hands and his feet would go numb. He was taking Hydromorphone 8mg every four hours. He also complained that his right hand got caught in a wood chipper. He complained of neck pain.

On 10/4/12 Petitioner returned to Dr. Fox. He was out of his Dilaudid. He also said he had a new primary physician, namely a Dr. Bernardi who was working with him to have his neck properly evaluated. Examination was as before. Diagnoses were as before. His medications were refilled.

Petitioner returned to see Dr. Fox on 11/7/12. He said he still had severe pain in the right side of his neck and his shoulder was "catching". Examination was as before. Diagnoses were as before. The Hydromorphone was stopped and he was to take Oxycodone IR, Gabapentin and Vicodin.

He returned to Dr. Fox on 12/6/12. The pain was the same as before. Examination was as before. His Oxycodone, Vicodin, Ambien and Gabapentin were refilled.

Petitioner underwent a CT of his abdomen and pelvis on 1/7/13 due to right lower quadrant pain and nausea. (RX 8)

On 3/29/13 Petitioner returned to Gateway Healthcare. He complained of pain and numbness in his legs. He was prescribed Gabapentin. No right forearm complaints were noted. (RX 2)

On 4/3/13 Dr. Fox wrote prescriptions for Vicodin and Oxycodone IR.

On 4/12/13 Petitioner presented to Memorial Hospital emergency room. He complained of chronic neck pain. He said that he would suffer from neck flares that were worse than usual. He complained of distal numbness and tingling in both upper extremities. He said that he rated his pain level at 7/10. Examination revealed tenderness to touch in the neck. There were no other neurological deficits. X-rays showed the fusion at C5-6. The employee said he felt much better after taking a dose of Dilaudid and was ready to go home. X-rays taken of that date at Memorial indicated a fusion device at C5-6 with a near complete fusion at that level. (RX 5; RX 8; PX 27)

4/18/13 x-rays showed a sold cervical spine fusion. (RX 5)

On 4/29/13 Petitioner returned to Dr. Fox. She said that his pain on the right side of his neck and shoulder had increased and he was requesting trigger point injections. He was given four trigger point injections. Diagnoses remained the same. Morphine Sulfate ER, Oxycodone IR, Vicodin and Gabapentin were refilled.

On 5/2/13 Petitioner was seen at SIFH in follow-up for pain medication. Petitioner complained of knee pain and tingling and coldness in his feet. Medication was given. (RX 8)

On 5/4/13 Dr. Bernard wrote a prescription for Ibuprofen 800mg.

On 5/29/13 Petitioner returned to Dr. Fox. Complaints and findings seem to be the same. He once again had to sign a drug policy agreement. The Morphine Sulfate ER was increased; Oxycodone, Vicodin and Gabapentin remained the same.

Petitioner saw Dr. Heffner on 5/31/13 and continued to complain of chronic neck pain and pain into his right shoulder. He said his neck pain was on a constant basis. He had difficulty in turning his head. He had difficulties with his knees and because of that he was using a cane. Examination revealed some tenderness over the right shoulder and

some tenderness over the knee joints. The doctor thought that x-rays showed the resorption of the anterior tractor spur indicative of elimination of motion at C5-6. He said there was some mild lucency around the metal spacer, but there was bone growth visible as well. The doctor said he thought he had partial bone growth and because of that it was very questionable whether additional surgery at that level would be a requirement. He was to follow up with the doctor in a few months. (RX 5) Petitioner did not return to Dr. Heffner. (RX 5)

Petitioner was seen at the emergency room on 6/1/13 for a stye in his eye. (RX 8) He returned again on 6/19/13 for an eye infection, noting he still could not work as he was disabled. (RX 8)

Petitioner returned to Dr. Fox on 6/27/13. He said he could not sleep. Examination was as before. He was taking Morphine Sulfate ER, Oxycodone, Vicodin and Gabapentin.

Petitioner returned to Dr. Fox on 7/25/13. He said that the increase in the Morphine Sulfate achieved a satisfactory level of pain control but that this left him sleepy. He said that he had tingling and numbness in the right arm. Assessment on this date was chronic right neck and right arm pain that was significantly decreased; history of disc compression at C5-6; right hand and forearm tingling and numbness-stable; persistent financial and social stressors and chronic depression and anxiety due to chronic pain. All medications remained the same and he was to return to see Dr. Fox in one month.

Petitioner was seen at SIFH on 11/6/13 for pain in his lower back. He also needed a dental referral for a broken tooth. Chronic pain syndrome was noted among other conditions. (RX 8) He returned again on 11/18/13 for abdominal pain but left before being examined. (RX 8) He returned again on 11/19/13 due to weakness and cellulitis in his toes. (RX 8)

Petitioner was under surveillance on 12/21/13 and 12/22/13. (RX 12)

At Respondent's request, Dr. Lange re-examined Petitioner on January 6, 2014 and a written report followed. Petitioner presented with residual symptoms he attributed to his work activities. While Petitioner initially suggested two work accidents, he was now claiming a third one as he felt his "symptoms initially began in '08'." (RX 1, Dep. Ex. 6) There was no single incident at that time; rather, he attributed his problems to repetitive heavy activities including the use of a jackhammer. Although he had right shoulder complaints, it was his belief that he also had a neck problem "even then." He then had the second issue in May of 2009 when lifting the culvert pipe and it significantly worsened his right shoulder discomfort. Petitioner then had a third accident on September 18, 2009 when his arm got stuck in a chipper and his neck, right shoulder and right upper extremity were aggravated by that incident. Subsequent to the wood

chipper event Petitioner reportedly underwent surgery "real quick." In actuality the surgery was March 11, 2010 after which Petitioner was better for three months and then they returned. Dr. Heffner reportedly had never released him and his care was transferred to other physicians. Petitioner's biggest problem was neck pain and diffuse discomfort about his right shoulder and parascapular region He also reported a persistent ache over the medial/proximal right forearm where he was hit by the chipper along with intermittent tingling in his right hand digits and a feeling of coldness. An exam was performed and medical records were reviewed. Dr. Lange's assessment was status post C5-6 anterior cervical fusion and chemical dependency. His causation opinion regarding Petitioner's neck remained unchanged. He did feel Petitioner was disabled for essentially all occupations at this point in time, in part due to his chemical dependency. While further treatment was necessary it would not be for a work-related issue. (RX 1 – Dep. Ex. 6)

Petitioner presented to SIHF on 3/18/14 for a routine check up on ongoing neck and right shoulder problems, bilateral knee pain, and dental caries. (RX 8)

On 3/24/14 Petitioner returned to Dr. Mary Fox for follow up. He told her his pain was better controlled with the current increase in the Morphine sulfate. He had decreased his use of Oxycodone to four every 24 hours and was using about six Hydrocodone per day. With regard to the physical examination she said that he was in no acute distress, he was using a cane in his right hand and that he had a mild antalgic gait. Assessment remained the same and she prescribed him Morphine Sulfate ER, Oxycodone, Hydrocodone and Gabapentin.

On 4/23/14 Petitioner returned to Dr. Fox. He said that his pain had "flared up". He ran out of Oxycodone about a week ago. He was taking 6-8 Hydrocodone per day. He was complaining of muscle cramps for two weeks and his personal physician had ordered lab tests. Physical exam was as before. Assessment was as before. He was prescribed the same medication as before.

Petitioner returned to Dr. Fox on 5/21/14. Examination was as before as was the assessment. Medications and amounts remained the same.

On 6/22/14 Petitioner went to Memorial Hospital complaining of neck pain. He gave a history of chronic neck pain that was due to an independent accident. He said that he sustained further injury to neck after he had a fusion. Later his right arm was caught in a wood chipper and he had pulled his arm out of the chipper, which later led to further damage to his neck. Diagnoses were dental caries and cervical radiculopathy. He was given Penicillin and Vicodin. (RX 8)

On 6/23/14 Petitioner returned to Dr. Fox. He said that he had overused his Morphine Sulfate due to severe tooth pain and a flare-up of neck and arm pain. He said he had

been only taking Hydrocodone since 6/12/14. He said he was seen in the emergency room at Belleville Memorial the day before and issued 30 Hydrocodone tablets. He said his average pain was 6/10 with a spike of up to 8/10. It was noted that he appeared to be in more pain and he was still using the cane. He also had tender right paracervical muscles with spasm extending into the right upper back. She added a diagnosis of acute-on-chronic right neck and arm pain and apparent overuse of opioid medications. She said that she had a lengthy and serious discussion with him concerning the use of the opioid medications. He wanted to see if he could find a pain management doctor in Illinois. Medications and amounts remained the same.

On 7/14/14 Petitioner returned to Dr. Fox. She said that this was an "early" visit. His average pain level was 4/10 and up to 7/10. Examination indicated that he was in no acute distress and he was ambulating with a cane in the right hand. She said that he had returned to his base line chronic right neck and right arm pain. Medications and amounts remained the same.

Petitioner again presented to SIHF on 7/22/14 regarding knee pain and low back pain. A psychiatric referral was recommended. (RX 8)

Dr. Lange was deposed on 8/5/14. (RX 1) He testified consistent with his earlier reports.

On 8/20/14 Petitioner returned to Dr. Fox. He said he wanted to see an orthopedic surgeon for his knee. He said he was on a new medication for his "nerves" from his personal physician. He said it was helping with irritability and anxiety. Examination revealed a mildly antalgic gait with a cane in his right hand. She said that he had chronic right neck and arm pain that fluctuated. Everything else remained the same. All the medications and their amounts remained the same.

On 9/8/14 Petitioner returned to Dr. Fox. His neck pain levels had remained stable since the last visit. Everything remained the same in terms of assessment and all the medications and the medication amounts remained the same.

Petitioner saw Dr. Fox again on 10/8/14. He said that his neck pain and right arm pain levels were fluctuating. He was complaining of more pain in his left arm, perhaps with the use of a cane. His average pain level was 4/10 and it was up to 7/10. Again the physical examination was the same as were the assessments of his conditions of ill-being. All the medications remained the same.

Petitioner returned to see Dr. Fox on 11/10/14. Neck and right arm pain levels increased lately due to his sister move out of their parents' home causing him to have more care tasks to perform. Physical examination was unchanged. Diagnoses were

unchanged. Medications prescribed included Morphine sulfate, Oxycodone IR, Hydrocodone and Medrol Dose Pak.

Petitioner was again under surveillance on 12/3/14 and 12/4/14.

Petitioner underwent bilateral knee x-rays, hip x-rays, and lumbar/thoracic spine x-rays at Dr. Mahrukh Khan's request on December 8, 2014. The latter revealed degenerative changes. (RX 2)

On 1/3/15 Petitioner underwent right foot x-rays due to right heel pain of six weeks duration. He denied any injury. (RX 8)

Petitioner continued to see Dr. Fox and his treatment remained the same.

Petitioner's case proceeded to arbitration on April 23, 2015. Petitioner testified that he was 59 years old at the time of hearing. He stated that he last worked for the City in 2009 and had worked about three years for them prior to that as a skilled laborer. He stated that he would perform a number of different activities, including lifting, shoveling, digging holes, weed eating, grass cutting, forming concrete, loading and unloading trucks, cleaning up, jack hammering, painting stripes and disposing of bulk trash. He stated that he started having symptoms in his right shoulder in 2008. He also had symptoms in his neck. He said that before 2009 he would take some medications and perform stretching exercises, but his shoulder was still bothering him in the spring of 2009. The pain seemed to be behind his right shoulder blade. He said that he was off work for 2-3 weeks in May 2009 and when he returned they were working with culvert pipes on driveways. He testified that he would have to get the pipe himself because they did not have any equipment.

He also testified that he did a lot of pot hole patching in April 2009. The culvert that he was lifting was aluminum in nature. He also did a lot of tree trimming where he would stand on the back of a truck and use a tree pole saw. Further, he was using a wood chipper to take care of the tree limbs that were removed. He stated that he also put in a lot of stop signs. He used a jackhammer maybe twice in the spring of 2009.

He said that on July 20, 2009 he was picking up pipes and used a jackhammer and his neck and shoulder started to bother him. He also testified that he was working with some concrete forms and that they were also using a device called a screed to level concrete. After that day he spoke to his supervisor and told him that he was in pain and he wanted to seek treatment. He filled out an incident report. He said that he underwent an MRI for his neck and that he reported that to his supervisor. He testified that he was off work for some time and then returned to work on 8/17/09. He said that he was still having some pain when he lifted or used his right arm.

He testified that on 8/19/09 they were trimming tree limbs and they were using a chipper after the limbs were cut. He said that he and a co-worker pulled a lever to start the chipper and something slammed on his right forearm. He said that he began screaming and was pulling and tugging on his arm. He said that his co-worker heard him, turned off the chipper, ran around to his side of the chipper and helped him pull his arm out of the chipper. He said that the plate that struck his arm on the chipper struck his right forearm about half way between his wrist and right elbow.

He testified that immediately after that event he experienced a lot of pain in the right forearm and up and down his right arm into his neck. He said that the pain was very bad. He stated that he had to go to the emergency room. He then started seeing a number of different physicians and went to a number of different facilities for treatment. Eventually, Dr. Heffner performed surgery on his neck. After that he saw a number of other physicians including a Dr. Pereira, Dr. Khan and Dr. Lakho. He was also referred to Dr. Robert Schultz for a second opinion. He saw a Dr. Bernard in 2012. He said that he had been referred there by Dr. Khan. He saw Dr. Matthew Gornet, who he also says he was referred to by Dr. Khan.

He was asked specifically about the types of difficulties he was having before the event of 8/19/09 and after the event of 8/19/09. He said that just before the event of 8/19/09 he testified to pain if he lifted or grabbed something. He said that he would have some throbbing, but it wouldn't last long. He said that if he lay down or took pain medication, it would normally go away. However, after the event of 8/19/09, he testified that his pain was "unbearable". He would have pain in his neck, down his right arm, with tingling of his fingers. After surgery he took a number of different pain medications prescribed by a number of different physicians.

At the hearing he testified that his pain level was a 4-5/10, provided he was taking his medication. He would experience numbness and tingling in the last three fingers of his right hand. He said he could not pick up anything over 5-10 pound. He could not raise his arm over his head except occasionally. He had difficulty moving his neck. He drives, although he is not supposed to drive given the medication that he is taking. He said that his medication would cause him to have a lot of anger, sadness and depression. He testified that he did very little during the course of a day because of his pain and the effects of his medication. He had not searched for any work since he last worked for Respondent. He testified that he was using a cane because the medication caused him to fall on one occasion while he was walking. He said that one of his treating doctors told him to use the cane at all times and that he used it because he was fearful of falling again.

On cross-examination he once again confirmed that he used the cane because of his medication, and denied that his knee problems had any role in the use of this device.

He admitted that Dr. Khattak had provided him with a number of injections in both of his knees.

He denied completing any information that was submitted with his time cards. He said that he never indicated what jobs he performed each day unless he was a lead person over the pot hole patch crew. He did say that he would write down what he did each day in a log book.

Petitioner was questioned regarding the activities that he believed he performed in a repetitive manner that caused problems with his neck or arm. He testified that it would have been pouring and pulling concrete. He thought that he would have to do this about ten times a month. He also stated that jack hammering, maybe twice a month, caused him problems. He stated that using a product called "cold patch" was difficult in that it would harden and would be difficult to shovel out of the back of the back of a truck. He said that he had to patch pot holes for Respondent every day for three months in a row.

Petitioner was questioned regarding his application for 7/20/09 wherein he alleged that he picked up some forms and felt pain in his right shoulder and neck. He admitted that his attorney had prepared that application, that had read it and signed it, and that he agreed that lifting concrete forms on 7/20/09 caused his right shoulder and neck pain. He said those forms weighed probably 50 to 60 pounds.

He once again stated that following the event of 7/20/09 he had pain in his neck and right arm and some tingling and numbness in his right hand. He said that the only similar symptom he had before that date was stiffness in the back of his right shoulder . He admitted that it was difficult for him to remember things because he was taking medication and it had been a number of years since some of the events took place.

Whenever he sought medical treatment he stated that he would try to give the doctor's as much information as possible and be as honest and straight forward with them as he could. He wanted to give them the proper information because he wanted proper care and treatment.

He testified that when he first saw Dr. Khattak on 7/22/09 he told him what had occurred at work. He also acknowledged going to St. Elizabeth's Hospital on 7/29/09 for the performance of an MRI, but could not recall what he might have told them about how his pain started in his neck. When asked if the records of St. Elizabeth's Hospital on 7/29/09 were correct in that it showed that he told them that he had neck symptoms for about six months prior to his visit, it was his belief that the history was incorrect..

He stated on cross-examination that the event of 8/19/09 made his prior symptoms in his neck and right arm worse and that they never returned to the same level as they

were before 8/19/09. He also reiterated that the event of 8/19/09 required the assistance of his co-worker to help him pull his arm out of the chipper, that he was screaming and that there was quite a bit of trauma to his right arm. He stated that when he went to the emergency room his arm was examined, and it was already swollen when he went there. He also complained of having a bruise already on his arm. He denied telling the staff at Memorial Hospital on that date that he had neck pain, but that it was due to an old injury.

He admitted seeing Dr. Khan following the event of 8/19/09 and being referred to St. Elizabeth's Hospital for physical therapy that began on 8/25/09. He was asked about the history that he provided to the medical providers at St. Elizabeth's Hospital on 8/28/09 when they recorded that he told them that his neck problems began in September 2008. He testified that he did not provide them with that history.

He was questioned regarding his Application for Adjustment of Claim concerning the event of 8/19/09. He admitted to reading over it after the attorney had completed it. He was asked why it merely listing his right arm when he was claiming that the event injured not only his right arm, but his neck (Id.). He had no explanation as to why his application merely said it was his right arm when he had always stated that the event aggravated his "C5-C6".

He was questioned about a second Application that he filed alleging a date of accident of 7/20/09 wherein he claimed injury through repetitive trauma. He was asked if he listed that the body parts injured were his neck and both shoulders. He said that he did not believe that he told his attorney that he hurt both shoulders. He stated that he did not say anything about both of his shoulders being hurt and that he was not making any claim for his left shoulder.

When asked whether it was repetitive trauma or the lifting of the forms on 7/20/09 that caused the injury to his right shoulder, right arm and neck, he said it was the repetitive activities.

Petitioner stated that he saw Dr. Robert Schultz in October 2009. He stated that he was referred there by Dr. Khattak. He said he could not recall what he told Dr. Schultz at that time and he would agree that his memory was probably better back then than it is now. When asked if the history recorded by Dr. Schultz stating that he had injured himself around the end of June when he was pulling on some rebar and using a jack hammer was correct, Petitioner stated that it was not correct. He insisted that he was there merely for a consultation and not for any treatment. He admitted that Dr. Schultz gave him medication after his first visit with him, but that he did not fill those prescriptions. He also admitted that Dr. Schultz wanted to see him again, but he did not return. He said that Dr. Khattak had something to do with his failure to return to Dr. Schultz. When he was asked whether the real reason for not seeing Dr. Schultz

again was because Dr. Schultz wrote him a letter stating that he did not want to see him again because he thought that Petitioner was abusing medications, he denied that was the reason, but did admit to receiving such a letter.

When he was confronted with the fact that he had seen five different medical providers in November 2009 and that all of them provided him with some medication, he denied that all of those medical providers gave him medications. However, he did recall that Dr. Khattak only gave him 20 Vicodin during that period of time and that Dr. Khattak told him that he could take all the medications that had been prescribed by Dr. Hall at that time. He was asked how he could remember those details in light of his previous testimony that he could not recall much of what occurred several years before the hearing, and he said it was because he had a dispute with Dr. Khattak and he was just following his orders.

Petitioner was then asked about records that showed that Dr. Khattak had referred him to Dr. Hall to take care of his pain medication, but that he continued to see Dr. Khattak and got medication from him. He once again testified that Dr. Khattak only gave him 20 pain pills and he thought he could continue to see Dr. Hall and get medications from his as well. He did admit that if Dr. Khattak's records showed that he was prescribed medication by him, he would have no reason to dispute that.

Petitioner agreed that he saw Dr. Lange on 1/28/10 and that Dr. Lange talked to him about how he got hurt. He agreed that he told Dr. Lange that he had been shoveling asphalt and using a post hole driver, that those activities worsened his shoulder pain, but that in July 2009 he was lifting a culvert pipe that increased his shoulder pain.

Petitioner stated that he could not recall what history he provided to Dr. Heffner on 2/5/10. After some dispute about what the records said on that date, he agreed that if Dr. Heffner's note of that date stated that he had been doing his regular job without a specific injury, that he did a lot of heavy lifting, that he had a work injury to his right arm in September 2009, but that he made it clear to the doctor that his neck injury was not related to any specific work event, then the records would be true. He also agreed that if Dr. Heffner stated a second time in his note that there was no specific injury that caused his problem, then that would be true.

Petitioner was asked why, if Dr. Hall had been requested to fill his pain medications by Dr. Khattak, did he still continued to see Dr. Khattak for medications, he testified that Dr. Hall was treating him for blood pressure and other things and that Dr. Khattak was giving him too many Vicodin. He also agreed that if the records showed that both Dr. Hall and Dr. Heffner had given him pain medication in April 2010, even though he told Dr. Hall that Dr. Heffner would not give him medication that would be true, but that he never took any medication from both of them as noted in the record. He also disputed the fact that the records indicated he was taking pain medication from Dr. Khan and Dr.

Hall in April 2010, although he stated that the prescriptions were only 5-8 days. However, he then admitted that he could not recall how many pills he was specifically given by those physicians at that time. He did agree that he was probably taking all medication that was prescribed to him by the doctors.

Petitioner denied calling Dr. Heffner's office to discuss what had caused him to have neck surgery. He was specifically asked if the doctor's records were accurate in stating that on 5/6/10 he had called in, requesting a note stating that the surgery was work-related. He said that that was a false statement by the doctor's office (Id.). He reiterated that the statement as contained in the doctor's records of 5/6/10 was something that he did not provide them. He said that it was the "machine's statement" not Dr. Heffner's own note on that date.

Petitioner was asked if he stopped seeing Dr. Khattak in June 2010 and he agreed, stating that he stopped seeing him because Dr. Khattak did not keep good records. However, he admitted that there was a note in his file from Dr. Khattak of 6/14/10 stating that Dr. Khattak had discharged him as a patient because he knowingly violated a narcotic agreement. He denied that Jawad Khan refused to see him after June 2010. He denied having a disagreement with the physical therapy department at St. Elizabeth's Hospital in June 2010 and said that if Dr. Heffner's records showed that he called his office, complained about the therapist, and wanted his records changed because he thought it would hurt his case, that would be another false statement by Dr. Heffner's office. He also testified that if Dr. Heffner's records from a visit of 6/11/10 said that he had made outstanding progress following his surgery, that would be an incorrect statement as far as he was concerned. He did agree that when Dr. Heffner's office wanted to return him back to Dr. Khattak, he told Dr. Heffner's office that he did not want to do so because Dr. Khattak wasn't doing anything for him. He did not tell Dr. Heffner that Dr. Khattak had discharged him for violating a narcotics agreement. He did agree that Dr. Hall told him in June 2010 that he would not give him any further medications. He stated that he would go to emergency rooms for treatment of his neck because the medication he was taking was not effective and it usually took an injection of Dilaudid or Morphine to ease his pain.

Petitioner stated that the records of Dr. Eugene Pereira on 8/16/10 were false in stating that the surgery had provided him with some relief. He recalled that Dr. Lakho did release him to return to work on a light duty basis in September 2010, but denied that he told the doctor's office that if he did return to work and got reinjured, that it was on Dr. Lakho. Even though he stated that he had been approved for a spinal cord stimulator as recommended by Dr. Pereira, he had no explanation as to why the records of the doctor did not mention a spinal cord stimulator. He said that he did not know why Dr. Richardson recorded that he got hurt at work on May 20, 2009 when he picked up a piece of pipe. He stated that Dr. Khan had referred him to Dr. Gornet in September or October 2011, even though Dr. Khan's office records ended in June 2010.. He agreed

that he wanted to go back and see Dr. Heffner after he saw Dr. Gornet, and probably told the doctor's office that he (Petitioner) would hate for Dr. Heffner's office to get a call from his attorney. He denied seeing a Dr. Mahrukh Khan and Dr. Crystal Carmichael with Gateway Healthcare beginning in March 2012. He started seeing Dr. Mary Fox in April 2012 who prescribed him Oxycodone, Vicodin, Gabapentin, Ambien and other drugs. He started seeing a Dr. Bernard in September 2012.

Although Petitioner recalled seeing Dr. Heffner in May 2003 about his neck pain, he denied telling Dr. Heffner that he was using a cane because of difficulties with his knees. He said that he told Dr. Fox about his leg collapsing because of his medication. However, she did not alter any of his medications as a result of that.

At the time of the hearing he was seeing both Dr. Fox and Dr. Bernard, but denied that Dr. Bernard was giving him any pain medication. He was taking Oxycodone, Vicodin, and Gabapentin. He said that he tried to wean off his medications one time but Dr. Fox told him not to do so and that he wanted to have surgery with Dr. Gornet.

Petitioner continues to have throbbing pain in the right side of his neck down his right shoulder, down the back of his right shoulder blade, and that the pain goes under his arm, down the side and all the way through his fingers. He continues to experience numbness and tingling in the last three fingers on his right hand and this occurs about two times a week. He is unable to pick up anything over 5-10lbs with his right arm and he cannot raise his arm over his head without a great deal of pain.

With regard to his neck, Petitioner testified he is unable to turn to his right and experiences less range of motion if he is without medication. He described that he is very limited in his ability to drive particularly considering the medication and his limited range of motion.

Petitioner's typical day is to get up, take his medicine and sit on the bed until the medicine starts providing relief about 30-45 minutes later. Sometimes the medicine makes him fall back to sleep. He is able to do some chores around the house such as sweep the floor or take out the trash but it limited due to pain. He takes his medication every six hours.

When asked again about driving Petitioner testified that he is not supposed to drive while taking Morphine but sometimes he does drive to get things that he needs such as making trips to Walmart.

Petitioner was observed to be carrying a cane and testified that he has fallen in the past when the medication (morphine) has hit him so he typically uses the cane wherever he goes.

Christopher Volkman testified for Respondent. He was the Director of Public Works/City Engineer. He held that position for about 5½ years and managed the street department. He was familiar with the work activities of his street crew. He testified that he normally did not have his workers lift more than 75 pounds. They had a number of machines to do lifting and moving of items. He said that it was not standard operating procedure for a worker to lift a culvert by himself as there was always a backhoe in the area to excavate ground to put the pipe in. He said that the material that was used to patch potholes would harden under compression and that the workers were able to shovel that material with a shovel holding about 20 pounds.

He testified to a form called the daily report form that was filled out by the lead laborers and would list all of the daily activities of the street crew, the employees who performed those activities and what equipment was used during the course of a day. That form was completed each day and it was maintained by the City of Fairview Heights. He brought the originals of those forms with him to the hearing. Mr. Volkman also testified to what was called a time sheet form. He said that each employee would have to fill out a time card at the end of each pay period (twice a month) and they would have to put down what activity they performed each day. This was supposed to contain what they did that day and how much time they spent doing it. He said that that would be how the employee would get paid and it would also be used in planning and budgeting for the street department. He provided a copy of the time sheet forms for 2008 and 2009 pertaining to Petitioner (RX 13)

Job logs are found in RX 12. Petitioner was working on 7.20.09 using a truck, roller, and John Deere equipment (small and large). They used cold patch and paint while "Cut R.O.W., painted streets, [?] prep." (RX 12)

Off work slips are found in PX 29.

Petitioner's medical bills are found in PX 30.

Photographs of equipment are found in PX 31.

The Arbitrator notes that many of the exhibits contain highlighting which was not done by her. The exhibits were tendered to her in that manner.

The Arbitrator concludes:

Issue (C) Accident and Issue (F) Causal Connection.

The Arbitrator acknowledges that the outline of the testimony of Petitioner, the testimony of Respondent's representative and an outline of the medical information in

these cases is quite extensive and detailed. However, this was necessary in order to develop a context in which Petitioner's testimony, and his allegations, are to be determined. Petitioner's credibility was tested on multiple occasions during his cross-examination. When his testimony, and the medical records mentioned above, are compared, it is apparent that Petitioner's testimony was not credible on a number of issues. Petitioner disagreed with many entries placed in the medical providers' notes concerning contact with him, and he went so far as to say that at least two physicians entered false entries in his medical records. However, he admitted that when those statements were made, his memory of the events that had occurred several years ago would be better than his memory of the events now. Even his comments about his recollection of events of several years ago caused the Arbitrator to question his credibility. Petitioner would freely admit that he was incapable of remembering things that he might have told medical providers many years ago, but testified quite clearly as to medications that he was given and even the number of pills that were prescribed 4-5 years ago. When confronted with this dichotomy, Petitioner admitted that he could not recall the specific number of pills given at any particular time.

The various histories that Petitioner provided to the medical providers near the time of the alleged events of 7/20/09 and at the time of the event of 8/19/09 were multiple and varied as well. In particular, the Arbitrator would note that when Petitioner saw Dr. Christopher Heffner, the operating neurosurgeon with regard to his cervical spine on 2/5/10, Dr. Heffner noted specifically in two sections of his record of that date that Petitioner denied any specific event as the cause for his neck and shoulder problems. However, Petitioner insisted during his testimony that not only did the 8/19/09 event injure his right forearm, but it made much worse his right shoulder and cervical spine complaints that he asserted began on 7/20/09. It should be noted that even his complaints of cervical spine issues and upper extremity issues preceded 7/20/09, according to the medical records offered into evidence. It seems that Petitioner would try to provide a history to a medical provider that might advance the cause of his pending Workers' Compensation claims. He gave multiple histories of events occurring in September 2008, May 2009, June 2009, July 2009 and August 2009, including histories of repetitive trauma. He described the alleged single specific event that occurred on 7/20/09 as lifting concrete forms, pulling rebar and using a jack hammer, lifting a culvert pipe or performing other heavy lifting on or about 7/20/09.

A review of the medical records on and after 7/20/09 up until the time of the 8/19/09 event do not reveal any indication of a single, specific event occurring on 7/20/09. Indeed, although the Petitioner alleged that he was lifting concrete forms on that date in his Application for Adjustment of Claim, the time card forms and the daily sheet forms provided by Respondent's witness (Mr. Volkman) do not indicate that Petitioner was handling or utilizing concrete forms at all on 7/20/09. Additionally, Petitioner's testimony that he had to lift a metal culvert by himself on or near 7/20/09 was undermined by Mr. Volkman's testimony that a backhoe was available to lift the culvert

because a backhoe had to be in the area so that it could dig the trenches into which the culvert was to be placed. He also said that it was the normal procedure of the department to use a machine to lift more than 75 pounds.

Further, with regard to Petitioner's credibility, the Arbitrator notes that Petitioner's care with three physicians was terminated for violating narcotic agreements or abusing prescription medications and that an additional physician stopped providing him medications (Dr. Hall). The records are also clear that on several occasions within two to four weeks, Petitioner would see three to five different medical providers and obtain prescription pain medications from all of them, including such narcotics as Oxycontin, Oxycodone, Percocet and Vicodin. Petitioner readily admitted that he did not advise the various physicians that he was receiving medication from more than one source nor did he advise the physicians that he was utilizing more than one pharmacy to obtain his medications. Petitioner admitted that he would go to various emergency rooms to receive injections of Dilaudid or other potent pain medications because his regular pain medication was not sufficient to control his pain, in spite of the fact that he was prescribed potent pain medications in pill form and his only surgical procedure was a single level disc fusion with hardware at C5-6. Indeed, most of Petitioner's physical examinations by the multiple medical providers were nominal in nature.

Although Petitioner may have performed heavy activities while working for Respondent as a skilled laborer, the Arbitrator finds that these activities were not repetitive enough in nature to constitute repetitive trauma under the Act. It is clear that Petitioner performed a number of duties every day (as he indicated during his testimony) and that his duties varied from day to day. Many of the activities were not heavy in nature. It was also apparent that Respondent had various pieces of machinery that could assist with the heavier duties that Petitioner might be required to perform. Further, the daily sheet forms and the payroll forms offered into evidence do not indicate that Petitioner patched pot holes for three months straight as he alleged in his testimony.

Therefore, with regard to the alleged repetitive trauma with an accident date of 7/20/09 the Arbitrator concludes that Petitioner has 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 that date or that his condition of ill-being was causally connected to that accident or his employment. Dr. Gornet's causation opinions were not persuasive as the doctor was completely unfamiliar with Petitioner's care and treatment pre-dating his involvement and Petitioner provided him with an inaccurate history. Petitioner's claim for compensation is denied and no benefits are awarded. All remaining issues are moot.

****

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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

Richard Rednour,

Petitioner,

vs. NO: 10WC 34599

Metro Contract Services,

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 8, 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.

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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: APR 7 - 2017
o040517
CJD/rlc
049

Charles J. DeVriendt

Elizabeth Coppoletti

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

REDNOUR, RICHARD -
Employee/Petitioner

Case# **10WC034599**

METRO CONTRACT SRRVICES
Employer/Respondent

17IWCC0216

On 10/8/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1433 MVP
TOM PETTIT
505 N 7TH ST SUITE 2100
ST LOUIS, MO 63101

0053 LYNN D BARNETT
STEVE TREFTS
906 OLIVE ST SUITE 400
ST LOUIS, MO 63101

17IWCC0216

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

Richard Rednour
Employee/Petitioner

v.

Metro Contract Services
Employer/Respondent

Case # **10** WC **34599**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Collinsville**, on **2/16/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned **$42,952.00**; the average weekly wage was **$826.00**.

On the date of accident, Petitioner was **40** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

Because Petitioner did not sustain his burden of proving his current condition of ill-being is causally related to his alleged work accident, 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

9/24/15
Date

ICArbDec p. 2

OCT - 8 2015

FINDINGS OF FACT

Petitioner had received treatment for a number of abdominal issues prior the alleged accident. He testified that he had been treated for a hernia in 2001. In May of 2009, Petitioner complained of a dull pain in his stomach with sharp left abdominal pain. (Pet. Ex. 5). He was assessed with diverticulitis. Dr. Beckman performed a left colon resection for diverticular disease in June of 2009. Petitioner was complaining of a constant burning sensation in his stomach on August 3, 2009. (Id.) In September of 2009 Petitioner was seen at Barnes Hospital with complaints of continued abdominal pain. Petitioner was seen by Dr. Pickett on March 4, 2010 and complained of abdominal pain. (Id.) He was diagnosed with abdominal pain with a history of ruptured diverticula and possible abdominal adhesions. (Id.) On July 2, 2010, Petitioner returned to Dr. Pickett, complaining of a bulge in the right side of his abdomen with occasional pain. (Id.) After a physical examination, Dr. Pickett noted the abdomen was "normal except palpable abdominal wall defect in the right middle abdomen consistent with hernia." (Id.) Both Petitioner's testimony and the records of Dr. Pickett reflect the hernia was reducible. Petitioner was diagnosed with a ventral hernia. (Id.) On July 2, 2010, Dr. Pickett referred Petitioner to a general surgeon for a hernia repair. (Id.)

Petitioner claims he sustained a work related injury on July 22, 2010. Petitioner testified that on July 22, 2010, he was employed by Metro Contract Services. He began working for Metro Contract Services in 2007. He did foundation installments. His job was labor intensive. On the day in question, Petitioner was working in a rail yard in Battle Creek, Michigan. He was moving railroad ties by hand in order to make a clear path for a bobcat. His body was positioned like a football player in a three point stance. He testified that as he grabbed a hold of a railroad tie to slide it on top of another one, something just went "boom" in his abdominal area. He further testified that his abdomen changed in appearance after the accident. He stated that his abdomen seemed to "stick out, extended" in the center of his abdomen, like everything was swollen. He did not seek medical treatment that day.

Following his return to Illinois, Respondent sent Petitioner to BarnesCare. Petitioner presented to BarnesCare on July 26, 2010 with pain and swelling in his right abdomen. (Pet. Ex. 6). He was diagnosed with a right ventral hernia and referred to a surgeon. (Id.) The records of BarnesCare describe the hernia as right para-midline above the umbilicus which "spontaneously reduces." There was no mention of the July 2, 2010 hernia diagnosis.(Id.) In fact, Petitioner specifically indicated on the "BarnesCare Authorization for release of Medical Information and Registration Form" that he had not treated for this abdominal injury previously; he denied any previous injury to "the part of your body injured today"; and further denied ever having had an "Inguinal injury or hernia." Id.

Petitioner was also evaluated by Dr. Pickett on July 26, 2010. (Pet. Ex. 5). Dr. Pickett noted Petitioner presented for a "follow up with increase in pain at a ventral hernia." (Id.) Dr. Pickett indicated Petitioner had "pain at the right middle abdomen without palpable defect." (Id.) Petitioner was again diagnosed with a ventral hernia. (Id.) In the July 26, 2010 report, Dr. Pickett noted Petitioner had an appointment scheduled with a surgeon on August 15, 2010. (Id.) There was no indication that the ventral hernia was different from the ventral hernia noted at the July 2, 2010 visit. In fact, according to the objective physical examination, the hernia was located in the "right middle abdomen" both on July 2, 2010 and July 26, 2010. Id.

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Petitioner first saw Dr. Hafenrichter on August 17, 2010. Petitioner was admitted to Missouri Baptist Medical Center on September 1, 2010 for an "incarcerated" ventral hernia. (Pet. Ex. 7). The Petitioner's condition was discovered to be more complex than originally thought. During the laproscopic examination a Bochdalek hernia involving the diaphragm was detected. Dr. Hafenrichter performed a diagnostic laparoscopy. lysis of adhesions, reduction of incarcerated diaphragmatic hernia, open repair of diaphragmatic hernia, open repair of complex ventral incisional hernia utilizing bilateral abdominal components separation technique, Sepramesh overlay bridge, primary closure of abdominal wound with Stratus overlay buttress graft and placement of drains. (Id.) Petitioner remained in the hospital until September 8, 2010 following the September 1, 2010 surgery. (Id.)

On September 16, 2010, Petitioner followed up with Dr. Hafenrichter. (Pet. Ex. 8). At that time, Dr. Hafenrichter noted Petitioner was doing well, with well controlled pain. (Id.) Dr. Hafenrichter was pleased with Petitioner's progress.(Id.) On September 23, 2010, it was noted Petitioner was doing well and one of the drains was removed. (Id.)

Petitioner presented to St. John's Mercy on October 12, 2010. (Pet. Ex. 10). A "wound vac" was ordered.(Id.) On October 26, 2010, the "wound vac" was removed.(Id.) On December 27, 2010, it was noted that Petitioner continued to heal well. (Id.)

On January 14, 2011, Petitioner returned to Dr. Pickett. (Pet. Ex. 5). At that time, Petitioner was complaining of pain and wanted a re-fill of his pain medication. He indicated his surgeon would not fill refill his pain medication. (Id.) Petitioner next saw Dr. Picket on June 2, 2011 complaining of periodic abdominal discomfort. (Id.) On June 20, 2011, Petitioner returned to Dr. Pickett for a burn he sustained on his right calf, from a motorcycle muffler, no other complaints were noted.(Id.) On September 22, 2011, Petitioner returned to Dr. Pickett complaining of abdominal pain following a recent surgery and requesting pain medication. Dr. Pickett prescribed Norco for breakthrough pain. (Id.) Petitioner then saw Dr. Pickett on January 17, 2012. It was noted he had been taking morphine, but that was not helpful, but Xanax and Vicodin did provide relief. He was next seen on February 14, 2012 and told the doctor "he thinks someone took some of his pain medicine." On February 29, 2012, Petitioner returned to Dr. Pickett to "discuss pain management" and that he wanted to switch his medication to Percocet and start taking a muscle relaxer. (Id.) It was noted by Dr. Pickett that Petitioner was taking more Norco and Xanax than prescribed. (Id.) On June 8, 2012 Petitioner indicated he was feeling depressed and was given refills of his medication. Petitioner last visited Dr. Pickett in November of 2012. (Id.) At that time, Petitioner indicated that he was out of Percocet and Xanax. (Id.)

On September 12, 2012, Dr. Meyers performed an evaluation of Petitioner at the request of Petitioner's Counsel. (Pet. Ex. 3). Dr. Meyers noted that on July 22, 2010, while cutting railroad ties, Petitioner "experienced immediate acute severe pain in the abdomen followed by the appearance of a bulge in the mid abdomen."(Id.) In the "Past Medical History" section of Dr. Meyers' report, there was no mention of a July 2, 2010 hernia.(Id.) Dr. Meyers diagnosed Petitioner with an incarcerated ventral incisional hernia requiring complex hernia repair, incarcerated Bochdalek diaphragmatic hernia requiring operative repair, depression secondary to his operation and his inability to resume normal work, and refractory post operative abdominal pain. (Id.) Dr. Meyers opined Petitioner's July 22, 2010 injury was the prevailing factor in causing Petitioner to sustain the above mentioned conditions. (Id.) He further opined Petitioner sustained 75% PPD of the body as a

whole related to his abdominal conditions and 25% PPD of the body as a whole related to his depression. (Id.) Lastly, Dr. Meyers opined Petitioner is 100% permanently and totally disabled as a result of the alleged work injury. (Id.)

Dr. Meyers indicated an "incarcerated ventral incisional hernia" happens when a patient has a pervious incision and then a hernia presents. (Pet. Ex. 3, p. 33-37). Dr. Meyers testified Petitioner's "incarcerated ventral incisional hernia" presented after his colectomy. (Id.) Dr. Meyers testified the Bochdalek hernia was traumatically induced when Petitioner lifted the railroad ties. (Id.) at p. 40-41. Dr. Meyers testified he reviewed several doctor's records following Petitioner's alleged work accident, but he did not review the records of Dr. Pickett. (Id. at p. 43-44). After viewing Dr. Pickett's July 2, 2010 report, Dr. Meyers admitted Dr. Pickett diagnosed Petitioner with a ventral hernia on July 2, 2010. (Id. at p. 46-47). Despite the pre-existing diagnosis, Dr. Meyers' testified the newly learned information that Petitioner had a pre-existing hernia would not change his opinion that the alleged work accident caused Petitioner's hernia and need for surgery. (Id. at 50-53).

Dr. Pruett evaluated Petitioner pursuant to §12 on March 12, 2014. (Res. Ex. 4). The Arbitrator notes that Dr. Pruett authored multiple reports regarding his evaluation of Petitioner. He initially indicated he believed that Petitioner's condition of ill-being was causally related to the alleged accident. He credibly explained, however that his initial opinions were based on the history that Petitioner had given him indicating no prior abdominal wall problems. After he had been made aware of Dr. Pickett's note of July 2, 2010 he prepared a report dated January 6, 2015. (Id.) Dr. Pruett noted Petitioner reported an abdominal wall hernia to his primary care physician 20 days prior to his alleged work injury. (Id.) Dr. Pruett further stated that the lifting incident on July 22, 2010 did not cause the hernia that was later addressed surgically by Dr. Hafenrichter. Dr. Pruett testified Petitioner told him that his abdominal pain was new, as of July 22, 2010. (Id. at p. 7-8). Dr. Pruett discussed Dr. Hafenrichter's findings during surgery and stated Petitioner had an abdominal wall hernia and a Bochdalek hernia, or diaphragmatic hernia. (Id. at p. 9). Dr. Pruett indicated a diaphragmatic hernia cannot be seen by looking at the outside of the patient. (Id.) Dr. Pruett testified that because Petitioner had a pre-existing hernia, the treatment he received from Dr. Hafenrichter was not related to the alleged work injury on July 22, 2010. (Id.) at p. 19. In regard to the Bochdalek hernia, Dr. Pruett explained it is a congenital hernia which cannot be traumatically induced. (Id. at p. 23). Dr. Pruett noted a Bochdalek hernia is a defect in the diaphragm, and by its definition is a birth defect that occurs during fetal development. (Id.)

Timothy Lalk testified by deposition in this matter on August 29, 2014. Mr. Lalk is a vocational rehabilitation counselor retained by Petitioner, whom he saw on June 11, 2014. (E100). Mr. Lalk noted Petitioner presented himself in a slow and guarded fashion. He stated Petitioner moved slowly; appeared stiff; and had difficulty walking, standing, and changing positions. (Id.). Petitioner told him that he can only stand for about ten minutes before he has pain in his abdomen. (E108). He can only walk for about twenty-five minutes and avoids bending at the waist. (Id.) It was Mr. Lalk's opinion that Petitioner was unemployable in the open labor market due to his work injuries of July 22, 2010. (E115). This was primarily due to the restrictions placed on Petitioner by Dr. Pickett in May 2012. (E115). Those restrictions were: no exerting more than ten pounds of force; occasionally standing; walking no more than fifteen minutes without interruption for a total of fifteen minutes in an eight-hour day; sitting no more than one hour in a work-day; and never balance stoop, crouch, kneel, or crawl. (E115). Specifically, Mr. Lalk testified that based upon the restrictions given to him by Dr. Pickett and the psychiatric assessment done in May 2012, it was his vocational rehabilitation opinion that

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Petitioner is unable to secure and maintain employment in the open labor market and is not able to compete for any position. The medical opinions would prevent him from working even at a sedentary level.

Petitioner has not worked since July 22, 2010. He testified that in addition to his pain, he also has depression and cries every day. He does not believe he can work because he has pain in his rib area all the time. He has lost strength in his upper body and is only able to lift about five to ten pounds. Walking is difficult for Petitioner. He states spends his days in his recliner or in bed. Once or twice a week his pain is so bad that he hardly moves. He can only sit, stand and walk for short periods of time.

CONSLUSIONS OF LAW

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

Under the Illinois Workers' Compensation Act, an employee's injury is compensable only if it arises out of and in the course of his employment. 820 ILCS 305/2. A petitioner must prove by a preponderance of the evidence that he or she suffered a disabling injury that arose out of and in the course of his or her employment. Sisbro, Inc. v. Industrial Commission, 797 N.E.2d 665, 671 (Ill. 2003). "In the course of employment" refers to "the time, place, and circumstances surrounding the injury." Id. The "arising out of" element refers to the causal connection between the accident and the Petitioner's injury. (Id.)

Petitioner claims he sustained an accident while working for Respondent in Michigan. Petitioner testified he was working in a rail yard in Battle Creek, Michigan. He was moving railroad ties by hand in order to make a clear path for a bobcat. His body was positioned like a football player in a three point stance. He testified that as he grabbed a hold of a railroad tie to slide it on top of another one, something just went "boom" in his abdominal area. He further testified that his abdomen changed in appearance after the accident. He stated that his abdomen seemed to "stick out, extended" in the center of his abdomen, like everything was swollen. Petitioner's testimony in this regard is unrefuted. The accident was reported when Petitioner returned from Michigan. Petitioner was sent for medical treatment at BarnesCare the day he reported the accident.

Although Petitioner's credibility is somewhat diminished by the fact that his testimony is conflicting with his medical records in a number of instances; he failed to disclose his prior hernia diagnoses to the doctors he saw following the incident in Michigan; and clearly provided false information on the forms he completed at BarnesCare, there is simply no direct evidence to contradict Petitioner's testimony that he felt abdominal pain while lifting a railroad tie.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner met his burden of establishing he sustained and accident which arose out of and in the course of his employment on July 22, 2010.

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

Petitioner also bears the burden of proving that a causal relationship exists between his present condition of ill-being and the work-related injury. Peabody Coal Co. v. Industrial Commission, 596 N.E.2d 1297 (Ill.

App. 4th Dist. 1992). The burden of proof is on Petitioner to establish all elements of his right to compensation. Hannibal, Inc. v. Industrial Commission, 231 N.E.2d 409, 410 (Ill. 1967).

There is no dispute that Petitioner had a pre-existing ventral hernia when he saw Dr. Pickett on July 2, 2010. On that day, Petitioner, complained of a bulge in the right side of his abdomen with occasional pain. Dr. Pickett noted the hernia was in the "right middle abdomen." Petitioner was diagnosed with a ventral hernia and referred to a general surgeon for a hernia repair. That appointment had already been scheduled when Petitioner returned to Dr. Pickett on July 26.

Although Petitioner testified that after the incident in Michigan he had two bulges in his abdomen this is simply not borne out in the medical records. When Petitioner returned to Dr. Pickett on July 26, 2010, Dr. Pickett noted Petitioner presented for a "follow up with increase in pain at a ventral hernia." Dr. Pickett indicated Petitioner had "pain at the right middle abdomen without palpable defect." The diagnosis remained a ventral hernia. Dr. Pickett noted Petitioner had an appointment scheduled with a surgeon on August 15, 2010. There was no mention of more than one abdominal bulge or that the ventral hernia was different from the ventral hernia noted at the July 2, 2010 visit. The location of the defect was the same on both visits, the "right middle abdomen." The physician who saw Petitioner at BarnesCare on July 26 also noted a reducible ventral hernia at the same location. His record describes Petitioner's hernia as right para-midline above the umbilicus which spontaneously reduces.

Dr. Hafenrichter repaired two hernias during his September 1, 2010 surgery. (Pet. Ex. 7). The first was a ventral hernia, and the second a Bochdalek, or diaphragmatic, hernia which was found during the laproscopic procedure. Id. The medical evidence in the record established that a diaphragmatic hernia is not visible on the outside of Petitioner's body. (Res. Ex. 4, p. 9). Based upon the foregoing the Arbitrator finds Petitioner's testimony that he had two perceptible bulges in the abdomen following the July 22 incident unpersuasive.

Petitioner also testified he told all of the doctors about his July 2, 2010 hernia diagnosis. However, this does not appear to be accurate. There is no mention of any pre-existing hernia in Dr. Hafenrichter's records. (Pet. Exs. 7 & 8). Petitioner outright denied any pre-existing hernia when he visited BarnesCare on July 26, 2010. (Pet. Ex. 6). In the "Past Medical History" section of Dr. Meyers' report there is no mention of a July 2, 2010 hernia diagnosis. (Id.) Dr. Pruett testified Petitioner told him the hernia was new, as of July 22, 2010. (Res. Ex. 4, p. 7-8).

The Arbitrator notes that neither Petitioner's primary care physician, Dr. Pickett, nor his treating surgeon, Dr. Hafenrichter, testified. Instead Petitioner presented the testimony of Dr. Meyers. Dr. Meyers was retained by Petitioner's counsel to conduct an evaluation of Petitioner on September 12, 2012. Dr. Meyers opined that the July 22, 2010 incident was the prevailing factor in causing Petitioner to sustain the incarcerated ventral incisional hernia, and the incarcerated Bochdalek diaphragmatic hernia. The fact that Petitioner had a pre-existing hernia was unknown to Dr. Meyers when he initially formulated his opinions. Dr. Meyers testified it was his understanding that Petitioner had no symptoms prior to July 22, 2010. (Pet. Ex. 3, p. 29). Although he admitted Dr. Pickett had assessed Petitioner with a ventral hernia on July 2, 2010 and referred him to a surgeon for repair, his opinion as to causation was unchanged. Dr. Meyers then went on to testify, that even though Petitioner had a surgical recommendation prior to the alleged accident on July 22, 2010, the accident

caused the hernia to become incarcerated and caused the need for surgery. Dr. Meyer did acknowledge that a reducible ventral hernia can become incarcerated on its own. The Arbitrator also notes that Dr. Meyers opinion that causal connection for the ventral hernia is established by the fact that the hernia had become incarcerated at the time of the July 22 accident is not supported by the evidence. When Petitioner was seen at BarnesCare the hernia was noted to be "spontaneously reducing." An incarcerated hernia, by definition, is one which cannot be reduced.

After Dr. Pruett reviewed Dr. Pickett's July 2, 2010 records he testified it definitely affects the causation determination. Dr. Pruett testified Petitioner's ventral hernia is not work related. (Res. Ex. 4, p. 18). Dr. Pruett noted Petitioner's ventral hernia was diagnosed 20 days before his alleged work accident and that there would be no way his prior hernia could have healed itself prior to the lifting accident. Id. at p. 19-20. Moreover, Dr. Pruett testified that hernias can become incarcerated with time. Id. at p. 21. In fact, he testified that as a general rule, hernias start small and get bigger and more complex with time, meaning that they start out reducible and become incarcerated in time without a significant event. Id. The fact that Petitioner was diagnosed with a reducible hernia and July 2, 2010, which remained reducible as of July 26, and then had an incarcerated hernia at the time of surgery on September 1, 2010 does not support the conclusion that Petitioner's preexisting ventral hernia became incarcerated at the time of the July 22 accident. The Arbitrator finds it significant that Petitioner had a preexisting hernia on July 2, 2010 and that he was referred to a surgeon for surgical intervention prior to his alleged work accident. Dr. Pruett explained that a Bochdalek hernia is congenital and occurs during fetal development. Id. at p. 23. He further explained that a Bochdalek hernia cannot be traumatically induced, and by its definition is a birth defect. Id. Dr. Meyers indicated that the defect which allows a Bochdalek hernia to develop is indeed congenital, but it was his opinion that the herniation itself could be the result of trauma. He stated the congenital component is the failure of the diaphragm to join with the abdominal and thoracic walls so as to create two separate compartments. He indicated that with certain trauma, such as a motor vehicle accident in which the seatbelt puts abnormal stress on the abdomen, the contents of the abdomen can be forced into the thoracic cavity. The Arbitrator finds the testimony and opinions of Dr. Pruett much more persuasive. Further, the Arbitrator notes that Petitioner's claim that his abdomen became greatly distended, which he described as a bulge, following the alleged incident, presumably due to the Bochdalek hernia, makes little sense. The Bochdalek hernia involves material from the abdomen migrating into the thoracic cavity resulting in a lower volume of material in the abdominal cavity.

The Arbitrator finds that based on the preponderance of the credible evidence in the file, Petitioner suffered from a preexisting ventral hernia as well as an asymptomatic Bochdalek hernia. At the time of the alleged accident Petitioner sustained an increase in the symptoms of his preexisting ventral hernia. However, Petitioner required surgery to correct his ventral hernia before the accident of July 22, 2010 ever occurred. Therefore it cannot be said that the accident of July 22 caused or contributed to the need for surgery. The preponderance of the medical evidence in this case indicates that had there been no incident on July 22. 2010, Petitioner would have seen the surgeon on August 15, 2010, as scheduled following his visit with Dr. Pickett on July 2, 2010. It is also more probable than not that the exact same surgery would have resulted, with the Bochdalek hernia being discovered, and the same result obtained.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has failed to establish that his current condition of ill-being, which required the surgical procedure performed by Dr. Hafenrichter, is causally related to the accident of July 22, 2010.

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?

Respondent did not contest the reasonableness or necessity of the bills for Petitioner's treatment; rather, Respondent contested the medical causal connection of the treatment. All of the doctors agreed the surgical treatment which Petitioner received was reasonable and necessary in light of his condition. Petitioner submitted medical bills in the amount of $85,227.86, which are listed in exhibits 11 and 12. The Arbitrator finds that the treatment rendered and documented in the Petitioner's exhibits were reasonable and necessary. However, In light of the Arbitrator's finding with respect to causation, as set forth above, Petitioner's claim for benefits is denied.

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

Based upon the Arbitrator's finding regarding Issue F above, Petitioner's claim for benefits is denied.

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

Although the Arbitrator found Petitioner sustained an accident on July 22, 2010, Petitioner failed to establish by a preponderance of the evidence that the accident caused any progression in the underlying preexisting condition or that Petitioner sustained any permanent disability as a result of the accident. Based upon the foregoing and the record taken as a whole, the Arbitrator finds this accident resulted in only a transient increase in Petitioner's pain complaints and no permanent disability. Petitioner's claim for benefits is denied.

17IWCC0245

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

Shane Palenica,

Petitioner,

vs. NO: 11WC 005115

LKQ U Pull It, Inc., Scrap Processors,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, temporary total disability, medical, benefit rates/wage calculations, 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 2, 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.

17IWCC0245

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: APR 20 2017

Charles J. DeVriendt

Joshua D. Luskin

Kevin W. Lamborn

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

PALENICA, SHANE
Employee/Petitioner

Case# **11WC005115**

LKQ U PULL IT INC SCRAP PROCESSORS
Employer/Respondent

17IWCC0245

On 2/2/2016, 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 0.46% 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:

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

2623 McANDREWS & NORGLE LLC
MICHAEL P LATZ
53 W JACKSON BLVD SUITE 315
CHICAGO, IL 60604

17IWCC0245

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)

Shane Palenica
Employee/Petitioner

v.

LKQ U Pull It, Inc. Scrap Processors
Employer/Respondent

Case # **11** WC **5115**

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 **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **November 12, 2015 and November 23, 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 17IWCC0245

On the date of accident, **November 12, 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 **$54,090.00**; the average weekly wage was **$1,002.49**.

On the date of accident, Petitioner was **32** 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 **$108,742.24** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $668.33 / week for 230 6/7 weeks commencing June 21, 2011 through November 23, 2015, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $108,742.24 for TTD benefits that have already been paid.

Respondent shall pay reasonable and necessary medical expenses in the amount of $136,582.09, subject to the Fee Schedule as promulgated and in existence at the time of this injury, as provided in Section 8(a) and 8.2 of the Act.

Respondent shall authorize and pay for any additional treatment or medical services recommended by Dr. Bernstein to lessen the effects of the injury as well as the surgical intervention to the Petitioner's cervical spine.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Deborah L. Simpson

Signature of Arbitrator

January 29, 2016
Date

FEB 2 - 2016

17IWCC0245

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Shane Palenica,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 11 WC 5115**
	)	
LKQ U Pull It Inc. Scrap Processors,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on November 12, 2010, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that on that date the Petitioner sustained accidental injuries that arose out of and in the course of the Petitioner's employment with the Respondent and that the Petitioner gave the Respondent notice of the accident which is the subject matter of the dispute within the time limits stated in the Act. They further agree that in the year preceding the injuries, the Petitioner earned $54,090.44.

At issue in this hearing is as follows: (1) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (2) What is the Petitioner's average weekly wage, calculated pursuant to Section 10 of the Act; (3) Were the medical services that were provided to the Petitioner reasonable and necessary and has the Respondent paid all appropriate charges for all reasonable and necessary medical services; (4) Is the Petitioner entitled to any prospective medical care; (5) Is Petitioner entitled to TTD benefits; (6) Should penalties or attorney's fees be imposed upon the Respondent; and (7) Is Respondent entitled to any credit.

STATEMENT OF FACTS

Petitioner testified that he was employed by the Respondent for approximately five years, in the capacity of a tractor-trailer operator and general laborer. His job required him to drive various vehicles, including tractor trailers. As a general laborer his duties included clearing out debris, scrap metal and any other items that had fallen from the trailers. He also had to make sure that the tires were cleared of debris before pulling away with his load. During his five year span of employment, his duties were essentially the same. He would drive both closed trailers and open trailers. With respect to the type of items and the weights of the items he was handling, Petitioner testified that he had to pull heavy motors, heavy iron, large pieces of steel and fully dressed engines that would fall out of the back.

On November 12, 2010, Petitioner was loading a 40-foot dump trailer with semi-truck brake drums. There was a front loader being operated by an individual identified as Paulie and when they were approximately three-quarters of the way filling the trailer, the loader repeatedly hit a pile of brake drums, causing them to haphazardly roll around. In cleaning up the area so that the loader did not run over anything, Petitioner was required to physically handle the last three or four hundred of these drums. He stated that it was easier to angle the bucket up on the machine, lift the drums off the floor individually and load them in the bucket. That way he could pick up the drums without getting too much dirt in the bucket. According to the Petitioner there were different types of brake drums which varied in weight. He testified that the average weight of these drums was anywhere from 85 to 110 pounds. Petitioner moved about 50 of the brake drums, when he experienced a sharp stabbing pain in his shoulder region while throwing a drum into the bucket using his arms.

Following the sensation of the sharp pain, he "worked his shoulder a little bit, tried to move it around" and then went back to work. He finished out the day and continued to work thereafter, hoping that the pain would eventually dissipate. When the pain got worse he was directed by his supervisor to see Dr. Theodore James with Blue Island Medical Center. The plant manager, Dan, completed the necessary paperwork so that the Petitioner could obtain medical treatment.

Petitioner saw Dr. James for the first time on November 23, 2010, and the records indicate that he did an examination and directed that Petitioner could return to work with restrictions. Petitioner testified that his employer did not follow the restrictions. Petitioner testified further that his work activities did not change in any way. Petitioner did admit however that he was told by his supervisor not to clear debris away from the truck, and was instead instructed to open the door and drive the tractor trailer and avoid physically lifting anything as much as possible. (PX 1)

Petitioner continued to see Dr. James while he was working. He received trigger point injections into his shoulder and the doctor continued the work restrictions as initially imposed. (PX 1)

In December of 2010, Dr. James sent Petitioner for an MRI. Petitioner was directed by Dr. James to continue on light duty and to begin a course of physical therapy, which began on December 29, 2010, at PTSIR physical therapy. (PX 1, 10)

In January of 2011, Petitioner sought treatment with Dr. Blair Rhode, a shoulder specialist. Petitioner saw Dr. Rhode for the first time on January 24, 2011. At the initial visit, Dr. Rhode began a course of conservative treatment, which included physical therapy. He directed the Petitioner to continue to work with the restrictions that were previously imposed. (PX 2)

On February 7, 2011, because there was little improvement, the doctor recommended that Petitioner undergo surgery. With this recommendation, Respondent requested that the Petitioner be examined by a doctor of their choice, pursuant to Section 12 of the Act. (PX 2)

Respondent chose Dr. Gregory Nicholson as their Section 12 examiner. Petitioner saw Dr. Nicholson on May 17, 2011. After Dr. Nicholson's examination of the Petitioner and review of his medical records and tests the surgery was authorized. (RX 3)

Petitioner underwent surgery by Dr. Rhode on June 21, 2011. Following the surgery, Petitioner was taken off of work completely by Dr. Rhode. (PX 2) Petitioner testified that he started to receive TTD benefits at this time. After surgery Dr. Rhode ordered Petitioner to resume physical therapy, this began in July and continued through August. (PX 10)

Petitioner began complaining of neck pain around this time and on September 2, 2011, Dr. Rhode recommended that Petitioner obtain an MRI of the cervical spine. The MRI was completed and then reviewed by Dr. Rhode. The result of that MRI was "benign": it revealed degenerative changes with a small disc protrusion at C3-C4. (PX 2, 3)

On January 16, 2012, Dr. Rhode discussed the MRI results with Petitioner and also discussed with Petitioner the recommendations of Dr. Nicholson who, in his report, recommended that Petitioner should undergo a CT scan. Dr. Rhode concurred with Dr. Nicholson's recommendation. (PX 2, RX 3) Dr. Rhode also referred the Petitioner to Dr. Alexander Ghanayem at Loyola, a spine specialist.

Petitioner saw Dr. Ghanayem on January 26, 2012, where he related the history of throwing 100 pound brake drums into the bucket and experiencing pain in his shoulder region while doing so. Dr. Ghanayem performed a physical examination of Petitioner and reviewed his cervical MRI scan. Dr. Ghanayem concluded that the MRI scan revealed some spondylosis in an area of disc degeneration, but no significant neurologic compression. Dr. Ghanayem noted no radicular pain. He reported that the Spurling's test was negative. Dr. Ghanayem stated that the MRI was unremarkable for any neurologic compression. Dr. Ghanayem recommended that he seek the intervention of a rehabilitation physician to attempt to maximize his functional capabilities. (PX 3)

Following the consultation with Dr. Ghanayem, Petitioner sought a second opinion with Dr. Guido Marra, a shoulder and elbow specialist, who he was referred to by Dr. Ghanayem.

Petitioner saw Dr. Marra initially on September 4, 2012. After a physical examination, Dr. Marra indicated it was his belief that further surgical intervention was necessary to Petitioner's shoulder. Dr. Marra performed surgery on Petitioner on October 1, 2012. Following surgery, Petitioner was referred by Dr. Marra for physical therapy which began on October 8, 2012, and continued through November. During this time Petitioner remained off of work. (PX 4)

The records of Dr. Rhode on January 18, 2012, report that Petitioner continued with neck and shoulder pain. On October 8, 2012, during the course of physical therapy the therapist also noted continuing difficulty and pain into his neck. Dr. Marra suggested that Petitioner consult with a spine specialist. (PX 4) Dr. Marra released Petitioner from care for his left shoulder on January 31, 2013, finding him to be at MMI with respect to his shoulder. Petitioner testified that he has not had any treatment by Dr. Marra for his shoulder since that time. Petitioner was still treating with Dr. Bernstein for his neck at this time and had not been released by Dr. Bernstein to

return to work. During the entire year of 2013, there are no records offered into evidence indicating that the Petitioner had been released by Dr. Bernstein to return to work.

Petitioner saw Dr. Avi Bernstein, a spine specialist, whom he had treated with in the past. On March 14, 2013, Petitioner saw Dr. Bernstein for an initial evaluation of the cervical spine. Petitioner provided the prior studies and MRIs. Dr. Bernstein was not satisfied with the quality of the MRIs, and he ordered Petitioner to obtain another diagnostic study. This was done on April 5, 2013. Dr. Bernstein observed degenerative changes in Petitioner's spine and referred Petitioner to his colleague, Dr. Henry Kurzydlowski, for epidural steroid injections into the cervical spine. (PX 9)

The first epidural was performed on May 15, 2013. Although the initial injection did not alleviate the pain the doctor determined that additional cervical steroid injections would be appropriate. Petitioner returned to see Dr. Bernstein on July 11, 2013, and reported that the injections provided no improvement. He then was directed by the doctor to try and obtain another diagnostic study, a cervical myelogram and CT scan which was performed on August 29, 2013. (PX 9)

Dr. Barry Rabin reported that his impression was that it was a normal CT cervical myelogram, with no herniation, no foraminal stenosis, and no spinal cord compression. On September 23, 2013, Dr. Bernstein reported that the CT myelogram was a benign study, and showed only mild degenerative changes at the C5-C6 level. (PX 9, 13)

At the follow-up visit of January 13, 2014, Dr. Bernstein continued Petitioner's off-work status. Dr. Bernstein also recommended a discogram. (PX 13) The discogram was aborted, and therefore inconclusive. (PX 13, Bernstein Deposition, p. 18)

After the CT myelogram, the Respondent requested that the Petitioner see Dr. Steven Mather, pursuant to Section 12 of the Act. The examination was scheduled for October 28, 2013. The Petitioner saw Dr. Mather and was examined by him on that day.

With respect to that examination and review of medical records, Dr. Mather testified that Petitioner complained of numbness in the volar aspect of the thumb and the front aspect of the left hand which is consistent with a carpal tunnel origin. (RX 4 p. 11) Dr. Mather testified that he could not reproduce any symptoms with a classic test for nerve compression. (RX 4 p. 11). Dr. Mather reviewed a CT myelogram from August 29, 2013. This CT myelogram revealed some disc degeneration at C5-C6, but no nerve compression." Dr. Mather testified that Dr. Rhode's notes from January 24, 2011, two months post-injury, revealed no neck complaints. (RX 4). Dr. Mather opined that within a reasonable degree of medical certainty that Petitioner did not sustain a structural injury to the cervical spine on November 12, 2012, because his MRI showed typical findings and he did not have any sign of nerve compression either on CT myelogram or on physical examination. Dr. Mather opined that Petitioner's described numbness and tingling were in the wrong distribution for either C4-C5 or C5-C6. (RX 4, p. 17).

Petitioner underwent a discogram which had to be aborted; this was discussed with Dr. Bernstein on March 27, 2014. Dr. Bernstein then ordered additional diagnostic testing in an effort to determine the cause of the Petitioners continued symptoms. Dr. Bernstein believed that

the clinical presentment of Petitioner demonstrated issues in the cervical spine but none of the diagnostic studies were of a quality which was definitively dispositive. (PX 13, p. 17-19, 30)

Petitioner underwent another MRI on April 17, 2014, the results of which were discussed with Dr. Bernstein on May 1, 2014. Based upon the review of the films, the doctor determined that there was a herniated disc at level C6-C7 which required surgical intervention in addition to the stenosis at C5-C6. The doctor recommended a two level fusion and continued to keep Petitioner off of work.

After Dr. Bernstein recommended surgery, the Petitioner was directed by Respondent to return to Dr. Nicholson pursuant to Section 12 of the Act. On June 17, 2014, Petitioner was examined by Dr. Nicholson. After Dr. Nicholson's examination and report, the surgery recommended by Dr. Bernstein was not authorized by Respondent.

Petitioner then continued to periodically see Dr. Bernstein and Dr. Marra up to the date of this hearing. Petitioner saw Dr. Marra on May 12, 2015, and was directed to remain off of work until his cervical issue was resolved.

Petitioner was able to proceed with surgery outside the scope of workers' compensation coverage and was admitted to Lutheran General Hospital on September 2, 2015, where surgery was performed by Dr. Bernstein.

Petitioner saw Dr. Bernstein on September 28, 2015, for follow-up after the surgery. At that time the doctor continued to direct that he should remain off of work and that he should begin physical therapy.

Petitioner testified that before surgery, he had stabbing pains in his shoulder between the shoulder blade and the spine and burning pains down into his fingers. He also testified that he had numbness in the left hand as well as tingling and a loss of strength, that he had difficulty sleeping, and that he had difficulty holding materials in his hand. He described his condition after the surgery and currently, at the time of this hearing, stating that he is feeling great, that the stabbing pains have disappeared, that he has no numbness or tingling and that his grip strength is returning. He testified that he notices improvement in his symptoms and that he continues to receive physical therapy three days a week. His next appointment with Dr. Bernstein is on November 30, 2015. Petitioner testified that he believes that with continued physical therapy, he may be able to resume his normal pre-accident activity.

Petitioner testified that he was not receiving benefits at the time of the hearing and had been cut off by the insurance company for an extended period of time. He did not recall the exact date, although he stated it was sometime in 2013. He also testified that the Respondent, to obtain a continuance of a previously scheduled hearing, provided an advance in August but no further periodic payments were made.

Petitioner testified that he would start his work day at approximately 5:00 a.m. He generally arrived at work twenty minutes before 5:00 a.m., did a pre-trip inspection of his vehicle, the tractor and trailer, and then he would commence his work activity. The number of

hours he worked was based upon the workload that was available. He was not allowed to return to his home base until he was given permission by his supervisor, Steve Hecknish. He testified that he had no flexibility of choice concerning the hours he worked, that all of his overtime was mandatory, and that he could not end his day until Mr. Hecknish gave him permission to come in to the yard. Petitioner offered into evidence an exhibit which demonstrated that his yearly earnings were $56,059.70. However, he did admit that the premium time for overtime should not be included, and thus his gross wages were $50,525.39. Petitioner testified that based upon Petitioner's Exhibit 12, the exhibit of his earnings, his average weekly wage was $1,002.49. Respondent did not offer any evidence to rebut this testimony or the exhibit.

Petitioner offered Exhibit No. 11 which, a compendium of medical bills totaling $136,582.09, which were incurred during the course of treatment with Dr. Marra, Dr. Rhode, Dr. Bernstein and Dr. Kurzydlowski. Petitioner testified that, to the best of his knowledge, all of the doctors were familiar with the Workers' Compensation Act and the billing Fee Schedule; however, he was not aware of whether the bills submitted were fee scheduled amounts.

Respondent offered two exhibits, the deposition transcripts of Dr. Mather (RX 4) and Dr. Peter Rogers, a board-certified neuro-radiologist, (RX 5) hired by the Respondent to review Petitioner's MRIs, which were challenged by Petitioner because the doctors were provided the "IME" reports as part of the records for review. An objection was made pursuant to the case of *Dugan v. Weber*, 175 Ill. App. 3d 1088, 530 N.E.2d 1007 (1988). The hearing was recessed so that the Arbitrator could review the deposition transcripts prior to ruling on admissibility, to determine whether the doctors testified that they relied on the "IME" reports in forming their opinions. The doctors identified, their own examinations of the Petitioner (Dr. Mather), the history provided by the Petitioner of the accident and his symptoms (Dr. Mather), a review of the medical records, tests and test results and letters from Dr. Bernstein, Nicholson, Marra and Ghanayem (Dr. Rogers) as the information that they relied upon in forming their opinions. All of the listed items were information that a doctor would normally rely upon in reaching a diagnosis or opinion. After reviewing the case law, and the transcripts, the Arbitrator overruled the objections and admitted Respondent's exhibits 4 and 5, concluding that the two doctors did not rely on those IME reports in forming their opinions therefore there was no violation pursuant to the decision in *Dugan v. Weber*.

At his deposition, Dr. Rogers stated that he reviewed the 2012 MRI of the cervical spine, the CT myelogram from August 2013, the cervical MRI from April 5, 2013, and the cervical spine MRI from April 2014. Dr. Rogers stated that in the MRI of 2012, he observed mild diffuse disc bulge, no significant central or foraminal stenosis at all three levels. (RX 5).

Dr. Rogers testified that he agrees with the report which said there was no significant foraminal or central stenosis. Dr. Rogers stated that the CT myelogram of 2013 also demonstrated that there was no significant central or foraminal stenosis. Dr. Rogers reviewed the April 5, 2014 C-Spine MRI, and reached the same conclusion initially reached by Dr. Ian Fisher, that there was no significant foraminal or central stenosis. (RX5).

Dr. Rogers testified further that as a radiologist he reviews MRI images, CT Scans and CT myelogram images. He prepares reports of what he sees in an objective way and sometimes discusses the results by phone or in person with the treating doctor(s). He explained that they

ask him to describe the findings and the significance of the findings. The surgeon is the doctor who makes the decision whether surgery is indicated or not. (RX 5) He does not tell the doctors to perform surgery or not to perform surgery, that is not his decision to make. (RX 5)

Dr. Rogers testified that he is not an orthopedic or a neurosurgeon or a spine surgeon, he is a radiologist. Dr. Rogers has not been involved in surgery for at least 23 years, which was at the time of his residency/fellowship. He did not know what a Hawkins test was, or a Spurling's test, nor did he remember or was he aware of what the significance of a positive Spurling's test was. Dr. Rogers, on cross examination agreed that sometimes doctors and radiologists see findings differently than other doctors or radiologists do.

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987).

An injury arises out of one's employment if it has its' origin in a risk that is connected to or incidental to the employment so that there is a causal connection between the employment and the accidental injury. *Technical Tape Corp. vs IndustrialCommission,*58 Ill. 2d 226, 317 N.E.2d 515 (1974).

The burden of proving disablement and the right to temporary total disability benefits lies with the Petitioner who must show this entitlement by a preponderance of the evidence. *J.M. Jones Co. v. Industrial Commission,*71 Ill.2d 368, 375 N.E.2d 1306 (1978)

For compensability of a claimed injury, where a pre-existing condition exists, recovery will depend on the employee's ability to show that a work-related injury aggravated or accelerated the pre-existing condition such that the employee's current condition of ill-being is said to have been causally connected to the work-related injury and not simply the natural sequela process of the pre-existing condition. *Sisbro Inc. v. Industrial Comm'n,* 207 Ill. 2d 193, 278 Ill. Dec.70, 797 N. E. 2d 665 (2003).

Employment need only remain a cause, not the sole cause or even the principal cause, of a claimant's condition. *Rotberg v. Industrial Comm'n,* 361 Ill.App.3d 673, 682, 297 Ill.Dec. 568, 838 N.E.2d 55 (2005).

Proof of an employee's state of good health prior to the time of injury, and the change immediately following the injury, is competent as tending to establish that the impaired condition was due to the injury. *Westinghouse Electric Co. v. Industrial Commission*, 64 Ill. 2d 244,356 N.E. 2d 28 (1976).

In support of the Arbitrator's decision with regard to whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein. The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes that Petitioner has proven by a preponderance of the credible evidence that both his shoulder and neck conditions are causally related to his work injury as set forth more fully below.

Petitioner, a truck driver/laborer was injured on November 12, 2010. At the time, he was manually loading brake drums from semi-trailers weighing 85 and 100 pounds into the bucket of a front loader. He handled approximately fifty brake drums, tossing them into the bucket when he felt a sharp pain. At the time the Petitioner was working with Paulie, who operated the loader, and Trevor Hecknish. Petitioner continued to work but the pain continued to increase. He was sent by his employer to Blue Island Medical Center for an evaluation by Dr. Theodore James, which occurred on November 23, 2010.

Petitioner gave a history of the injury to Dr. James who examined him, primarily focusing on his shoulder, and concluded that Petitioner had suffered a strained shoulder. Dr. James ordered X-rays of the left shoulder, prescribed Motrin 800 and suggested that a trigger point injection might be appropriate. He released Petitioner to light duty, with restrictions consisting of fifteen pound maximum lifting with his left arm and no over the shoulder work with the left arm.

Petitioner continued to treat with Dr. James, who ordered an MRI of the shoulder, which was performed on December 16, 2010. It showed prominent changes of the AC joint with surrounding subchondral edema, although there was no evidence at that point of rotator cuff tear. The pain continued and Petitioner continued to work on restricted duty.

Dr. James also prescribed a course of physical therapy, which Petitioner started on December 29, 2010. Petitioner's condition did not improve and he sought treatment with an orthopedic surgeon named Blair Rhode on January 24, 2011.

Petitioner gave Dr. Rhode a consistent history of throwing the brake drums – the doctor described it as using a side motion – when he experienced deep stabbing pains with radiation to the lateral shoulder. The physical exam demonstrated a positive impingement sign, specifically with internal rotation. The doctor concluded that Petitioner had a positive O'Brien's test for a SLAP lesion. The doctor changed Petitioner's medications and increased the use of Mobic, Norco and Prilosec and restricted his duties to no lifting over twenty-five pounds. He also provided a Kenalog injection.

In February of 2011, Dr. Rhode determined that Petitioner was a candidate for surgery. The Respondent requested a medical examination pursuant to Section 12 of the Act. Petitioner saw Dr. Gregory Nicholson of Rush Orthopedics on May 17, 2011, at the direction of Respondent. After taking a history from Petitioner, an examination of Petitioner and review of the medical records and test results, Dr. Nelson determined that Petitioner's condition was consistent with left shoulder AC joint post-traumatic arthralgia and post-traumatic subacromial bursitis impingement syndrome. Dr. Nicholson concluded that this was related to the accident and that the surgery as outlined by Dr. Rhode was appropriate. Surgery was approved and on June 21, 2010, Petitioner underwent surgical intervention, a subacromial decompression,

acromioclavicular arthroplasty and suprascapular nerve block, by Dr. Rhode, at South Chicago Surgical Solutions.

The surgery was not successful and Petitioner was referred to Dr. Guido Marra, a shoulder and elbow specialist at Northwestern Memorial Hospital, who performed a second surgery on Petitioner's left shoulder. The surgical procedure, a Revision Arthroscopic Subacromial Decompression and a Revision Left Acromial Joint Debridement was performed by Dr. Marra on October 1, 2012. The records of Dr. Rhode and Dr. Marra demonstrate that Petitioner's shoulder condition of ill-being is clearly related to the accident that occurred on November 20, 2010. This is further confirmed by the Section 12 examination reports of reports of Dr. Nicholson.

With respect to the challenge by Respondent that Petitioner's cervical condition is not related to the original injury it is a little more difficult. It is apparent from the medical records of the treating doctors that the focus was on Petitioner's shoulder problems at first. Following the first shoulder surgery and the physical therapy afterwards Petitioner was still making significant pain complaints which were documented by Dr. Rhode. Dr. Rhode performed certain tests which indicated the involvement of the cervical spine, this was in September of 2011.

On September 2, 2011, Dr. Rhode's examination showed that Petitioner suffered a positive Spurling's test of the C-spine. This problem with regard to the neck area was confirmed again on September 23, 2011, when Petitioner again exhibited a positive Spurling's test on the C-spine, a test which Dr. Mather and Dr. Bernstein both testified as indicative of disc pathology and could lead to radiculopathy. On that date the doctor ordered an MRI for the Petitioner of the cervical spine. The MRI was not performed despite the fact that on both October 14 and November 11, 2011, Dr. Rhode again reported a positive Spurling's test of the C-spine. However, the doctor was advised that Petitioner was directed to see Dr. Nicholson again.

Petitioner saw Dr. Nicholson for the second time on December 6, 2011, where the doctor stated that he did not see any significant cervical issues but felt that his symptoms seemed to be located at the AC resection margin. He concluded that aggressive physical therapy, which apparently Petitioner was undergoing, could aggravate the AC joint anomaly and create more pain. The doctor suggested an AC joint injection would be something to consider and that a CT scan should be obtained. He also concluded that Petitioner could return to work with lifting restrictions consisting of no over-the-shoulder level lifting and a maximum of fifty pounds push/pull. He concluded that the subjective complaints of pain matched the objective findings.

Subsequent to that Petitioner continued to follow up with Dr. Rhode, who performed post-op examinations of Petitioner with regard to his shoulder but also renewed his request for an MRI of the C-spine because Petitioner continued to demonstrate a positive Spurling's test. This was recorded on December 16 and December 30, at which point the doctor agreed with Dr. Nicholson's request for a CT scan, and directed Petitioner to remain off of work and obtain the diagnostic study.

On January 16, 2012, the C-spine MRI was accomplished and it showed degenerative changes with a small central disc protrusion at C3-C4 and disc bulging at C5-C6. The doctor

discussed this MRI with Petitioner and awaited the results of the CT scan. On January 18, 2012, Dr. Rhode concluded that the CT did not demonstrate a recurrence of AC compression, Petitioner's condition did not improve with the AC injection and he continued to exhibit a positive Spurling's test. Dr. Rhode then wrote a referral to Dr. Alexander Ghanayem, a spine specialist at Loyola.

Dr. Ghanayem examined the cervical region and on his initial report of evaluation, dated January 26, 2012, he concluded that Petitioner had some referred pain in the mid-cervical region. However, he stated that there was no radicular pain into the arm per se, but there was pain around the left elbow. His physical examination disclosed discomfort over the cervical base, tenderness over the AC joint on the left, pain with left shoulder range of motion, difficulty stabilizing the left shoulder girdle and, in reviewing the cervical MRI, demonstrated some spondylosis and an area of disc degeneration of C4-C5. He concluded that there was no significant neurological compression. In Dr. Ghanayem's report of the January 26, 2012 consultation, he indicated that Petitioner did have neck pain that was probably multi-factorial in nature, and that he believes that Petitioner aggravated this when he threw the 100-pound brake drums. He noted that there is obviously some shoulder contribution given that the muscles that stabilize the shoulder take their origin from the midline in the cervical region. He concluded that Petitioner should seek the intervention of a rehabilitation physician to maximize his functional capabilities but that at this point he was not a candidate for cervical spine surgery.

In a report authored by Dr. Nicholson on May 1, 2012, he concluded that the CT scan was not conclusive of his shoulder anomalies but Petitioner could indeed have some neck issues. He concluded that Petitioner had residual left acromioclavicular joint pain and recommended a revision at the AC joint resection. He went on to conclude that this was work related and that Petitioner was not at MMI.

Petitioner was referred to Dr. Guido Marra for a second opinion with regard to his shoulder issues. Petitioner saw Dr. Marra on September 4, 2012. The physical examination demonstrated a positive impingement sign, a positive O'Brien's test, a positive painful arc and 4/5 on the strength scale, but there were no fractures or dislocations shown. In Dr. Marra's opinion, the CT scan previously performed showed a minimal resection of the distal clavicle. Dr. Marra's conclusion was that Petitioner needed further revision of the AC joint resection and again concluded that he was capable of light duty with no use of the left arm. The surgery was performed on October 1, 2012. Following his discharge from the hospital the doctor directed that he remain off of work and commence physical therapy.

Physical therapy was started again at PTSIR Physical Therapy on October 8, 2012, and the initial note completed by Petitioner stated that he has continuing neck complaints when he moves his neck. Periodically there was documentation of tightness in the levator scapula, which was described in the notes as the back and side of the neck. Petitioner returned to Dr. Marra on November 15, 2012, where Petitioner continued to rate his pain as 7/10. Dr. Marra documented a positive Neer sign, positive Hawkin's and positive painful arc and directed Petitioner to continue physical therapy.

The records of PTSIR Physical Therapy, commencing on November 21, 2012,

consistently discuss the cervical issues, pointing to the C5-C6 levels and provided therapy to the neck and shoulder. These complaints were documented in the physical therapy visits between November 21, 2012, and December 19, 2012.

In a follow-up appointment with Dr. Marra on December 20, 2012, Dr. Marra documented the difficulty Petitioner was having and noted that Petitioner feels he has had increasing symptoms in the area of his neck and a stabbing pain that travels down his arm to his fingers. A physical examination showed that the impingement signs were negative and there was less tenderness over the AC joint. Dr. Marra directed Petitioner to return to Dr. Ghanayem for reevaluation, which was subsequently scheduled for January 24, 2013. During the interim, Petitioner continued with physical therapy, wherein radicular symptoms were documented on most of the visits between December 26, 2012, and January 23, 2013.

Petitioner saw Dr. Ghanayem on January 24, 2013. In his report, Dr. Ghanayem recited that Petitioner had undergone two surgical interventions to his shoulder, had physical therapy for his neck and shoulder pain, continued to have pain in his neck with numbness and tingling into the first three fingers in his left hand and still exhibited a limited range of motion. The physical exam confirmed a limited range of motion of the cervical spine, increased pain on rotation to the left, and numbness and tingling into his left hand. Dr. Ghanayem's diagnosis was cervicalgia. Dr. Ghanayem's recommendation at that point was to continue a conservative approach to his cervical pain. The doctor recommended a follow-up with a physical medicine rehabilitation doctor as well. He was also to remain off of work.

Petitioner continued physical therapy. On the January 30, 2013 visit, the therapist noted that Petitioner continued radiating symptoms into the left upper extremity and cervical erector spine.

On January 31, 2013, Petitioner returned to see Dr. Marra. Petitioner advised Dr. Marra that the treatment of Dr. Ghanayem did not prove to be helpful. Since Petitioner's continued to seek treatment for the continuing pain in his neck, Dr. Marra referred him to a Dr. Patel. Petitioner was advised not to proceed to work hardening until the cervical issues were resolved. Petitioner sought treatment with Dr. Bernstein instead of Dr. Patel.

Petitioner was directed to see Dr. Nicholson for a fourth time, which he did on February 26, 2013. The doctor concluded that Petitioner was improving substantially from the standpoint of his left shoulder, but believed his residual symptomology in the left upper extremity is cervical spondylosis and cervical radiculopathy. He believed that no further shoulder workup was necessary, but he was convinced that a visit to a cervical spine specialist and possibly a second opinion was necessary. He also determined that Petitioner was not at MMI and that his progress was being compromised by the cervical issues. He documented that no symptom magnification elements were present.

Petitioner initially saw Dr. Avi Bernstein for a consult on March 14, 2013. The doctor related that he had previously seen Petitioner for a spinal fusion in the lumbar area and then documented the injury of November 12, 2010. Dr. Bernstein noted that subsequent to the injury, the Petitioner had a constant burning of his left shoulder, complained of shoulder pain and had

injections, physical therapy and surgery, but the treatments did not resolve his neck problems. The doctor's physical exam disclosed a negative Spurling's maneuver but guarded range of motion. In his deposition, the doctor testified that the MRIs were of poor quality because Petitioner's massive size prevented him from entering a closed machine. At that juncture, the diagnosis of the doctor was chronic neck pain with symptoms suggesting cervical radiculopathy. Dr. Bernstein then suggested that a better quality MRI was required. He concluded that Petitioner seemed to have disc abnormality at C5-6 and based upon the consistent symptoms and reported history, he believed that Petitioner's neck complaints were causally related to his work incident.

On April 5, 2013, an MRI was again obtained which demonstrated conspicuous degenerative changes at C5-6 with mild central spinal canal narrowing and a small central disc protrusion at C3-4. This had not materially changed since the MRI of January 16, 2012. In reviewing the MRI with Petitioner on April 15, 2013, Dr. Bernstein concluded that the MRI showed straightening of the cervical spine, and disc bulging in the lower cervical spine without a distinct disc herniation or nerve root compression. Dr. Bernstein concluded that the scan, which was done in an open scanner because of Petitioner's size, did not provide definitive diagnostic efficacy to make further recommendations. Therefore, the doctor recommended a trial of cervical epidural steroid injections.

Petitioner was directed to see Dr. Henry Kurzydlowski for epidural steroid injections. Following the initial visit with Dr. Kurzydlowski, Petitioner underwent the cervical ESI on May 17, 2013. Following the initial injection, Petitioner saw Dr. Bernstein on June 3, 2013, where Petitioner stated that he had three to four days of worsening pain, then some improvement for approximately a week, but after that the symptoms returned. Based upon this discussion, he was directed to obtain another epidural steroid injection. He returned to see Dr. Kurzydlowski on June 13, 2013, where he was prescribed Neurontin and scheduled to obtain a second cervical epidural, which was accomplished on June 26, 2013.

Petitioner returned to see Dr. Bernstein on July 11, 2013, where he reported he had the two epidurals without any improvement but that he was returning to see Dr. Kurzydlowski the next day, on July 12. Dr. Bernstein wanted Petitioner to obtain a standup MRI in Deerfield because he has had success getting good imaging in the past with this MRI form. On July 12, Dr. Kurzydlowski once again documented that the pain persisted. He increased the Neurontin dosage and continued Norco and recommended a repeat epidural steroid injection.

On August 29, 2013, at the direction of Dr. Bernstein, Petitioner underwent a cervical myelogram and post-myelogram CT. On September 3, 2013, Dr. Bernstein stated it was benign but did show mild degenerative changes at C5-C6 with some irregular endplate changes even into the left foramen. However, there was no clear evidence of nerve root compression or disc herniation. Based upon the clinical findings at the September visit, Dr. Bernstein directed the Petitioner to undergo a multilevel cervical discogram in an effort to confirm a pain generator.

Petitioner was sent by Respondent to Dr. Steven Mather on October 28, 2013, for his fifth examination pursuant to Section 12. Dr. Mather testified in his deposition and wrote in his report that Petitioner is suffering from a functional overlay psychogenic pain and concluded that

Petitioner did not suffer a cervical injury. He concluded that all of the pain complaints were from the shoulder and not referable to the cervical spine. He concluded that no further diagnostic testing was necessary and that Petitioner could return to work without restrictions. Dr Mather admitted that if Petitioner did have a cervical strain it should have resolved within two to four weeks given the mechanism of injury. In reviewing the history taken by Dr. Mather and what he admitted to during his deposition Dr. Mather had minimal insight into the mechanism of injury. Dr. Mather indicated that he had not performed shoulder surgery in many years and that he focused his practice on spine anomalies. None the less, Dr. Mather opined, in an addendum that was offered on behalf of Respondent that Petitioner was at MMI for his shoulder condition and required no further treatment or restrictions.

Petitioner saw Dr. Bernstein again on January 13, 2014, where he reviewed the Section 12 report of Dr. Mather. Dr. Bernstein stated during his deposition that he disagreed with Dr. Mather's conclusion. Dr Bernstein noted in his chart on January 13, 2014, that Petitioner was suffering from a discogenic lesion most likely at the C5-C6 level. He also noted this is a very difficult patient (Petitioner) to image and evaluate due to his large size. Dr. Bernstein renewed his request for a cervical discogram to the extent that one could be completed. In his deposition Dr. Bernstein admitted this is the first time, given the large body habitus of Petitioner, that he had encountered such difficult issues to diagnose.

On January 17, 2014, Petitioner followed up with Dr. Marra. Dr. Marra commented that an FCE would be useful in determining what restrictions were required because of Petitioner's shoulder. However, because of the continuing cervical issues, he felt that there would be no benefit to obtaining the FCE until the cervical spine issues were resolved.

Dr. Bernstein continued to advocate for surgical intervention to the neck. He directed Petitioner to undergo another MRI, which was done on April 17, 2014. This report showed that there was a shallow, broad based, left foraminal disc protrusion at C6-7 which was abutting and encroaching upon the exiting left C7 nerve root within the neuroforamen. The radiologist documented this as being new compared to the prior studies. He also documented that Petitioner had mild cervical spondylosis and mild disc bulges indenting on the thecal sac at C3-4, C5-6, C6-7. Dr. Bernstein testified in his deposition that this was the first test accurate enough to confirm his theory that Petitioner had cervical disc lesions which required surgical intervention. Respondent denied authorization for proceeding with the surgery.

On June 14, 2014, Petitioner again returned to see Dr. Nicholson, who concluded that the AC joint resection performed by Dr. Marra was successful, no further treatment was necessary and that Petitioner was at MMI relative to his left shoulder. He agreed with Dr. Marra that an FCE was appropriate and that any FCE for the left shoulder would be adversely affected by the cervical spine and radiating pain issues. During his deposition, Dr. Nicholson admitted that he was not a spine specialist and that he was not tasked with investigating the cervical issues, but he did find some elements of cervical difficulties.

Dr. Bernstein continued to recommend surgical intervention as demonstrated by the herniated disc in the April 2014 MRI and continued to seek approval for the surgery. Dr. Marra concluded that Petitioner would be unable to return to work until an FCE could determine what

he was capable of. The FCE could not be performed until his cervical issues were resolved.

Petitioner was admitted to Lutheran General Hospital on September 2, 2015, where Dr. Bernstein performed a C5-6-7 anterior cervical microdiskectomy with spinal canal and nerve root decompression and a fusion of C5-6, C6-7 from the anterior direction. He followed up with Petitioner thereafter and six days following surgery Petitioner returned to see Dr. Bernstein, and indicated he was doing well. Petitioner still had some mild dysphasia but his radiating arm pain was gone and he had typical post-operative neck discomfort. He was to begin physical therapy and follow up in one month.

Petitioner returned to see Dr. Bernstein on September 28, 2015, where they re-dressed his cervical incisions and he was directed to return in approximately four weeks. At the time of the hearing, Petitioner testified that he was absolutely overjoyed with the results of the surgery, that his shooting pain had resolved, that the numbness was receding and that he was making progress in physical therapy. He stated that he had a return appointment with Dr. Bernstein on November 30, 2015.

The exhibits offered on behalf of Petitioner and Respondent were reviewed very carefully by this Arbitrator. Dr. Mather's deposition, unfortunately, falls short with regard to its weight. The doctor was not requested to prepare an addendum as he had for the shoulder with regard to the new findings of the MRI on April 17, 2014, nor was he provided with the records to review them, therefore, his opinions were not based upon all of the medical records.

The Petitioner's complaints were consistent with respect to his neck and the effects it was having on the left arm and shoulder, after two shoulder surgeries. Dr. Ghanayem tried to determine the cause of Petitioner's complaints but ultimately gave up. Dr. Bernstein continued to search for a test that would accurately allow him to diagnose the cause of Petitioner's pain and did not give up until he found the source of the pain.

Concerning the testimony of Dr. Rogers, whose opinions were vehemently objected to by Petitioner, Dr. Rogers' testimony is informative in the sense that he agreed with Dr. Bernstein that the prior studies were not optimal in diagnosing the condition and, in fact, concluded that they were all suboptimal. His opinion that there was nothing in the films or scans that indicated to him that the Petitioner was a surgical candidate are not persuasive given the fact that he testified specifically he is not a surgeon, orthopedic or otherwise, and does not make determinations or recommendations regarding surgical intervention, he merely "objectively reports what he sees" and the significance of it. He agreed that radiologists do, from time to time, differ in their interpretations of radiological scans and films.

Dr. Nicholson in his deposition testified that the CT scan that he had requested was not performed at the appropriate levels but this was addressing the shoulder issue. Dr. Nicholson did, in his reports, indicate that Petitioner has cervical issues, which was supported by both Dr. Rhode and Dr. Marra. The Arbitrator also notes that the physical therapy records of PTSIR contain documented complaints of ill-being with regard to the cervical region.

Given the complaints of Petitioner and the high level of quality of the doctors that he saw, the Arbitrator concludes that based upon the testimony of Dr. Bernstein, Petitioner suffered a cervical injury at the time of the injury on November 12, 2010. The Arbitrator also finds that the testimony of Dr. Bernstein is the most consistent and most credible in dealing with this issue. Taking all the medical records in their totality, that is the records of Dr. Rhode, Dr. Ghanayem, Dr. Bernstein and the physical therapy records of PTSIR, the Arbitrator finds that there is a causal connection between the incident of November 12, 2010, and Petitioner's shoulder and cervical region. The Arbitrator also finds that the surgery performed by Dr. Bernstein was reasonable and necessary to cure the results of this injury.

In support of the Arbitrator's decision with regard to what Petitioner's earnings were, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

Petitioner testified credibly and unrebutted that he would begin his work day shortly before 5:00 a.m. He would depart on his assigned stops collecting scrap metal, driving a tractor-trailer, going to various sites and then returning to his home facility. He testified that overtime was mandatory in that once he left for the day he would not be able to return to the main facility until he was given specific direction by his boss, Steve Hecknish, that he in fact was finished for the day. The records of his wages introduced as Petitioner's Exhibit No. 12 clearly indicate overtime on a fairly consistent basis. Given the nature of the business as well as the description provided by Petitioner, as well as the failure of the Respondent to dispute the testimony, the Arbitrator finds that overtime was mandatory. Therefore, those hours calculated at the regular pay rate will be included in his wages in calculation of average weekly wage pursuant to Section 10. The Arbitrator determines, by reviewing the appropriate exhibit and the testimony of Petitioner, that Petitioner's average weekly wage is $1,002.49 per week.

In support of the Arbitrator's decision with regard to whether the medical services that were provided to Petitioner were reasonable and necessary and whether Respondent paid all appropriate charges for reasonable and necessary medical treatment, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Arbitrator having found that there is a causal connection between the incident of November 12, 2010, and Petitioner's shoulder and cervical region also finds that the two surgeries performed on Petitioner's left shoulder as well as the surgery performed by Dr. Bernstein on the Petitioner's neck were reasonable and necessary to cure the results of this injury. Therefore, the Arbitrator awards Petitioner medical expenses in the amount of $136,582.09, subject to the Fee Schedule as promulgated by the Act and in existence at the time of this injury.

In support of the Arbitrator's decision regarding whether the Petitioner is entitled to any prospective medical care, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

Based upon the testimony of Petitioner and Dr. Avi Bernstein's medical records indicating that Petitioner underwent surgical intervention for the injury to his cervical spine, the Arbitrator hereby directs that Respondent pay for any ensuing medical treatment required to lessen the effects of the injury as well as the surgical intervention to the affected area.

In support of the Arbitrator's decision with regard to the amount due for temporary total disability, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Petitioner testified that following his injury he was directed to perform light duty work accommodating the restrictions placed upon him by the treating doctors. He testified that he essentially did his usual job but was directed not to lift anything if possible. He continued to work under this mandate until his surgery with Dr. Blair Rhode on June 21, 2011. Since that time, Petitioner's treating physicians have not released him to return to work. Thus, the Arbitrator finds that there has not been a determination by any of the treating physicians that he has attained stability with regard to his condition.

He underwent surgery on his cervical spine with Dr. Bernstein several weeks prior to the hearing before this Arbitrator, and testified that he had significant improvement in his condition following the surgical intervention. Dr. Bernstein continued him in an off work status and ordered that he continue with physical therapy. The Arbitrator determines that based upon the records of Dr. Blair Rhode, Dr. Guido Marra, and Dr. Avi Bernstein, as well as the deposition of Dr. Bernstein, that Petitioner is entitled to temporary total disability benefits from June 21, 2011, up to and including the final day of hearing in this matter, November 23, 2015, for a period of 230, 6/7 weeks. The temporary total disability benefits would be payable at the rate of $668.33 for a total temporary total disability amount subject to any credits of $154,288.75. These conclusions are supported by Petitioner's credible testimony as well as the documents contained in the various exhibits of the treating physicians.

The Arbitrator is mindful that Respondent, in taking the deposition of Dr. Gregory Nicholson and Dr. Mather, argues that Petitioner had reached maximum medical improvement previously and thus they terminated his benefits in December of 2013. The Arbitrator gives less weight to the opinions of Dr. Mather and Dr. Nicholson with regard to maximum medical improvement, especially given Dr. Nicholson's commentary that he had agreed with Dr. Marra and Dr. Rhode as to Petitioner's condition of ill-being, the need for continuing treatment and the fact that his condition or efforts to obtain MMI were compromised because of the dispute over the cervical issues. The Arbitrator concludes that Petitioner is entitled to the temporary total

disability benefits beyond the date it was terminated by Respondent. Therefore, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits as stated above.

Based upon the foregoing discussion, the Arbitrator finds Petitioner's alleged period of temporary total disability, from June 21, 2011, up to and including the final day of hearing in this matter, November 23, 2015, for a period of 230, 6/7 weeks payable at the rate of $668.33 to be supported by the record.

In support of the Arbitrator's decision with regard to whether penalties or fees should be imposed upon the Respondent, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

Petitioner requested penalties and fees for failure to authorize the cervical spine surgery recommended by Dr. Bernstein and for stopping TTD payments after the Section 12 examination of Dr Mather indicating that Petitioner was at MMI and did not require any additional treatment for the shoulder injury. Section 19(k) of the Illinois Workers' Compensation Act states that "[i]n cases where there has been any unreasonable or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which do not present a real controversy, but are merely frivolous or for delay, then the Commission may award compensation additional to that otherwise payable under this Act equal to 50% of the amount payable at the time of such award.

Section 19(l) of the Act states that "[i]f the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30.00 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 $10,000.00. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay.

Section 16 of the Act states that "[w]henever the Commission shall find that the employer, his or her agent, service company or insurance carrier has been guilty of delay or unfairness towards an employee in the adjustment, settlement or payment of benefits due such employee within the purview of paragraph (c) of Section 4 of this Act; or has been guilty of unreasonable or vexatious delay, intentional under-payment of compensation benefits, or has engaged in frivolous defenses which do not present a real controversy, within the purview of the provisions of paragraph (k) of Section 19 of this Act, the Commission may assess all or any part of the attorney's fees and costs against such employer and his or her insurance carrier.

The Arbitrator notes that "[s]pecific procedures or treatments that have been prescribed by a medical service provider are 'incurred' within the meaning of section 8(a) even if they have

not been performed or paid for." *Bennett Auto Rebuilders, Inc. v. Industrial Comm'n,* 306 Ill. App. 3d 650, 655-56 (1999). The claimant bears the burden of proving, by a preponderance of the evidence, his or her entitlement to an award of medical care under section 8(a). *Westin Hotel v. Industrial Comm'n,* 372 Ill. App. 3d 527, 546 (2007).

Although Respondent relies on the opinions of Dr. Nicholson and Dr. Mather to deny the surgery recommended by Dr. Bernstein, a conflicting medical opinion does not present an absolute defense to imposition of 19(l) penalties. "The test is not whether there is some conflict in medical opinion. Rather, it is whether the employer's conduct in relying on the medical opinion to contest liability is reasonable under all circumstances presented. *Continental Distributing v. Industrial Comm'n,* 98 Ill.2d 407 (1983). The Arbitrator concludes in this case, in light of the current case law that although misguided it was not unreasonable for Respondent to rely on the opinions of Dr. Nicholson and Dr. Mather.

In this case the medical information was confusing and contradicting at best. In addition to the reports of Dr. Nicholson and Dr. Mather that the cervical issues were not related to the injury sustained in 2010 and that no additional treatment was required for the shoulder, there was also the reports of the treating doctors, Ghanayem, who gave up trying to find out the cause of the continued pain the Petitioner was experiencing and Dr. Bernstein's notations of benign findings, suboptimal test scans and the difficulty to find a test that supported his belief that there were in fact spinal issues causing Petitioner's continuing pain. Dr. Ghanayem and Dr. Nicholson both reported negative tests for radiculopathy. Dr. Ghanayem after examining Petitioner in 2011 found no cervical injury.

However, Dr. Nicholson agreed with Dr. Marra and Dr. Rhode as to Petitioner's condition of ill-being, that he needed continuing treatment for his cervical spine, and that his condition or efforts to obtain MMI were compromised because of the dispute over the cervical issues. They recommended holding off on an FCE until the cervical spine issues were resolved.

The Arbitrator concludes although the actions were misguided, the Respondent acted reasonably and in good faith in denying Petitioner's claim for temporary total disability payments after the Section 12 reports of Dr. Nicholson and Dr. Mather, and refusing to pay for the surgery recommended by Dr. Bernstein. Respondent's reliance on the opinion of Dr. Ghanayem as well as the opinion of Dr. Mather was reasonable and supported by multiple MRI's studies which demonstrated no cervical injury requiring surgery even though all of the doctors, including Respondent's board certified diagnostic radiologist agreed they were of suboptimal quality. Respondent did not act vexatiously and in bad-faith, therefore, Petitioner's claim for penalties and attorneys' fees is denied.

ORDER OF THE ARBITRATOR

Respondent shall pay Petitioner temporary total disability benefits of $668.33 / week for 230 6/7 weeks commencing June 21, 2011 through November 23, 2015, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $108,742.24 for TTD benefits that have already been paid.

Respondent shall pay reasonable and necessary medical expenses in the amount of $136,582.09, subject to the Fee Schedule as promulgated and in existence at the time of this injury, as provided in Section 8(a) and 8.2 of the Act.

Respondent shall authorize and pay for any additional treatment or medical services recommended by Dr. Bernstein to lessen the effects of the injury as well as the surgical intervention to the Petitioner's cervical spine.

Deborah L. Simpson

Signature of Arbitrator

January 29, 2016
Date

17IWCC0245

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHARLES ADELSBERGER,

Petitioner,

17IWCC0236

vs.

NO: 11 WC 20038

STATE OF ILLINOIS/VIENNA
CORRECTION CENTER,

Respondent.

DECISION AND OPINION PURSUANT TO SECTIONS 19(h) AND 8(a)

This cause comes before the Commission on Petitioner's Petition for Review pursuant to §§19(h) and 8(a), filed initially November 9, 2012, amended February 3, 2015 and notice given to all parties. Commissioner Luskin conducted a hearing in this matter on March 25, 2015 at which time counsel for Petitioner and Respondent were present and a record was made. Oral arguments were heard in this matter on January 24, 2017.

Petitioner seeks temporary total disability (TTD) benefits from May 15, 2014 to the date of the hearing, March 25, 2015, a period of 44 6/7 weeks, and prospective medical benefits for Petitioner's left and right knee surgeries.

In reviewing a section 19(h) petition, the evidence presented in the original proceeding must be considered to determine if the petitioner's position has changed materially since the time of the Commission's first decision. *Gay v. Industrial Commission*, 178 Ill.App.3d 129, 132, 532 N.E.2d 1149, 1151 (1989).

After reviewing the record in its entirety and considering the issues including medical expenses, temporary total disability, and prospective medical, and being advised of the facts and law, the Commission finds that that the determination of permanent partial disability is

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premature. The Commission further finds that the Petitioner is entitled to additional temporary total disability compensation and prospective medical expenses as set forth below.

Petitioner is a correctional officer for Respondent. On June 30, 2010, Petitioner sustained injury to his left knee after he was involved in an inmate altercation. Petitioner subsequently underwent a left knee arthroscopic surgery consisting of partial medial and lateral meniscectomies, patellofemoral and medial compartment chondroplasties, and removal of a tibial eminence bone spur on August 16, 2010. (Rx2) On December 2, 2010 his surgeon, Dr. Milne opined that Petitioner was a candidate for a left total knee replacement (TKR). (Rx2) Petitioner was released to return to regular duty work and at maximum medical improvement (MMI) on February 15, 2011 with the Plan stating "He knows he needs to try and delay TKR." Petitioner returned to full-time work for Respondent. Petitioner settled case number 10 WC 29796, for the June 30, 2010 injury, accepting 22.5% loss of use of the left leg for permanent partial disability (PPD) pursuant to §8(e) and closing his rights under §19(h) and §8(a). (Cx2, 6/22/12, Px5)

Petitioner was re-injured on April 30, 2011 when working in the accommodated position in the segregation unit for Respondent. Petitioner was being relieved by his lieutenant. Petitioner turned to lock the door, then turned around to follow his lieutenant, slipped on water and fell. Petitioner testified that his right leg went forward, causing him to go down on his left knee and striking it on the concrete floor. The Petitioner's left knee proved to be significantly symptomatic despite injections, use of an unloader brace, and other conservative care. Dr. Michael Milne, who had observed the Petitioner both before and after the April 30, 2011 accident, explained that a knee replacement is for pain and that is the only reason you do a knee replacement. (CX2). Dr. Milne conceded that Petitioner would have needed a TKR due to his June 30, 2010 injury but opined that Petitioner's need for TKR was likely hastened by the April 30, 2011 accident. (Cx2) Dr. Farley examined Petitioner at Respondent's request pursuant to Section 12. Dr. Farley opined that Petitioner's need for a left TKR had absolutely nothing to do with the April 30, 2011 incident. Dr. Farley felt Petitioner had lost a significant amount of cartilage which left him with "a bone on bone" problem and that would be a very painful condition. (Cx2)

June 22, 2012 Arbitration Hearing

At the Arbitration hearing on June 22, 2012, Petitioner described that prior to the April 30, 2011 accident, his left knee was not perfect; he had knee pain and difficulty going up stairs. After the April 30, 2011 accident, Petitioner described his knee swelling as constant. Petitioner testified that he is in more pain and is uncomfortable, he is having a difficult time sitting still, he has to continually adjust his position, and he is unable to walk long distances. He described increased popping, locking, and stability issues in his knee. He also described losing balance, taking pain medication, and being relatively inactive. (Cx2) The Arbitrator awarded Petitioner 45% loss of the left leg for the second left leg case on July 30, 2012, however, Respondent received credit for the previously received PPD of 22.5% loss of use of the left leg. Applying the credit, Petitioner was awarded an additional 22.5% loss of use of the left leg PPD for the second accident. The Commission (former Panel A composed of Commissioners Lamborn, Tyrrell and Donohoo) reviewed the Arbitrator's award and issued a Decision and Opinion on Review on May 8, 2013, affirming and adopting the Arbitrator's July 30, 2012 award.

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Petitioner subsequently had a second left knee surgery consisting of a high tibial osteotomy to straighten his leg, an anterior cruciate ligament (ACL) reconstruction, partial lateral meniscectomy and chondroplasty of the trochlea and medial femoral condyle on May 15, 2014 performed by Dr. Nathan Mall. (Px7) Dr. Mall planned to also perform an osteochondral allograft transplantation as well as medial meniscus transplantation in the future to give Petitioner improved symptoms and ultimately postponing the left knee TKR. Dr. Mall testified it became apparent after the second surgery that Petitioner was not a candidate for cartilage restoration and that his next step for the left knee was the TKR. As of the date of Dr. Mall's deposition in March 2015 the left knee TKR surgery was scheduled for the following May 15, 2015. (3/11/15, Px3)

March 25, 2015 Commission Hearing on Petitioner's Sections 19(h)/8(a) Petition

Petitioner filed the instant petition under §19(h) and §8(a) and a hearing was held before Commissioner Luskin on March 25, 2015. The following evidence was adduced at that hearing.

Petitioner testified at the §19(h) Commission hearing on March 25, 2015 that following the appeal of the Arbitration Decision, and receipt of the Commission Decision affirming and adopting the Arbitration Decision, he continued to have symptoms in the left knee including pain, swelling, weakness in the knee, the leg giving out, and the knee giving out when walking and standing. (T, p. 8) In late 2013, Petitioner's attorney referred him to Dr. Mall. Petitioner testified that within the last few months his right knee has started popping, swelling, and he had stiffness, cracking in the joint and throbbing, dull pain. Petitioner also testified that he has fallen on his right knee as a result of his left knee giving out. (T, p.13, 15) Petitioner testified that he never had right knee problems prior to the deterioration of his left knee condition. (T, pp. 17, 18)

At Respondent's request pursuant to §12, Dr. Michael Nogalski examined Petitioner and opined that the right knee condition was not causally related to the April 30, 2011 incident because there was nothing in his histories or his medical records which supports that these symptoms in his right knee would be related to physical therapy itself or an altered gait. Dr. Nogalski opined that Petitioner has osteoarthritis and chondral abnormalities in both knees that relates predominantly to genetic issues. (Rx7, p. 12) Dr. Nogalski also testified Petitioner was a candidate for a TKR of his left knee if he so chooses to move forward with that type of an approach to his knee at this point in time. (Rx7, p. 19)

Dr. Mall testified Petitioner is at higher risk of developing knee symptoms on the contralateral side if there are symptoms on one side. (Px10, p. 17) Dr. Mall noted that Petitioner had a right knee full-thickness cartilage defect of the medial femoral condyle, a focal defect about a centimeter wide and a centimeter long with an effusion present on the MRI. (Px10, p. 21) Dr. Mall opined that the Petitioner had an asymptomatic focal cartilage defect that became symptomatic after the Petitioner was on crutches and overloading the right leg. Dr. Mall testified the worsening of Petitioner's left knee overall as a result of his work accidents is what led to his right knee symptoms. Dr. Mall opined because Petitioner was on crutches and having to put all of his weight through the right knee, the right knee is going to see a lot more load than it typically would if he had a normal left knee. Dr. Mall testified that both the 2010 and 2011

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injuries played a role in aggravating the left knee and in the development of pain to the right knee. (Px10, pp. 23-25) Dr. Mall causally related the right knee to Petitioner's April 30, 2011 accident and recommended right knee arthroscopy and debridement of the medial femoral condyle cartilage defect and assessment for future treatment in the right knee should Petitioner have continued complaints. (Px10, pp. 25-28)

The Commission finds Petitioner has proven his condition has destabilized and he requires more treatment as evidenced by Dr. Mall's recommendation for left total knee replacement which was scheduled to proceed on May 15, 2015, one year after the left knee high tibial osteotomy, anterior cruciate ligament (ACL) reconstruction, partial lateral meniscectomy, chondroplasty of the trochlea and medial femoral condyle that was performed on May 15, 2014.

The Commission further finds Dr. Mall testified credibly that Petitioner's right knee condition became symptomatic as a result of his left knee condition and he requires arthroscopic surgery for his right knee.

With regard to Petitioner's claim for additional temporary total disability benefits, the Commission finds Petitioner is entitled to an award of temporary total disability benefits, for the period of May 15, 2014 to the date of the §19(h) hearing on March 25, 2015, a period of 44 6/7 weeks. In so finding, the Commission relies upon *Poore v. Industrial Comm'n*, 298 Ill.App.3d 719, 723-724 (1998), 700 N.E.2d 732, 735 (1998) citing *World Color Press v. Industrial Comm'n*, 249 Ill.App.3d 105 (1993), 619 N.E.2d 159 (1993). In *Poore*, the court disagreed with the employer's argument that claimant must first prove that his permanent partial disability materially increased before he can obtain an additional award of TTD benefits "Rather, all claimant must show is that his disability destabilized and required more treatment or recovery time and that, consequently, he was temporarily and totally disabled." *Id.*

Having carefully reviewed the entire record, the Commission finds that Petitioner established a causal connection exists between his April 30, 2011 accident and his condition of ill-being with respect to his left and right knees. The Commission notes that at the time of the March 25, 2015 hearing on review with respect to the §§ 19(h) and 8(a) Petitions, Petitioner was still under active medical care and the issue of whether Petitioner sustained a material increase in his disability in his left knee is premature.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay the medical expenses attendant to both the left total knee replacement surgery and the right knee arthroscopic surgery pursuant to §8(a) of the Act, and subject to the Medical Fee Schedule under §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $730.75 per week for a period of 44 6/7 weeks, for the period of May 15, 2014 to March 25, 2015.

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

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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: APR 13 2017
KWL/bsd
O-01/24/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

Andrew Gavelys,

Petitioner,

17IWCC0250

vs.

NOS: 11 WC 20416
13 WC 21323

Central Illinois Floor Covering,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical, prospective medical 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 7, 2016, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired

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without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $50,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 21 2017
o4/6/17
DLS/rm
046

Deborah L. Simpson

Deborah L. Simpson

David L. Gore

David L. Gore

Stephen J. Mathis

Stephen J. Mathis

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

17IWCC0250

GAVELYS, ANDREW
Employee/Petitioner

Case# **11WC020416**

13WC021323

CENTRAL ILLINOIS FLOOR COVERING
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:

1465 DOC HALLIDAY AAL
RONALD E HALLIDAY
5901 N PROSPECT RD SUITE 7-A
PEORIA, IL 61602

2593 GANAN & SHAPIRO PC
SARAH E ANTRIM
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

17IWCC0250

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)

ANDREW GAVELYS,
Employee/Petitioner

v.

CENTRAL ILLINOIS FLOOR COVERING,
Employer/Respondent

Case # **11** WC **20416**

Consolidated cases: **13 WC 21323**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Peoria**, on **5/18/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the dates of accident, **9/28/10 and 4/23/12**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On 9/28/10 date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

On 4/23/12 date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

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

Petitioner's current condition of ill-being ***is*** causally related to the accident on 4/23/12.

In the year preceding the injury on 9/28/10, Petitioner earned **$54,829.18**; the average weekly wage was **$1,054.41**.

In the year preceding the injury on 4/23/12, Petitioner earned **$53,477.54**; the average weekly wage was **$1,028.41**.

On 9/28/10, Petitioner was **32** years of age, ***single*** with **0** dependent children.

On 4/23/12, Petitioner was **33** 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 **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00** for other benefits, for a total credit of **$00.00**.

Respondent is entitled to a credit of **$970.22** for the injury on 9/28/10 and **$13,032.63** for the injury on 4/23/12, under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, for all treatment to petitioner's low back from 9/28/10 through 5/18/16, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for all reasonable and necessary medical services to the low back from 9/28/10 through 5/18/16 that have been paid pursuant to the Fee Schedule.

Respondent shall pay all reasonable and necessary medical expenses for the Coflex stabilization and decompression procedures at L3-L4 and L4-L5 as recommended by Dr. Kube, pursuant to 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.

Signature of Arbitrator

6/2/16
Date

ICArbDec19(b)

JUN 7 - 2016

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT: 17IWCC0250

Petitioner, a 32 year old laborer, sustained an accidental injury to his back that arose out of and in the course of his employment by respondent on 9/28/10 (11 WC 20416). Petitioner, a 33 year old laborer, alleges he sustained an accidental injury to his back that arose out of and in the course of his employment by respondent on 4/23/12 (13 WC 21323).

Prior to the injury on 9/28/10 petitioner had been seeing a chiropractor in April of 2010. Petitioner saw Dr. Daniel Joseph 3 times in April 2010, for neck, mid and lower back pain, moderately severe; moderately severe right arm pain and headaches. He rated all pain at 7/10 except for his low back which was 6/10. In May 2010 he was treated 13 times for his neck, mid and low back and headaches. At the end of the month he rated his neck, headache and low back pain at 4/10 and his mid back pain was 3/10. In June of 2010 he treated 9 times for the same body parts. At the end of the month he rated his neck and headache pain at 4/10 and his midback and low back at 4/10. In July 2010 he treated 9 times for the same body parts. At the end of the month he rated his neck, mid back and low back pain at 3/10, and his headaches at 4/10. In August 2010 he treated 6 times for the same body parts. At the end of the month he rated his neck, mid back and low back, and headache pain at 3/10. In September 2010 he treated 5 times for the same body parts. On 9/28/10 he rated his neck, mid back and low back, and headache pain at 3/10. On 9/29/10 he rated his neck, mid back and headache pain at 3/10, and his low back pain at 7/10. In October 2010 he treated 5 times for the same body parts. At the end of the month he rated his neck, mid back and headache pain at a 3/10, and his low back pain at 7/10. In November 2010 he treated 2 times for the same body parts. At the end of the month he rated his neck, mid back and headache pain at a 3/10, and his low back pain at 7/10. In December 2010 he treated 2 times for the same body parts. In January 2011 he treated once. In February, March, April, May, June, and July 2011 he treated 2 times each month. At the end of each month he rated his neck, mid back and headache pain at a 3/10, and his low back pain at 5/10.

Petitioner worked for respondent on 9/28/10 and 4/23/12, and is still working for respondent. Petitioner's duties include demolition of flooring, and laying new flooring. Petitioner demolishes and installs floor tiles, carpet tiles, vinyl and all types of flooring. Petitioner tears up carpet by hand, and vinyl with a tool. He also lays all kinds of flooring. Petitioner spent 70% of the time doing demolition, and 30% of the time laying flooring.

On 9/28/10 while petitioner was lowering a roll of vinyl weighing 350-400 pounds it fell onto his chest and bent him backwards. Petitioner immediately felt a sharp pain shooting down his right leg.

Petitioner immediately reported the accident to his boss Don Sullivan. Petitioner continued working the rest of the day and had intermittent radiating sharp pain down his right leg.

When petitioner got up to go to work on 9/29/10 he noted that his right leg pain was numb. He called his supervisor Sullivan to report the change in symptoms and his need for medical treatment. Sullivan referred petitioner to the secretary to report the injury and get a claim number, etc. After that petitioner called his primary care physician Dr. Baylor, and was given an appointment for 9/30/10.

On 9/30/10 petitioner presented to Dr. Baylor and provided a consistent history of the accident and his complaints. Dr. Baylor ordered an x-ray of petitioner's low back. Dr. Baylor examined petitioner and noted mid-thoracic and lumbar spine pain upon palpation. No sensory deficit was noted. He assessed low back pain. Petitioner followed-up with Dr. Baylor on 10/8/10. Following an examination Dr. Baylor assessed back pain, leg numbness, and questioned whether there might be radiculopathy. He ordered an MRI of the lumbar spine.

On 10/11/10 petitioner underwent an MRI of the lumbar spine. The impression was multilevel degenerative changes in the lumbar spine. These changes included degenerative changes in the facet joints without significant central cord or neural foraminal stenosis at L1-L2, and L2-L3; diffuse bulging disc annulus with posterior facet joint hypertrophy combining to cause bilateral neural foraminal stenosis and anterior effacement of the thecal sac with effacement of the lateral recesses bilaterally at L3-L4; diffuse bulging disc annulus with central disc protrusion and lateral extension bilaterally combined with posterior ligamentous and facet joint hypertrophy to produce moderate central canal stenosis with effacement of the lateral recesses bilaterally, but particularly on the left and with mild effacement of the neural foramina bilaterally at L4-L5; a diffuse bulging disc annulus with a small right paracentral/lateral disc protrusion causing some effacement of the right lateral recess and minimal displacement of the proximal right SI nerve root.

On 11/22/10 petitioner presented to Dr. Jacob Tony for evaluation of his low back pain. Petitioner complained of low back pain with numbness down his leg. Petitioner said he was not taking any medications. Petitioner provided a consistent history of the accident. He rated his pain as constant and a 6/10. Dr. Tony prescribed Neurontin and ordered an EMG of the bilateral lower extremities. He referred petitioner to the Spine Center and for physical therapy.

On 12/1/10 petitioner began a course of physical therapy at Methodist on the referral of Dr. Tony. Petitioner underwent 11 of 16 scheduled treatment sessions between 12/1/10 and 2/8/11. Petitioner's current pain level at that time was a 5/10.

On 12/6/10 petitioner underwent an EMG of the lower extremities. The impression was an abnormal study showing right sural sensory neuropathy. There was no evidence of right lower lumbar or right sacral radiculopathy.

Petitioner underwent a L5-S1 interlaminar epidural steroid injection and a L4-L5 interlaminar epidural steroid injection. Petitioner stated that the relief from the epidural steroid injections lasted for about three days. Petitioner also underwent bilateral L3-L5 medial branch blocks. Petitioner did not have any lasting relief.

On 3/1/11 petitioner presented to Dr. Patrick O'Leary for his work injury. Petitioner provided a consistent history of the accident, and his treatment to date. Petitioner reported pain in his low back and numbness down the outside of both legs. He rated his pain at a 6/10. Dr. O'Leary examined petitioner and reviewed the x-rays, EMG, and MRI of petitioner's back. Dr. O'Leary's impression was lumbar disk disease and possible peripheral neuropathy. Dr. O'Leary was of the opinion that petitioner had a work related injury which is consistent and likely aggravated and exacerbated an underlying condition that is 3-level disk disease. He also noted that petitioner has a component of stenosis, but noted that it is somewhat unclear whether his symptoms in his legs were consistent with stenosis. He did not have a good explanation for his leg pain. He did not recommend a laminectomy, diskectomy, or any type of decompressive procedure. He was of the opinion that a medial branch block would be reasonable. Dr. O'Leary did not feel petitioner was a candidate for any fusion given his age. However, if he continued to have pain he might be a candidate for a diskogram. He released petitioner to full duty work and released him on an as needed basis.

On 3/21/11 petitioner underwent a Section 12 examination performed by Dr. Julie Wehner, at the request of the respondent. Petitioner provided a consistent history of his accident on 9/28/10 and his symptoms. Petitioner complained of pain down his right leg and down the anterior aspect of his left leg to his foot. He also reported right leg coldness and left leg being hot. Petitioner reported that he is better when he is bent over. Petitioner stated that he had been working full duty. Petitioner gave a history of his treatment to date. Dr. Wehner examined petitioner and performed a record review. Dr. Wehner diagnosed low back pain consistent with a sprain and radiologic findings of disk degeneration at L3-L4 and L4-L5 and spinal stenosis at L3-L4 and L4-L5. She was of the opinion that these findings were a pre-

existing condition and were not caused by the injury on 9/28/10. She was also of the opinion that petitioner's treatment to date has been reasonable and necessary and his subjective findings correlated well. She agreed that it appeared that petitioner had some type of back problems prior to this date of injury and had been treating with a chiropractor on a regular basis prior to the injury. She was of the opinion that there was no expectation that facet joint injections would significantly alleviate his pain for any prolonged period of time. Dr. Wehner was of the opinion that based on the extent of his degenerative changes, she would not recommend the medial branch blocks of the radiofrequency lesion. She believed petitioner's progress was fair. She was of the opinion that the long term outlook for petitioner being able to do a job such as his for the next 20-30 years given his extent of disk degeneration was poor. Dr. Wehner was of the opinion that petitioner sustained a temporary exacerbation of his preexisting condition and could return to full duty work. She was also of the opinion that he had reached maximum medical improvement, and any further treatment was related to his pre-existing problems and not related to the injury on 9/28/10. Dr. Wehner wanted to see the records of Dr. Joseph.

Petitioner testified that in March of 2011 and thereafter he still had numbness, tingling and low back pain. He also testified that he had hot and cold feelings in his legs. Petitioner reported that it was hard to stand straight up due to back pain, could not walk long distances, and used handrails on the stairs because of the numbness in his legs. Petitioner testified that his boss Sullivan altered his work duties and his demolition work dropped to 30-40% of his work, instead of 70%. He testified that an apprentice took up the slack. Petitioner testified that these symptoms continued and got a little worse until the incident on 4/23/12.

On 4/23/12 petitioner was taking some carpet up off the floor with his hands. He testified that while he was bent over and pulling the carpet up off the floor with great force because it was glued down, he felt a pop and pain in his back. Petitioner reported this injury that day. Petitioner testified it was the worst pain he had ever had in his back, but the leg numbness was about the same. An accident report was generated by Louis Lykins.

That same day petitioner presented to St. Mary Medical Center. Petitioner reported a recurrent problem. He stated that the problem occurs constantly, and had been getting gradually worse. He associated the pain that day with pulling up a carpet. He complained of pain in the lumbar spine that was aching. He reported that the pain radiates to the left thigh, left foot, left knee, right thigh, right knee and right foot. He rated his pain as moderate, and aggravated by bending, twisting and certain positions. He stated that the pain is the same all the time. He also reported stiffness, leg pain, paresthesias and tingling.

Petitioner reported that it does not hurt for him to bend over, but does hurt to come back up. Petitioner reported that one leg was hot and one leg was cold. X-rays of the lumbar spine were taken that noted disc space narrowing at L3-L4 and L4-5, and anterior osteophytes at these levels, most pronounced at L3-L4. No acute osseous abnormality was seen. His vertebral heights and alignment were maintained. Petitioner was given medications and diagnosed with back pain and injury. He was told to follow-up with Occupational Medicine.

Over the next year petitioner's legs got a little weaker, but his back pain remained the same. Petitioner testified that he could not seek treatment during this time because respondent had denied his claim. Petitioner's insurance also denied him treatment because of his pending work comp claim. Petitioner continued to work without any further treatment until he was referred to Dr. Kube by his attorney.

On 6/25/13 petitioner presented to Dr. Kube for evaluation and second opinion. He wanted to know what other options besides a 3 level fusion were available. Petitioner gave a consistent history of the injury on 9/28/10. He reported that he hyperextended his back and had immediate shooting pain down his right leg and it had continued since. He then reported that he had a second injury when he tried to bend over and pick up an object, and had a pop in his back, and his back became slightly worse, and his legs continued to be about the same. Petitioner reported that he continued to have right and left leg pain, right slightly worse than left. Petitioner reported that he had epidurals and rehab without lasting or complete relief. Dr. Kube examined petitioner and assessed sacroilitis, low back pain, and probably aggravated degenerative disease. Dr. Kube wanted to rule out sacroiliac joints so he ordered injections.

On 6/25/13 petitioner presented to Dr. Cummings on the referral of Dr. Kube, for discussion regarding a sacroiliac joint injection. Dr. Cummings examined petitioner and noted that petitioner had had epidurals in the past which did not provide any relief. Dr. Cummings ordered sacroiliac joint injections and performed a trigger point injection. On 7/5/10 petitioner reported that the trigger point injection did not help.

On 7/10/13 petitioner underwent a left and right sacroiliac joint injection, and arthrogram of the left and right sacroiliac joint performed by Dr. Cummings. Petitioner reported that these injections did not do anything for him.

On 8/22/13 petitioner followed-up with Dr. Kube. Since the sacroiliac joint injections did not help Dr. Kube believed petitioner had a lumbar issue. He wanted to avoid the 3-level fusion that Dr. O'Leary mentioned. Dr. Kube ordered an EMG.

On 9/5/13 petitioner presented to Dr. Trudeau for an EMG of his lower extremities. Petitioner gave a history of his accident on 9/28/10 and reported that he had severe low back and bilateral lower extremity pain and paresthesias, weakness, pain and paresthesias in both lower extremities, right greater than left. He reported that the longer he walks the more his legs have a tendency to give out. He complained of more pain and paresthesias in the anterior aspect of either thigh and calf, and down to either foot with tingling and numbness. The results of the EMG were bilateral L4 radiculopathies, moderately severe on either side, right greater than left, consistent with the assessment of Dr. Kube. No other positive findings were noted.

On 9/17/13 petitioner returned to Dr. Kube. Dr. Kube recommended a provocative discogram, L2-S1 to determine if the disks are or are not the distinct pain generators.

On 9/30/13 petitioner underwent a provocative discogram from L2-S1 and radiographic interpretation of L2-S1 discogram. The discogram was negative at all levels. On 10/1/13 Dr. Kube was of the opinion that petitioner had facet arthropathy, radiculopathy, and pain. He was of the opinion that at a minimum petitioner would be looking at L4 decompressions bilaterally because of his lateral recess stenosis at L3-L4 in addition to the severe foraminal stenosis at L4-L5. Dr. Kube recommended diagnostic facet injections from L3-L5. Dr. Kube noted that he was inclined to attempt doing a dynamic stabilization procedure, namely Coflex procedure. He was of the opinion that if they could identify a specific facet area for him, this procedure tends to be fairly beneficial in helping alleviate the discomfort and help stabilize the pain. It also avoids a fusion.

On 10/24/13 petitioner underwent bilateral L3-L4 and bilateral L4-L5 facet joint injections performed by Dr. Kube. On 10/31/13 petitioner followed-up with Dr. Kube. Petitioner reported very little, if any, relief of his pain after the blocks were performed. Dr. Kube ruled out the L3-L4 and L4-L5 facets as pain generators. Petitioner stated he could live with the back pain but not the radiating leg pain, numbness and tingling. Dr. Kube noted significant foraminal stenosis at L4-L5. Dr. Kube ordered a CT myelogram.

On 11/22/13 petitioner underwent a myelogram of the lumbar spine. The impression was central and lateral recess spinal stenosis at L3-L4 and L4-L5 greater than L5-S1 where the changes were minor.

Also noted were numerous nerve root cutoffs. The CT lumbar spine myelogram impression was congenitally small spinal canal L2 downward with degenerative changes causing central and lateral recess spinal stenosis, and multiple nerve root cutoffs at least partly due to degenerative facet and disc changes.

On 12/10/13 petitioner returned to Dr. Kube. Dr. Kube was of the opinion that petitioner's leg symptoms could be improved with decompression at L3-L4 and L4-L5 levels. With the discogram negative he did not recommend a fusion. He believed stabilization of these degenerative disks probably could be helpful. Dr. Kube was of the opinion that he would look to perform a dynamic stabilization device if he was going to do a decompression in this way to be able to stabilize petitioner at these levels and increase the odds of improving his back pain at least 50/50. Dr. Kube noted that petitioner is a relatively young man and is out of options.

On 11/7/14 the evidence deposition of Dr. Robert Kube was taken on behalf of petitioner. Dr. Kube was of the opinion that the results for a three level fusion aren't always great, and he would not recommend it for a young individual. Dr. Kube was of the opinion that pain was not coming from any of the discs, and was either facet based, muscular or something like that. Dr. Kube wanted to stabilize the spine, but avoid a fusion, based on the discogram. Dr. Kube wanted to decompress L3-L4 and L4-L5. Dr. Kube did not want to do a fusion because of petitioner's age. He opined that another procedure to stabilize the spine and allow motion to occur would be better than a fusion. It would allow him to address the back pain without fusing and also stabilized where he took the pressure off the nerve roots. Dr. Kube opined that by doing a fusion you are starting a cascade of events involving adjacent discs over time, which is more problematic the younger the patient is. Dr. Kube opined that stabilizing the arthritic discs at L3-L4 and L4-L5, using the Coflex device and decompression, rather than fusing them would provide more motion, faster recovery and less back pain. Dr. Kube opined that this procedure would take the pressure off the nerve roots, and that would help relieve his leg pain, and give petitioner an opportunity to improve his back pain. He believed this procedure could take care of nearly 75% (1/2 of back pain and all leg pain) of petitioner's problems. Dr. Kube opined that the reoperation rate on the stabilization device is way lower than for the fusion.

Dr. Kube opined that the injury on 9/28/10 and later treatment could have aggravated a preexisting condition, causing the need for medical treatment and the continued problems he has today. He further opined that the bending over and attempting to pull up carpet that had been glued to the floor on 4/23/12 could have further caused an aggravation of his preexisting conditions and caused the need for the medical treatment he was recommending. Dr. Kube opined that his treatment to date has been reasonable

and necessary, and the proposed surgery is also reasonable and necessary. On cross-examination, Dr. Kube opined that petitioner has significant stenosis at L4-L5.

On 1/13/14 petitioner underwent another Section 12 examination performed by Dr. Wehner at the request of the respondent. Petitioner provided a history of his injury on 4/23/12, and his subsequent treatment. Following an examination and record review Dr. Wehner diagnosed petitioner with chronic back pain. Dr. Wehner believed petitioner's injury when he was picking up a piece of carpet tile was the same mechanism used in daily life to pick up objects off the floor at home or to bend over and tie one's shoes. She was of the opinion that this incident was a manifestation of his preexisting back problems and did not constitute a new injury. Dr. Wehner believed SI joint injections, facet injections, and trigger point injections have no medical efficacy in chronic low back pain due to degenerative changes. She also believed the second EMG was not medically necessary for the injury dates. She recommended a self home exercise program aimed at core stabilization, and instructed petitioner to avoid smoking. Dr. Wehner believed petitioner's stenosis was mild to moderate and had a degenerative process, and had not reached the point where surgical intervention would significantly improve his complaints. She did not relate the numbness and pain running down the front legs to the L3-L4 and L4-L5 stenosis complaints and that was another reason why decompression would most likely not alleviate enough of his complaints to make it worthwhile. She also believed a 2 level fusion at L3-L4 and L4-L5 would not improve his complaints substantially, and he would not be able to return to his regular duty job. With respect to the dynamic stabilization procedure she believed there was a theoretical advantage of maintaining some motion at the fused sites and therefore avoiding adjacent level degeneration, but was of the opinion there were no long term studies with regard to this procedure. Dr. Wehner believed the decompression and dynamic stabilization procedure would have a poor prognosis for alleviating a significant portion of petitioner's present pain complaints. She also believed that even Dr. Kube felt it was a 50/50 chance petitioner would improve with these procedures. She again reiterated that petitioner had reached maximum medical improvement as a result of his injury on 9/28/10, and for any aggravation from this injury. She recommended petitioner should seek a different type of employment in the future because his chronic underlying back condition and chronic pain complaints will make it difficult for him to continue this type of work.

On 2/27/15 the evidence deposition of Dr. Wehner, an orthopedic surgeon, was taken behalf of the respondent. Petitioner's attorney was not present. She testified that 25-30% of her practice is IME's with almost all being for respondents. Dr. Wehner was of the opinion that dynamic stabilization is trying to

mobilize the disk partly, and that does not make sense because that would still leave motion of the disk and that would still create pain. She was of the opinion that this device is put between the spinous process, and it is anchored into the facet joints, and the patient would still have movement there. She was also of the opinion that the kind of dynamic stabilization Dr. Kube is talking about is a very nontraditional type of idea, and does not have long term documented studies or prospective studies of good results. She said the very idea of this in a 32 year old male does not make sense. She was of the opinion that since petitioner is still working and not using a lot of pain medication, not operating is in his best interest. She also noted that she would not operate on a person with only a 50/50 chance of improving their back pain when it puts them at risk for multiple future surgeries.

Currently, petitioner experiences leg weakness, tingling and numbness. He reports pins and needles feeling in his thighs, and his back pain feels like it is bulging out. Petitioner stated that he has to hold on to the railing when going down stairs. He stated that his legs go numb while walking and he has a hard time standing up. Petitioner also reported a hot or cold feeling in his legs every day. Petitioner no longer runs, jumps, golfs, plays softball, or rides mountain bikes. Petitioner continues to do his regular duty job without restrictions.

Petitioner testified that he wants the surgery recommended by Dr. Kube.

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

Respondent only disputes accident as it relates to the alleged injury on 4/23/12. The respondent bases this opinion on the findings of Dr. Wehner. Petitioner provided a consistent history of his accident on 4/23/12, which was that while he was bent over and pulling up carpet off the floor with great force because it was glued down, he experienced the worse pain he had ever had in his back. Petitioner sought treatment for this injury the same date. Despite this history Dr. Wehner believed that petitioner's alleged injury when he was picking up a piece of carpet tile was the same mechanism used in daily life to pick up objects off the floor at home or to bend over and tie one's shoes.

Based on the above, as well as the credible evidence, the arbitrator finds the act of pulling up carpet that was glued to the floor with great force is not analagous to someone just bending down to pick up something off the floor or bending down to tie one's shoes. The arbitrator finds the origin of the force petitioner needed to pull up the carpet with his hands that was glued down is in a risk connected with or incidental to the employment petitioner has with respondent, and is an activity that places the petitioner at an increased risk to which he was subject to as compared to the general public. For these reasons the

arbitrator finds the petitioner has proven by a preponderance of the credible evidence that he sustained an accidental injury to his low back that arose out of and in the course of his employment by respondent on 4/23/12.

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

Petitioner claims his current condition of ill-being as it relates to his causally related to the injuries he sustained on 9/28/10 and 4/23/12. Respondent claims petitioner's current condition of ill-being as it relates to his low back is not causally related to the injuries he sustained on 9/28/10 and 4/23/12, but rather to his preexisting lumbar spine condition for which was treating before the injury on 9/28/10.

The arbitrator notes that it is unrebutted that prior to 9/28/10 petitioner underwent chiropractic treatment for his neck, mid and low back, and headaches from April through 9/27/10. During this period petitioner's low back complaints improved from a 6/10 to a 3/10 by July 2010 and remained at that level through 9/27/10.

Following the injury on 9/28/10 petitioner immediately felt a sharp pain shooting down his right leg. On 9/29/10 when he developed numbness in his right leg, respondent set him up for an appointment on 9/30/10. On that day petitioner had mid and low back pain in addition to his right leg pain and was assessed with low back pain, and leg pain and numbness that may represent radiculopathy. The arbitrator finds the chiropractic records prior to 9/28/10 do not reflect any radiculopathy.

Thereafter petitioner underwent an MRI of the lumbar spine. On 11/22/10 he rated his low back pain at a 6/10 and continued to complain of right leg pain. An EMG of the lower extremities revealed right sural sensory neuropathy. Petitioner underwent epidural steroid injections with no lasting relief. The arbitrator notes there is no credible medical evidence to support a finding that petitioner had any neurological findings or injections related to his low back prior to 9/28/10.

Petitioner was evaluated by Dr. O'Leary on 3/1/11 and opined that petitioner sustained a work injury that likely aggravated and exacerbated an underlying condition that is a 3 level disk disease. Dr. O'Leary recommended medial branch block injections. He also released petitioner to full duty work.

On 3/21/11 Dr. Wehner examined petitioner. She diagnosed low back pain consistent with a sprain and radiologic findings of disk degeneration at L3-L4 and spinal stenosis at L3-L4 and L4-L5. She opined that these findings were a preexisting condition and were not caused by the injury on 9/28/10. Dr. Wehner opined that petitioner only sustained a temporary exacerbation of his preexisting condition.

Despite Dr. Wehner's opinion petitioner continued to complain of numbness, tingling and low back pain. He also noted that his boss altered his work duties and reduced his demolition from 70% to 30-40%.

Based on the above, as well as the credible evidence, the arbitrator finds petitioner's current condition of ill-being as it relates to his low back is causally related to the injury on 9/28/10 through 4/22/12. The arbitrator bases this finding on the fact that petitioner had low back pain of 3/10 on the date before the injury and no radicular symptoms. However, immediately after the injury petitioner's low back pain increased and he developed radicular symptoms, that were not present before the injury on 9/28/10. For these complaints petitioner underwent conservative treatment that included epidural steroid injections that did not provide any lasting improvement. Additionally, as of 4/22/12 petitioner was still treating for his increased low back pain and was prescribed additional injections. For these reasons the arbitrator finds Dr. Wehner's opinion that petitioner sustained only a temporary aggravation of his preexisting low back condition not supported by the credible record, and without merit.

On 4/23/12 petitioner then sustained a second work injury. Following this injury petitioner had the worst low back pain he had ever had. Over the next year petitioner's legs got a little weaker, but he could not treat because worker's compensation declined it and his primary insurer would not pay because they claimed the treatment was related to a work injury.

Petitioner began treating again with Dr. Kube on 6/25/13. Dr. Kube looked for other alternatives to a 3 level fusion which he felt was not appropriate. Petitioner's complaints continued and he reported that he had injections and rehab without any lasting results. Petitioner has continued to treat with Dr. Kube and Dr. Kube performed multiple diagnostic tests to determine the pain generator. He ultimately decided, based on the results of the tests that petitioner's leg symptoms could be improved with a decompression at L3-L4 and L4-L5. Petitioner's condition has not changed.

Based on the above, as well as the credible evidence the arbitrator finds the as a result of the injury on 4/23/12 petitioner's symptomatology worsened and alternative methods for treating this pain were explored, and petitioner awaits of approval of the procedure recommended by Dr. Kube. For these reasons the arbitrator finds the petitioner's current condition of ill-being as it relates to his low back is causally related to the injury on 4/23/12 since after that date his symptomatology worsened.

J. WERE 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 the petitioner sustained accidental injuries to his low back on 9/28/10 and 4/23/12, and his current condition of ill-being as it relates to his low back condition before 4/23/12 is causally related to the accident on 9/28/10, and his current condition of ill-being as it relates to his low back is causally related to the injury on 4/23/12, the arbitrator finds all treatment petitioner received for his low back from 9/28/10 to 5/18/16 was reasonable and necessary to cure or relieve petitioner from the effects of his injuries on 9/28/10 and 4/23/12.

Respondent shall pay all reasonable and necessary medical expenses as it relates to petitioner's low back from 9/28/10 to 5/18/16, pursuant to Sections 8(a) and 8.2 of the Act.

K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

Petitioner claims he is entitled to the decompression at L3-L4 and L4-L5 is reasonable and necessary to cure or relieve petitioner from the effects of his injury. Respondent claims the procedure is not reasonable or necessary and relies on the opinions of Dr. Wehner.

Petitioner was 32/33 years old when he sustained his injuries. After the first injury Dr. O'Leary recommended a 3 level fusion. If petitioner was to undergo this procedure he would not be able to return to his regular duty job.

After the second injury petitioner eventually sought treatment from Dr. Kube, in an attempt to evaluate other forms of treatment that would not prevent him from returning to his regular duty job for respondent. Dr. Kube was of the opinion that the results of a three level fusion are not always good, and he would not recommend it for a young individual like petitioner.

Dr. Kube had petitioner undergo a multitude of diagnostic tests and procedures to rule out different causes. These procedures included sacroiliac joint injections, EMG of the lower extremities, provocative discogram L2-S1, bilateral facet joint injections at L3-L4 and L4-L5, and myelogram and CT myelogram of the lumbar spine. After reviewing the results of all these procedures Dr. Kube was of the opinion that petitioner's leg symptoms could be improved with decompression at L3-L4 and L4-L5. He believed stabilization of these degenerative disks probably could be helpful. Dr. Kube recommended a dynamic stabilization device if he was going to do a decompression in this way to be able to stabilize petitioner at these levels and increase the odds of improving his back/leg pain 75%. He opined that this procedure would stabilize the spine and allow motion to occur and that would be better than a fusion. It opined that the procedure would take the pressure off the nerve roots, which would help relieve his leg pain, and give petitioner an opportunity to improve his back pain without fusing. He stated that he would use the Coflex

device and decompression. He further opined that the reoperation rate in the stabilization device is way lower than for the fusion.

Dr. Wehner did not believe surgical intervention would help petitioner's complaints. She believed the procedures Dr. Kube did had no medical efficacy in chronic low back pain. The arbitrator notes that Dr. Kube used these procedures primarily to narrow down where petitioner's pain was coming from. She believed a decompression would most likely not alleviate enough of his complaints to make it worthwhile. However, Dr. Kube is also using the Coflex device for stabilization along with the decompression. Dr. Wehner was against the Coflex device not because there was theoretical advantage of maintaining some motion at the fused sites and therefore avoiding adjacent level degeneration, but because she did not believe there were long enough studies with respect to this procedure. She believed the prognosis for alleviating a significant portion of petitioner's present pain complaints with these procedures was poor. His recommendation was that petitioner find a different type of employment.

Based on the above, as well as the credible evidence, the arbitrator finds the opinions of Dr. Kube more persuasive than those of Dr. Wehner. The arbitrator finds Dr. Kube has taken a very methodical approach in determining the best procedure for petitioner given his age, and desire to return to his full duty job, given his very young. The arbitrator finds Dr. Wehner offered petitioner nothing more than a recommendation that he find alternative employment. For these reasons the arbitrator finds the respondent shall pay all reasonable and necessary medical expenses for the Coflex stabilization and decompression procedures at L3-L4 and L4-L5 as recommended by Dr. Kube, pursuant to Sections 8(a) and 8.2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WINNEBAGO

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cindy Tipton,
Petitioner,

vs. NO: 11 WC 30262

17IWCC0228

Paradise Homes and the Illinois State Treasurer,
Ex Officio Custodian of IWBF,
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 sole issue of nature and extent of Petitioner's permanent partial disability and being advised of the facts and law, affirms the Decision of the Arbitrator, which is attached hereto and made a part hereof.

In so affirming, the Commission does modify one aspect of the Arbitrator's decision. On page 5 of the rider, in Section L, the Arbitrator notes "As it was not a 100% loss, petitioner is not entitled to the statutory minimum rate of $466.13, but rather $150.00 per week." While the Arbitrator is correct in that the petitioner's PPD rate would be $150.00 per week, the Commission deletes this sentence as inconsistent with the Appellate Court's ruling in *Modern Drop Forge Corporation v. The Industrial Commission*, 284 Ill.App.3d 259, 671 N.E.2d 753 (1st Dist. 1996). All other findings and awards of the Arbitrator are affirmed and adopted.

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 Section 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.

17IWCC0228

IT IS THEREFORE ORDERED BY THE COMMISSION that, other than as stated above, the Decision of the Arbitrator filed February 19, 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 $4,900.00.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: APR 13 2017

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

o-04/05/17
jdl-jl
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TIPTON, CINDY
Employee/Petitioner

Case# **11WC030262**

PARADISE HOMES AND THE ILLINOIS STATE TREASURER EX OFFICIO CUSTODIAN OF IWBF
Employer/Respondent

17IWCC0228

On 2/19/2016, 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:

2489 BLACK AND JONES LAW
JASON ESMOND
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ROCKFORD, IL 61101

0000 PARADISE HOMES
3925 W MAIN ST
MC HENRY, IL 60050

4987 ASSISTANT ATTORNEY GENERAL
LAURA HARTIN
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

17IWCC0228

STATE OF ILLINOIS)
) SS
COUNTY OF WINNEBAGO)

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

Cindy Tipton
Employee/Petitioner
v.

Case # 11 WC 30262

Paradise Homes and the Illinois State Treasurer, Ex Officio Custodian of IWBF
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 M. Ory**, Arbitrator of the Commission, in the city of **Rockford**, on **November 19, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. 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. X What was Petitioner's age at the time of the accident?
I. X 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 X TTD
L. X What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. X Other **Insurance Compliance**

FINDINGS

On **October 24, 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 **$7,800.00;** the average weekly wage was **$150.00.**

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

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

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

To date, Respondent has paid **$ 0** in TTD and/or for maintenance benefits, and is entitled to a credit for any and all amounts paid.

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

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

ORDER

Medical
Respondent shall pay the bills from OSF St. Anthony Medical Center totaling **1,956.00,** subject to the fee schedule and pursuant to §8 and §8.2.

Permanent Disability
Respondent shall pay Petitioner the sum of **$150.00**/week for a period of **19** weeks, as provided in Section **8 (e) 3** of the Act, because the injuries sustained caused **50 % loss of use of the right middle finger.**

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

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

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

Christine Moy

02/19/2016

Signature of Arbitrator | Date

ICArbDec p. 3

FEB 19 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cindy Tipton	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 11 WC 30262**
	)	
Paradise Homes and the Illinois State Treasurer, as Ex Officio Custodian of the Illinois Injured Workers' Benefit Fund,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing on November 19, 2015 in Rockford, Illinois. Petitioner provided notice of the hearing date to Respondent, Paradise Homes, by certified mail. (PX. 4). No representative for the respondent was present despite being provided proper notice of the proceedings. As Respondent did not have workers' compensation insurance coverage, the Illinois Attorney General's Office appeared on behalf of the Illinois State Treasurer, as ex-officio custodian of the Injured Workers' Benefit Fund. (PX. 3).

At issue in this hearing is as follows:

A. Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. Was there an employee-employer relationship?
C. Did an accident occur that arose out of and in the course of petitioner's employment by Respondent?
D. What was the date of 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 series that were provided to petitioner reasonable and necessary? Has respondent paid all appropriate charges for all reasonable and necessary medical services?
L. What is the nature and extent of injury?
O. Other-Insurance Compliance

STATEMENT OF FACTS

Petitioner testified she was born on August 29, 1958; was married and had no dependents at the time of the claimed accident on October 24, 2010. She had been hired by Dianna Akers, respondent's owner, as a property manager two years before the accident. As property manager, petitioner mowed lawns, removed and installed carpeting, painted houses/apartments, ran power saws to cut baseboards, put up wall paper, changed toilets, and removed and replaced fixtures.

Petitioner introduced a letter dated September 8, 2010, authored by Dianna Akers identifying herself as owner of Paradise Homes Rentals and copied petitioner as manager (PX.5). Petitioner also introduced a Landlord's Five Days' Notice dated September 15, 2010 identifying Dianna Akers as landlord and petitioner as [respondent's] agent (PX.6).

Petitioner worked approximately 80 hours per week for which she was paid $650 per month for her rent. She was not paid hourly. She had worked for a year before the accident and paid nothing for rent. Petitioner introduced a letter dated June 15, 2011, authored by Dianna Drury Akers identified as Owner of respondent stating petitioner was paid $650 a month in rent in exchange for work she performs for respondent; which included maintenance duties, yard work, inspections, etc. (PX.7).

Petitioner testified that on October 24, 2010, she was working on 8th street, cleaning out an apartment for respondent. She was removing a marble slab when it fell on her right middle finger. She called Dianna Akers on the way to the hospital. Akers told petitioner to say she was hurt at home as Akers did not have workers' compensation insurance. At the direction of Akers, petitioner told the emergency room personnel that she dropped a potato drawer on her finger, even though petitioner did not know what a potato drawer was.

She received treatment at Rockford Memorial Hospital. X-ray showed an indentation of the tip, but the bone itself was intact. Diagnosis was acute traumatic right middle fingertip amputation. Pain medication and antibiotic was prescribed. Petitioner was referred to orthopedic surgeon, Dr. Kenneth Korcek, for follow up. (PX.8, p.89)

She returned to Rockford Memorial Hospital on October 26, 2010 where she was seen by Dr. Korcek. Dr. Korcek reviewed the X-ray and noted petitioner suffered a tuft fracture. He recommended debridement or possible distal phalangeal shortening. (PX. 8, pp. 20-22 & 76).

Dr. Korcek performed surgical distal phalangeal shortening with treatment of open fracture without manipulation on October 29, 2010 (PX.8, pp.26-30). Petitioner received follow up treatment by Dr. Korcek at Rockford Memorial on November 9, 2010 November 30, 2010 and December 14, 2010 (PX.8). She received physical therapy at OSF ST. Anthony Hospital (PX.9). Petitioner testified that she had been discharged from care on December 21, 2010.

She was off approximately one week, but her rent was continued so she did not lose any wages. She returned to her regular job and worked until the end of July, 2011, when she was terminated.

Petitioner testified that she does not have any real pain in the finger, only residual hypersensitivity to hot and cold in her finger. She is right-handed. She has problems picking up things. Cold weather makes her whole hand throb.

CONCLUSIONS OF LAW

A. In support of the Arbitrator's decision with regard to whether Petitioner and Respondent were operating under and subject to the Illinois Workers Compensation or Occupational Diseases Act, the Arbitrator makes the following conclusions of law:

Pursuant to §3(1), as petitioner's job requited her to maintain, remodel and alter structures in behalf of respondent; and pursuant to §3(8), as petitioner's job required to operate power tools, which included power saws; as well as pursuant to §3(15) wherein petitioner operated mowers, there is automatic coverage under the Illinois Workers' Compensation Act.

B. In support of the Arbitrator's decision as to whether there is a relationship one of employee and employer, the Arbitrator makes the following conclusions of law:

Petitioner testified, without rebuttal, that she was hired by respondent the year before the accident as property manager. She worked 80 hours a week performing work as a property manager, which included mowing lawns, removing and installing carpeting, painting, installing baseboards, wallpapering, changing toilets and removing and replacing fixtures. Petitioner received rent as payment of her work for respondent. The June 15, 2011 letter from respondent owner, Dianna Akers, identifying petitioner as working for respondent in return for $650 per month in rent.

Based upon the foregoing, the Arbitrator finds petitioner was an employee of respondent.

C. In support of the Arbitrator's decision with regard to whether Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent, the Arbitrator makes the following conclusions of law:

Petitioner testified, without rebuttal, that she injured her right middle finger when performing her job as property manager. Petitioner testified she dropped a marble slab on her right middle finger while working at respondent's property, at the direction of respondent. Although the emergency room record indicates petitioner dropped a potato box on her finger, she stated this only said at the direction of respondent's owner as respondent admitted to petitioner she did not have workers' compensation insurance.

For these reasons, the Arbitrator finds petitioner sustained accidental injuries to her right middle finger as a result of an accident which arose out of and in the course of her employment with respondent on October 24, 2010.

D. In support of the Arbitrator's decision as to the date of accident, the Arbitrator makes the following conclusions of law:

Petitioner originally filed the Application for Adjustment of Claim alleging a date of accident of October 28, 2010. At the time of hearing, petitioner moved to amend Application for Adjustment of Claim to reflect a date of accident of October 24, 2010. This date of accident conforms with the testimony of petitioner and the medical evidence. The Arbitrator therefore finds petitioner's date of accident was October 24, 2010.

E. In support of the Arbitrator's decision with regard to whether Petitioner gave the Respondent notice of the accident within the time limits stated in the Act, the Arbitrator makes the following conclusions of law:

Petitioner testified, without rebuttal, that she called respondent owner immediately after the accident on the way to the hospital to report the accident. This is sufficient proof that petitioner provided notice of the accident within the time limit in accordance with the Act.

F. In support of the Arbitrator's decision with regard to whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions of law:

Petitioner's testimony and the medical records support a finding that petitioner's injury to her right middle finger was caused by the work accident of October 24, 2010.

G. In support of the Arbitrator's decision with regard to what the Petitioner's earnings were in the year preceding the Accident and what the Petitioner's average weekly wage was calculated pursuant to Section 10 of the Act, the Arbitrator finds as follows:

Petitioner's testimony that she been paid $650 in rent by respondent during the year pre-dating the accident as payment for work performed for respondent is supported by the June 15, 2011 letter from respondent's owner. Therefore, the Arbitrator finds petitioner's average weekly wage pursuant to the provisions of §10, is $150.00.

H. In support of the Arbitrator's decision with regard to what the Petitioner's age, the Arbitrator finds the following:

Petitioner testified her date of birth is August 29, 1958. This is the same date of birth listed on her medical records. Therefore, petitioner was age 52 at the time of the work accident.

I. In support of the Arbitrator's decision with regard to Petitioner's marital status at the time of injury, the Arbitrator finds the following:

Petitioner testified that she was married with no dependents. This is sufficient evidence to find petitioner was married with no dependents at the time of the accident.

J. In support of the Arbitrator findings as to whether the medical services that were provide to Petitioner reasonable and necessary, and whether Respondent paid all appropriate charges for all reasonable and necessary, the Arbitrator makes the following:

Petitioner's testimony, as supported by the medical records from Rockford Memorial Hospital, which included treatment by orthopedic surgeon, Dr. Kenneth Korcek, and OSF St. Anthony Hospital, supports a finding that the treatment was necessary due to the injury petitioner sustained to her right middle finger in the work accident of October 24, 2010. No evidence was introduced to contest the reasonableness or necessity of said treatment.

Therefore, the Arbitrator awards the outstanding medical bills, pursuant to the fee schedule, the outstanding bills from OSF, St. Anthony, totaling $1,956.00.

L. In support of the Arbitrator's decision with regard to the nature and extent of Petitioner's injury, the Arbitrator finds the following:

The medical evidence supports a finding that petitioner sustained an injury to her right middle finger which resulted in surgical amputation of the tip of the distal phalanx including a portion of the tuft. Petitioner's finger remains hypersensitive to hot and cold. Based upon the foregoing, the Arbitrator finds petitioner sustained a statutory 50% loss of the right middle finger. As it was not a 100% loss, petitioner is not entitled to the statutory minimum rate of $466.13, but rather $150.00 per week.

O. In support of the Arbitrator's decision with regard to the question of Insurance compliance and automatic coverage, the Arbitrator makes the following conclusions of law:

Based upon the testimony of the petitioner that respondent's owner, Dianna Akers, admitted respondent did not have workers' compensation insurance and the Certification of Lain Hines, an employee of NCCI Holdings, that no policy was found for respondent, the Arbitrator finds respondent did not have workers' compensation insurance to cover petitioner's work injury that was caused by the work accident of October 24, 2010, that arose out of and in the course of petitioner's employment with respondent.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jack Lingenfelter,
Petitioner,

vs.

NO: 11 WC 30578

17IWCC0258

Cloverleaf Golf Course, Inc.,
Respondent.

DECISION AND OPINION ON REMAND

Petitioner appealed the Decision of Arbitrator Lindsay finding that Petitioner failed to prove an employer/employee relationship existed between Petitioner and Respondent and Petitioner further failed to prove Petitioner sustained an accidental injury arising out of and in the course of his employment on June 26, 2011. Lastly, the Arbitrator found that Respondent was not entitled to a "no show" credit for Dr. Pernound's scheduled visit. Petitioner appealed the Arbitrator's decision to the Commission. On May 20, 2015, the Commission issued a decision in which it affirmed the Arbitrator's decision. The Commission found that there was no employer/employee relationship. The Commission also found that there was no concurrent employment and lastly noted that they would defer to the Arbitrator's holding that Petitioner was not credible. Petitioner appealed the decision to the Circuit Court. On November 17, 2015, Justice Barber of the Third Judicial Circuit Court reversed the Commission and held that an employer/employee relationship existed between Petitioner and Respondent on June 26, 2011. The Judge found that the Commission's findings were against the manifest weight of the evidence and the Judge remanded the case to the Commission to determine all other remaining issues. On remand, the Commission finds that in accordance with the Circuit Court's Order that an employer/employee relationship existed between Petitioner and Respondent on June 26, 2011. Having reviewed the record again, the Commission continues to find that there was no concurrent employment and continues to defer to the Arbitrator's holding that Petitioner was not credible. The Commission further finds that Petitioner sustained an accidental injury arising out

of and in the course of his employment on June 26, 2011. Additionally, the Commission finds Petitioner reached a point of maximum medical improvement on April 2, 2013 and Petitioner's current condition of ill-being is not casually related to the June 26, 2011 left eye injury As a result of the accident, Petitioner established that he is entitled to $3,597.00 in medical expenses. The Commission lastly finds that Petitioner failed to uphold his burden of proving by a preponderance of the evidence his average weekly wage under the Act and as a result no temporary total disability or permanent disability is being awarded.

As noted above, the Commission previously considered the record in its entirety. The Commission reviewed the facts of the matter, both from a legal and a medical/legal perspective, In doing so, the Commission analyzed the elements of an employer/employee relationship and found while there were some factors that weighed in favor of a finding of employer/employee there were more factors that weight against a finding of employer/employee. In particular, there was little evidence of an exercise of control and no evidence of the normal examples of agreed employment such as an employment application, a W-9 or a W-2, vacation/sick time, insurance, a retirement plan and the like. Be that as it may, it is not the intent of the Commission to ignore the Order of the Circuit Court and as such the Commission now finds per the directive of the Circuit Court that an employer/employee relationship existed between Petitioner and Respondent on June 26, 2011.

With that understanding, the Commission now turns to the underlying issues in this claim. In terms of the concurrent employment issue, the Commission finds that the evidence clearly shows that on June 26, 2011 Respondent was well aware of the fact that Petitioner was on an employee related disability leave and he was bartering/trading his services to keep busy, pursuing a hobby as an avid golfer and ensuring that he did not jeopardize his disability benefits from a separate claim through receiving monetary compensation for his services. The Commission notes the case at bar is significantly factually distinguishable from *Jacobs v. Industrial Commission,* 269 Ill App. 3d 444 (1995) where the claimant was able to claim concurrent employment by two employers during a temporary layoff from his job. Unlike *Jacobs,* id. where the claimant was working a second part-time job during a layoff period from his primary job; he was using the part-time job to supplement his primary source of income and he knew that anytime he needed to be readily available and could be subject to a recall to his primary employment, Petitioner volunteered at the golf club to keep busy, pursue his hobby and barter/traded his time for non-monetary golf privileges while he was on disability. Respondent in this case knew Petitioner was on disability at the time he was volunteering and Petitioner could only return to work at his long time employer once his right eye had stabilized and he was no longer disabled. As such, the Commission finds that no concurrent employment was evident as of June 26, 2011.

In terms of the issue of accident, the Commission finds that Petitioner's employment as a voluntary ranger for Respondent subjected him to an increase risk of harm which was greater than a member of the general public. Specifically, the time Petitioner spent on the course as a ranger lead him to be more likely than a member of the general public to be exposed to errant

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projectiles, vehicles or hazards that could cause harm or injury. Accordingly, the Commission finds Petitioner established that he sustained an accidental injury arising out of and in the course of his employment on June 26, 2011 when he was in the performance of his ranger duties and was hit in the left eye by a golf ball. The Commission further finds based on the Arbitrator's finding that Petitioner lacked credibility and on Dr. Pernound's finding that Petitioner reached maximum medical improvement as of his April 2, 2013 evaluation, Petitioner reached a point of stabilization on April 2, 2013 and Petitioner's current condition of ill-being is not casually related to the June 26, 2011 left eye injury. The evidence does demonstrate Petitioner incurred reasonable and necessary medical expenses in the amount of $3,597.00 for treatment which is causally related to the June 26, 2011 work accident and the Commission awards the same according.

In terms of establishing Petitioner's average weekly wage, the Commission notes that in a workers' compensation claim, the Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim. *O'Dette v. Industrial Commission*, 79 Ill. 2nd 249 (1980), Additionally, the Commission finds that liability under the Act "cannot be premised upon imagination, speculation or conjecture but must arise from the facts," *Illinois Bell Telephone Co. v. Industrial Commission,* 265 Ill. App. 3d 681.

In regard to establishing the element of average weekly wage, Petitioner testified as follows:

> As a ranger he was not paid any wages for his duties. Rather, gratuitous golf was given to him. He was put on the schedule for six to eight hours a week; he performed his duties over 3 days and he would always work weekends. He then played as many games of golf as possible during the week. He "probably" played four or five rounds a week. The cost for a 18 hole round of golf for someone like him who had a golf cart "probably" cost $25.00. He was not getting any other cash for his services. He does not know if he was there long enough to get a W-2. He had no written contract of hire with Respondent.

Brian Lawson, the vice president and operations manager of the golf course, testified:

> He considered Petitioner to be a part-time volunteer. As a volunteer, Petitioner requested and he was allowed to play golf for free. He does not recall Petitioner ever asking for a W-2 tax form. Mathematically, during the time Petitioner volunteered he played more golf than he expended time volunteering. Mr. Lawson testified that typically most paid rangers are paid minimum wage which ranges around $7.50 per hour. This is what the state mandated as the minimum wage in June of 2011. A paid ranger would probably work 20 to 30 hours per week. During the week an 18 hole rounds of golf with unlimited play was around $20.00 . During the weekends it was higher and "probably" cost $25.00 to $27.00.

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The Commission notes that in an attempt to establish Petitioner's average weekly wage Petitioner's attorney cited to two cases in which the claimant acted as a volunteer. The first case is *the Village of Creve Coeur v. Industrial Commission*, 32 Ill. 2nd 430 (1965) in which the claimant, who was acting as a volunteer fireman, was paid a standard fee of $3.00 when he appeared at a fire. The Village maintained payroll records showing payment to firemen as employees and it carried a workmen's compensation policy on village employees which specifically covered fireman, but it did not withhold any income or social security taxes. The other case cited by Petitioner's attorney is *Pearson v. Industrial Commission*, 318 Ill. App. 3d 932 (2001) in which the dissenting Justice noted that the majority in not finding claimant to be an employee relied heavily of the fact that he received no pay or other remuneration for his services. The Justice found that given the fact that other firefighters received $8.00 each as volunteer firemen that the majority placed too much weight on claimant not receiving pay or other remunerations for his services. Petitioner's attorney then asked the Commission to view Petitioner both as an employee of Respondent and to find that Petitioner was receiving remuneration for his time as a ranger with unlimited golf and the use of a cart, which was valued by Respondent as being between $80.00 and $100.00 per week based on the amount of golf played by Petitioner, while Respondent actually represented via Brian Lawson's testimony of rangers being paid $7.50 an hour for 20 to 30 hours per week, that Petitioner's average weekly wage should equal "approximately" $187.00, based on a mathematical mean of a 25 hour work week.

The Commission notes that the two cases cited by Petitioner in an attempt to establish his average weekly wage are factually similar to the case at bar in that claimant's volunteer status was analyzed in relationship to the determination of whether the claimant was an employee subjected to the Illinois Workers' Compensation Act. Where the cases differ is that the Courts highlight the monetary amounts that the claimants were compensated for their labor as one of the factors of establishing whether or not an employment relationship exists. The Commission further notes that the dissenting Justice in *Pearson,* Id. made a reference to "other remunerations" for services as well. Thus, assuming arguendo that Petitioner is an employee under the Act and that Petitioner was compensated via remunerations for his services, the Commission still finds that the amount of remunerations for services is speculation at best. More specifically, the Commission notes that Petitioner testified to a "probable" cost of golf which he "probably" played four to five times a week. He further estimated that "someone like him" would "probably" pay $25.00 for a round of golf and the use of a cart. Lastly, Petitioner asserted in his Statement of Exceptions that the Commission should use Respondent's valuation of "between $80.00 and $100.00 per week" to determine Petitioner's average weekly wage. The Commission finds that Petitioner's testimony regarding the fact that "someone like him" would "probably" pay of $25.00 for a round of golf that he "probably" played four to five times a week results in speculation as to the amount of remunerations for the ranger services Petitioner provided to Respondent. Additionally, upon reviewing all of the evidence in the record, the Commission finds that Respondent's use of a mathematical mean of a 25 hour work week at a rate of

17IWCC0258

$7.50 an hour for range of 20 to 30 hours per week to result in a determination of Petitioner's average weekly wage being equal to approximately" $187.00 a week is equally speculative in nature. Furthermore Petitioner's valuation of his average weekly wage differs anywhere from $87.00 to $107.00 per week from that of Respondent's valuation. Thus, based on the above, the Commission finds that Petitioner failed to uphold his burden of proving by a preponderance of the evidence his average weekly wage under the Act and as a result no temporary total disability or permanent disability is being awarded.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent is to pay Petitioner the sum of $3,597.00 for medical expenses under §8(a) of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,700.00.

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

DATED: APR 24 2017

KL/jm

O: 3/9/17

43

Kevin W. Lamborn

Stephen Mathis

David Gore

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

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 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 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.

17IWCC0178

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: MAR 23 2017
SJM/sj
o-3/9/2017
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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. Rowe Gillman

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 ST.CLAIR)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daniel Bitner,

Petitioner,

vs. NO. 11WC 35234

Menard Correctional Center,

Respondent.

17IWCC0208

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 1, 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.

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

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

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: APR 6 - 2017
SJM/sj
o-3/9/2017
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

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

BITNER, DANIEL
Employee/Petitioner

Case# **11WC035234**

17IWCC0208

COPY

MENARD CORRECTIONAL CENTER
Employer/Respondent

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:

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

0558 ASSISTANT ATTORNEY GENERAL
KENTON OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT SYSTEMS
RISK MANAGEMENT SECTION
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

JUN 1 = 2016

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

17IWCC0208

STATE OF ILLINOIS)
)SS.
COUNTY OF St. Clair)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Daniel Bitner
Employee/Petitioner

v.

Menard Correctional Center
Employer/Respondent

Case # **11** WC **35234**

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 **Brandon Zanotti**, Arbitrator of the Commission, in the city of **Belleville, IL**, on **05/27/2014**. 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **08/03/2011**, 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 **$73,978.00**; the average weekly wage was **$1,422.65**.

On the date of accident, Petitioner was **45** years of age, ***married*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $2,562.00, 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. Young, 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

5/17/16
Date

ICArbDec19(b)

JUN 1 - 2016

17IWCC0208

FINDINGS OF FACT

On August 3, 2011, Petitioner was a forty-five (45) year old food service supervisor III employed with the State of Illinois at its Menard facility. He testified at trial that he has been employed with the State and specifically at Menard Correctional Center for over twenty-five (25) years. When he was first hired, Petitioner worked as a correctional officer for approximately seven to eight (7-8) months where he worked as available which means that every day he was on a different assignment. He was then temporarily assigned to the dietary apartment and he began performing the duties of a food service supervisor I. Petitioner testified extensively concerning his job duties. His testimony was consistent with his written job history timeline that he was a food service supervisor I for approximately eight (8) years.

As a food service supervisor I, Petitioner worked in the dining rooms and kitchens on various different days. He would serve meals, get tools and utensils out, run trash, and supervise the inmates. He would cook meals as well as supervise and train inmates on the proper ways of cooking it.

Petitioner testified that inside of a maximum security prison like Menard all of the food, supplies and utensils are kept under lock and key. He indicated "you constantly have to get anything and everything out that has to be used." (T.23). To lock and unlock utensils like knives and smaller utensils, padlock keys would be used, but larger doors were operated with Folger's Adam keys. This would include the storerooms, and coolers. The coolers are big enough to put pallets of food through the doors. He estimated the doors to be five feet wide and six to seven feet tall. He indicated that the doors would get hit by inmates with carts and it would spring the hinges a little, so even if the locks were working, the torque that would be put on the doors would be pretty intense to where you would have to use a lot of leverage with your shoulder or your foot or whatever just to align the lock in order to turn the key. In addition the moisture and steam from preparing meals causes the metal doors to swell, and the locks to become extremely tight. He indicated, "they get locked or get stuck pretty regularly." (T.25). Petitioner indicated that when opening these doors with locks, he was required to use both hands. Petitioner would be required to turn locks and open doors several hundred times a day.

Petitioner also testified he was required to lift eight-inch inserts of food weighing anywhere from twenty (20) to forty (40) or fifty (50) pounds anywhere from one to fifty (50) times per shift. (T.28-29). He indicated that when cooking for individuals at the facility, he was preparing meals for 3,600 people two times per day. He was also required to lift items like carts or trash. Sometimes they had inmate workers to assist them and other times they did not. When they would go on deadlock they would not have any inmate workers and use pallet jacks to bring skids full of food, skids full of chicken that has to be thawed out into the kitchen area.

Petitioner indicated that even when instructing inmates on how to perform tasks correctly, he was constantly using his hands and arms to do so.

When preparing food Petitioner would use big steam pots. He testified that the pots were seventy-five (75) gallons, and four (4) feet tall and four (4) feet across. Petitioner indicated, "usually you'll have to get a milk crate and stand on top of the milk crate so you can get over the top of the steam pot and actually use both hands to dig down to the bottom of the pot with that paddle. If you try to stand up and it comes up to here (indicating), you don't have enough leverage to paddle with your hands to turn it, so you stand on a milk crate and get up over it and actually dig like you're rowing a boat." (T.40-41). He described the paddle used to stir these pots as a "four and a half to five foot long stainless steel or cast aluminum type metal" which resembles a

boat oar. (T.41). Petitioner indicated he would clench both wrists and hands grip the paddle with enough force to do the job.

After eight (8) years as a food service supervisor I, Petitioner was promoted to the position of food service supervisor II. When asked to describe how his job duties as a food service supervisor II compared with those he performed as a I, he testified, "they're basically the same job duties...." (T.45).

The record contains an extensive amount of evidence regarding Petitioner's job duties: a Genex Job Site Analysis (JSA) procured at Respondent's request (RX8); a DVD produced at Respondent's direction which depicts the job duties of a CFSS I & II (RX9); a CMS Demands of the Job (RX5); a job description prepared by Petitioner (PX6); and CMS Position titles for CFSS I, II, & III. (RX10, 11, 12).

Petitioner disagreed with the job site analysis admitted into evidence as Respondent's Exhibit 8, which indicates that food service supervisor IIs are never required to lift more than twenty-five (25) pounds. He indicated that, for example, potatoes are in fifty (50) pound bags. There are cases of canned goods that might have to be moved around. There are several occasions that he would have to lift that kind of weight, even moving inserts, which exceed twenty five pounds. He indicated they had several pans that might weigh as much as twenty (20) pounds before you put food in it.

Petitioner also disagreed with the Job Site Analysis' assessment that food service supervisor I and IIs are required to perform firm grasping with the upper extremities infrequently, or 2-5% of the time. Specifically, he indicated that he was required to use firm gripping simply to open the cooler doors in the dietary department and also to access locks in the storeroom, which he indicated may have to be turned up to fifteen or twenty (15 or 20) times to unlock it. He similarly disagreed with the Job Site Analysis' indication that food service supervisors I and IIs are required to perform simple grasping and fine manipulation with the upper extremities only six to thirty three (6-33) percent of the time.

Petitioner also testified that he reviewed Respondent's Exhibit 9, a DVD which purportedly depicted the job duties of a food service supervisor I and II. Petitioner testified that the DVD "showed not a whole bunch. It showed one of the food supervisors in the kitchen getting a few things out for the diet line." (T.53). He described the DVD as very inaccurate. He stated "It showed inmates jumping up to serve a line coming into the dining room, and I don't know that I've ever seen all the inmates jump in unison to serve a line coming in the dining room. Inmates just don't usually act like that." (T.56-57).

Finally, Petitioner testified that he also reviewed Respondent's Exhibit 5, a Demands of the Job Form with regard to the positions of a food service supervisor I and II. He indicated he disagreed with that document's assessment that a food service supervisor II would never be required to life more than ten (10) pounds, and also disagreed with its characterization that his hands would only be used for gross manipulation for zero to two (0-2) hours per day, and that he would only be required to use his hands for fine manipulation only for two to four (2-4) hours per day.

After twelve and a half (12.5) years as a food service supervisor II, Petitioner was promoted to the position of food service supervisor III in 2009. When asked to describe his job duties as a food service supervisor III, Petitioner testified:

My primary responsibilities were—there's three kitchens. There's an employee kitchen, the inmate kitchen and MSU. I would have circulated between all three of them every day. I'd start my morning in the inmate kitchen. I'd come in, sign in, make sure there wasn't any specifics job duties I needed to take care of, checked my e-mail or whatever might be going on there.

Then I would leave that establishment and go down to the employee kitchen where I would go in and check, make sure that the meal was going properly there, help with whatever I needed to do there, possibility inventory the storeroom depending on what day it was. I had to – you know, there's caustics in there, was paper good orders; and there was household orders and frozen food orders; so you inventory the coolers and the freezers and things of that nature; and there was a dining room set up off to the side which used to be a gym which was feeding part of north population out of north two cellhouse. I would help supervise the kitchen, taking care of making sure the meal was done properly and help with that meal while the other food supervisor was over setting up the dining room over there.

When I would ensure that that was going properly, I would leave that kitchen, go back out of the institution, get in my car and drive to MSU. I would sign in there and get another set of keys and go to my assignment there. I would be there in time to hopefully stand and be in the dining room during one of the feeds to help with the feed there in case trucks came in. Other staff would go back – because, you know, vacations and shortages of staff, you know, I'll get there – there's not as many staff as you would like to have to cover everything, so you're covering assignments for them.

So when trucks came in, they would go back, unload the truck. I would run the dining room out there and get the tools out, feed the inmates out there, help get the staff meal going, things of that nature. I'd also have a computer set up there where I would check my e-mail. I would do any memos I would need taken care of. I would do the MSU staff scheduling.

We have several different types of memos or things that I would need to update as far as copying paper from the copiers, getting enough of the forms and all that stuff, copying anywhere and everywhere; and I had a desk there that was locked up; and all the personal information for the staff up there was locked up there that I would take care of.

After I would get that pretty well wrapped up, I would leave MSU and go back to the employee kitchen in the pit, get back in my car and go back down there, check in on them to make sure they were going well, do whatever I needed to there, then go back to the inmate kitchen to finish up my day there. (T.57-60).

Petitioner indicated that as a food service supervisor III, he constantly used his hands and arms to perform his job duties, and specifically indicated "even if I was in my office, I would be either on the computer or filling out forms, overtime slips, filling overtime when I had duty, inventory, so I was constantly using my hands. If I had to go through an inventory, like there I had inventory sheets that I drew up on the computer; and I'd print them off; and I'd go back; and I'd count them, the stock to see what we had to make the orders up; so,

yeah, I was doing some sort of thing like that all the time." (T.61). He indicated that he was still responsible for preparing food as a food service supervisor III. He personally was responsible for the food coming out, so if at any time he was needed to help get the meal done and served he did so. He stated that especially when they were short staffed or one of the staff was over setting up the dining rooms he had to cover the kitchen, was helping cook the meal.

Petitioner also indicated that he had reviewed Respondent's Exhibit 12, a position description for the food service supervisor III position. He disagreed with the statement that he only used his hands and arms approximately forty-five (45) percent of the time in that position.

In the course of performing his job duties, Petitioner began to notice symptoms in his hands and arms, and specifically "a lot of lack of grip, numbness and tingling especially when I exerted my hands on most things, opening – going through some of those doors were – was just – was pretty rough." (T.68). Petitioner indicated that his arms would become numb while he slept, and that for the past four (4) years, he has slept with a pillow under his arm to elevate his arms to a forty-five (45) degree angle in order for him to sleep. (T.69).

Petitioner testified that his symptoms began in approximately 2007 or 2008, and that he attempted to work through his symptoms until he required treatment. Petitioner acknowledged that he had undergone prior rounds of physical therapy for an unrelated injury to his feet, and, while in the course of this therapy, asked his physical therapist for several exercises he could do on his own to attempt to alleviate his upper extremity symptoms. He indicated he did not know what was causing his symptoms at this time. He stated he "just knew that they were there and as they were getting worse and trying to work with them as best I could until they got to a point of being very painful that I couldn't do much with them myself." (T.163)

Ultimately, when he was no longer able to manage his symptoms, Petitioner presented to his family physician Dr. Dale Blaise, on July 26, 2011 with complaints of pain, numbness and tingling in his bilateral hands and arms (PX3, Dr. Dale Blaise, 7/26/11). He was seen by Dr. Blaise's assistant, Emily Hanson. *Id.* It was noted that the onset of Petitioner's pain had been gradual and had occurring in an intermittent pattern for months. *Id.* A nerve conduction study/EMG was recommended for both of Petitioner's upper extremities. (PX3, Dr. Dale Blaise, 7/26/11; T. 71).

Dr. Blaise then referred Petitioner to Dr. Fakre Alam for nerve conduction studies to be performed on both of Petitioner's upper extremities. (PX4, SI Neurology & Sleep Medicine, LLC, 8/3/11). Dr. Alam's impression was moderately severe bilateral carpal tunnel syndrome and mild-to-moderate bilateral ulnar neuropathy at the elbow. *Id.*

Petitioner testified that when he saw Ms. Hanson at Dr. Blaise's office, he had no idea what type of condition or problem he may have had. (T.71). Rather, he indicated that August 3, 2011, the date he had the nerve conduction study performed by Dr. Alam and received the results of that test, was the first time that he had any indication that he had carpal or cubital tunnel syndrome and that these conditions were related to his employment. (T.72-73). Petitioner testified that Dr. Alam referred him to Dr. Young, an orthopedic surgeon in Herrin, Illinois. (T.72).

Only one day after receiving a diagnosis, Petitioner reported his condition to his employer and filled out a Form 45, or an Employee's First Notice of Injury. (T.73; RX2). This document was admitted into evidence as

Respondent's Exhibit 2. (RX2). He testified specifically that he reported his injury to Lloyd Hanna, his immediate supervisor. (T.73). When asked to describe how the injury occurred, Petitioner indicated "repeatedly opening locks and doors." (RX2). The document also indicates that Petitioner reported he was "opening and locking doors in kitchen" at the time of the injury. (RX2).

Petitioner then presented to Dr. Stephen Young, a board certified orthopedic surgeon, on September 8, 2011. (PX5, Dr. Young, 9/8/11). Dr. Young noted that Petitioner had a positive Tinel's and a positive ulnar nerve compression test bilaterally, a positive Tinel's and a positive median nerve compression test, as well as a positive Phalen's in the wrist bilaterally. *Id.* He noted that the nerve conduction study performed by Dr. Alam revealed evidence of severe bilateral carpal tunnel syndrome and mild to moderate bilateral ulnar neuropathy. *Id.* Dr. Young's assessment was bilateral carpal tunnel and cubital tunnel syndrome, and indicated, "at this time, it was decided we would request approval from workman's comp for a bilateral carpal tunnel release and ulnar nerve transposition. The procedure was explained to the patient in detail to include risks and benefits, and he would like to proceed. We will wait on workman's comp. Once we hear from them, we will go ahead and place him on the schedule."

Dr. Young testified by way of deposition. (PX7). Dr. Young testified that he is a board certified orthopedic surgeon who specializes in hand and upper extremity surgery. (PX7, p. 4). He testified that he performs approximately 400-500 surgeries on individuals who suffer from carpal and cubital tunnel syndrome annually. (PX7, p. 6). Dr. Young testified that Petitioner correlated his symptoms with his job duties, and in particular, opening and closing locked doors and gates "all day long." (PX7, p. 10). He also indicated that Petitioner reported he was required to "supervise up to 35 staff, fill roster, overtime, order food, train staff, supervise inmates, ensure the inmate population gets food according to the master menu and special diets." (PX7, p. 11). Dr. Young reviewed Petitioner's Exhibit 6, a Work History and Job Description authored by Petitioner. (PX6; PX7, p. 16). Based upon all of the information he reviewed regarding Petitioner's job duties, Dr. Young opined within a reasonable degree of medical certainty that Petitioner's job duties, and specifically: "tool and key control, entering kitchen with Folger Adams locks multiple times a day, on multiple occasions throughout the day would be required to stir 75-gallon pots holding close to 1,000 pounds of food each, with a tool the size of a 5-foot metal boat paddle. Every tool in cabinet inside dietary is locked which requires muptiple unlocking and locking of doors and padlocks" would cause, contribute to or aggravate the development of carpal and cubital tunnel syndrome. (PX7, p. 16-17).

Additionally, Dr. Young testified that he reviewed the Job Site Analysis of a Food Service Supervisor I and II position. When asked whether any of the job duties listed in that document would serve as a contributing or aggravating factor to the development of carpal and cubital tunnel syndrome, Dr. Young testified, "Unlocking various equipment and tools is mentioned, fine manipulation, lifting 11 to 25 pounds. Those would potentially contribute." (PX7, p. 20). He indicated that according to Petitioner, Folder Adams keys were used at Menard, and it could potentially take a great deal of force to open and close some locks with those types of keys. (PX7, p. 20). Dr. Young also testified that keying locks up to 400 times in an 8-hour shift would contribute to and aggravate the development of carpal and cubital tunnel syndrome. (PX7, p. 21).

Dr. Young also testified that the only potential identifiable co-morbid risk factor Petitioner possessed with regard to carpal or cubital tunnel syndrome was a slightly increased body mass index. (PX7, p. 22).

Respondent had Petitioner's medical records reviewed by Dr. Anthony Sudekum, who testified by way of deposition. (RX 7). Dr. Sudekum testified that he had never examined or encountered Petitioner. (RX7, p. 61). He acknowledged that the standard of care in medicine is to take a history directly from a patient and perform a physical examination prior to establishing a diagnosis. (RX7, p. 62-63). He additionally acknowledged that it was important to obtain a work history and job description from the worker who actually performs the job. (RX7, p. 65). Dr. Sudekum testified that he did not know if the DVD or JSA of a food service supervisor I and II depicted Petitioner or showed the manner in which he performed his job. (RX7, p. 66-67). He similarly acknowledged that "medical providers who are asked to render opinions regarding causation and work relatedness, but who are not provided with complete and accurate medical and/or job duty information are at a significant disadvantage in attempting to determine work relatedness of the specific condition." (RX7, p. 68).

Dr. Sudekum also testified that he believed there were only 1,500 inmates and 500 staff members at Menard and therefore food service supervisors would only be responsible for making meals for as many individuals. (RX7, p. 79). He was also of the belief that cabinets were occasionally left open in the dietary department "because they're going to be going in and out more frequently." (RX7, p. 80-81). Dr. Sudekum also testified that stirring one of the pots in dietary with the large paddle would "not necessarily" require heavy gripping." (RX7, p. 83).

When asked if food service supervisors lifted and carried hundreds of pounds of food items, Dr. Sudekum testified, "No, in general that does not appear to be the case based on the information I've read and my experience in the food service departments at Menard and elsewhere." (RX7, p. 88). Dr. Sudekum was of the opinion that Petitioner's twenty-five (25) year work history for the State of Illinois had absolutely no correlation with the development of any neuropathic condition in his upper extremities, despite the fact that he had never seen Petitioner perform any of his job duties, and did not take an in-person job history from Petitioner. (RX7, p. 91-92).

Dr. Sudekum also acknowledged that he was never provided with the records of Dr. Stephen Young, Petitioner's treating orthopedic specialist, despite the fact that his report was prepared on December 27, 2011 and Dr. Young's record was generated on September 8, 2011. (RX7, p. 43).

Petitioner testified at trial that he had the opportunity to review Dr. Sudekum's deposition. When asked if Dr. Sudekum's understanding of his job duties was accurate, Petitioner indicated there were "many things in there that were not even close to being accurate. I believe some of the things that stood out the most were, he thought we served two meals a day. We actually serve three. He didn't know how many inmates were there. As far as his deposition, he said something about all the skilled inmate workers from the MSU dietary came down to work during deadlocks. That's impossible. That would close the MSU dietary. All the inmates that come down were unassigned off B and D wing that didn't have jobs." (T.79).

Petitioner additionally testified that he has never been diagnosed with diabetes, high blood pressure or hypothyroidism, does not smoke, and since January of 2011, when he underwent gastric bypass surgery, his weight has remained relatively consistent at around 190 pounds. (T.76-77). When asked about any extracurricular activities or hobbies, Petitioner testified that he goes fishing approximately four (4) times per

year. (T.78). He indicated he has not camped since approximately 2008, and has not hunted since his father passed away many years ago. (T.78).

Respondent called Lloyd, Hanna, to testify on its behalf. Mr. Hanna testified that he was hired by Respondent at its Menard facility in 2007, and the only position he has ever held has been that of a dietary manager. He acknowledged that he has never been employed at Menard as a food service supervisor. On cross-examination, Mr. Hanna acknowledged that Petitioner was a good employee, and that he had never observed Petitioner perform his job duties for an entire shift. Mr. Hanna testified that in his opinion, food service supervisors would turn keys to open locks approximately 150-200 times per shift.

Petitioner testified at the time of hearing that he has not undergone the treatment recommended by Dr. Young because he has been unable to take time off work without pay, but that he wishes to have the surgeries recommended by Dr. Young. He indicated that he is still having constant symptoms in his hands and arms, and his arms now become numb after only driving a vehicle for ten (10) minutes. His sleep has also continued to be affected. (T.76).

CONCLUSIONS OF LAW

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?

The Arbitrator finds that Petitioner was a credible witness. The Arbitrator notes that Petitioner was required to use his upper extremities extensively in the course of his duties as a CFSS I, II, and III. Even assuming the estimate of Respondent's witness is correct, and Petitioner unlocks doors and drawers 150 to 200 times per shift, this is still significantly repetitive.

The Arbitrator finds the testimony and opinions of Dr. Young more persuasive than those of Dr. Sudekum. Dr. Young testified that Petitioner's employment caused and/or aggravated his bilateral carpal tunnel and cubital tunnel syndrome. Dr. Sudekum believed that Petitioner conditions had nothing to do with her employment. The Arbitrator finds it significant that Dr. Sudekum did not examine of obtain a history from Petitioner. Instead, he based his opinion solely on medical records, which did not include all of the information from Dr. Young, and Respondent's documentary evidence regarding job duties.

Petitioner's medical history, job activities, onset of symptoms while performing his work activities, sequence of events, Petitioner's credible testimony, and the testimony of Dr. Young all support a finding that Petitioner suffered an accident which arose out of and in the course of his employment with Respondent and that his current condition of ill-being is causally related to the accident.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner has met his burden of establishing that he sustained accidental injuries which arose out of and in the course of his employment with Respondent, and that his current conditions of ill-being are causally related to the employment.

Issue D: What was the date of the accident?
Issue E: Was timely notice of the accident given to Respondent?

Petitioner credibly testified that the prior to the electrodiagnostic studies of Dr. Alam he had never received a diagnosis of carpal or cubital tunnel syndrome and that the day he received the results of the studies, August 3, 2011, was the first day he realized that he suffered a work-related injury. The Arbitrator finds that August 3, 2011 is an appropriate manifestation date under the Act.

It is undisputed that Petitioner completed an incident report on August 4, 2011. Petitioner has provided proper notice as required by the Act.

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?

As a result of his repetitive job duties, Petitioner sustained bilateral carpal and cubital tunnel syndromes. Petitioner obtained EMG Nerve Conduction Studies to diagnose his condition. Petitioner has attempted to manage his symptoms conservatively. However, Petitioner's symptoms continue and he would like to continue to receive appropriate treatment, including the surgery recommended by Dr. Young. Since Petitioner has established that his injuries are causally related to his employment and Petitioner has not reached maximum medical improvement, the Arbitrator finds that he is entitled to medical care required to relieve him from the effects of injury.

~~Respondent is therefore ordered to pay the medical expenses set forth in Petitioner's exhibit 1 totaling~~ $2,562.00, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall have credit for any amounts previously paid. Respondent shall indemnify and hold Petitioner harmless from claims by any health providers contained therein. Respondent shall authorize and pay for the treatment recommended by Dr. Young, including, but not limited to surgical intervention.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

WENDY SKORNIA,

Petitioner,

vs.

SCHOOL DISTRICT U-46 TRANSPORTATION,

Respondent,

No: 12 WC 24518

ORDER

This matter comes before the Commission on Petitioner's Motion to Refile Reply Brief of Petitioner Instanter, the Commissioner states the following facts and rules as follows:

1) On or about August 5, 2016 Arbitrator Granada issued his decision on Arbitration.
2) On or about December 30, 2016, Petitioner timely filed her Statement of Exceptions and Brief.
3) On or about January 18, 2017, Respondent timely filed its Response to Petitioner's Statement of Exceptions.
4) On February 1, 2017, Petitioner filed a Reply Brief.
5) Respondent filed a Motion to Strike Petitioner's Reply Brief on March 2, 2017.
6) In response, Petitioner filed her Motion to Refile Reply Brief of Petitioner Instanter and Respondent filed an Objection thereto.

50 Ill. Adm. Code 9040.70 does not contain a provision for appellant to file a reply brief *See* Weaver v. Decatur Overhead Door, 2010 Ill. Wrk. Comp. LEXIS 212. Petitioner filed her Reply Brief without first seeking leave to do so. In response to Respondent's Motion to Strike, Petitioner argued that Respondent's rights would not be harmed or prejudiced if Petitioner were allowed to file a Reply Brief. This argument is not persuasive.

Further, Petitioner has failed to show why a departure from the rules in this case is necessary. 820 ILCS 305/16 states in pertinent part that "the process and procedure before the

Commission shall be as simple and summary as reasonably may be." "The Commission shall make and publish procedural rules and orders for carrying out the duties imposed upon it by law and for determining the extent of disability sustain, which rules and orders shall be deemed prima facie reasonable and valid." Petitioner does not set forth any facts in her Motion to Refile Reply Brief that would support a departure from the rule regarding Statements of Exception(s) and Supporting Briefs and Abstracts.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Petitioner's Motion to Refile Reply Brief of Petitioner Instanter, is denied.

DATED: APR 10 2017

Charles J. DeVriendt

CJD/dmm
49

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

Enrique Diaz-Rosas,

Petitioner,

vs.

NO: 12WC 001676

17IWCC0210

Most Valuable Personnel, loaning employer and Gold Standard Baking, Inc., borrowing employer,

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 26, 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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $25,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 6 - 2017
o032317
SM/jrc
044

Stephen Mathis

David L. Gore

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DIAZ-ROSAS, ENRIQUE
Employee/Petitioner

Case# **12WC001676**

17IWCC0210

MOST VALUABLE PERSONNEL LOANING EMPLOYER AND GOLD STANDARD BAKING INC BORROWING EMPLOYER
Employer/Respondent

On 10/26/2015, 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:

1922 SALK, STEVEN B & ASSOC LTD
DAMIAN R FLORES
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

4944 KOREY RICHARDSON LLC
AMY HOFFMAN
20 S CLARK ST SUITE 500
CHICAGO, IL 60603

0532 HOLECEK & ASSOCIATES
MONOCA DEMBNY
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

17IWCC0210

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

ENRIQUE DIAZ-ROSAS
Employee/Petitioner

v.

Most Valuable Personnel, loaning employer and Gold Standard Baking, Inc., borrowing employer
Employer/Respondent

Case # 12 WC 01676

An *Application for Adjustment 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 **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

17IWCC0210

FINDINGS

On 12/21/15, 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, in part,* causally related to the accident.

In the year preceding the injury, Petitioner earned $6,708.64; the average weekly wage was $419.29.

On the date of accident, Petitioner was 21 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 $2,200.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $2,200.00.
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 $279.53/week for 23-5/7 weeks, commencing on 12/28/11 through 3/13/12 & 3/20/12 through 6/17/12, pursuant to Section 8(b) of the Act.

Respondent shall pay Petitioner **permanent partial disability benefits** of $251.57/ week for a further period of 10 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused the 2% loss of use of a person as a whole.

Respondent shall pay $8,270.86 in reasonable and necessary medical services for treatment rendered as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay to Petitioner attorneys fees of $0, as provided in Section 16 of the Act; $0, as provided in Section 19(k) of the Act; and $10,000.00, as provided in Section 19(l) of the Act.

Respondent shall pay Petitioner all compensation benefits that have accrued from 12/21/2011 through 4/9/2015 and shall pay the reminder 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

October 26, 2015
Date

OCT 26 2015

FINDINGS OF FACT

Petitioner testified via a Spanish interpreter. Petitioner understands English, but wanted to use an interpreter.

At the beginning of the trial, Respondents, Most Valuable Personnel, Inc. ("MVP") and Gold Standard Baking, Inc. ("Gold Std") stipulated on the record that Most Valuable Personnel was the loaning employer and Gold Standard Baking was the borrowing employer. It was agreed that between the two employers, Most Valuable Personnel would be responsible for the payment of compensation benefits and had already paid benefits to Petitioner regarding this claim. MVP and Gold Std will collectively be referred to as "Respondent" in the remainder of this decision.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on December 21, 2011. He was an employee of MVP, working at Gold Std (a large bakery) as a machine operator. In this position, Petitioner would make dough and would be required to lift and carry a plastic container of dough, weighing 60 to 80 pounds, about every 15 minutes. Petitioner lifted up a container to place it on a cart and he felt pain in his low back. He rated the pain as being 4 or 5 out of 10.

Petitioner reported the injury to his supervisor, Gerard. Gerard instructed Petitioner to report the injury to Janet. Janet was not there, so Petitioner finished his shift. His back hurt him as he worked out his 11 hour shift. He went home and went to bed. The next day, Petitioner went back to work and reported the injury to Janet. He was referred by Janet to Physicians Immediate Care ("PIC"). He went to Physicians Immediate Care and they were closed.

Petitioner did receive treatment at PIC on December 23, 2011. The history was of a lifting injury at work. The physical exam was largely benign. The lower extremity exam was unremarkable. Decreased lumbar range of motion was noted. There was slight tenderness to palpation, L2-L4. Positive straight leg raising was noted on the left. A lumbar x-ray showed a mild levoscoliosis at L3-L4. The assessment was Lumbar Strain. Petitioner was given a back support, biofreeze, Naproxen and Tylenol ES. He was released to work at full duty, without restrictions, and was advised to follow up on December 29, 2011. (PetEx. 1)

Petitioner worked that Saturday, Monday and Tuesday. His back pain did not go away. He had pain in his buttocks and down his leg.

Thereafter, on December 28, 2011, Petitioner sought treatment at Marque Medicos with Dr. Phillip Gattas, a chiropractor. Petitioner had complaints of low back pain that moved from side to side. It would radiate to the right buttock. Dr. Gattas diagnosed low back pain and recommended a lumber MRI and PT. Petitioner was taken off work. Petitioner's pain drawing documents low back pain only. The initial PT evaluation of December 30, 2011 reveals no complaints of numbness and tingling and notes that the pain radiates down the left buttock. The MRI was read by the radiologist to show minimal disc bulging at L4/5. Dr. Gattas referred Petitioner to Dr. Andrew Engel, a pain management physician. Dr. Engel prescribed PT and medication. Petitioner said that the PT helped. Dr. Engel prescribed an EMG/NCV study that was performed on January 27, 2012. The study was said to show "acute denervation of the left L5/S1 nerve roots. Dr. Engel reviewed the MRI and thought that it showed a left paracentral contained disc herniation which caused left lateral recess stenosis. Petitioner was released back to work with restrictions on February 6, 2012. (PetExs. 2 & 3)

Petitioner called MVP and went to their office in an effort to return to work. He was told that they had no modified duty. Eventually, MVP contacted Petitioner regarding return to work. Petitioner worked at MVP on March 14 and March 15, 2012. His back pain increased and he returned to see Dr. Engel.

Dr. Engel took Petitioner off work as of March 20, 2012. Petitioner continued on a course of care by Dr. Engel, including 3 injections (TESI procedures on 3/2/2012, 5/23/2012 and 9/5/2012). Petitioner was referred to Dr. Robert Erickson, a neurosurgeon, who saw Petitioner on April 13, 2012. Dr. thought that the MRI showed a small bulge at L4-L5 on the left. The EMG was said to show an abnormality at L5-S1 on the left. Dr. Erickson ordered a SSEP test, which he thought showed moderate delays. The diagnosis was symptomatic lumbar disc disease. Dr. Erickson thought that therapy was in order and surgery was not recommended. As of November 6, 2012, Dr. Erickson thought that discography might be appropriate if the patient improve with more therapy. The radicular pain was said to be of minor concern. Dr. Engel thought that a HEP and work with restrictions was appropriate. The discogram was not performed. The last chart from Dr. Erickson of January 15, 2013 states that Petitioner was not taking pain medication. It was hoped that surgery would be avoided. Petitioner was to continue PT to progress to work conditioning. (Pet Exs. 2,3, &4)

Petitioner had work conditioning at Elite Physical Therapy from January 21, 2013 through January 25, 2013. (PetEx. 5) There was no further treatment.

Petitioner was seen by Dr. Alexander Ghanayem for a §12 examination at Respondent's request on June 18, 2012. Dr. Ghanayem testified via evidence deposition on July 19, 2014. Dr. Ghanayem is a board certified orthopedic surgeon and he concentrates in spinal surgery. The physical examination was benign. The neurologic examination was negative. Dr. Ghanayem reviewed the MRI film and thought that it was completely normal; there was nothing pathological about the study. The EMG was said to be positive, but because the MRI showed no encroachment, it was thought by Dr. Ghanayem to be a false positive. The diagnosis was: back sprain, secondary to work activities. Petitioner was at MMI. He could return to work at full duty. There was no herniated disc. The MRI did not show a pinched nerve, so the patient could not have radiculopathy. The ESI could help radiculopathy and could mask radicular symptoms, but not in this patient, as he did not have anything that could be causing radiculopathy. Therapy appeared to be helping the patient. The ESIs were not reasonable and necessary. (ResEx. 1)

Dr. Engel's chart of July 30, 2012 criticizes Dr. Ghanayem's opinions. Petitioner did not have radiculopathy because of the recent ESI (May 23?). It was not likely that 3 doctors could overread the MRI. (PetEx. 2)

Petitioner obtained work as a stocker in a warehouse, lifting 100 30# boxes in a day. He worked full time. He felt pain every day. Petitioner now works as a machine operator, lifting containers. He does not perform heavy lifting. He received improvement with the treatment that he received from Dr. Engel. He improved his physical condition so that he could be able to work. He is not 100% improved. His back pain is about 3 or 4 without physical activity. If he has physical activity, his pain can be an 8. He takes Tylenol and Aspirin every day. He is not as active as before the injury. He used to dance and play soccer and he no longer does.

Petitioner denied prior low back injuries.

Petitioner could not remember exactly when he started work for MVP. His date of hire was September 20, 2011. His pay dates shown on his wage stubs were: 11/18/11, 12/9/11 and 12/16/11. He agreed that the first pain drawing that he did circled the low back only. The pain was in his low back and bottom when he was first seen at Marque. Later, it went into to his legs and alternated (one leg one day, the other the next). Petitioner testified that he was never prescribed a HEP. The therapist told him to do exercises at the clinic.

Petitioner claimed medical bills of $16,623.49. (Pet Exs. 6-13) Petitioner claimed TTD from 12/28/2011 through 1/15/2013. (ArbExs. 1&2) Respondent paid Petitioner TTD benefits of $2,200.00, via a check date of March 23, 2012 (10 weeks at $220.00?)

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below. The Arbitrator finds the opinions of Dr. Ghanayem to be credible and persuasive in this case.

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, as stated by Dr. Ghanayem in his deposition (status post back sprain related to work activity, resolved at MMI as of June 18, 2012, with normal lumber MRI findings), is causally related to the injury. Petitioner does not have a herniated disc.

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:

Respondent apparently relies on the opinion of Dr. Ghanayem to dispute the payment of medical bills (ESIs not reasonable and necessary, MMI as of 6/18/2012). Dr. Ghanayem did not testify that the lumbar x-ray and MRI studies were not reasonable and necessary and did rely on the "normal" MRI study to support his opinions.

Respondent did not provide any UR studies, as is required by §8.7(i)(3) of the Act, in order to dispute the reasonableness and necessity (extent and scope excessive and unnecessary) of the claimed bills. Respondent does not have a legal basis to dispute the bills incurred before Petitioner reached MMI (June 18, 2012). Therefore, the bills incurred before June 17, 2012 are awarded, with the exception of travel expenses, which are not awarded to this Petitioner, who lives at 5524 S. Sacramento Avenue and chose to seek treatment with a provider located at 4176 W. Montrose Street, all in the city of Chicago. (PetEx. 2&14) The bills incurred after June 18, 2012 are denied, based upon Dr. Ghanayem's opinion that Petitioner is at MMI.

Accordingly, the Arbitrator awards the following bills, subject to §8(a) and 8.2 of the Act. Respondent is entitled to a credit for all bills paid.

- Marque Medicos: $3,655.05
- Archer Open MRI: $1,132.43
- Specialized Radiological Consultants: $ 39.95
- Ambulatory Surgical Care Facility: $3,443.43

TOTAL: $8,270.86

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 award for TTD is for 23-5/7 weeks for the time periods of 12/28/2011-3/13/2012 and 3/20/2012-6/17/2012 based upon Petitioner's testimony and the medical records. Petitioner's claim for TTD subsequent to 6/17/2012 is denied, based upon Dr. Ghanayem's opinion that Petitioner was at MMI and capable of full duty work as of that date.

Petitioner was taken off work by his various physicians beginning December 28, 2011. His unrebutted testimony was that he tried to go back to work at limited duty (as recommended by Dr. Engel) in February of 2012, but was told by MVP that there was no modified duty. He then returned to work on March 14, 2012 and also worked on March 15, 2012. He was excused from work again on March 20, 2012.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

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

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical record.

No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. Therefore, this factor is given no weight in determining PPD.

With regard to subsection (ii) of §8.1b(b), the Arbitrator notes that Petitioner was employed as a machine operator. He now works as a machine operator, but he does not do heavy lifting. Dr. Ghanayem opined that Petitioner could return to work at full duty, as of June 18, 2012. This factor is given some weight in determining PPD.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 21 years old at the time of the accident. The injury resulted in a back sprain, with no disc pathology, that has resolved. This factor is given some weight in determining PPD. Petitioner is a young man and he has recovered from his injury.

With regard to subsection (iv) of §8.1b(b), the Arbitrator notes that Petitioner has recovered from the back sprain injury. This factor is given no weight in determining PPD.

With regard to subsection (v) of §8.1b(b), the Arbitrator notes that the electrodiagnostic findings are found to be false positives or incidental findings and do not persuade the Arbitrator that petitioner's subjective complaints are supported by the treating medical records. Petitioner has residual complaints which can be related to the injury. This factor is given some weight in determining PPD.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 2% loss of use of a person as a whole pursuant to §8(d)2 of the Act.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator does not find that Petitioner is entitled to §16 fees or §19(k) penalties. Respondent's disputes in this case and its non-payment of benefits are not found to be unreasonable or vexatious.

Petitioner is entitled to §19(l) penalties, due to the non-payment of the bills incurred prior to the Dr. Ghanayem exam (especially the MRI bill!) and the TTD underpayment. Certainly TTD was clearly owed until the June 18, 2012 opinion of Dr. Ghanayem was known and the TTD that was paid (albeit late and in violation of Rule 7110.70) was paid at the incorrect rate of $220.00. The §19(l) penalty rate is $30.00 per day and, obviously, more than 333 days have elapsed without payment of the bills or the correct amount of TTD owed, so the amount of penalties awarded is $10,000.00, in accordance with §19(l).

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

Crystal Rose Cascio,
Petitioner,
vs.

NO: 12 WC 07617

Chester Mental Health Center,
Respondent,

17IWCC0223

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

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.

DATED: APR 13 2017
o040617
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

CASCIO, CRYSTAL(ROSE) Case# **12WC007617**

Employee/Petitioner

CHESTER MENTAL HEALTH CENTER

Employer/Respondent

17IWCC0223

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:

0478 FISHER KERKHOVER COFFEY
JORDAN D GREMMELS
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0558 ASSISTANT ATTORNEY GENERAL
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0498 STATE OF ILLINOIS
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1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
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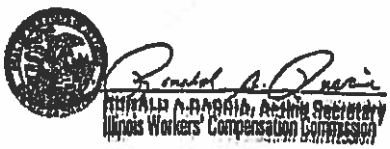
SPRINGFIELD, IL 62794-9208

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

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

AUG 15 2016



STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

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

CRYSTAL CASCIO (ROSE)
Employee/Petitioner

v.

CHESTER MENTAL HEALTH CENTER
Employer/Respondent

Case # 12 WC 07617

Consolidated cases: _____

17IWCC0223

An *Application for Adjustment 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 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. ☒ 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 _____

17IWCC0223

FINDINGS

On the date of accident, **June 29, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

The issue of timely notice of this accident is moot.

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

In the year preceding the injury, Petitioner earned **$57,290.69**; the average weekly wage was **$1,101.74**.

On the date of accident, Petitioner was **56** 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 paid occupational disability benefits that qualify under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner has failed to prove that she sustained accidental injuries arising out of and in the course of her employment with the Respondent on 6/29/11. She failed to prove that her job activities constituted a repetitive accident within the meaning of the Act and Illinois case law.

As a result of this finding, all other issues are moot, and 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 22, 2016
Date

ICArbDec19(b)

AUG 15 2016

STATEMENT OF FACTS

The Petitioner testified she has been employed as a security therapy aide (STA I) at the Respondent's Chester Mental Health facility since approximately 1990. She was performing that job at the time of her alleged accident, but testified that at the time of the hearing she was working for the Respondent as a transportation officer. Prior to the alleged accident date of 6/29/11, she would rotate between days and second shift, and worked a lot of overtime due to the facility being shorthanded, and her voluntary desire for more pay. Her regular shift was eight (8) hours, barring overtime. She had been assigned to Unit B for about seventeen (17) years.

The Petitioner's job involved handling the safety and security of the facility's mental health residents. Regarding her job duties, she testified: "We used to unlock each door of the individuals, which would be about 24 doors between two or three staff. Then you have to open up the cabinets for them to get their cosmetics, their commissary, whatever they're needing. The module, you have to go -- go on the stem, you have to unlock a door, and that's numerous times throughout the day. You have to restrain the patients." She testified that she would have to unlock cabinet padlocks to access various items approximately 3 times per shift, and would access the commissary cabinets about 2 times per shift. On cross exam, she testified that there are six cabinets total, some of which are like regular doors, and she opens them 10 to 15 times per day. Locks are also unlocked and relocked when there is a need to go to the nurse's cage (up to 10 times per day), resident showers (once per day) water closet (once or twice a week) and the staff bathroom (a couple of times per day).

On cross examination, the Petitioner agreed that the resident's doors were opened electronically via a computer touch screen since approximately 2005 or 2006, and thus there was no further keying of the resident room locks after that time. She would still have to "twist the door" to open it, which the Arbitrator infers meant she still had to turn a doorknob to open the door. Prior to the change, the Petitioner and one or two coworkers would have to unlock the 24 room doors up to 3 times per day. At some point, still prior to 2005 or 2006, residents no longer ate in their rooms, and this reduced the need to unlock a resident's room to one (1) time per day. She testified that the module doors are electronic, but the doors from the stem to the three modules require a key to open, as well as the break room – 4 doors total – and that she uses a key on these doors 10 to 15 times per day. It is unclear to the Arbitrator exactly how many times module and/or stem doors had to be unlocked, or if, after about 2006, those doors also were opened electronically or with a key. Petitioner agreed that there are 3 to 4 STAs, including herself, who staff the area and are involved in these activities. The Petitioner would have to perform these activities more often when she would work overtime. She testified that the force required to turn keys in locks at work was similar to that required to unlocking the door of her home.

The Petitioner testified that she also would have to restrain residents, who can be combative, which included grasping them to hold them, bringing them to their rooms and, if needed, strapping them down to a bed with belts. This sometimes includes using handcuffs and/or a chest "posey", though the charge aide would be responsible for the handcuffs. This would occur from 0 to 3 times per day, and other STAs would generally assist in this process.

A Genex Job Analysis was submitted by the Respondent as Rx5 with regard to the position of STA I. The job is listed as medium-heavy. An STA I walks around their area every 15 minutes for 80 to 100 feet to make sure things are in order and there are no altercations. They also have to do a patient count. They will walk patients in groups to meals, education, church, etc., at which time they have to count and cross count, and to make corrective statements to a patient who makes untoward actions. It specifically notes that the STA I uses a key to

open the dining room door when escorting patients to meals. They collect and account for meal trays and utensils. Once accounted for, the dining room door is again unlocked to escort the patients back. STA I's provide personal and commissary items to patients, which involves unlocking and locking padlocks on various cabinets. An STA has to chart their observations in handwritten form of things that take place with patients. In what appears to be the most strenuous part of the job, an STA must physically act to subdue and restrain patients who act violently, and this document indicates that usually there are other STA's who assist in this. A separate part of this document indicates that horizontal reaching and sitting is performed frequently. Occasionally the STA I must lift 50 to 100 pounds, perform total body push/pull, simple and firm grasping and "flexion/extension/deviation." All other listed potential activities are either not performed or performed infrequently. (Rx5).

The CMS Position Description, with regard to the physical aspects of the job, indicates an STA performs routine checks of the building and its interior to ensure the integrity of all locks and security systems, performs searches of resident rooms for contraband, maintains logs and reports as to resident activity and behavior, provides necessary supplies and generally assists residents with their daily tasks. (Rx6).

The Petitioner testified that in 2011 she noticed numbness and tingling in her hands, along with reduced grip strength, which made it hard to hold onto residents to restrain them. The symptoms were worst at bedtime, but it did sometimes bother her at work. She sought treatment with her primary care provider, Dr. Tucker, who referred her for a 6/29/11 EMG/NCV with Dr. Sawar, who told her she had carpal tunnel syndrome (CTS). She testified that she had never been diagnosed with CTS before, and had never before undergone treatment for these complaints before. Dr. Tucker then referred her to Dr. Brown, who agreed with the diagnosis and recommended surgery. She testified she'd had no real treatment prior to seeing Dr. Brown on 4/16/12, but she had purchased wrist braces for herself. She did not have surgery with Dr. Brown, and was eventually referred by Dr. Tucker to Dr. Jones, who also prescribed CTS release surgery. The Petitioner testified she had the same ongoing symptoms, which continued to be the worst at night, when she was in a relaxed state. She testified that she didn't follow up with Dr. Brown because his treatment wasn't being covered by workers compensation. She believed that Dr. Jones was covered by her group health insurance, but couldn't say why she then hadn't already had the surgery performed under that policy. On redirect exam, she indicated that she was concerned about being paid while off work for the surgery if she was not covered by workers' compensation.

Medical records were submitted into evidence by both parties. On 5/11/10, Dr. Tucker noted Petitioner had controlled hypertension, which she was taking medication for. Petitioner went to Marshall Browning Hospital on 3/21/11 with complaints of numbness in her right hand and right sided chest pain, with no injury or trauma. She reported 2-3 days of chest tightness, and that she woke up yesterday with her right hand numb and tingling for about 10 minutes, and she experienced the same symptoms today while driving. No specific condition was diagnosed at discharge, and she was advised to follow up with Dr. Tucker. His testing on 3/21/11 indicated a high level of uric acid, or hyperuricemia. As there was a question of gout based on complaints of swelling and pain in the right lower leg, she was given medication for gout. (Px3).

The Petitioner testified that she did not recall being diagnosed with gout, and that her foot swells and stays swollen. She also testified that a physician specialist took her off of a thyroid medication because he believed it was causing the swelling in her foot, that her family doctor did not agree with this, and that going off the medication sometime around 2011 didn't resolve the swelling.

On 4/18/11, Petitioner was following up after undergoing a stress test. Dr. Tucker noted an impression of hypertension and a history of gout. On 6/1/11, Petitioner followed up with Dr. Tucker regarding her hyperuricemia. She advised she was still taking her Uloric, but the swelling continued. (Px3, Px4).

An EMG/NCV was performed by Dr. Sawar on 6/29/11, and it appears this covered all extremities with a patient history indicating low back, right foot and neck pain as well as bilateral hand numbness and tingling. Dr. Sawar's conclusions were mild chronic right L5 radiculopathy, mild right and moderately severe left CTS. There was no evidence of ulnar or large fiber peripheral neuropathy, or of cervical radiculopathy. (Px2).

On 8/10/11, Petitioner presented to Dr. Tucker with complaints of swollen right foot and open blister on her right foot. In August 2011, she was diagnosed with right foot cellulitis with venous insufficiency in the right leg. (Px3).

On 8/15/11, Petitioner completed an Employee's Notice of Injury. She listed 6/29/11 as her date of injury, and indicated she injured her arms and hands by "turning of keys". The blank for indicating the injury report date was left blank. (Rx1). The 8/16/11 Supervisor's Report of Injury, completed by what appears to be an L. Hubert, states that "Michelle Clover emailed to inform that this is a carpal tunnel case." (Rx3). A Form 45, also completed on 8/16/11, also indicates a 6/29/11 date of accident, stating: "Worker has been diagnosed with Carpal Tunnel Syndrome in both wrists, from repetitively turning keys unlocking doors and closets." (Rx2).

On 9/28/11, Petitioner presented to Dr. Tucker, who reported that Petitioner saw neurologist Dr. Sawar, who did an EMG/NCV, and she said he (Sawar) told her there was nothing that could be done for her CTS. Petitioner wanted a second opinion regarding surgery and requested a referral to Dr. Coleman, a doctor who had treated her friend. Petitioner was assessed with CTS, hypertension, peripheral vascular disease, and hypothyroidism, and she was referred to Dr. Coleman. (Px3).

The records indicate Petitioner next saw Dr. Tucker on 2/15/12 complaining of intermittent low back pain, noting the pain had moved from her knee back to her right side. The diagnosis was muscle spasms. After initially going to Marshall Browning Hospital, she returned to Dr. Tucker on 2/17/12 with complaints of neck and left shoulder pain following an assault by a resident, who pinned her to the wall and hit her before they fell to the ground, with the Petitioner hitting her shoulder and neck. She underwent cervical and left clavicle x-rays which were negative for fracture. She was returned to work on 3/2/12 after receiving chiropractic treatment. On 3/27/12, Petitioner presented to Dr. Tucker requesting a referral to Dr. Brown for possible CTS release surgery, which Dr. Tucker provided. (Px3).

The Petitioner saw orthopedic surgeon Dr. Brown on 4/16/12. Intake forms from this visit reflect the following: Petitioner is right handed; Petitioner has high blood pressure and thyroid problems; Petitioner does not smoke; her symptoms are right and left hands, possibly elbows (illegible), neck and "should". With regard to her work history, Petitioner indicated "turning keys all day" - the remainder is not legible to the Arbitrator - and she works 40 hours per week, sometimes more. Following examination and review of the 6/29/11 EMG/NCV, Dr. Brown diagnosed bilateral carpal tunnel, left worse than right, and based on the failure to improve with months of splinting, surgery was recommended. Dr. Brown's report notes Petitioner's history of hypothyroidism, hypertension and heart disease. He released her to unrestricted work duties pending surgery. (Px2).

On 7/28/12, the Petitioner was diagnosed at Marshall Browning Hospital with vitamin D deficiency and hypothyroidism. The records to do not reflect the symptoms that brought her to the hospital. (Px4). The Petitioner thereafter had two additional visits to the hospital (2/5/13 & 6/29/13), where the diagnoses indicated were hypertension and/or hypothyroid. (Px4).

Petitioner was examined by Dr. Stewart at Respondent's request pursuant to Section 12 of the Act on 4/29/13. (Rx7). He reviewed the Petitioner's medical records and examined her, subsequently agreeing with the

diagnosis of bilateral CTS and the recommended release surgeries. He noted he reviewed his synopsis of the medical records with the Petitioner, and "she essentially concurred as far as the accuracy." Dr. Stewart indicated he had a very specific discussion with the Petitioner regarding her work activities: "She states that this is a Mental Health Center and it does not have the heavy prison type doors. These are essentially locked doors and she has to utilize a normal key to go through and each time she is passing into and out of a room or passing through the center she has to open and close the doors appropriately so they can maintain safety for the patients. The opening and closing of a specific regular door takes less than 2 seconds worth of time. Cabinet padlock is similar and she states that there is a small padlock on each cabinet for protection as well. When specifically questioned we tried to come up with a ballpark figure as far as how many times she thinks this may happen a day. This is very much a guess on her part having not given specific consideration but guessing between 100 and 150 times per day that she may be altering either the padlocks or obviously the locks on the doors." In his conclusions, Dr. Stewart indicated that, while there are activities that involve an increased risk of carpal tunnel, they involve "forceful repetitive activities and it is truly a combination of those two." Simple repetitive activities such as data entry, presuming a reasonable position at a work station, do not increase the risk. He opined: "Similarly if we take even a high number of 150 doors per day at approximately 2 second per door that is only 300 seconds or approximately 5 minutes of time that she is doing this over a work day. Certainly there would be a much greater period of time for recovery." He noted that Petitioner has an elevated BMI and hypothyroidism, which can impact both the development and symptoms of carpal tunnel. (Rx7).

The Petitioner testified on cross examination that it was accurate that it took 2 seconds to unlock a door, and that her estimate of 100 to 150 times using a key per day goes back to when she was still involved in opening resident room doors with a key. She also testified that the 100 to 150 per day estimate would include overtime, and thus on a regular shift she would do this half as often.

On 8/15/13 the Petitioner went to Marshall Browning Hospital following an unspecified work injury, and complained of bilateral shoulder and arm pain, and neck/upper back pain, as well as hands tingling. It appears that physical therapy was prescribed by Dr. Tucker, but no specific diagnosis was indicated. An initial therapy evaluation report from 8/15/13 indicates she was injured on 8/12/13 when, while escorting a patient to a secure area, the patient had to be laid down on the floor due to the patient kicking at her and her co-workers. Once the patient was on the ground, she tried to reaffirm her grasp on the patient's leg, but he kicked causing her to strain her arms, neck and back. The Petitioner also noted she has had carpal tunnel for a while but hasn't had surgical approval, and she complained of achy pain in the bilateral arms (hands to shoulders), neck and upper back between the shoulder blades. She also reported stiffness in her arms and upper body, headaches and an episode of insidious onset of numbness in her right leg that had resolved. The subsequent therapy records indicate that Petitioner was trying to get an MRI and NCV approved, but there is no indication if either test was performed. Therapy continued through what appears to be 2/27/14, and it appears that therapy did not provide significant improvement, but was ongoing. The diagnosis at that point, per the therapy records, was cervicalgia and bilateral upper extremity radiculopathy. She had not undergone an NCV or injections yet, but was back to work, and she had been provided a TENS unit. It appears that these things were prescribed by a neurosurgeon, Dr. Jones. She continued to complain of burning arm pain into the hand that wakes her up at night. (Px4).

On 9/23/14, Dr. Tucker noted Petitioner was there for follow up and medication refills with regard to her workman's comp injury involving neck pain with radiculopathy.

Dr. Jeffrey Jones testified via evidentiary deposition on 2/2/16. (Px1). A board certified neurosurgeon, Dr. Jones testified that while the spine and brain were his main practice areas, he treated patients with carpal tunnel injuries, and performed approximately 20 to 30 carpal tunnel surgeries per year. He testified that he treated the Petitioner for her carpal tunnel condition as well as a subsequent cervical condition, which is not related to the

case at bar. He first saw the Petitioner in January of 2014, when she complained of bilateral arm pain and parethesias. He testified that Petitioner complained of the symptoms after an 8/12/13 work injury while restraining a patient, but that he "heard" she had treated for carpal tunnel prior to the alleged 8/12/13 work injury. He conducted a physical examination and reviewed an EMG/NCV reflecting severe right median nerve carpal tunnel syndrome as well as mild to moderate left carpal tunnel syndrome. Dr. Jones testified that nothing in detail about work duties was discussed with his assistant, Angie, at the initial visit on 1/14/14, but that Angie did record some detail about Petitioner's job duties at the second visit of 5/1/14. Angie stated that the Petitioner reported working security for a facility for 20 plus years, used her right upper extremity in repetitive ways, including desk work, and was right handed and thus used her right hand for everything. Dr. Jones did not see or examine the Petitioner himself until the 5/1/14 visit. He recommended carpal tunnel surgery. Given that her hand symptoms were the most severe complaint, and carpal tunnel was less invasive surgery than cervical, Dr. Jones opined that carpal tunnel surgery should be performed first, to see if the remaining symptoms were something she could then live with or not. (Px1).

Asked to opine to a hypothetical, Dr. Jones testified that a person who turns keys, cuffs mental patients, locks and unlocks doors as well as gross hand manipulation for six to eight hours per day could have an effect on the development of carpal tunnel syndrome. Dr. Jones further testified: "Anybody that uses their hands for a living is going to be at increased risk", with the dominant hand being most at risk. (Px1, p. 13). He also testified that the Petitioner's cervical condition was separate and unrelated to her carpal tunnel condition, explaining that the Petitioner's cervical pathology level (C6/7) could potentially overlap with an ulnar nerve problem, not a median nerve problem. However, he did indicate that it was possible the Petitioner isn't able to separate carpal tunnel from radicular symptoms. Dr. Jones agreed that the Petitioner's history of hypothyroidism and her BMI level could increase her risk for the development of carpal tunnel syndrome, but that not all people with these comorbidities develop carpal tunnel. He noted that he hadn't reviewed the carpal tunnel literature in a long time, and thus could not comment on whether gout could be related to carpal tunnel, or if a female is more likely than a male to develop carpal tunnel. He also testified that her job activities might or could have contributed to the development of her carpal tunnel syndrome, or might or could have aggravated any pre-existing carpal tunnel syndrome. Dr. Jones explained the Petitioner's comorbid factors, i.e. hypothyroidism, and BMI, could have placed her at an increased risk, when combined with her work duties, to develop carpal tunnel syndrome. He believed the Petitioner's work to be a factor specifically due to her being right hand dominant and her carpal tunnel being worse on the right side. (Px1).

On cross examination, Dr. Jones agreed he had not reviewed the records of Dr. Brown, and wasn't certain if he reviewed the prior EMG/NCV of Dr. Sawar. He also did not review any formal or written job descriptions, he just relied on what the Petitioner told him and what Angie indicated in the medical notes. He also agreed that he did not personally recall whatever work duty history he took from the Petitioner, and that it was likely he did not go into it with Petitioner with any depth. He further testified that he didn't discuss any prior history or injuries other than the 8/12/13 incident. Asked about his understanding of what type of doors the Petitioner was keying at work, he testified: "Oh, I don't even know if I even went that far with the thought process. I just assumed she did repetitive - - you know, I am thinking in my head, you know, 'One Flew Over the Cuckoo's Nest' type thing and going through and handing out pills. That's probably what I thought'." (Px1, p. 26). Asked about Dr. Stewart's understanding of keying up to 150 times per day, and that being about 5 minutes of her entire workday, Dr. Jones testified: "I'm not sure I thought about it that much. I mean, I just looked at it as okay, she's got a repetitive job. She has been working at it a long time. You know, if she said well, I had this job for six months, I'm getting these symptoms . . ." (Px1, p. 27). He ultimately testified that there was no way for him to say for sure how much her job may have contributed, just that it likely did: "But her being right handed, being at the same job for 20 years, and she probably has a predisposition for it because of the other medical comorbidities, I cant give you an educated – well, not even an accurate description of how much the job

contributed to it. Did it contribute to it? Probably, but I can't tell you how much it did." (Px1, p. 28). He was not familiar with any studies which indicated that hand posture and/or force were relevant to whether job duties were causative of carpal tunnel, but testified he wouldn't be surprised by that, and that he did not have any information regarding the Petitioner's hand postures or hand force at work. He reiterated that he believed Petitioner's job contributed to her carpal tunnel, but couldn't say how much, and that "it could be very small." He agreed that Petitioner had the condition bilaterally, but that it was more severe on the right, acknowledging that the bilateral nature would make it seem more like it would be due to non-work issues, and that ". . . even though it is more severe on the right hand, it doesn't really help us all that much as to the work causing it." (Px1, p. 35). The fact that she did the same job over and over for 20 plus years is where he determined that the work duties were repetitive: "With her, it may have taken 20 years because it wasn't that demanding, but over a 20 year period it probably contributed somewhat." (Px1, p. 37). He further testified: "I am pretty sure it contributed because everything you do throughout your day (is) going to contribute." (Px1, p. 38).

Dr. Patrick Stewart testified, via evidentiary deposition, on 11/26/13. (Rx8). A board certified surgeon, he testified that he treats about 200 to 300 carpal tunnel patients yearly, and performs 100 to 150 release surgeries per year. Dr. Stewart testified he conducted a physical exam of the Petitioner and reviewed her prior records and diagnostic studies. He also testified that he reviewed a written job description and took a history from Petitioner directly regarding her job activities, noting they reviewed the written job description together and the Petitioner did not find any discrepancy with it. He agreed with the diagnosis of bilateral carpal tunnel syndrome and with the reasonableness of bilateral release surgeries. Dr. Stewart testified that Petitioner's age, gender, increased BMI, hypothyroidism, hypertension, history as a smoker, and diagnosis of gout all were factors which increased Petitioner's risk of developing carpal tunnel syndrome. Dr. Stewart agreed that the records he reviewed did not show any evidence that Petitioner had gout diagnosed in her upper extremities.

Dr. Stewart testified that it was his opinion within a reasonable degree of medical certainty that Petitioner's job duties did not cause or contribute to the development of her bilateral carpal tunnel syndrome. Dr. Stewart testified that his opinion was based upon the absence of any of the environmental risk factors associated with an increased risk of developing the condition, which include forceful repetitive activity, cold exposure, and vibratory exposure of a significant duration as to result in an increased risk. Dr. Stewart testified that Petitioner gave a rough estimate she would turn 100 – 150 door and padlock keys in a given shift, and that it would take two seconds or less to turn a key. Dr. Stewart testified that this resulting period of time would have only been five minutes over an eight hour day. He noted that the isolated job duties Petitioner was most concerned about was the turning of keys, that he questioned her specifically about this. He believed she could work full duty pending surgery. (Rx8).

On cross-examination, Dr. Stewart testified that the job description he reviewed suggested the Petitioner performed fine hand manipulation up to zero to two hours per regular shift and gross hand manipulation up to six to eight hours per regular shift. He opined that even if such gross manipulation was done that often, it would not be contributory if there is no weight associated with it. He agreed that a high BMI level could predispose a person to a number of possible medical problems, and that he did not know how often the Petitioner smoked. (Rx8). Asked if simple, repetitive activities that are performed over the course of 20 years could impact a person's carpal tunnel, Dr. Stewart testified that "studies have not shown that." (Rx8, p. 32).

The Respondent was represented at the hearing by Bobby Misuraca. Mr. Misuraca did not testify.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, and WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner has failed to prove that she sustained accidental injuries to the bilateral wrists and hands which arose out of and in the course of her job duties with the Respondent on 6/29/11.

The Petitioner's testimony indicated that any use of her hands to open locked doors was not significantly repetitive. Dr. Stewart's report and testimony is well taken in terms of his indication that, based on the Petitioner's own reporting, she was spending a total of approximately 5 minutes per shift opening locks. It further appears that this estimate included the Petitioner's overtime work as well. Additionally, the Petitioner testified that her symptoms began in 2011, while in 2005 or 2006 the Respondent's facility changed over to an electronic lock system for most resident doors which resulted in the Petitioner having to open locked doors much less often than she had before. Based on this evidence, the Arbitrator does not believe that the Petitioner's work duties in unlocking doors and cabinets was repetitive within the meaning of the Act.

The Arbitrator also notes that the evidence does not support a finding of a causal connection in this case between the work duties and the Petitioner's diagnosed condition of bilateral carpal tunnel. First, the initial EMG/NCV of 6/29/11 indicated that the Petitioner's left carpal tunnel was significantly worse than the right. The Petitioner is right handed, and thus it doesn't seem to make logical sense that her left side would be worse than the right side if her condition was due to the turning or keys. Secondly, the Petitioner's initial report, per the Arbitrator's review of the records, of carpal tunnel-like symptoms was on 3/21/11 at Marshall Browning Hospital. At that time she reported two to three days of right chest tightness, and that she had awoken with numbness and tingling in her right hand.

The Petitioner, according to both Dr. Jones and Dr. Stewart, had multiple comorbidities which could be related to the development of carpal tunnel syndrome: among these are hypertension, hypothyroid, female gender, elevated body mass index, gout and peripheral vascual disease.

The Arbitrator notes that, per Rx1 and 2, the Petitioner's reporting of an injury and alleged workers compensation accident specifically alleged that her hand/wrist conditions were due to turning keys at work. The Arbitrator questions the Petitioner's statement to Dr. Tucker in September, 2011 she was told by Dr. Sawar, following her 6/28/11 EMG/NCV testing, that nothing could be done for her condition. Clearly, something could be done for her condition and ultimately was, so it is not believable that Dr. Sawar would have made such a statement.

The Arbitrator finds that the testimony of Dr. Stewart was more persuasive than that of Dr. Jones with regard to causation. First, the Arbitrator notes that Dr. Stewart's practice is significantly more focused on the hands and upper extremities than that of Dr. Jones. Ultimately, in opining that there was a causal connection, Dr. Jones' testimony was essentially, as he specifically testified, that anyone who uses their hands for a living is going to be at an increased risk of carpal tunnel syndrome. The Arbitrator must take this to mean that any use of the hands will increase the risk of carpal tunnel syndrome. While this supports a determination that the Petitioner's CTS condition could be related to her work duties, it does not support a finding that an accident occurred which arose out of and in the course of her employment. People who use their hands in their employment include virtually all workers. There may be some jobs which involve little to no hand use, but the Arbitrator would have difficulty identifying many jobs which do not in some way involve the use of the hands to perform the job. At one point during his testimony, Dr. Jones was asked about how a comorbidity could contribute to carpal tunnel,

and he indicated that a hand specialist would likely know a lot more about such issues because they work with this stuff every day. Dr. Jones did not appear to be as well versed in the literature with regard to carpal tunnel syndrome.

Dr. Stewart's calculation of the total time that the Petitioner would have spent at work turning keys to be 5 minutes was significant in this case, particularly since this would be on the high side given the Petitioner's testimony that this calculation was based on her shifts including overtime. Dr. Stewart's testimony also noted that an increased risk of the development of carpal tunnel from work duties would be based on forceful repetitive activity in a case like this, and that there was no evidence of same in the Petitioner's reported work duties.

Overall, the greater weight of the evidence indicates that the Petitioner failed to prove either a compensable accident, or that her bilateral carpal tunnel condition was causally related to her work duties.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's finding that the Petitioner failed to prove accident, this issue is moot.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's finding that the Petitioner failed to prove accident, this issue is moot.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's finding that the Petitioner failed to prove accident, this issue is moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Samuel F. Gentile,

Petitioner,

vs. No. 12 WC 07755

Universal Insulation, Inc.,

17IWCC0237

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical care, temporary disability and permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission agrees with the Arbitrator's Decision in all respects, except the extent of Petitioner's disability. The Commission finds the injuries sustained caused permanent disability to the extent of 3 percent of the person as a whole. Petitioner testified that he twisted, slipped and fell when, while backing away from a ladder, he stepped on some pipes on the ground. Emergency room records note a history of accident consistent with Petitioner's testimony. While the Commission agrees with the Arbitrator that the surgery Petitioner underwent is causally related to his preexisting condition, the Commission finds the accident did cause some residual permanent disability. The Commission notes that approximately six weeks after the accident, Dr. Butler diagnosed a lumbar strain and recommended injections followed by a four week course of physical therapy. Dr. Butler anticipated Petitioner would reach maximum medical improvement after eight weeks of treatment. The Arbitrator relied on the opinions of Dr. Butler. The Commission believes an award of permanent disability to the extent of 3 percent of the person as a whole is consistent with Dr. Butler's opinions and supported by the record.

17IWCC0237

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 29, 2016, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $1,168.00 per week for a period of 14 4/7 weeks, from February 14, 2012 through May 25, 2012, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the emergency room bill in the sum of $2,694.00 pursuant to §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $695.78 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 permanent disability to the extent of 3 percent of the person as a whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $30,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 14 2017
o-03/23/2017
SM/sk
44

Stephen Mathis

David L. Gore

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GENTILE, SAMUEL F
Employee/Petitioner

Case# **12WC007755**

UNIVERSAL INSULATION INC
Employer/Respondent

17IWCC0237

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:

0147 CULLEN HASKINS NICHOLSON ET AL
DAVID B MENCHETTI
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0560 WIEDNER & McAULIFFE LTD
BROOKE TORRENGA
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

S. Gentile v. Universal Insulation, Inc., 12 WC 07755

17IWCC0237

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

Samuel F. Gentile
Employee/Petitioner

Case # 12 WC 07755

v.

Universal Insulation, 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 Jeffrey Huebsch, Arbitrator of the Commission, in the city of Chicago, on April 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. ☒ 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 02/13/2012, 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.

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

In the year preceding the injury, Petitioner earned $91,104.00; the average weekly wage was $1,752.00.

On the date of accident, Petitioner was 48 years of age, *single* with 0 dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $1,168.00/week for 14-4/7 weeks, commencing February 14, 2012 through May 25, 2012, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner reasonable and necessary medical services pursuant to Section 8(a), Section 8.2, the medical fee schedule and the holding in Springfield Urban League, 2013 Il App (4th) 120219WC: University of Chicago Hospitals, emergency room, February 13, 2012, $2,694.00.

Petitioner failed to prove a causal connection between the accidental injuries of February 13, 2012 and his current condition of ill-being regarding his low back. Thus, any claim for permanent partial disability 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 27, 2016
Date

JUN 29 2016

FINDINGS OF FACT

On February 13, 2012, the Petitioner Samuel F. Gentile (Petitioner) was working as a pipe insulator for the Respondent Universal Insulation, Inc. (Respondent). Petitioner had worked full duty for Respondent for 6 years. The job of pipe insulator required Petitioner to climb ladders, crawl, bend and stoop and to carry various weights. The job of pipe insulator is classified within the heavy physical demand level.

Prior to February 13, 2012, Petitioner had problems with his back and had received medical treatment for his back. Petitioner had been involved in a motor vehicle accident in February of 2011. He began treatment with Dr. Mark Sokolowski, M.D. on September 6, 2011. Dr. Sokolowski provided injections, without much relief. A Lumbar MRI had been done on August 19, 2011 and was said to show degenerative changes at many levels, with a bulging disc at L3-L4 and moderate stenosis. On November 10, 2011, Dr. Sokolowski noted that Petitioner had an unremarkable EMG and Dr. Sokolowski was not certain that surgical decompression would help Petitioner at that time. Therefore, Petitioner was referred to Dr. E. Boone Brackett for examination of his back and hip. (Rx #3) On December 21, 2011, Dr. Brackett indicated that Petitioner's neurological exam was normal and that straight leg raising test was normal. (Rx # 2) On January 6, 2012, Petitioner underwent comprehensive pain management consultation with Dr. Shobhana Patodia, M.D. Petitioner complained of low back pain radiating down to the left leg. "He has to watch his every move. He cannot turn his back." (Rx #4) A report from Accelerated Rehabilitation on January 12, 2012 indicated that Petitioner's work status was full duty. Petitioner wanted to stop therapy and pursue low back surgery. (Rx# 2)

On February 13, 2012, Petitioner was working for Respondent in his full duty capacity as a pipe insulator at the University of Chicago. As Petitioner descended a ladder, he stepped on some pipes on the ground, twisted and fell to the ground. Petitioner immediately noticed pain in his back and pain in his leg. Respondent presented no evidence disputing this incident.

Petitioner was brought from the scene of the incident to the University of Chicago Hospitals emergency room by ambulance. He arrived at 11:11 am. (Px# 1) Petitioner gave history of mechanical fall off last rung of ladder and stepping back on to some pipes. Petitioner was

assessed with acute worsening of low back pain and sciatica after fall. Petitioner gave history of being unable to walk after falling, taking Norco related to chronic back problems and having sciatica into the left leg prior to the fall. The physical exam revealed that strength and sensation of the bilateral lower extremities was intact and equal. There was no evidence of bruising or abrasions. Petitioner was discharged ambulatory at 2:20 pm. The ER bill of $2,694.00 was claimed by Petitioner and submitted as a part of Petitioner's Exhibit No. 1. (Px# 1)

On February 14, 2012, Petitioner followed up with Dr. Patodia and gave a history of the fall and diagnosis was lumbar radiculopathy status post fall. On February 27, 2012, Dr. Patodia noted left lumbar radiculopathy, new injury. (Rx #4)

On March 9, 2012, the Respondent's medical case manager Debra Ragusa, R.N., spoke with the Respondent's safety manager Sam Eckman, who confirmed how the Petitioner's accident happened. (Px #3)

Petitioner was seen by Dr. Jesse Butler, M.D. for a §12 exam, at the request of Respondent, on March 30, 2012. Dr. Butler diagnosed lumbar strain and lumbar spinal stenosis. Dr. Butler noted negative straight leg raising, a normal gait and negative neurologic findings. Dr. Butler recommended that Petitioner remain off work pending treatment recommendations, including additional injections to reduce Petitioner's referred leg pain. Dr. Butler believed that maximum medical improvement would be achieved in 8 weeks. Subsequently, Dr. Butler reviewed a large amount of medical records, including the 8/19/2011 and the 4/5/2012 MRI films. He thought that the later study showed no change from the prior study. (Rx #1)

A Lumbar MRI performed April 5, 2012 showed broad based concentric disc bulge or protrusion at L3-L4 causing mild central and bilateral foraminal stenosis, along with other degenerative changes. The radiologist compared this study with the August 19, 2011 study and found no change. (Px #4)

On May 7, 2012, Dr. Patodia informed the Respondent's medical case manager Debra Ragusa, R.N., that Petitioner's symptoms had increased since the accidental injuries of February 13,

2012. On May 21, 2012, Dr. Patodia recommended lumbar epidural steroid injection and physical therapy. On June 12, 2012 Petitioner underwent epidural steroid injection by Dr. Patodia. (Px #3)

On June 13, 2012, Petitioner followed up with Dr. Sokolowsiki who noted that Petitioner had significantly greater pain and significantly more functional limitation after the fall of February 13, 2012. Dr. Sokolowski made the following diagnoses that were causally related to the work injury: acute worsening of lumbar pain and acute worsening of lumbar radiculopathy and recommended the epidural steroid injection with Dr. Patodia. On July 3, 2012, Dr. Sokolowski proposed L3-4 lumbar decompression. (Px #2)

On October 24, 2012, Petitioner underwent operative procedure on his back by Dr. Sokolowski at Westlake Hospital consisting of L3 and L4 laminectomy, with decompression from L3-L5. (Rx # 3) After the operative procedure, Petitioner continued to follow up with Dr. Sokolowski who recommended physical therapy and ongoing pain management with Dr. Patodia. (Px #2)

Petitioner reported improvement in his back and leg pain after the operative procedure in February 2013. On January 14, 2013, Petitioner stated that he was glad he had the surgery and was in a much better place. (Px #3)

On April 2, 2013, at the referral of Dr. Sokolowski, Petitioner underwent a functional capacity evaluation at Function 1st Physical Therapy that showed Petitioner demonstrated the ability to perform 100% of the physical demands of his job as a pipe insulator. PX 2, p. 30. On April 3, 2013, Dr. Sokolowski released Petitioner to return to work full duty. (Px # 2)

After the release to return to work full duty, Petitioner continued to follow up with Dr. Sokolowski . (Px # 2)

Dr. Sokolowski testified by evidence deposition taken by agreement of the Parties. (PX 5) Dr. Sokolowski diagnosed Petitoner with acutely worsened lumbar pain and acutely worsened radiculopathy, causally connected to the work injury of February 13, 2012. Dr. Sokolowski

opined within a reasonable degree of medical certainty that there is a causal connection between Petitioner's condition of L3 to L5 radiculopathy and the work-related accidental injuries of February 13, 2012. Dr. Sokolowski was aware of Petitioner's pre-existing condition prior to February 13, 2012 and noted sensory changes and changes in Petitioner's sitting straight leg raising after the February 13, 2012 accidental injuries. Dr. Sokolowski noted that Petitioner experienced significant decrease in the magnitude of radiculopathy after the operative procedure of October 24, 2012 and, because of that, Dr. Sokolowski opined that the treatment rendered to Petitioner was reasonable and necessary. Dr. Sokolowski's goal in performing the surgery on Petitioner was to diminish Petitioner's lumbar radiculopathy symptoms. Dr. Sokolowski was aware that Petitioner had a negative EMG in October 2011, before the accidental injuries of February 13, 2012. Dr. Sokolowski noted that Petitioner had a markedly positive sitting straight leg raise at 30 and 45 degrees after February 13, 2012, whereas before then, Petitioner had a positive straight leg raise only at full extension or 90 degrees. (Px# 5)

Dr. Jesse Butler testified by evidence deposition taken by agreement of the Parties. (Rx #1) Dr. Butler saw Petitioner at Respondent's request pursuant to Section 12 on March 30, 2012 and performed a records review on July 17, 2014. (Rx #1, DepX 2 & DepX 3) Dr. Butler agreed that Petitioner suffered an injury to his back on February 13, 2012. As of March 30, 2012, Dr. Butler felt the Petitioner was unable to work in his job as a pipe insulator due to the accidental injuries of February 13, 2012 and that Petitioner would not reach maximum medical improvement for 8 weeks from that time. Dr. Butler believed that all the treatment Petitioner received from Dr. Sokolowski was reasonable and necessary, but Dr. Butler felt that it was not related to the work-related accidental injuries of February 13, 2012. Dr. Butler stated that relief of pain and radicular symptoms would be reasons for a person to undergo the type of surgery Petitioner had. There was no causal connection between the fall of February 13, 2012 and Petitioner's condition of ill-being regarding his low back that led to the surgery. The work injury did not alter Petitioner's complaints. The imaging studies do not show structural changes as a result of the fall. Petitioner's pain scores were virtually identical, before and after the fall. (Rx #1)

Petitioner introduced the bill from the University of Chicago Hospitals for emergency room treatment on February 13, 2012. (Px #1) The Parties stipulated that all other medical bills were

paid by Respondent through a group medical plan for which credit is allowed to Respondent pursuant to Section 8(j) of the Act.

Petitioner apparently did not work at all from February 14, 2013 through April 4, 2013. Petitioner is currently working as a pipe insulator. Petitioner continues to notice pain in his back and pain in his left leg. He feels that he has to watch his movements now. He is less able to do activities that he was able to perform before the accident.

On cross-examination, Petitioner said that he believes that the option of back surgery was offered before the accident, after first saying that he did not recall. He did not know why therapy stopped in January of 2012. He was taking pain medication for his low back at the time of the accident.

CONCLUSIONS OF LAW

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

Issue (C), Did Petitioner sustain accidental injuries which arose out of and in the course of Petitioner's employment by Respondent on February 13, 2012?

The Arbitrator finds that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on February 13, 2012 when he stepped off a ladder and fell on some pipes, striking his back and buttocks on the ground based upon Petitioner's testimony, the University of Chicago ER records and the notation confirming that Respondent agreed that the accident occurred contained in nurse Ragusa's records (Px #3).

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

The Arbitrator finds that Petitioner's current condition of ill-being regarding his low back is not causally related to the injury. The opinions of Dr. Butler are credible and persuasive on this

issue. Further, the radiologist interpreting the 2 Lumbar MRI studies found no change after the accident. Petitioner was taking narcotics for low back pain before the accident. He had advised that he wanted to stop therapy and pursue back surgery as of January 12, 2012, some one month before the accident. The records of Dr. Patodia do not support that an acceleration or aggravation of Petitioner's spinal condition occurred. Dr. Sokolowski's opinion is not persuasive in this case, especially since he did not see Petitioner until 4 months after the accident and some 7 months after the last pre-accident visit in November of 2011.

The surgery and Petitioner's current condition of ill-being regarding his lumbar spine is causally related to the progression of the degenerative condition of his lumbar spine that he had before the fall of February 13, 2012 and which was not aggravated, accelerated or exacerbated by the accident.

Issue (J). Medical Expenses

Based upon the Arbitrator's findings above regarding accident and causal connection, the Arbitrator awards the claimed bill from University of Chicago ER, in the amount of $2,694.00, pursuant to §§8(a) and 8.2 of the Act.

Issue (K), TTD

The Arbitrator awards TTD in the amount of $1,168.00/week for 14-4/7 weeks commencing February 14, 2012 through May 25, 2012, based upon the findings above regarding accident and causation and the opinion of Dr. Butler that Petitioner would reach MMI 8 weeks after the exam date of March 30, 2012 and that said treatment (and Petitioner's inability to work) was causally related to the accident.

Issue (L), Nature and Extent

Based upon the Arbitrator's finding regarding causation, Petitioner's claim for PPD is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

☒ 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

Dennis Evans,

Petitioner,

17IWCC0259

vs.

NO: 12 WC 8643
14 WC 32298

Hostess Brands,

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 prospective medical, permanent partial disability, temporary total disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 $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: APR 25 2017
KWL/vf
O-4/11/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Stephen Mathis

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

17IWCC0259

EVANS, DENNIS
Employee/Petitioner

Case# **12WC008643**

14WC032298

HOSTESS BRANDS
Employer/Respondent

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:

4707 LAW OFFICE OF CHRIS DOSCOTCH
DAMON YOUNG
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PEORIA, IL 61604

4136 ADELSON TESTAN & BRUNDO
MARCY E BENNETT
125 S WACKER DR SUITE 1717
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

17IWCC0259

Dennis Evans
Employee/Petitioner

Case # 12 WC 08643

v.

Consolidated cases: 14 WC 32298

Hostess Brands
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 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 Vocational Rehabilitation/Job Assistance

17IWCC0259

FINDINGS

On the date of accident (manifestation), January 30, 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 $40,884.48; the average weekly wage was $786.24.

On the date of accident, Petitioner was 49 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 $96,744.97 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $96,744.97. The parties stipulated that all TTD benefits were paid through September 24, 2015.

Respondent is entitled to a credit of $4,575.30 under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner maintenance benefits of $524.16 per week for 42 1/7 weeks, commencing September 25, 2015, through July 15, 2016, as provided in Sections 8(a) of the Act.

Respondent shall provide vocational rehabilitation and job assistance services to Petitioner as provided in Section 8(a) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

August 11, 2016
Date

AUG 16 2016

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim both of which alleged that Petitioner sustained repetitive trauma injuries arising out of and in the course of his employment for Respondent. In case number 14 WC 32298, the Application alleged a date of accident (manifestation) of January 20, 2012, and that Petitioner sustained repetitive trauma to the neck, left shoulder and bilateral arms. In case number 12 WC 08643, the Application, as amended, alleged a date of accident (manifestation) of January 30, 2012, and that Petitioner sustained repetitive trauma to the right arm, right hand, left arm, left hand and left shoulder (Petitioner's Exhibit 1).

Respondent stipulated that Petitioner sustained repetitive trauma injuries as alleged in the Applications and did not dispute Petitioner's diagnoses of right and left rotator cuff tears and related treatment until September 8, 2015. Petitioner claimed that he was entitled to payment of temporary total disability benefits for 184 4/7 weeks, commencing March 12, 2012, through September 24, 2015. Respondent stipulated that Petitioner was entitled to payment of temporary total disability benefits for that period of time. Petitioner also claimed that he was entitled to maintenance benefits for 42 weeks, commencing September 25, 2015, through July 15, 2016 (the date of trial). Respondent disputed liability for that period of maintenance benefits on the basis of causality. Petitioner claimed that he was an odd lot permanent and total disability (Arbitrator's Exhibit 1).

At trial, Petitioner testified that while working for Respondent in January, 2012, his job duties required him to lift/move racks that contained loaves of bread on trays. Over a period of time, Petitioner began to have pain in both of his shoulders. During the course of Petitioner's testimony, it was determined that he sustained a stroke in December, 2013. Petitioner did not allege that the stroke was related to either of his work-related accidents; however, the Arbitrator noted that Petitioner did experience some difficulties in speaking and understanding questions when he testified.

Petitioner initially sought medical treatment from Dr. Daniel Hoffman, on January 20, 2012 (the date of manifestation alleged in 14 WC 32298). At that time, Petitioner informed Dr. Hoffman that he had right shoulder pain and numbness in the hands over the last several months. Dr. Hoffman opined that Petitioner had carpal tunnel syndrome and a possible rotator cuff tear. He ordered an MRI scan of the right shoulder (Petitioner's Exhibit 8).

The MRI of Petitioner's right shoulder was performed on January 27, 2012. It revealed rotator cuff tendinosis with a partial under surface tear of the supraspinatus tendon, a degenerative labral tear with paralabral cyst, AC joint arthritis and mild subscapularis tendinosis (Petitioner's Exhibit 10).

Dr. Hoffman saw Petitioner on January 30, 2012 (the date of manifestation alleged in 12 WC 08643). He restated his diagnosis of carpal tunnel syndrome and possible rotator cuff tear and indicated he was going to refer Petitioner to Dr. Brent Johnson, an orthopedic surgeon (Petitioner's Exhibit 8).

Dr. Johnson saw Petitioner on February 8, 2012. At that time, Petitioner advised that he had injured his right shoulder at work on January 3, 2012, while pulling bread trays at or above shoulder height. Dr. Johnson examined Petitioner and reviewed the MRI scan. He opined that Petitioner had a right shoulder partial thickness rotator cuff tear and a right shoulder degenerative labral tear with paralabral cyst. He discussed treatment options of injections/physical therapy or proceeding with arthroscopic surgery (Petitioner's Exhibit 9).

Petitioner was again seen by Dr. Hoffman on March 1, 2012. At that time, Petitioner complained of pain in both the right and left shoulders. Dr. Hoffman opined that Petitioner had carpal tunnel syndrome and a possible rotator cuff tear in regard to the left shoulder. He ordered an MRI scan of the left shoulder (Petitioner's Exhibit 8).

The MRI was performed on March 8, 2012. It revealed rotator cuff tendinosis with a partial bursal and under surface tears of the supraspinatus and infraspinatus tendons, subscapularis tendinosis, labral degeneration and degenerative labral tearing with paralabral cyst formation, AC joint arthritis and synovitis and some muscle atrophy (Petitioner's Exhibit 10).

Petitioner continued to be treated by Dr. Hoffman for bilateral shoulder pain from March through July, 2012. Dr. Hoffman's treatment consisted primarily of anti-inflammatory medications (Petitioner's Exhibit 8).

Petitioner was subsequently seen by Dr. Johnson on October 28, 2013. At that time, Petitioner complained of significant pain in both shoulders especially when he had to do any lifting. Given the fact that Petitioner's symptoms had not improved, he recommended that they proceed with surgery on the right shoulder (Petitioner's Exhibit 9).

In December, 2013, Petitioner moved to Aurora, Colorado. On December 10, 2013, Petitioner was evaluated by Dr. Michelle Wolcott, an orthopedic surgeon. Dr. Wolcott recommended that Petitioner have an MRI of the right shoulder. On December 13, 2013, she gave Petitioner a steroid injection. Dr. Wolcott saw Petitioner on December 23, 2013, and Petitioner advised that the injection only gave him some temporary relief. She noted that there was a problem in obtaining authorization for the MRI (Petitioner's Exhibit 2).

Dr. Wolcott performed arthroscopic surgery on Petitioner's right shoulder on February 6, 2014. The procedure consisted of subacromial decompression, distal clavicle resection and rotator cuff repair (Petitioner's Exhibit 2).

Following the right shoulder surgery, Petitioner continued to be treated by Dr. Wolcott for bilateral shoulder pain. On August 27, 2014, an MRI scan was performed on Petitioner's left shoulder. It revealed a partial thickness tear of the distal supraspinatus and leading edge fibers of the infraspinatus, anterior inferior labral tear with paralabral cyst complex, partial thickness cartilage damage of the humeral head and possible impingement of the acromion (Petitioner's Exhibit 2).

Dr. Wolcott performed arthroscopic surgery on Petitioner's left shoulder on October 23, 2014. The procedure consisted of subacromial decompression, distal clavicle excision and rotator cuff repair (Petitioner's Exhibit 2).

Subsequent to the left shoulder surgery, Petitioner continued to be treated by Dr. Wolcott. When Dr. Wolcott saw Petitioner on March 17, 2015, she gave him a cortisone injection in the subacromial space and recommended further physical therapy. When Dr. Wolcott saw Petitioner on April 28, 2015, she continued his physical therapy and imposed work restrictions of no overhead reaching and lifting up to 30 pounds as long as he lifted below shoulder height (Petitioner's Exhibit 2).

The last time Dr. Wolcott saw Petitioner was on September 8, 2015. At that time, she authorized Petitioner to return to work, but stated that he could not do any overhead lifting (Petitioner's Exhibit 2).

Dr. Wolcott was deposed on February 12, 2016, and her deposition testimony was received into evidence at trial. In regard to her treatment of Petitioner for his bilateral shoulder conditions, Dr. Wolcott's testimony was consistent with her medical records. Dr. Wolcott stated that she performed arthroscopic surgery on Petitioner's right shoulder on February 6, 2014, and that Petitioner had recovered from that surgery to where he had full strength and range of motion. Dr. Wolcott opined that Petitioner had no restrictions in regard to the right shoulder (Petitioner's Exhibit 3; pp 11, 22-23).

In regard to Petitioner's left shoulder, Dr. Wolcott testified that she performed arthroscopic surgery on the left shoulder on October 23, 2014, and that she last saw Petitioner was on September 8, 2015. She testified that Petitioner should not lift more than 10 to 15 pounds overhead because it would aggravate Petitioner's left shoulder condition (Petitioner's Exhibit 3; pp 15; 19-20).

On cross-examination, Dr. Wolcott reaffirmed her opinion regarding the work restrictions she imposed on Petitioner in regard to his left shoulder. She also stated that they were likely to be permanent (Petitioner's Exhibit 3; pp 25-26).

At trial, Petitioner testified that Respondent did not offer him a job that conformed to his work restrictions. Further, Respondent did not offer to provide any assistance to him to secure employment.

Petitioner testified that he conducted a self-directed job search. He stated that he did approximately 10 searches per week, some of which he did online. Petitioner's record of his job searches was tendered into evidence at trial. It showed various jobs that Petitioner searched between September 4, 2015, and June 6, 2016. Petitioner completed a number of applications both online and by telephone. A significant number of Petitioner's job searches were indicated as being telephone contacts. Some of the telephone contacts indicated that he also submitted a resume. It was not stated whether the resumes were submitted electronically or through the mail (Petitioner's Exhibit 5). At trial, Petitioner testified that he was not interviewed by any prospective employers. He received no job offers.

At the direction of his attorney, Petitioner was evaluated by Kathleen Mueller, a Vocational Rehabilitation Counselor, on December 18, 2015. Because Mueller is located in Naperville, Illinois, and Petitioner was residing in Aurora, Colorado, the interview was conducted by telephone. Subsequent to the interview, Mueller reviewed medical records and the deposition transcript of Dr. Wolcott. Her report of March 10, 2016, was received into evidence at trial.

Mueller's report included Petitioner's vocational history. Prior to his being employed by Respondent, Petitioner worked as a home health aide, industrial truck operator and material handler. She categorized Petitioner's job with Respondent and the material handler job in the heavy category of physical demands. She categorized Petitioner's jobs as a home health aide and industrial truck driver in the medium category of physical demands. She noted that Petitioner attended high school through the 11th grade, but later obtained his GED.

Mueller noted that Petitioner could not return to work to the job he had at the time of the accident and performed a transferable skills analysis. She opined that Petitioner had sustained a loss of trade, but that there were a limited number of positions that might be available to him, some of which would require additional training or education. She recommended that a Labor Market Survey be conducted (Petitioner's Exhibit 6).

Mueller subsequently performed a Labor Market Survey and her report regarding it was received into evidence at trial. Mueller conducted the survey via internet to determine job availability in Aurora, Colorado, area. She also contacted by telephone some staffing agencies in the Aurora, Colorado, area. She was able to identify four viable options for Petitioner. However, Mueller noted that Petitioner was "...a relatively inexperienced and unsophisticated job seeker who has been provided with no Vocational Rehabilitation Assistance...." and that he conducted a self-directed job search, but had received no offers. She opined that given Petitioner's work restrictions and lack of transferable skills that he was unemployable (Petitioner's Exhibit 6).

Respondent obtained a Labor Market Survey from Sara Nowotny, a Rehabilitation Counsel. The survey was conducted between May 25, and June 14, 2016, and was received into evidence at trial. Nowotny contacted prospective employers in the Aurora, Colorado, area, and identified 20 employers that had jobs that purportedly conformed to Petitioner's restrictions. Ten of the employers had no current openings, eight had current openings, and two had recently hired or anticipated hiring someone (Respondent's Exhibit 1).

At trial, Petitioner testified that his right shoulder is persistently cold. In regard to his left shoulder, Petitioner stated that he has limited strength, is unable to do any overhead lifting and experiences sleep disruption because of his left shoulder symptoms. Petitioner agreed that he has not seen Dr. Wolcott since September 8, 2015.

Conclusions of Law

As noted herein, Petitioner filed two Applications for Adjustment of Claim, both of which alleged Petitioner sustained repetitive trauma to both upper extremities. In case number 14 WC 32298, the date of accident (manifestation) was alleged as January 20, 2012. In 12 WC 08643, the date of accident (manifestation) was alleged as January 30, 2012. Respondent did not dispute

that Petitioner sustained repetitive trauma injuries to both shoulders and paid both medical and temporary total disability benefits. The medical treatment provided to Petitioner subsequent to January 20, 2012, and before January 30, 2012, was the evaluation by Dr. Hoffman on January 20, 2012, and the MRI of January 27, 2012. Accordingly, the Arbitrator's award of benefits to Petitioner will be in respect to case number 12 WC 08643 with the date of manifestation of January 30, 2012.

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

The Arbitrator concludes that Petitioner's current condition of ill-being is causally related to the accident of January 30, 2012.

In support of this conclusion the Arbitrator notes the following:

Respondent stipulated that Petitioner's bilateral rotator cuff injuries were causally related to his work accident(s); however, Respondent disputed liability on the basis of causality after September 8, 2015.

September 8, 2015, was the last time Petitioner was seen by Dr. Wolcott. While Dr. Wolcott authorized Petitioner to return to work with restrictions, she was still of the opinion that Petitioner's bilateral shoulder conditions were work-related.

In regard to disputed issues (L) and (O) the Arbitrator makes the following conclusions of law:

The Arbitrator concludes that Petitioner is entitled to maintenance benefits for 42 1/7 weeks commencing September 25, 2015, through July 15, 2016 (the date of trial).

The Arbitrator concludes that Petitioner is entitled to vocational rehabilitation/job assistance services.

In support of these conclusions the Arbitrator notes the following:

For the reasons stated herein, the Arbitrator has determined that it is premature to determine the nature and extent of permanent disability and he is entering this decision pursuant to Section 19(b).

At trial, Petitioner alleged that he was an odd lot permanent and total disability.

In ABBC-E v. Industrial Commission, 316 Ill.App.3d 745, 750, the Court stated that a Petitioner can demonstrate permanent and total disability in three ways:

"...by a preponderance of the medical evidence, by showing a diligent but unsuccessful job search, or by demonstrating that because of their age, training, education, experience, and condition, no jobs are available to a person in their circumstances."

In regard to the medical evidence, the Arbitrator notes that none of Petitioner's treating physicians, in particular, Dr. Wolcott, opined that Petitioner was permanently and totally disabled. Dr. Wolcott imposed no restrictions at all in regard to the right shoulder. In regard to the left shoulder, Dr. Wolcott imposed restrictions of no overhead lifting of over 10 to 15 pounds. This restriction, in and of itself, does not establish that Petitioner is permanently and totally disabled.

While Petitioner's job search long included a significant number of contacts, virtually all of the employers were contacted by Petitioner either online or by telephone. Petitioner was never interviewed and received no job offers. It is not clear to the Arbitrator how diligent Petitioner actually was in attempting to secure employment. However, the Arbitrator also notes that even though Respondent terminated payment of temporary total disability benefits to Petitioner, Respondent never offered any vocational rehabilitation or job seeking assistance to Petitioner.

The Arbitrator specifically notes that Kathleen Mueller, the Vocational Rehabilitation Counselor retained by Petitioner's counsel, noted that Petitioner was "...a relatively inexperienced and unsophisticated job seeker who has been provided with no Vocational Rehabilitation Assistance...." The Arbitrator finds that the preceding may have contributed to the Petitioner's lack of success in his job search.

In the Labor Market Surveys conducted by both vocational rehabilitation experts, Kathleen Mueller and Sara Nowatny, there were job openings which, hypothetically, Petitioner was qualified for and which fell within Petitioner's restrictions.

In Westin Hotel v. Industrial Commission, 372 Ill.App.3d 527, 545, the Court noted that "...most recent cases making an odd lot determination on the basis that there is no stable job market for a person of the claimant's age, skills, training, and work history have required evidence from a rehabilitation services provider or a vocational counselor." In this case, the Arbitrator finds that the Labor Market Surveys conducted by both vocational rehabilitation counselors are not conclusive of there being no stable job market available for the Petitioner.

The Arbitrator finds that Petitioner has not proven, at this time, that he is an odd lot permanent and total disability.

The Arbitrator finds that while Respondent took the position that Petitioner was employable, Respondent offered no vocational rehabilitation or job assistance services to him.

The Arbitrator finds that Petitioner is entitled to both payment of maintenance benefits and vocational rehabilitation/job assistance services.

William R. Gallagher, Arbitrator

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

17IWCC0259

EVANS, DENNIS
Employee/Petitioner

Case# **14WC032298**

12WC008643

HOSTESS BRANDS
Employer/Respondent

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:

4707 LAW OFFICE OF CHRIS DOSCOTCH
DAMON YOUNG
2708 N KNOXVILLE AVE
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4136 ADELSON TESTAN & BRUNDO
MARCY E BENNETT
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STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

17IWCC0259

Dennis L. Evans
Employee/Petitioner

v.

Hostess Brands
Employer/Respondent

Case # 14 WC 32298

Consolidated cases: 12 WC 08643

An *Application for Adjustment 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 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 Vocational Rehabilitation/Job Assistance

FINDINGS

On the date of accident (manifestation), January 20, 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 $40,884.48; the average weekly wage was $786.24.

On the date of accident, Petitioner was 49 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, all benefits are awarded in consolidated case 12 WC 08643 with a date of accident of January 30, 2012.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

August 11, 2016
Date

AUG 16 2016

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim both of which alleged that Petitioner sustained repetitive trauma injuries arising out of and in the course of his employment for Respondent. In case number 14 WC 32298, the Application alleged a date of accident (manifestation) of January 20, 2012, and that Petitioner sustained repetitive trauma to the neck, left shoulder and bilateral arms. In case number 12 WC 08643, the Application, as amended, alleged a date of accident (manifestation) of January 30, 2012, and that Petitioner sustained repetitive trauma to the right arm, right hand, left arm, left hand and left shoulder (Petitioner's Exhibit 1).

Respondent stipulated that Petitioner sustained repetitive trauma injuries as alleged in the Applications and did not dispute Petitioner's diagnoses of right and left rotator cuff tears and related treatment until September 8, 2015. Petitioner claimed that he was entitled to payment of temporary total disability benefits for 184 4/7 weeks, commencing March 12, 2012, through September 24, 2015. Respondent stipulated that Petitioner was entitled to payment of temporary total disability benefits for that period of time. Petitioner also claimed that he was entitled to maintenance benefits for 42 weeks, commencing September 25, 2015, through July 15, 2016 (the date of trial). Respondent disputed liability for that period of maintenance benefits on the basis of causality. Petitioner claimed that he was an odd lot permanent and total disability (Arbitrator's Exhibit 1).

At trial, Petitioner testified that while working for Respondent in January, 2012, his job duties required him to lift/move racks that contained loaves of bread on trays. Over a period of time, Petitioner began to have pain in both of his shoulders. During the course of Petitioner's testimony, it was determined that he sustained a stroke in December, 2013. Petitioner did not allege that the stroke was related to either of his work-related accidents; however, the Arbitrator noted that Petitioner did experience some difficulties in speaking and understanding questions when he testified.

Petitioner initially sought medical treatment from Dr. Daniel Hoffman, on January 20, 2012 (the date of manifestation alleged in 14 WC 32298). At that time, Petitioner informed Dr. Hoffman that he had right shoulder pain and numbness in the hands over the last several months. Dr. Hoffman opined that Petitioner had carpal tunnel syndrome and a possible rotator cuff tear. He ordered an MRI scan of the right shoulder (Petitioner's Exhibit 8).

The MRI of Petitioner's right shoulder was performed on January 27, 2012. It revealed rotator cuff tendinosis with a partial under surface tear of the supraspinatus tendon, a degenerative labral tear with paralabral cyst, AC joint arthritis and mild subscapularis tendinosis (Petitioner's Exhibit 10).

Dr. Hoffman saw Petitioner on January 30, 2012 (the date of manifestation alleged in 12 WC 08643). He restated his diagnosis of carpal tunnel syndrome and possible rotator cuff tear and indicated he was going to refer Petitioner to Dr. Brent Johnson, an orthopedic surgeon (Petitioner's Exhibit 8).

Dr. Johnson saw Petitioner on February 8, 2012. At that time, Petitioner advised that he had injured his right shoulder at work on January 3, 2012, while pulling bread trays at or above shoulder height. Dr. Johnson examined Petitioner and reviewed the MRI scan. He opined that Petitioner had a right shoulder partial thickness rotator cuff tear and a right shoulder degenerative labral tear with paralabral cyst. He discussed treatment options of injections/physical therapy or proceeding with arthroscopic surgery (Petitioner's Exhibit 9).

Petitioner was again seen by Dr. Hoffman on March 1, 2012. At that time, Petitioner complained of pain in both the right and left shoulders. Dr. Hoffman opined that Petitioner had carpal tunnel syndrome and a possible rotator cuff tear in regard to the left shoulder. He ordered an MRI scan of the left shoulder (Petitioner's Exhibit 8).

The MRI was performed on March 8, 2012. It revealed rotator cuff tendinosis with a partial bursal and under surface tears of the supraspinatus and infraspinatus tendons, subscapularis tendinosis, labral degeneration and degenerative labral tearing with paralabral cyst formation, AC joint arthritis and synovitis and some muscle atrophy (Petitioner's Exhibit 10).

Petitioner continued to be treated by Dr. Hoffman for bilateral shoulder pain from March through July, 2012. Dr. Hoffman's treatment consisted primarily of anti-inflammatory medications (Petitioner's Exhibit 8).

Petitioner was subsequently seen by Dr. Johnson on October 28, 2013. At that time, Petitioner complained of significant pain in both shoulders especially when he had to do any lifting. Given the fact that Petitioner's symptoms had not improved, he recommended that they proceed with surgery on the right shoulder (Petitioner's Exhibit 9).

In December, 2013, Petitioner moved to Aurora, Colorado. On December 10, 2013, Petitioner was evaluated by Dr. Michelle Wolcott, an orthopedic surgeon. Dr. Wolcott recommended that Petitioner have an MRI of the right shoulder. On December 13, 2013, she gave Petitioner a steroid injection. Dr. Wolcott saw Petitioner on December 23, 2013, and Petitioner advised that the injection only gave him some temporary relief. She noted that there was a problem in obtaining authorization for the MRI (Petitioner's Exhibit 2).

Dr. Wolcott performed arthroscopic surgery on Petitioner's right shoulder on February 6, 2014. The procedure consisted of subacromial decompression, distal clavicle resection and rotator cuff repair (Petitioner's Exhibit 2).

Following the right shoulder surgery, Petitioner continued to be treated by Dr. Wolcott for bilateral shoulder pain. On August 27, 2014, an MRI scan was performed on Petitioner's left shoulder. It revealed a partial thickness tear of the distal supraspinatus and leading edge fibers of the infraspinatus, anterior inferior labral tear with paralabral cyst complex, partial thickness cartilage damage of the humeral head and possible impingement of the acromion (Petitioner's Exhibit 2).

Dr. Wolcott performed arthroscopic surgery on Petitioner's left shoulder on October 23, 2014. The procedure consisted of subacromial decompression, distal clavicle excision and rotator cuff repair (Petitioner's Exhibit 2).

Subsequent to the left shoulder surgery, Petitioner continued to be treated by Dr. Wolcott. When Dr. Wolcott saw Petitioner on March 17, 2015, she gave him a cortisone injection in the subacromial space and recommended further physical therapy. When Dr. Wolcott saw Petitioner on April 28, 2015, she continued his physical therapy and imposed work restrictions of no overhead reaching and lifting up to 30 pounds as long as he lifted below shoulder height (Petitioner's Exhibit 2).

The last time Dr. Wolcott saw Petitioner was on September 8, 2015. At that time, she authorized Petitioner to return to work, but stated that he could not do any overhead lifting (Petitioner's Exhibit 2).

Dr. Wolcott was deposed on February 12, 2016, and her deposition testimony was received into evidence at trial. In regard to her treatment of Petitioner for his bilateral shoulder conditions, Dr. Wolcott's testimony was consistent with her medical records. Dr. Wolcott stated that she performed arthroscopic surgery on Petitioner's right shoulder on February 6, 2014, and that Petitioner had recovered from that surgery to where he had full strength and range of motion. Dr. Wolcott opined that Petitioner had no restrictions in regard to the right shoulder (Petitioner's Exhibit 3; pp 11, 22-23).

In regard to Petitioner's left shoulder, Dr. Wolcott testified that she performed arthroscopic surgery on the left shoulder on October 23, 2014, and that she last saw Petitioner was on September 8, 2015. She testified that Petitioner should not lift more than 10 to 15 pounds overhead because it would aggravate Petitioner's left shoulder condition (Petitioner's Exhibit 3; pp 15; 19-20).

On cross-examination, Dr. Wolcott reaffirmed her opinion regarding the work restrictions she imposed on Petitioner in regard to his left shoulder. She also stated that they were likely to be permanent (Petitioner's Exhibit 3; pp 25-26).

At trial, Petitioner testified that Respondent did not offer him a job that conformed to his work restrictions. Further, Respondent did not offer to provide any assistance to him to secure employment.

Petitioner testified that he conducted a self-directed job search. He stated that he did approximately 10 searches per week, some of which he did online. Petitioner's record of his job searches was tendered into evidence at trial. It showed various jobs that Petitioner searched between September 4, 2015, and June 6, 2016. Petitioner completed a number of applications both online and by telephone. A significant number of Petitioner's job searches were indicated as being telephone contacts. Some of the telephone contacts indicated that he also submitted a resume. It was not stated whether the resumes were submitted electronically or through the mail (Petitioner's Exhibit 5). At trial, Petitioner testified that he was not interviewed by any prospective employers. He received no job offers.

At the direction of his attorney, Petitioner was evaluated by Kathleen Mueller, a Vocational Rehabilitation Counselor, on December 18, 2015. Because Mueller is located in Naperville, Illinois, and Petitioner was residing in Aurora, Colorado, the interview was conducted by telephone. Subsequent to the interview, Mueller reviewed medical records and the deposition transcript of Dr. Wolcott. Her report of March 10, 2016, was received into evidence at trial.

Mueller's report included Petitioner's vocational history. Prior to his being employed by Respondent, Petitioner worked as a home health aide, industrial truck operator and material handler. She categorized Petitioner's job with Respondent and the material handler job in the heavy category of physical demands. She categorized Petitioner's jobs as a home health aide and industrial truck driver in the medium category of physical demands. She noted that Petitioner attended high school through the 11th grade, but later obtained his GED.

Mueller noted that Petitioner could not return to work to the job he had at the time of the accident and performed a transferable skills analysis. She opined that Petitioner had sustained a loss of trade, but that there were a limited number of positions that might be available to him, some of which would require additional training or education. She recommended that a Labor Market Survey be conducted (Petitioner's Exhibit 6).

Mueller subsequently performed a Labor Market Survey and her report regarding it was received into evidence at trial. Mueller conducted the survey via internet to determine job availability in Aurora, Colorado, area. She also contacted by telephone some staffing agencies in the Aurora, Colorado, area. She was able to identify four viable options for Petitioner. However, Mueller noted that Petitioner was "...a relatively inexperienced and unsophisticated job seeker who has been provided with no Vocational Rehabilitation Assistance...." and that he conducted a self-directed job search, but had received no offers. She opined that given Petitioner's work restrictions and lack of transferable skills that he was unemployable (Petitioner's Exhibit 6).

Respondent obtained a Labor Market Survey from Sara Nowotny, a Rehabilitation Counsel. The survey was conducted between May 25, and June 14, 2016, and was received into evidence at trial. Nowotny contacted prospective employers in the Aurora, Colorado, area, and identified 20 employers that had jobs that purportedly conformed to Petitioner's restrictions. Ten of the employers had no current openings, eight had current openings, and two had recently hired or anticipated hiring someone (Respondent's Exhibit 1).

At trial, Petitioner testified that his right shoulder is persistently cold. In regard to his left shoulder, Petitioner stated that he has limited strength, is unable to do any overhead lifting and experiences sleep disruption because of his left shoulder symptoms. Petitioner agreed that he has not seen Dr. Wolcott since September 8, 2015.

Conclusions of Law

As noted herein, Petitioner filed two Applications for Adjustment of Claim, both of which alleged Petitioner sustained repetitive trauma to both upper extremities. In case number 14 WC 32298, the date of accident (manifestation) was alleged as January 20, 2012. In 12 WC 08643, the date of accident (manifestation) was alleged as January 30, 2012. Respondent did not dispute

that Petitioner sustained repetitive trauma injuries to both shoulders and paid both medical and temporary total disability benefits. The medical treatment provided to Petitioner subsequent to January 20, 2012, and before January 30, 2012, was the evaluation by Dr. Hoffman on January 20, 2012, and the MRI of January 27, 2012. Accordingly, the Arbitrator's award of benefits to Petitioner will be in respect to case number 12 WC 08643 with the date of manifestation of January 30, 2012.

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

The Arbitrator concludes that Petitioner's current condition of ill-being is causally related to the accident of January 30, 2012.

In support of this conclusion the Arbitrator notes the following:

Respondent stipulated that Petitioner's bilateral rotator cuff injuries were causally related to his work accident(s); however, Respondent disputed liability on the basis of causality after September 8, 2015.

September 8, 2015, was the last time Petitioner was seen by Dr. Wolcott. While Dr. Wolcott authorized Petitioner to return to work with restrictions, she was still of the opinion that Petitioner's bilateral shoulder conditions were work-related.

In regard to disputed issues (L) and (O) the Arbitrator makes the following conclusions of law:

The Arbitrator concludes that Petitioner is entitled to maintenance benefits for 42 1/7 weeks commencing September 25, 2015, through July 15, 2016 (the date of trial).

The Arbitrator concludes that Petitioner is entitled to vocational rehabilitation/job assistance services.

In support of these conclusions the Arbitrator notes the following:

For the reasons stated herein, the Arbitrator has determined that it is premature to determine the nature and extent of permanent disability and he is entering this decision pursuant to Section 19(b).

At trial, Petitioner alleged that he was an odd lot permanent and total disability.

In ABBC-E v. Industrial Commission, 316 Ill.App.3d 745, 750, the Court stated that a Petitioner can demonstrate permanent and total disability in three ways:

"...by a preponderance of the medical evidence, by showing a diligent but unsuccessful job search, or by demonstrating that because of their age, training, education, experience, and condition, no jobs are available to a person in their circumstances."

In regard to the medical evidence, the Arbitrator notes that none of Petitioner's treating physicians, in particular, Dr. Wolcott, opined that Petitioner was permanently and totally disabled. Dr. Wolcott imposed no restrictions at all in regard to the right shoulder. In regard to the left shoulder, Dr. Wolcott imposed restrictions of no overhead lifting of over 10 to 15 pounds. This restriction, in and of itself, does not establish that Petitioner is permanently and totally disabled.

While Petitioner's job search long included a significant number of contacts, virtually all of the employers were contacted by Petitioner either online or by telephone. Petitioner was never interviewed and received no job offers. It is not clear to the Arbitrator how diligent Petitioner actually was in attempting to secure employment. However, the Arbitrator also notes that even though Respondent terminated payment of temporary total disability benefits to Petitioner, Respondent never offered any vocational rehabilitation or job seeking assistance to Petitioner.

The Arbitrator specifically notes that Kathleen Mueller, the Vocational Rehabilitation Counselor retained by Petitioner's counsel, noted that Petitioner was "...a relatively inexperienced and unsophisticated job seeker who has been provided with no Vocational Rehabilitation Assistance...." The Arbitrator finds that the preceding may have contributed to the Petitioner's lack of success in his job search.

In the Labor Market Surveys conducted by both vocational rehabilitation experts, Kathleen Mueller and Sara Nowatny, there were job openings which, hypothetically, Petitioner was qualified for and which fell within Petitioner's restrictions.

In Westin Hotel v. Industrial Commission, 372 Ill.App.3d 527, 545, the Court noted that "...most recent cases making an odd lot determination on the basis that there is no stable job market for a person of the claimant's age, skills, training, and work history have required evidence from a rehabilitation services provider or a vocational counselor." In this case, the Arbitrator finds that the Labor Market Surveys conducted by both vocational rehabilitation counselors are not conclusive of there being no stable job market available for the Petitioner.

The Arbitrator finds that Petitioner has not proven, at this time, that he is an odd lot permanent and total disability.

The Arbitrator finds that while Respondent took the position that Petitioner was employable, Respondent offered no vocational rehabilitation or job assistance services to him.

The Arbitrator finds that Petitioner is entitled to both payment of maintenance benefits and vocational rehabilitation/job assistance services.

William R. Gallagher, Arbitrator

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

Donald Colvis,
Petitioner,

17IWCC0251

vs.

NO: 12 WC 9252

Menard Correctional Center,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical, causal connection, notice, 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 17, 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: APR 21 2017
o4/6/17
DLS/rm
046

Deborah L. Simpson
Deborah L. Simpson

David L. Gore
David L. Gore

Stephen J. Mathis
Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

46

17IWCC0251

COLVIS, DONALD
Employee/Petitioner

Case# **12WC009252**

MENARD CORRECTIONAL CENTER
Employer/Respondent

On 2/17/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.41% 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:

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 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
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

FEB 17 2016

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

17IWCC0251

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Donald Colvis
Employee/Petitioner

v.

Menard Correctional Center
Employer/Respondent

Case # 12 WC 9252

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Collinsville, IL**, on **May 19, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [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 _____

17IWCC0251

FINDINGS

On **03/05/2012**, 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 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 **$59,340.00**; the average weekly wage was **$1,141.15**.

On the date of accident, Petitioner was **60** years of age, ***married*** with **0** dependent children.

Respondent is not liable for any medical services.

Respondent is entitled to a credit for all payments made by group under Section 8(j) of the Act.

ORDER

Because Petitioner failed to sustain his burden of establishing: that he sustained an accident which arose out of and in the course of his employment with Respondent; failed to establish a manifestation date of his repetitive trauma injuries of March 5, 2012; failed to provide Notice as required by the Act; and further failed to establish that his current condition of ill-being is causally related to his employment duties, 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

1/29/16
Date

FEB 17 2016

BACKGROUND

Petitioner alleges that he sustained injuries to his right and left hands and arms as a result of repetitive duties while working for Menard Correctional Center. Petitioner alleged a date of accident of March 5, 2012. This is a repetitive trauma claim where Respondent disputed accident, causation, notice, medical bills, and nature and extent. The parties stipulated that Respondent is entitled to a credit of 5% loss of use of the left arm as a result of disability payments in an earlier claim. The parties further stipulated that Petitioner's medical expenses were reasonable and necessary, although Respondent disputed liability for those expenses based upon the above mentioned disputed issues.

FINDINGS OF FACT

Petitioner began employment at Menard Correctional Center as a correctional officer on January 3, 2000. He retired on April 1, 2012. He worked the 3:00 pm-11:00 pm shift. The first six years of his employment were spent at the Menard Correctional Center maximum security facility, commonly known as "the pit". Petitioner "ran available," which meant that he worked in almost every assignment available. When he first started at Menard he worked three times a week as a gallery officer. From 2006 until his retirement in 2012 he worked at Menard medium security unit or "MSU." Petitioner testified that he also ran available at MSU, filling in for officers that weren't at work. His job duties varied throughout his career at Menard. MSU is a much newer facility than the maximum security facility. Petitioner confirmed MSU had a control panel to electronically open doors; the majority of the keys were the size of house keys; and the only bar rapping which occurred at MSU was if you were assigned as the D tunnel officer. The bar rapping of the D tunnel officer would take a minute or two. Petitioner estimated that he would work one day a week as a gallery officer at MSU.

In 2009 Petitioner began experiencing numbness and tingling of his hands, primarily at night but also occasionally during the day. About that same time, he developed severe heart disease and underwent a four-vessel coronary artery bypass with grafting procedure in December 2009. He then underwent two stenting procedures in December 2010. He was off work for several months because of his cardiac condition and surgeries and his bilateral upper extremity symptoms continued unchanged while he was off work.

On November 29, 2010, Petitioner presented to his family doctor, Dr. David Walls, for follow-up regarding his cardiac treatment. Petitioner indicated his hands would go numb. Dr. Walls recommended nerve conduction studies/EMG. (RX7) Petitioner underwent a nerve conduction study at Washington University. The report generated following the testing states "[t]his 58 year-old man complains of numbness of both hands worse at night. Query carpal tunnel syndrome (CTS)." (RX8) The study showed bilateral mild to moderate CTS, slightly worse on the right. (*Id.*)

On March 5, 2012, Petitioner completed a "Workers' Compensation Employee's Notice of Injury". He reported injury to both hands due to turning keys. The place where injury occurred was listed as "MSU (Menard C.C.)". (RX2) A "Supervisor's Report of Injury or Illness" was completed by Lt. Jim Dilday. He reported that Petitioner was a correctional officer at Menard Correctional Center who reported numbness in both hands due to repetitive motion. (RX3) An "Initial Workers' Compensation Medical Report" was completed by Kimberley Criss which indicated Petitioner complained of bilateral hands going numb; worse recently. (RX5) Also this same day Petitioner completed an Incident Report in which he wrote:

> This report is written documentation that I was seen by my personal doctor, who referred me to Barnes Hospital in St. Louis for a nerve conduction test on my hands. The results showed damage to both hands. Also on today's date I was seen by CNP Kimberley Criss of Menard Health Care Unit. (RX4)

On March 8, 2012, Petitioner's supervisor completed a "Demands of the Job" form. It was noted that Petitioner's use of hands for gross manipulation (grasping, twisting, handling) was 2-4 hours per day and use of hands for fine manipulation (typing, good finger dexterity) was 2-4 hours per day. (RX6)

On March 12, 2012, Petitioner was seen by Dr. Walls for "CTS?." It was recommended that he follow-up with a hand specialist. (RX7)

A §12 examination was performed by Dr. Anthony Sudekum on June 12, 2012. He noted that in 2009 Petitioner first began to experience numbness and tingling of his hands, primarily night, but also occasionally during the day. The doctor indicated that Petitioner reported that "he was off work for several months because of his cardiac condition and surgeries and states that his bilateral upper extremity symptoms continued unchanged while he was off work on medical disability. He retired from his job at Menard in March of 2012 and indicates that his upper extremity symptoms have failed to resolve or improve significantly since that time.' (RX9 at 4) Petitioner reported that he currently experienced "swelling, tightness and pain of the bilateral volar wrist and palms as well as numbness and tingling of the fingers, left worse than right which primarily involved the ring and little fingers but intermittently also involved the thumb, index, and middle fingers. He states that his upper extremity symptoms occurred primarily at night, but also intermittently during the day. He also complains of intermittent elbow and left shoulder pain." (*Id.*)

Dr. Sudekum performed a physical examination which revealed no evidence of muscle atrophy. Petitioner had no tenderness to palpation of the bilateral hands, wrists, forearms or elbows. Grip and pinch strength were normal bilaterally. Petitioner exhibited full normal range of motion of the bilateral elbows, forearms, wrists, thumbs and fingers and normal sensation in both hands. Grip and pinch strength were normal. There were mild osteoarthritic changes noted in both elbows and the left 1st CMC joint.

Dr. Sudekum obtained bilateral nerve conduction studies that day which revealed electrodiagnostic evidence of mild/moderate left ulnar neuropathy but no evidence of left median neuropathy or left carpal tunnel syndrome. There were minimal abnormalities of the right median and ulnar nerves, but these were not diagnostic of right carpal or cubital tunnel syndrome in his view.

Dr. Sudekum reviewed Petitioner's medical records, workers' compensation documents, written position description from Petitioner's employer, and obtained a verbal job description from Petitioner. He opined that the work activities Petitioner performed at Menard Correctional Center did not cause or aggravate carpal tunnel syndrome and/or cubital tunnel syndrome. Dr. Sudekum noted that the job duties performed by correctional officers at the Menard Medium Security Correctional Center involve light to moderate manual activities and did not appear to involve any significant forceful, repetitive or sustained activity which would serve to cause or aggravate pathologic repetitive trauma conditions of the upper extremity. (*Id.*, at 36) Dr. Sudekum also noted that Petitioner had multiple risk factors which could predispose him to develop peripheral neuropathies such as carpal and/or cubital tunnel syndrome, including a history of CAHD (coronary artery disease), osteoarthritis, hypertension, hyperglycemia and/or diabetes. Dr. Sudekum noted that all of these non-work-related factors put

Petitioner at a relatively high risk for development of peripheral neuropathies regardless of employment activities. (*Id.*, at 36-37)

On August 24, 2012, Petitioner presented to Dr. Harvey Mirly at Belleville Hand Surgery. He completed a "Health History" which indicated he had numbness and tingling in the fingers on both hands. He reported the date of injury/onset as "started around 2009". He reported his current medications included Metformin. (PX5 at 16) The history taken by Dr. Mirly is as follows:

> Mr. Colvis is a 60-year-old right hand dominant male seen for an evaluation of bilateral hand pain, numbness and tingling. I believe he is currently retired, but previously worked at Menard. I received some outside records including a nerve conduction study from 12/18/10 from Dr. Lopate at Washington University showing right carpal tunnel syndrome with median motor and sensory delay and left seonsry. The ulnar nerve was normal. I received a quite lengthy letter from Dr. Sudekum, 39 pages, which gave a very erudite description regarding worker's compensation in general regarding Mr. Colvis in particular and we received a work comp denial letter.
>
> In discussion with Mr. Colvis, he certainly has symptoms consistent with carpal tunnel with a positive Tinel's and Phalen's test along with nocturnal symptoms. The nerve conduction study from Washington University again shows right greater than left carpal tunnel. He has symptoms of ulnar neuropathy as well with ring and small finger numbness with an irritability of palpation of the ulnar nerve, but the nerve conduction study was normal. (*Id.*, at 1)

Dr. Mirly diagnosed bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome. Dr. Mirly discussed the conditions and a conservative course of splints with avoidance of elbow flexion. If Petitioner's symptoms persisted or worsened, operative treatment would be considered. They discussed the possibility of treatment of the carpal tunnel alone, or in combination with the ulnar nerve of the same side concurrently. Dr. Mirly recommended using wrist braches as Petitioner has had and avoidance of elbow flexion. Petitioner was given an article regarding symptoms. If Petitioner wished to proceed with surgical intervention, Dr. Mirly was glad to accommodate him. (*Id.*)

On October 19, 2012, Petitioner returned to Dr. Mirly and was scheduled for a right open carpal tunnel release and an anterior transposition of the right ulnar nerve. On November 28, 2012, Petitioner underwent a right open carpal tunnel release and anterior transposition of the right ulnar nerve performed by Dr. Mirly. Petitioner reported significant improvement in his preoperative symptoms and wished to proceed with similar treatment on the left side. On December 17, 2012, Petitioner underwent a left open carpal tunnel release and an anterior transposition of the left ulnar nerve by Dr. Mirly. On December 28, 2012, Petitioner returned to Dr. Mirly. Petitioner reported excellent resolution of his preoperative symptoms and was quite pleased. Petitioner was released from care and was instructed to call Dr. Mirly with any questions or problems.

Dr. Mirly testified that Petitioner did not have any predisposing medical factors for the development of carpal or cubital tunnel syndromes other than his age and that he appeared to take Metformin, a medication used to treat adult onset diabetes. (PX7 at 12-15). He testified that Petitioner identified no hobbies which would be considered arm or hand intensive. (*Id.* at 15). Dr. Mirly testified that there is a period of time between an individual's manifestation of symptoms and their exposure to the causative or aggravating factor with regard to

carpal and cubital tunnel syndrome, and that this period of time varies from individual to individual. (*Id.* at 17-18). He confirmed that this concept is commonly known as a latency period. (*Id.)* Dr. Mirly opined that Petitioner's job duties at Menard CC "would be contributory to the development" of Petitioner's upper extremity conditions. (*Id.*, at 19-21) Specifically he indicated that:

> I base that when things are forceful and repetitive. Position—the classic occupation, again, being a meat cutter—you're holding a knife, can't open your fingers, and you're putting your wrists through all kinds of motions. So you look at things that have abnormal postures, vibration—again, the cell-rapping—hitting, holding the baton, and it gets the vibration. The forceful twisting of the keys. (*Id.*, at 20)

Dr. Mirly also stated "I did have the opportunity to read through Dr. Sudekum's rather lengthy description, and it does appear in the report that the duties are less forceful at the medium. I have not personally toured the medium-security. I've been to the maximum." (*Id.*) Petitioner did not give Dr. Mirly a job description when he saw him. (*Id.*, at 16) Dr. Mirly noted that Petitioner was retired at the time of his first visit. Dr. Mirly admitted that Petitioner's age, diabetes and a BMI over 30 were risk factors for the development of carpal and cubital tunnel syndrome. (*Id.*, at 29) Dr. Mirly did not know Petitioner's specific job assignments while at Menard Correctional Center; had not toured Menard MSU; did not know the types of keys used at MSU; did not know the number of doors opened at MSU; and did not know the frequency or duration of the individual duties.

Dr. Anthony Sudekum also testified by deposition. Dr. Sudekum explained that he had toured both Menard Maximum Correctional Center and Menard Medium Security Unit or "MSU". He testified that he performed key turning at Menard MSU. Dr. Sudekum stood by his opinion as outlined in his June 12, 2012, report in that he did not believe Petitioner's job duties at Menard MSU would cause or aggravate carpal or cubital tunnel syndrome.

Petitioner reported that his upper extremity symptoms failed to resolve or improve significantly after retiring. Petitioner reported that he currently experienced swelling, tightness and pain of the bilateral volar wrist and palms as well as numbness and tingling of the fingers, left worse than right which primarily involved the ring and little fingers but intermittently also involved the thumb, index, and middle fingers. Petitioner reported that his upper extremity symptoms occurred primarily at night, but also intermittently during the day. Petitioner also complained of intermittent elbow and left shoulder pain.

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?

It is not lost on the Arbitrator that Dr. Sudekum appears to base his opinions on the incorrect assumption that Petitioner's entire employment at Menard was in the MSU. However, Petitioner last worked in the maximum security facility in 2006 and he did not begin to experience symptoms until 2009. In this case Dr. Sudekum's knowledge of the job duties of a correctional officer at Menard Correctional Center, in both the maximum and medium security facilities, is more extensive than that of Dr. Mirly. Dr. Sudekum reviewed Petitioner's medical records, job assignment history, job description, workers' compensation documents. (*see*

RX 2-6, 11-12) He had also toured both the Menard Correctional Center Maximum and Medium Security Units. The Arbitrator found the testimony and opinions of Dr. Sudekum more persuasive.

Further, a claimant fails to prove causation from repetitive trauma when the treating physician testifies repetitive motions caused the injuries but fails to detail what repetitive motions the petitioner engaged in and the frequency of the motions. *Gambrel v. Mulay Plastics*, 97 IIC 238. Dr. Mirly did not do so in this case. He indicated in his testimony that he did not know the duration or the times of Petitioner's various job duties. (PX7 at 49)

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner has failed to meet his burden of establishing that he sustained accidental injuries which arose out of and in the course of his employment with Respondent. Petitioner has also failed to establish that his current condition of ill-being with regard to his upper extremities is causally related to his employment duties with Respondent. Benefits are therefore denied.

Issue (D): What was the date of the accident?
Issue (E): Was timely notice of the accident given to Respondent?

The record clearly indicates Petitioner's symptoms began in 2009. His condition was diagnosed in November of 2010. He reported his accident to Respondent on March 5, 2012 and claims this as his date of manifestation. The Arbitrator notes there were no visits with any health care providers regarding his upper extremities between his diagnosis in 2010 and his Reporting of the condition. Petitioner completed an Incident Report on March 5, 2012 in which he wrote:

> This report is written documentation that I was seen by my personal doctor, who referred me to Barnes Hospital in St. Louis for a nerve conduction test on my hands. The results showed damage to both hands. Also on today's date I was seen by CNP Kimberley Criss of Menard Health Care Unit. (RX4)

Clearly Petitioner was aware of his diagnosis in November 2010. There is nothing in this record to indicate that Petitioner gained any information between his diagnosis and the date of his report to indicate a health care professional had advised him that there was a causal relationship between his condition and his work. Yet, on his "Workers' Compensation Employee's Notice of Injury," which was completed on March 5, 2012, Petitioner reported injury to both hands "due to turning keys." (RX2) The Arbitrator concludes Petitioner became aware of his condition and its relationship to his employment in 2010.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has failed to establish a manifestation date of his repetitive trauma injuries of March 5, 2012. Rather, the manifestation date was in 2010 when his condition was diagnosed, therefore Petitioner has also failed to provide Notice as required by the Act.

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?

Respondent does not dispute the reasonableness or necessity of Petitioner's medical care. Respondent only disputed liability for medical expenses based upon its dispute of the above issues. Therefore the Arbitrator

finds the medical expenses incurred in the amount of $34,489.33 (PX1) were reasonable and necessary. The parties further stipulated that Respondent shall have credit for any medical expenses paid by its group carrier and shall indemnify and hold Petitioner harmless from any claims arising from any of the medical expenses for which it claims credit, pursuant to Section §8(j) of the Act.

Based upon the above findings regarding Issues C, D, E, and F, however benefits are denied.

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 no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner is retired. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 60 years old at the time of the accident. Because of Petitioner's advanced age and his reduced healing capacity, 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 because Petitioner has retired, reduced earning capacity is not relevant. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. Petitioner developed bilateral carpal and cubital tunnel syndromes which all required surgical intervention. Petitioner testified that despite the improvement resulting from surgery and the return of feeling in his hands, he has significant residual symptoms. He indicated that he still experienced pain and soreness in his hands and arms, as well as decreased grip strength. Opening jars and squeezing small household objects, as well as driving for prolonged periods of time continue to be difficult. His hobby of bow hunting has been curtailed, and his hands still occasionally become numb while he sleeps. Because the medical records and evidence taken as a whole corroborate the Petitioner's complaints of pain, weakness and loss of function in his hands and arms, the Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 12.5% loss of use of each hand, and 10% loss of use of each arm pursuant to §8(e) of the Act.

The parties stipulated that Respondent is entitled to credit because Petitioner received an award of 5% permanent partial disability of his left arm in claim 83 WC 44562. (AX1). The Arbitrator so finds.

Based upon the above findings regarding Issues C, D, E, and F, however benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Lucas,
Petitioner,

17IWCC0249

vs.

NO: 12 WC 10866

Tri-County Coal, LLC,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of occupational disease, 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 30, 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: APR 21 2017
o4/6/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0249

LUCAS, JAMES
Employee/Petitioner

Case# **12WC010866**

TRI-COUNTY COAL LLC
Employer/Respondent

On 6/30/2015, 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:

5236 CULLEY FEIST KUPPART & TAYLOR
ROMAN KUPPART
3 S MAIN ST SUITE 2
HARRISBURG, IL 62949

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

17IWCC0249

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

James Lucas
Employee/Petitioner

v.

Tri-County Coal, LLC
Employer/Respondent

Case # 12 WC 10866

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on May 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. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other Sections 1(d)-(f) of the Occupational Diseases Act

FINDINGS

On May 23, 2010, Respondent was operating under and subject to the provisions of the Act.

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

On this date, Petitioner did not sustain an occupational disease that arose 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 alleged occupational disease.

In the year preceding the injury, Petitioner earned $51,423.32; the average weekly wage was $1,087.50.

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

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $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 compensation is denied.

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

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

William R. Gallagher, Arbitrator

June 15, 2015
Date

JUN 30 2015

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an occupational disease to his lungs and/or heart arising out of and in the course of his employment for Respondent. The Application alleged a date of last exposure of May 23, 2010, and that Petitioner sustained the occupational disease as a result of inhalation of coal mine dust including but not limited to coal dust, rock dost, fumes and vapors for a period in excess of 33 years.

At the time of trial, Petitioner was 57 years old. Petitioner resides in Morrisonville, Illinois. He graduated from high school and had approximately 33 years of coal mine employment with 26 years being underground. While working in the coal mines, Petitioner was regularly exposed to coal and rock dust. He testified that there were other exposures in the coal mine that bothered his breathing. He testified that he worked in maintenance and did a lot of fabrication and maintenance on machinery which involved cutting, welding and grinding of oxidized steel and rust. He worked on the electrical panels which would sometimes come apart and blow up He testified that he was exposed to glue and solvents while working in the coal mine.

Petitioner's last day of employment with Respondent was May 23, 2010, at its Crown III Mine. Petitioner was 52 years old on that date. His job classification was repairman. Petitioner testified that on that day he was exposed to and breathed coal dust. Petitioner testified that he retired on that date because he basically was "wore out." He testified that working six days per week was mandatory in maintenance. He stated that the concentration of the rock dust and the coal dust took a toll on his breathing. He testified that it became more laborious as time went on. He really noticed the breathing problems increasing in the last five or six years of his employment.

Petitioner testified that he has not looked for work since leaving the coal mines. He testified that he is on Social Security disability for his knees. Petitioner started working in the coal mines in 1977 for Peabody. He worked there until August, 1994, as a general laborer, timberman, shuttlecar operator, miner operator, roof bolter, bratticeman, repairman and beltman. From August 1994 to March 1998, Petitioner had various periods of unemployment and short term work doing mine construction as well as some carpentry and remodeling work. From March 1998 to February 2001, Petitioner worked for Kincaid PP as an electrician and repairman. He then went to work for Respondent in October 2001. Petitioner described his work in the repair department for Respondent as pretty physical because everything is big and heavy. His job required a lot of lifting and carrying. He testified that those job duties caused him breathing problems.

Petitioner testified that he was a unit repairman when he first noticed his breathing problems in the mine. He worked in a running section where there were about 18 pieces of equipment. He worked on jacks, hoses and anything that would go down in the line of production to try to get them running again. Petitioner testified that he had to carry tools. Petitioner testified that there were six or eight times in the years that he worked for Respondent that he had to walk the slope out of the mine. He testified that he, as well as a lot of other guys, could not go very far. As of the time of trial, Petitioner could walk on level ground for 25 yards before he noticed a change in his breathing. He testified that he could climb a half to one flight of stairs before taking a break.

Petitioner testified that from the time he first noticed his breathing problems until trial they had continued to progress. As of trial Petitioner was taking breathing medication in the form of Albuterol. He takes it two times a day and has been taking same for five to eight years.

Petitioner testified that his breathing problems affect his activities of daily life. It affects mainly his walking and anything that is laborious physically. He testified that he hunts a little bit but not like he used to. He does not hunt out of a tree stand because it is too hard to get up and down. He testified that he has lost about 60 pounds since he retired, but it has not really helped his breathing. Petitioner testified that while working in the mines he would have to take breaks because of his breathing. At times he would also need the help of a co-worker to finish a job because of his breathing. Petitioner has never had a job that was anything other than manual labor. Petitioner testified that he has never smoked. Petitioner testified that if he were offered a job today doing his last job as a repairman, he would not physically be able to do it because of a combination of his knees and breathing problems.

Petitioner developed bilateral knee problems while working for Respondent. He treated for that condition with Dr. Roger McClintock who was his primary care physician at that time. His current treating physician is Dr. Roger McFarlin. He sees him at least every 90 days to check his diabetes. Petitioner testified that his knees had been one of the factors why Dr. McClintock took him off work at the end of his mining career. Petitioner agreed that the primary diagnosis for his award of Social Security Disability was bilateral knee arthritis and secondary diagnosis was obesity. When Petitioner applied for Social Security Disability he listed the physical conditions that limited his ability to work as lumbar disc disease, severe bilateral knee arthritis, hypertension, diabetes, bilateral leg neuropathy, vertigo, morbid obesity, anxiety, sleep apnea, hearing loss, bilateral knee arthritis, diabetes, hypertension and vertigo. He testified that these were the conditions that caused him to stop working. On his Social Security Disability claim he completed a function report wherein he stated that in his line of work as a coal mine repairman, he must be able to walk long distances, lift heavy objects and work in different positions. Due to his knees he could not stand or bear the weight. Petitioner testified that he never worked again after he left Respondent.

Petitioner took a normal retirement pension from Respondent. The official date of his retirement was May 23, 2010, which was his last day in the mine. He received a pension. Petitioner never filled out a panel form to be subject to recall to any sister mine within Respondent's organization.

Dr. William Clapp is a pulmonary physician. He treats patients with occupational diseases. He has done black lung exams for the Department of Labor for three or four years. (Petitioner's Exhibit 1, pp 5-6). Dr. Clapp's coal miner patient census is approximately 5% of his outpatient census. (Petitioner's Exhibit 1, p 5-6). Dr. Clapp evaluated Petitioner through the Springfield black lung outreach clinic. Dr. Clapp saw Petitioner on September 9, 2011. (Petitioner's Exhibit 1, pp 6-7).

Petitioner reported to Dr. Clapp that he was a lifelong non-smoker. (Petitioner's Exhibit 1, p 9). On examination Petitioner's lungs were clear. He complained of a longstanding cough and

progressive shortness of breath. (Petitioner's Exhibit 1, p 9). Petitioner was taking Albuterol, two puffs every four to six hours as needed for shortness of breath. Dr. Clapp testified that if he has someone with simple coal workers' pneumoconiosis radiographically, he expects to see anything from severe symptoms and shortness of breath and cough to no symptoms at all. He testified that it was not unusual for someone with simple coal workers' pneumoconiosis to be asymptomatic. Dr. Clapp testified that the physical examination of Petitioner's chest was within normal limits. (Petitioner's Exhibit 1, p 10). Dr. Clapp testified that the spirometry performed as part of his examination was essentially within normal limits. He testified that an individual with simple coal workers' pneumoconiosis can have anything from severe impairment to absolutely normal pulmonary function. He testified that the spirometry that he mentioned is a measure of global impairment of both of the lungs. (Petitioner's Exhibit 1, pp 11-12).

Dr. Clapp has been a B-reader since January 1, 2011. (Petitioner's Exhibit 1, p 15). Dr. Clapp diagnosed Petitioner with simple coal workers' pneumoconiosis which was caused by many years of underground coal mine dust exposure. (Petitioner's Exhibit 1, p 15). Dr. Clapp testified that the scar tissue of pneumoconiosis is permanent and does not carry on the function of healthy lung tissue. (Petitioner's Exhibit 1, pp 17-18). Dr. Clapp testified that by definition if one has coal workers' pneumoconiosis, he has an impairment of the function of the lungs at least at the site of the scarring and emphysema. (Petitioner's Exhibit 1, p 18). Dr. Clapp also diagnosed Petitioner with chronic bronchitis. He testified that the major cause of that was due to his longstanding exposure to underground coal mine dust. Dr. Clapp testified that chronic bronchitis is a productive cough for more than two months a year for more than two years. (Petitioner's Exhibit 1, pp 15-16). Dr. Clapp testified that because Petitioner has coal workers' pneumoconiosis, his immune system and his lungs are impaired, and he should not go back to any situation where he would be inhaling significant amounts of dust. (Petitioner's Exhibit 1, pp 20-21).

Dr. Clapp testified that the history he obtained from Petitioner was accurately recorded in his report to the best of his knowledge. The history he obtained was complete. Petitioner related to him that he was not able to walk in hilly terrain because he runs out of breath. Petitioner thought it was due to his obesity because he gained some weight, but he was still short of breath after he lost some weight. Petitioner reported a daily cough productive of one teaspoon of brown sputum, which primarily occurred in the morning. (Petitioner's Exhibit 1, pp 26-27). Dr. Clapp testified that there are many causes for exertional dyspnea and the presence of same does not necessarily imply a disease state. He testified that deconditioning is a very common cause of exertional dyspnea. (Petitioner's Exhibit 1, p 27).

Dr. Clapp did not review any medical records regarding Petitioner. He testified that medical records are of value in evaluating an individual for the presence of an occupational disease or the significance of that disease if it is present. He testified that medical records provide a historical review of an individual in terms of his complaint over time including a review of systems respiratory, physical examinations over time as well as diagnostic testing. Dr. Clapp testified that Petitioner's medications included Lisinopril which is an ace inhibitor that has a known side effect of cough. (Petitioner's Exhibit 1, pp 30-31). Dr. Clapp did not know why Petitioner retired in

May 2010. He was unaware that Petitioner had been awarded Social Security Disability in August 2010, or the reason he was awarded same. (Petitioner's Exhibit 1, p 33).

Dr. Clapp interpreted the October 5, 2009, September 1, 2011, and March 5, 2012, chest x-rays as positive for pneumoconiosis, profusion 1/0. Dr. Clapp noted P/Q opacities in all lung zones on the September 1, 2011, chest x-ray. Dr. Clapp noted P/P opacities in the middle and lower lung zones on the October 5, 2009, and March 5, 2012, chest films. (Petitioner's Exhibit 1, Deposition Exhibit 2). Dr. Clapp interpreted the chest x-ray dated September 1, 2011, on October 20, 2011. He was unaware of any earlier diagnoses of black lung in Petitioner before his interpretation on October 20, 2011. (Petitioner's Exhibit 1, p 34).

Dr. Clapp testified that the results of his spirometry were accurately recorded in his report. The spirometry did not reveal the presence of an obstructive disease. He testified that spirometry alone is not able to determine whether or not restrictive disease is present. The fact that Petitioner had a forced vital capacity of 90% of predicted suggested that restrictive physiology was not present. He testified that one could not make the diagnosis of restriction without lung volumes. (Petitioner's Exhibit 1, pp 42-43). Dr. Clapp testified that because spirometry is not a complete set of pulmonary function studies, he could not say if Petitioner was capable of heavy manual labor. (Petitioner's Exhibit 1, pp 47-48). Dr. Clapp testified that his diagnosis of chronic bronchitis was based on the history related to him. If that history was incorrect, then his diagnosis of chronic bronchitis could be incorrect. (Petitioner's Exhibit 1, p 48).

Petitioner did not tell Dr. Clapp that he left mining due to a breathing problem. He did not tell Dr. Clapp that he left mining at the time he did on the advice of a physician because of a pulmonary problem. Petitioner did not relate to Dr. Clapp an inability to perform his job duties beyond the fact that when he had to lift the steel plate covers of 150 pounds, it would make him out of breath. (Petitioner's Exhibit 1, p 49).

Dr. Michael Alexander, a board certified radiologist and B-reader, interpreted the chest x-ray dated September 1, 2011. Dr. Alexander found the chest x-ray to be positive for coal workers' pneumoconiosis, profusion 1/0 with P/P opacities in all lung zones. (Petitioner's Exhibit 2).

At the request of Respondent's counsel, Dr. Cristopher A. Meyer reviewed chest x-rays for Petitioner dated October 5, 2009, September 1, 2011, and March 5, 2012. All the chest x-rays were quality 1. (Respondent's Exhibit 1, p 40). Dr. Meyer testified that the lungs were completely clear, and there were no findings of coal workers' pneumoconiosis. (Respondent's Exhibit 1, pp 40-41). Dr. Meyer testified that it is of benefit to have serial films for reading when trying to determine whether an individual has a lung disease or not. It is helpful to have serial examinations over time to determine whether findings in the lung are acute and may go away, as is frequently the case with infections or edema, or are chronic as one would expect with coal workers' pneumoconiosis. (Respondent's Exhibit 1, p 41).

Dr. Meyer has been board certified in radiology since 1992 (Respondent's Exhibit 1, p 7). Dr. Meyer has been a B-reader since 1999 (Respondent's Exhibit 1, p 19). Dr. Meyer was asked to

take the B-reading exam by Dr. Jerome Wiot (Respondent's Exhibit 1, pp 19-20). Dr. Wiot was on the original committee that designed the training course which is called the B-reader program. (Respondent's Exhibit 1, p 21). Dr. Meyer has recently been asked to have a more active academic role with the B-reader course. (Respondent's Exhibit 1, p 32). Dr. Meyer testified that radiologists have a 10% higher pass rate on the B-reading exam than other specialties. In Dr. Meyer's opinion radiologists have a better sense of what the variation of normal is. (Respondent's Exhibit 1, pp 34-35).

Dr. Meyer testified that the B-reader looks at the films of the lung to decide whether there are any small nodule opacities or any linear opacities and based on the size and appearance of those small opacities, they are given a letter score. (Respondent's Exhibit 1, p 22). Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described by small round opacities. (Respondent's Exhibit 1, pp 28-29). The distribution of opacities is also described because different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper zone predominant process. (Respondent's Exhibit 1, pp 22-23). The last component of the interpretation is the extent of the lung involvement or the so-called profusion. (Respondent's Exhibit 1, p 23). Dr. Meyer testified that the profusion defines the density of the small opacities in the lung. (Respondent's Exhibit 1, p 30).

At the request of Respondent's counsel, Dr. James R. Castle reviewed medical records regarding Petitioner. (Respondent's Exhibit 2, p 21). Dr. Castle is a pulmonologist and is board certified in internal medicine and in the subspecialty of pulmonary disease. (Respondent's Exhibit 2, p 4). Dr. Castle practiced in Roanoke, Virginia, for 30 years. His practice was limited to pulmonary disease and chest disease which encompassed critical care medicine. (Respondent's Exhibit 2, p 7). Dr. Castle's practice included treating patients with occupational lung disease. He had some patients in his practice that had coal workers' pneumoconiosis. (Respondent's Exhibit 2, p 8). Dr. Castle has been certified as a B-reader since 1985. (Respondent's Exhibit 2, p 13). Two of Dr. Castle's instructors at West Virginia University School of Medicine were Dr. Keith Morgan, and Dr. Lee Lapp. Dr. Morgan was one of the early individuals in the country who started looking at coal workers' pneumoconiosis to determine the extent of the disease and its effect on the individual. (Respondent's Exhibit 2, pp 13-14).

Dr. Castle testified that based upon his review of the medical records, there was no evidence whatsoever of reactive airways disease, including asthma. (Respondent's Exhibit 2, p 43). Dr. Castle testified that based upon his review of the medical records and in particular the pulmonary function testing that was performed on Petitioner by Dr. Clapp, it was his opinion that from a ventilatory standpoint, Petitioner was capable of heavy manual labor. Dr. Castle testified that based upon the ventilatory studies, Petitioner had no evidence of any impairment whatsoever from any cause. (Respondent's Exhibit 2, p 44).

Dr. Castle testified that more likely than not simple pneumoconiosis will not progress once exposure ceases. (Respondent's Exhibit 2, pp 44-45). Dr. Castle testified that he is familiar with the position taken by the American Thoracic Society that an older worker with a mild

pneumoconiosis can continue working as a coal miner and may be at low risk for working in currently permissible exposure levels until he reaches retirement age. (Respondent's Exhibit 2, p 45). Dr. Castle testified that based on a thorough and extensive review of all the submitted medical data, it was his opinion that Petitioner did not suffer from coal workers' pneumoconiosis or any pulmonary disease or impairment occurring as a result of his occupational exposure. (Respondent's Exhibit 2, pp 45-46).

Dr. Castle testified that a risk factor for the development of pulmonary symptoms is obesity. He testified that Petitioner had a history of significant obesity with a BMI between 35 and 41 on various occasions. Petitioner also had apparent obstructive sleep apnea syndrome related to his obesity. Dr. Castle testified that this degree of obesity can result in significant shortness of breath as well as physiologic changes including restrictive lung disease and hypoxemia. (Respondent's Exhibit 2, pp 46-47). Dr. Castle testified that Petitioner did not demonstrate any consistent physical findings indicating the presence of an interstitial pulmonary process. He did not have a consistent finding of rales, crackles or crepitations. Dr. Castle testified that the vast majority of radiographic reports indicated that there was no evidence whatsoever of any significant lung disease including any findings of coal workers' pneumoconiosis. (Respondent's Exhibit 2, p 47).

Dr. Castle reviewed a chest x-ray dated September 11, 2011. He testified that there are no parenchymal abnormalities consistent with pneumoconiosis on that film. He also reviewed chest x-rays on CD dated October 5, 2009, and March 5, 2012. He testified that neither of these films showed any evidence consistent with coal workers' pneumoconiosis. (Respondent's Exhibit 2, p 40).

Dr. Castle testified that with coal workers' pneumoconiosis there is scarring and fibrosis that occurs in the lungs. The scar tissue that is caused by coal workers' pneumoconiosis cannot carry on the function of normal healthy lung tissue. (Respondent's Exhibit 2, p 53). Dr. Castle testified that the scarring and fibrosis represents an alteration in the structure and function of the involved lung tissue. (Respondent's Exhibit 2, pp 54-55).

Dr. Castle testified that the standard definition of chronic bronchitis is a chronic cough productive of sputum for at least three months out of the year for two consecutive years. In the records it was noted that Petitioner had a daily cough with sputum production for a period of 15 years. Dr. Castle testified that based on that history, Petitioner would meet the definition of chronic bronchitis. Dr. Castle testified that chronic bronchitis is not caused by the inhalation of coal mine dust. He testified that coal mine dust causes something called industrial bronchitis, which is associated with a cough that may or may not be productive. Industrial bronchitis typically abates within about six months of leaving the coal dust exposure. (Respondent's Exhibit 2, p 68). Dr. Castle testified that there are many causes of shortness of breath. It is a non-specific finding. He testified that a common cause of shortness of breath would be obesity. He testified that deconditioning is perhaps the most common cause of shortness of breath with exertion. (Respondent's Exhibit 2, p 70).

Medical records from the Springfield Clinic were admitted into evidence. The first office note was dated November 27, 1965. It noted that Petitioner had more than average upper respiratory infections. (Respondent's Exhibit 3, 575). Petitioner was seen on September 24, 1998, with complaint of sinus drainage and congestion for three to four days. His lungs were clear on examination. The impression was sinusitis, allergic versus bacterial. (Respondent's Exhibit 3, p 519). Petitioner was seen on February 4, 1999, with complaint that his lungs felt congested. His lungs were clear on that date. The impression was bronchitis and possible influenza. (Respondent's Exhibit 3, p 512). Petitioner was seen on March 18, 1999, with symptoms of cough, fever and sore throat. He was coughing up green phlegm. Petitioner reported that he was around a lot of refined coal dust and that since he had been around this he had been sicker more recently. Physical examination of the chest on that date revealed occasional rhonchi. The impression was sinusitis. In an addendum, Dr. McClintock stated that Petitioner had been sick on three separate occasions and that he told Petitioner to protect himself as much as he can against the refined coal dust so as not to have recurrent respiratory symptoms. (Respondent's Exhibit 3, p 509).

When Petitioner was seen on March 15, 2000, he requested a chest x-ray because he had been coughing up stuff and felt like he does when he gets bronchitis. Physical examination of the chest revealed the lungs to be clear. (Respondent's Exhibit 3, p 494). A chest x-ray was taken the same day and interpreted by Dr. Darrel Anderson. Dr. Anderson charted that the lungs were clear and that there was no change when compared to films taken in June 1990. (Respondent's Exhibit 3, p 567). Petitioner was seen on March 2, 2002, with complaint of respiratory problems. He reported that he had trouble breathing and that same had been going on for a couple of weeks. He was coughing up yellow phlegm. Physical examination of the chest revealed some bilateral rhonchi with occasional expiratory wheeze. The impression was acute bronchitis. (Respondent's Exhibit 3, p 479).

Petitioner was seen on February 17, 2006, with a bad cold. He related coughing and symptoms of one week duration. Physical examination of the chest revealed the lungs to be clear. The impression was sinusitis. (Respondent's Exhibit 3, p 216). When Petitioner was seen on June 20, 2006, he related problems with a cough and wheeze. Physical examination of the chest revealed the lungs to be clear. (Respondent's Exhibit 3, pp 212-213). Petitioner was seen on February 25, 2008, regarding his hypertension. The doctor suspected that Petitioner suffered from sleep apnea. It was also noted that his high blood pressure had been quite resilient to amelioration. The doctor was concerned with the fact that because Petitioner had some occasional shortness of breath that he may have some diastolic dysfunction due to his hypertension. (Respondent's Exhibit 3, pp 172-173).

Petitioner saw Dr. Thomas Cahill, a cardiologist, on March 6, 2008. At that time he had no chest pain or shortness of breath. On examination his lungs were clear. (Respondent's Exhibit 3, pp 170-171).

Petitioner was seen on October 5, 2009, with complaint of increased sinus congestion and coughing. Physical examination of the chest revealed the lungs to be clear to auscultation with

somewhat diminished breath sounds but symmetrical chest expansion. The assessment was cough and acute sinusitis. (Respondent's Exhibit 3, pp 147-149). Chest x-ray performed on same date revealed no abnormality beyond mild degenerative changes in the thoracic spine. (Respondent's Exhibit 3, pp 360-361).

Petitioner was seen on October 7, 2009, reporting intermittent fever. He had no shortness of breath at rest. Physical examination of the chest revealed the lungs clear to auscultation. The assessment was cough and acute sinusitis. (Respondent's Exhibit 3, pp 145-146). Petitioner was seen on May 6, 2010. Physical examination of the chest revealed the lungs to be clear. He was taken off work because of his knees and having a hard time getting around. The doctor charted that he told Petitioner that he thought he should look into disability. (Respondent's Exhibit 3, pp 108-109). Petitioner returned to the doctor on June 17, 2010. On that date physical examination of the chest revealed the lungs to be clear. The doctor's chart indicated that Petitioner had been away from the coal mine and actually looked better than he had for a long time. (Respondent's Exhibit 3, pp 106-107). The doctor authored a letter To Whom It May Concern regarding Petitioner's medical history. His history did not include any respiratory condition other than sleep apnea. The doctor noted that Petitioner was unable to work in the coal mines at this point as walking underneath the ground is just bothering his knees considerably. (Respondent's Exhibit 3, p 258).

Petitioner was seen on March 5, 2012, complaining of cough for three weeks. He related coughing up some brown, yellowish discharge. He denied history of asthma. He denied shortness of breath. Breath sounds were coarse. The doctor charted that Petitioner had very reactive airway and there was noticeable bronchospasm. The assessment was cough, acute bronchitis and bronchospasm. (Respondent's Exhibit 3, pp 76-78). A chest x-ray performed that date revealed no abnormality beyond degenerative changes of the thoracic spine. (Respondent's Exhibit 3, pp 354-355).

Petitioner was seen on April 2, 2012. He reported he was doing fine with no problems. His medications included ProAir HFA. Under active problems the following were listed: acute sinusitis, bronchospasm, cough, shortness of breath, sinusitis and sleep apnea. (Respondent's Exhibit 3, pp 74-75).

Medical records of St. John's Hospital were admitted into evidence. On April 27, 2009, Petitioner underwent a nuclear stress test. The indication for same was shortness of breath. In the testing, there were no ECG changes for ischemia. Petitioner had a normal myocardial profusion with anterior and inferior attenuation artifact. Petitioner had a normal ejection fraction of 61%. (Respondent's Exhibit 4, pp 24-25). On August 26, 2011, Petitioner underwent a colonoscopy. Physical examination revealed his lungs to be clear to auscultation and percussion. (Respondent's Exhibit 4, pp 10-11). In a document entitled Pre-Procedure Phase, it was indicated that Petitioner suffered from GERD and asthma. One of the medications he listed was Albuterol which was used on an as needed basis. (Respondent's Exhibit 4, p 16).

Medical records from St. Francis Hospital were admitted into evidence. In an emergency room visit on October 16, 2004, for injury to his right hand, Petitioner denied shortness of breath. On review of systems pulmonary, Petitioner was negative for cough, shortness of breath, wheezing, asthma and COPD. (Respondent's Exhibit 5, pp 5-6).

Medical records of Prairie Cardiovascular Consultants were admitted into evidence. Petitioner was seen by Dr. Holly Novak on April 20, 2009, at which time he related a significant history of hypertension. Petitioner related episodes of elevated blood pressure at work as well as episodes of shortness of breath. Petitioner was noted to be a non-smoker. (Respondent's Exhibit 6, pp 49-53). Petitioner was seen on July 19, 2010. He reported that he had recently retired from coal mining. Review of systems respiratory revealed no chronic cough. Physical examination of the chest revealed same to be clear to auscultation. Petitioner was walking a mile to a mile and a half per day. (Respondent's Exhibit 6, pp 16-20). Petitioner was seen on September 14, 2011. He was trying to exercise on a regular basis, but was limited by his knee pain. Review of systems respiratory revealed no chronic cough. Physical examination of the chest revealed same to be clear to auscultation. (Respondent's Exhibit 6, pp 4-8).

Petitioner filed for Social Security Disability on May 31, 2010. He claimed an inability to work beginning May 29, 2010. Petitioner was awarded Social Security Disability based upon the primary diagnosis of bilateral knee arthritis and the secondary diagnosis of obesity. (Respondent's Exhibit 7, p 4). On the Function Report – Adult completed on behalf of Petitioner, he stated that in his line of work as a coal mine repairman he must be able to walk long distances, lift heavy objects and work in different positions. He stated that due to his knees he could not stand or bear weight. (Respondent's Exhibit 7, p 67).

Conclusions of Law

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

The Arbitrator concludes that Petitioner did not sustain an occupational disease arising out of and in the course of his employment for Respondent that manifested itself on May 23, 2010.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified that he really noticed his breathing problems increasing in the last five to six years of his employment. Petitioner testified that he is on Social Security Disability for his knees. Petitioner testified that from the time he first noticed his breathing problems until arbitration they continued to progress. Petitioner was performing his job duties in the mine up until his knees caused him to stop working.

Dr. Clapp testified that the spirometry performed as part of his examination was essentially within normal limits. Furthermore, Dr. Clapp testified that the scar tissue and fibrosis of pneumoconiosis is permanent and does not go away. If the changes seen in the chest x-ray on

September 1, 2011, by Dr. Clapp were the opacities of pneumoconiosis, same would not have disappeared from the upper lung zones as of the March 5, 2012, chest x-ray.

Dr. Alexander, a B-reader, noted the chest x-ray of September 1, 2011, was positive for coal workers' pneumoconiosis.

Dr. Meyer, a B-reader, reviewed the chest x-rays of October 5, 2009, September 1, 2011, and March 5, 2012, and opined Petitioner's lungs were completely clear and there were no findings of coal workers' pneumoconiosis.

Dr. Castle testified that based upon the pulmonary function testing that was performed by Dr. Clapp Petitioner was capable of heavy manual labor from a ventilatory standpoint. Although Dr. Clapp testified that further exposure to coal mine dust would risk progression of Petitioner's coal workers' pneumoconiosis, Dr. Castle testified that the American Thoracic Society takes the position that an older worker with a mild pneumoconiosis can continue working as a coal miner and may be at low risk for working in currently permissible exposure levels until he reaches retirement age.

Dr. Clapp's finding of opacities in the middle and lower lung zones to the exclusion of the upper lung zones is not consistent with Dr. Meyer's testimony that coal workers' pneumoconiosis is generally an upper lung zone predominant process.

The Arbitrator finds the opinions of Dr. Meyer and Dr. Castle to be more persuasive than those of Dr. Clapp and Dr. Alexander.

In regard to disputed issues (L) and (O) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issues (C) and (F).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Matthew Olson,
Petitioner,

vs.

Lukasz Guzy, individually and as President/Secretary d/b/a Mobil Digital and Illinois State Treasurer as Ex-Officio/Custodian of the Injured Workers' Benefit Fund,
Respondent.

17IWCC0219

NO: 12 WC 20640

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 19, 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.

IT IS FURTHER ORDERED BY THE COMMISSION that 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.

17IWCC0219

Bond for removal of this cause to the Circuit Court by Respondent Lukasz Guzy, individually and as President/Secretary d/b/a Mobil Digital is hereby fixed at the sum of $74,200.00. Bond for removal of this cause to the Circuit Court by Respondent Illinois State Treasurer as Ex-Officio/Custodian of the Injured Workers' Benefit Fund is hereby fixed at the sum of $66,400.00. 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: APR 12 2017
o3/30/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0219

OLSON, MATTHEW
Employee/Petitioner

Case# **12WC020640**

GUZY, LUKASZ INDIVIDUALLY AND AS PRESIDENT/SECRETARY D/B/A MOBIL DIGITAL AND ILLINOIS STATE TREASURER AS EX-OFFICIO/CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 2/19/2016, 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.

0491 SOSTRIN AND SOSTRIN PC
RACHEL SOSTRIN
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CHICAGO, IL 60603

1779 BRANDER & SERPE
MIKE C BRANDER
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17IWCC0219

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

Matthew Olson
Employee/Petitioner

v.

Case # **12** WC **20640**

Consolidated cases: **D/N/A**

Lukasz Guzy, individually and as President/Secretary d/b/a Mobile Digital; and 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 **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **1/20/2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **6/10/2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$25,336.00**; the average weekly wage was **$487.23**.

On the date of accident, Petitioner was **22** 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.

Petitioner did not place temporary total disability at issue. Petitioner agrees that Respondent Guzy/Mobile Digital paid him $391.84 in temporary total disability benefits. Arb Exh 1.

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

ORDER

Respondent shall pay Petitioner reasonable and necessary medical services of $34,232.69, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $292.34/week for 38 weeks, because the injuries sustained caused the 100% loss of the right middle finger, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner additional permanent partial disability benefits of $292.34/week for 71.75 weeks, because the injuries sustained caused the 35% loss of the right hand, as provided in Section 8(e) of the Act.

Respondent Guzy/Mobile Digital shall pay to Petitioner attorney fees of **$2,221.78**, as provided in Section 16 of the Act and penalties of **$5,554.46**, as provided in Section 19(k) of the Act. The Arbitrator does not find Respondent Injured Workers' Benefit Fund liable for any penalties or fees.

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

Molly C Mason

Signature of Arbitrator

2/19/16
Date

FEB 19 2016

Matthew Olson v. Lukasz Guzy, individually and as
President/Secretary d/b/a Mobile Digital and
Injured Workers' Benefit Fund
12 WC 20640

Arbitrator's Summary of Disputed Issues

Respondent Lukasz Guzy, the owner of Mobile Digital, appeared at the January 20, 2016 hearing and was represented by counsel. Guzy acknowledged Mobile Digital had no workers' compensation coverage as of Petitioner's June 10, 2011 accident. Guzy stipulated to all issues other than medical expenses, nature and extent and penalties/fees. Respondent Injured Workers' Benefit Fund [hereafter referred to as "IWBF"] placed all issues in dispute.

Arbitrator's Findings of Fact

Based on the certified NCCI records, to which neither Respondent objected, the Arbitrator made a preliminary finding that Mobile Digital lacked workers' compensation coverage as of June 10, 2011.

Petitioner testified he was born on March 22, 1989. As of the June 10, 2011 accident, he was 22 years old and single. He had no minor children as of that date.

Petitioner testified he is right-handed.

Petitioner described Mobile Digital as an installer of car electronics, including sound equipment, alarms and remote starts. Mobile Digital was located in Wheeling. Its business involved the use of sharp-edged instruments and power equipment.

Petitioner testified his first contact with Mobile Digital was as a customer. At some point in 2008, he went to Mobile Digital to pick up his car, after having work done, and spoke with the owner, Lukasz Guzy, about the training he was undergoing in car electronics. Guzy told Petitioner he could work for Mobile Digital once he had finished his training.

Petitioner testified he returned to Mobile Digital later in 2008 and again spoke with Guzy. At that point, he was working elsewhere. After Guzy reiterated his job offer, he provided his employer with two weeks' notice and began working part-time for Mobile Digital.

Petitioner testified that, when he first started working for Mobile Digital, he earned about $9 or $10 per hour. By 2011, he was earning about $12 hour and working full-time. Guzy paid him via checks and deducted taxes from his earnings. Petitioner identified PX 2 as the W2 tax form he received from Mobile Digital in 2011. PX 2 reflects earnings of $25,336 for that year.

Petitioner testified that, as of June 10, 2011, Guzy told him what to do, work-wise, and provided him with materials.

Petitioner testified his health was good when he arrived at work on June 10, 2011. He denied having any injuries prior to that date.

Petitioner testified that business was slow on June 10, 2011 so Guzy assigned him to work on a car that he was trying to "flip." This was not a typical task for Petitioner but Guzy paid him his regular wages for performing this task. Guzy assigned Petitioner to install an air conditioning compressor in the car. As Petitioner was performing this assignment, his right hand slipped and got caught in the serpentine belt. His right middle finger was smashed between the belt and the pulley. He was working alone at the time of the accident. He felt a lot of pain. He called out to Guzy, who was in an adjacent office with a friend, and told Guzy to call an ambulance. Either Guzy or Guzy's friend called 911. Paramedics arrived and transported Petitioner to Glenbrook Hospital's Emergency Room.

The Emergency Room records reflect that Petitioner caught his right hand in a serpentine belt in a car at work. A physician's assistant noted an avulsion of the distal tip of the right middle finger, with exposed bone, tenderness and a puncture wound at the second metacarpal and an abrasion to the right lateral hand. X-rays showed a comminuted fracture involving the shaft of the second metacarpal of the right hand and a large soft tissue defect involving the distal aspect of the third digit of the right hand with no associated fracture. An orthopedic surgeon, Dr. Levitz, came to the hospital for purposes of a consultation. He recorded a consistent history of the work accident and noted that Petitioner denied any prior right hand injuries. After examining Petitioner he recommended surgery. He told Petitioner he would likely require amputation of at least part of the right middle finger. Later the same day, Dr. Levitz performed the following procedures: 1) irrigation and debridement of the right index finger metacarpal; 2) open reduction and internal fixation of the right index finger metacarpal fracture; 3) irrigation and debridement of the right long finger; 4) amputation of the right long finger at the level of the PIP joint; 5) use of C-arm fluoroscopy. In his operative report, he noted a "significant contamination" of imbedded grease and dirt in the soft tissue of the right middle finger. He indicated he did not view this tissue as viable due to the degree of contamination. After extensively debriding the contaminated area, he removed the middle phalanx at the PIP joint and closed the soft tissue over the stump with 4 sutures. He then turned to the right index finger metacarpal fracture. He described this fracture as significantly comminuted. He inserted a DePuy hand-locking plate, K-wires and screws. Postoperatively, Petitioner was placed in a splint and continued on intravenous antibiotics and Dilaudid. He was discharged from the hospital on June 12, 2011 with directions to take Keflex, Oxycontin and Norco and follow up with Dr. Levitz. PX 4.

Petitioner followed up with Dr. Levitz on June 15, 2011. On that date, the doctor noted that Petitioner denied numbness, tingling or significant pain. After removing the splint and dressings, the doctor described the amputation and surgical sites as healing well. He indicated that Petitioner was able to actively flex and extend his fingers and thumb, albeit to a limited

degree. He noted no rotational deformity of the index finger with limited active flexion. He obtained right hand X-rays. He interpreted the films as showing the amputation, good alignment of the surgical hardware and two small tabs on the plate that he described as "part of the plate construct." He indicated he did not remove these tabs at the time of the surgery. He told Petitioner that these tabs would typically be removed and that "no screws were placed into these holes at the time of the procedure." He did not anticipate that the tabs would interfere with the tendon, based on their location, but told Petitioner it would be possible to surgically remove them if they impeded his motion. He indicated that Petitioner asked him whether the tabs could break off and that he told Petitioner this was unlikely, since the tabs were "screwed into the plate." He prescribed occupational therapy, to include fashioning of a new splint. He directed Petitioner to return in one week for removal of the sutures. PX 5.

Petitioner underwent an initial therapy evaluation at AthletiCo on June 21, 2011. The evaluating therapist, Kelly Conroy, OT, noted a report of 7/10 pain with active range of motion and difficulty with daily activities such as grooming, dressing, bathing and driving. She noted that Petitioner worked as a car electronics installer and that he had resumed light duty, with his current tasks involving answering the phone and driving a vehicle to pick up parts. On examination, she noted a 7.5 centimeter incision with sutures intact on the right index finger metacarpal region, bruising and slight loosening of the right index finger nail, amputation of the right middle finger PIP joint, a wound on the ulnar aspect of the right ring finger and a wound on the right small finger. She also noted edema and decreased strength throughout the right hand. She indicated Petitioner would require specialized desensitization for the amputation. She described Petitioner as having "multiple functional deficits due to the status of his right hand and amputation of the middle finger." She recommended therapy and a home exercise program. PX 6.

Petitioner returned to Dr. Levitz on June 27, 2011. The doctor noted that Petitioner was participating in therapy, applying ice as needed and keeping his hand elevated. The doctor removed the surgical sutures. On examination, he noted tenderness to palpation along the tip of the right middle finger, flexion of the right ring and small fingers down to the distal palmar crease, the ability to flex the MP joint of the right middle finger and a limited range of motion of the right index finger.

Dr. Levitz directed Petitioner to continue wearing the splint, other than when resting at home, and continue attending therapy. He told Petitioner he would "really need to push the range of motion of the index finger" so as to be able to begin strengthening exercises. He also indicated Petitioner would need to be fitted with a right middle finger "shrinker" to get the swelling down. He directed Petitioner to return to him in two weeks. PX 5.

In a report dated August 1, 2011, Petitioner's therapist updated Dr. Levitz on Petitioner's progress. She indicated that Petitioner reported using his right hand on a daily basis for daily activities and work tasks but still had issues with tasks involving grip strength and fine motor skills. She indicated that Petitioner reported dropping items because he was still adjusting to the right middle finger amputation. She also noted that Petitioner received a digi-

gel cap for his right middle finger that day. She described Petitioner as having resumed full duty as a car electronics installer. She recommended continued desensitization for the right middle finger, due to the recent loss of the post-operative scab, and therapy for the right hand to rebuild strength. She noted that Petitioner demonstrated "significant decreased strength [in the right hand] compared to the non-dominant left hand." PX 6.

On August 8, 2011, Petitioner returned to Dr. Levitz. The doctor noted that Petitioner reported progress in therapy. He also noted that Petitioner had returned to work and was "doing most activities."

On examination, Dr. Levitz noted that Petitioner could fully extend his right index, ring and small fingers and flex them down to the distal palmar crease. He also noted that Petitioner could flex the MP joint of his right middle finger to 75 degrees with no discomfort. He further noted "no rotational deformity" of the right index finger. He indicated Petitioner's grip strength measured 60 pounds on the right versus 125 pounds on the left. He obtained X-rays of the right hand. He interpreted the films as showing the plate and screws to be in good position. He also noted "further interval healing at the fracture site." He recommended that Petitioner progress with strengthening exercises, while going slowly with heavy weight lifting due to the healing fracture. He directed Petitioner to return to him in four weeks. PX 5.

A therapy note dated August 15, 2011 reflects that Petitioner denied right hand pain and reported using the digi-gel cap as directed. The therapist recommended additional therapy in order to increase strength. PX 6.

A therapy note dated August 22, 2011 reflects that Petitioner reported falling onto a fence and scraping his right hand. The therapist noted scrapes and abrasions on Petitioner's right hand but "no open wounds." She indicated that Petitioner reported no residual pain associated with the fall. She also indicated that Petitioner performed various exercises, including putty pinching and gripping, clothespin pinching, jar turns and screwdriver turns. PX 6.

The last therapy note in evidence is dated August 29, 2011. On that date, a therapist measured Petitioner's right hand grip strength at 47 pounds, right hand lateral pinch strength at 14 pounds and right hand two-point pinch at 7 pounds. She measured Petitioner's right index finger active range of motion at 65 degrees MP, 90 degrees PIP and 65 degrees DIP. She measured the right middle finger MP joint active range of motion at 80 degrees. She noted that Petitioner performed various exercises. PX 6.

On September 12, 2011, Petitioner's therapist sent a final report to Dr. Levitz indicating that Petitioner had made excellent gains in regards to range of motion. She stated that Petitioner had "room for improvement for strength" but that this was "able to be acquired with continued integration with his daily tasks such as use of hand tools." PX 6.

Petitioner last saw Dr. Levitz on September 12, 2011. In his lengthy note of that date, the doctor indicated that Petitioner had progressed with therapy and was "essentially back to doing all work without any restrictions." He indicated Petitioner reported performing a lot of hand-intensive activities, including squeezing and gripping. He noted that Petitioner denied pain, numbness or tingling.

On examination, Dr. Levitz noted good healing and no swelling at both surgical sites. He indicated Petitioner was able to make a full composite fist and extend all his fingers. He noted that Petitioner could flex his right index finger down to the distal palmar crease "with no rotation" and flex his right middle finger MP joint to 80 degrees with no discomfort. He measured Petitioner's grip strength at 70 pounds on the right versus 125 on the left.

Dr. Levitt obtained another set of right hand X-rays. He interpreted the films as showing further interval healing at the metacarpal fracture site. He also noted that the films showed that the plate "appears to have fractured at the site of the fracture."

Dr. Levitt saw no need for additional formal therapy. He believed that Petitioner's normal activities would allow him to improve his strength. He informed Petitioner that the repeat X-rays showed that the plate had broken since Petitioner's last visit. He addressed the etiology of the plate fracture as follows: "Based on the fact that he has no pain at the fracture site, I do not think that he has developed a non-union but clearly, with the strengthening that he has done, the plate has not withstood the stress." He indicated that the plate might need to be removed at some point in the future but he indicated Petitioner could continue his current activities since he has not experiencing any pain in the area of the fracture.

Dr. Levitz addressed the extent of the right middle finger amputation as follows:

> "I explained that the amputation site was done through the PIP joint, which involves removing the cartilage off the head of the proximal phalanx and rounding off the bone. He essentially has no PIP joint."

Dr. Levitz directed Petitioner to return to him if he had any concerns "or in approximately two months to check the healing of the fracture." PX 5.

On December 1, 2015, Petitioner filed a Petition for Penalties and Fees alleging, in part, that Respondent failed to pay for his medical treatment and his statutory amputation. PX 7.

Petitioner testified he feels a sharp pain in his right hand in the area where the plate was inserted when the weather gets cold. He cannot use his right hand to wipe himself. He has difficulty shooting a gun due to reduced grip strength. At work, it is difficult for him to pick up small objects such as screws. He has tried to adapt to his injuries. The stump of his right middle finger is sensitive to the touch. If he forgets about his missing finger and accepts change from a retail clerk after making a purchase, the coins fall through the gap in his hand.

Under cross-examination by the Fund's attorney, Petitioner testified he typically worked from 9 AM to 6 PM, Monday through Friday, and from 9 AM to 4 PM on Saturday. He did not wear a mobile device. He used his own tools while working for Mobile Digital. His tool set contained basic items such as screwdrivers and ratchets. If he lacked a tool, he would borrow one from Guzy. When he first started working at Mobile Digital, he primarily acted as an assistant, helping Guzy install car alarms, radios, sub-woofers and remote starts. It was not common for him to actually perform work on a car. On the day of the accident, however, conventional work was slow so Guzy asked him to perform work on a car that Guzy was hoping to sell. He received his usual wages for performing this work. He believes Guzy owned the car he was working on at the time of the accident. At the time of the accident, he was working alone. Guzy and Guzy's friend were in an adjacent office. No one witnessed his accident. After the accident, Guzy came out of the office. At the hospital, he completed some paperwork in connection with a workers' compensation claim. He brought this paperwork to Guzy. It was when he presented the paperwork to Guzy that Guzy admitted he had no workers' compensation coverage. As of the accident, he was the sole employee at Mobil Digital. He never showed his surgeon any photographs. He received paychecks from Guzy on a weekly basis. He believes these checks were company rather than personal checks. He has no stubs because no stubs were attached to the paychecks he received. He put trust in Guzy that Guzy was deducting taxes from his earnings. He does not recall seeing any "off work" slips. Dr. Levitz did not impose any permanent restrictions on September 12, 2011. He has not undergone any additional treatment for his injuries since that date. He is not currently taking any medication for his injuries.

Under cross-examination by Guzy's attorney, Petitioner testified he believes he related his symptoms to Dr. Levitz. He would not disagree with the doctor's note of June 15, 2011 if it reflects he denied numbness, tingling and significant pain. At that point, his hand was still bandaged and he was not using it. As of August 8, 2011, he was back to work and performing most activities. As of the last visit, on September 12, 2011, he was performing full duty, including tasks that required squeezing and gripping. He would not disagree with Dr. Levitz's September 12, 2011 note if it reflects he denied pain. He attended sixteen occupational therapy sessions. On September 12, 2011, Dr. Levitz told him that the plate in his hand had broken. He was not previously aware of this. He has not had any right hand treatment since his last visit to Dr. Levitz. He has not had any right hand problems that were significant enough to prompt him to return to the doctor. In addition to the co-payments, he paid AthletiCo $152, via check. Guzy reimbursed him for the co-payments he made. He is not receiving any medical bills at home. He has not received any medical bills relating to his injuries since he retained counsel. His mother's group carrier, United Healthcare, paid some of his medical bills. He does not know the status of the remaining bills. He cannot recall exactly what treatment he received on September 12, 2011 but he believes he underwent X-rays. He continued working for Guzy until approximately March 22, 2013, when he began working for his current employer, Lund Industries. After his accident, Guzy changed the name of his business and moved to a different location. At Lund Industries, he builds emergency vehicles. Specifically, he installs lights and sirens onto police and fire vehicles. He earns more now than he did when he worked for Guzy.

On redirect, Petitioner testified he would agree with Dr. Levitz's note of September 12, 2011 if it states he had resumed performing his regular duties. On that date, Dr. Levitz gave him the option of having the plate removed from his hand. He declined because he did not want to undergo more surgery. He was discharged from occupational therapy on September 12, 2011 but he lacked strength at that point. After being discharged from therapy he continued performing home exercises. The exercises involved manipulating putty and using a device to build strength.

Under re-cross by Guzy's attorney, Petitioner testified he does not intend to return to Dr. Levitz.

Lukasz Guzy testified on behalf of Mobile Digital. Guzy acknowledged he used to own Mobile Digital. The company no longer exists. He now operates Car Mania. He denied operating any other company before he operated Mobile Digital. He came to the United States from Poland in 2000. He started Mobile Digital in 2004. Initially, he went to various car dealerships and installed equipment there.

Guzy testified he has never had any employees other than Petitioner. Petitioner initially started working for him as a helper. Once Petitioner finished his schooling, he began doing more. After the accident, he told Petitioner he would help pay the medical bills, starting with the smaller bills. He gave Petitioner money to use to pay his therapy expenses. He also gave Petitioner money to pay the ambulance bill. He cannot recall exactly which bills he paid but "they were the smaller bills." From a technical standpoint, he did not give Petitioner other funds to cover the remaining medical bills but he did perform services for Petitioner. He repaired two cars for Petitioner. Petitioner did not pay him for the work he performed on the cars. About a week after the accident, Petitioner and one of his relatives, maybe an uncle, came to Mobile Digital. Petitioner told him he was not going to go after him. Petitioner apologized for the accident and asked if he could continue working. Petitioner left his employment in 2012, not 2013. On the day that Petitioner quit, Petitioner showed him various medical bills. He (Guzy) told Petitioner he would pay these bills.

Under cross-examination by Petitioner's counsel, Guzy admitted he did not have workers' compensation coverage on the date of the accident. He has no documentation of the amounts he paid to Petitioner to cover the bills. He believes Petitioner left his employment in March 2012. He could see that one of Petitioner's fingers was amputated.

Under cross-examination by the Fund, Guzy testified he has workers' compensation insurance for Car Mania. He opened this business in January 2012.

Arbitrator's Credibility Assessment

Petitioner came across as a stoical individual who has made every effort to adjust to his significant injuries. The Arbitrator found him very credible.

Arbitrator's Conclusions of Law

[The Arbitrator addresses all issues, despite Mobile Digital's stipulations, because the Fund placed all issues in dispute.]

Were Petitioner and Respondent operating under the Act on June 10, 2011? On that date, was the relationship between Petitioner and Respondent one of employee and employer?

The Arbitrator finds that Respondent Guzy was operating under the Act as of June 10, 2011. In so finding, the Arbitrator relies in part on Guzy's stipulation. This stipulation is binding pursuant to Walker v. Industrial Commission, 345 Ill.App.3d 1084, 1088 (4th Dist. 2004). The Arbitrator also relies on Petitioner's testimony that sharp-edged tools and power equipment were used in Mobile Digital's operations. Guzy, who operated Mobile Digital as of the accident, did not dispute this testimony. Section 3 of the Act provides that the provisions of the Act shall apply automatically and without election to any employer engaged in a business deemed to be extra-hazardous. Subsection (8) places "any enterprise in which sharp-edged cutting tools, grinders or implements are used" in the extra-hazardous category. Subsection 15 places any enterprise in which power driven equipment is used in the same category.

The Arbitrator further finds that the relationship between Petitioner and Guzy was one of employee and employer as of June 10, 2011. Guzy stipulated to employment. Separate and apart from this binding stipulation, the evidence establishes an employment relationship. While Petitioner acknowledged using his own tools at work, he testified he used materials and specialized tools provided by Mobile Digital and consistently took direction from Guzy. He also testified that the tasks he performed were in the "nature of" Mobile Digital's car electronics business and that taxes were deducted from his paychecks. Guzy did not refute his testimony on these points. Immediately before the accident, Petitioner was working on a car that Guzy planned to sell, rather than an outside customer's car, but the evidence establishes he was performing this task at Guzy's specific direction in exchange for his regular wages.

Did Petitioner sustain an accident arising out of and in the course of his employment on June 10, 2011?

The Arbitrator finds that Petitioner sustained an accident arising out of and in the course of his employment on June 10, 2011. In so finding, the Arbitrator relies on the following: 1) Guzy's binding stipulation to accident; 2) Petitioner's credible and detailed testimony concerning the circumstances of the accident; and 3) the corroborating Emergency Room and inpatient records of June 10-12, 2011, all of which reflect that Petitioner reported getting his right hand caught in a serpentine belt while fixing a car at work. Guzy did not refute any of Petitioner's accident-related testimony. The evidence establishes that the accident happened on Mobile Digital's premises, during a regular workday, while Petitioner was working on a vehicle at Guzy's direction.

Did Petitioner establish a causal connection between the June 10, 2011 accident and his current conditions of ill-being?

The Arbitrator finds that Petitioner established a causal connection between his June 10, 2011 accident and his current right middle finger and right first metacarpal/hand conditions of ill-being. In so finding, the Arbitrator relies in part on Guzy's binding stipulation to causation. The Arbitrator also relies on Petitioner's credible denial of any pre- and post-accident injuries along with the chain of events. Petitioner's credible description of an acute onset of symptoms is supported by Guzy and the treatment records.

What were Petitioner's earnings and average weekly wage?

Petitioner testified he began working for Mobile Digital several years before his June 10, 2011 accident. Petitioner also testified he was paid by the hour, with his hourly rate increasing over time. He indicated that Guzy issued paychecks to him on a regular basis and deducted taxes from his earnings. He did not produce any specific weekly payroll information but explained that the paychecks he received lacked stubs. Petitioner identified PX 2 as the 2011 W2 form he received from Mobile Digital. This form shows he grossed $25,336.00 from Mobile Digital in 2011. This gross figure very likely includes post-accident earnings, since Petitioner resumed working for Mobile Digital shortly after the accident, but Mobile Digital stipulated to earnings of $25,336.00 and an average weekly wage of $487.23. Arb Exh 1. This stipulation is binding under Walker v. Industrial Commission, 345 Ill.App.3d 1084, 1088 (4th Dist. 2004).

Based on the W2 form and Guzy's binding stipulation, the Arbitrator finds that Petitioner's earnings were $25,336.00 and that his average weekly wage was $487.23.

What was Petitioner's age as of June 10, 2011? Was Petitioner married on that date and did he have any dependent children?

Petitioner testified he was born on March 22, 1989 and was 22 years old as of his June 10, 2011 accident. His medical records corroborate his birth date. The Arbitrator finds Petitioner was 22 years old as of the accident.

Petitioner testified he was single and had no dependent children as of the accident. Guzy did not refute this testimony. The Arbitrator finds that Petitioner was single and had no dependent children as of the June 10, 2011 accident.

Is Petitioner entitled to reasonable and necessary medical expenses?

Both Mobile Digital and the Fund placed medical in dispute. Arb Exh 1.

The evidence shows that Guzy indirectly paid three of Petitioner's smaller medical bills by advancing funds to Petitioner which Petitioner used to purchase money orders. PX 3A. Guzy also claimed he provided free car repairs to Petitioner, in consideration of other medical

expenses, but he offered no evidence as to the value of these services. The evidence further shows that Petitioner's mother's group insurance carrier paid some of the remaining bills and that other bills remained outstanding as of the hearing.

As a preliminary matter, the Arbitrator finds the treatment rendered to Petitioner to be reasonable, necessary and causally related to the June 10, 2011 accident. Petitioner's testimony and records establish that the accident caused significant acute injuries to the right hand and fingers, including the index and middle fingers. Dr. Levitz's operative report and final office note establish that the accident and contamination with grease and dirt brought about the need for surgical removal of a significant part of Petitioner's right middle finger, including the PIP joint. Dr. Levitz was also required to stabilize the metacarpal fracture by inserting surgical hardware. At the doctor's direction, Petitioner underwent occupational therapy postoperatively. The AthletiCo records show that Petitioner derived improvement from this therapy, although he was left with strength deficits. Guzy did not offer any medical opinion suggesting that Petitioner's treatment was unnecessary or excessive.

Guzy maintains he is liable only for the medical expenses that remain unpaid, arguing that Petitioner would receive a double recovery if the Arbitrator awarded expenses previously paid by Petitioner's mother's group carrier, United Healthcare. Guzy also asserts that Petitioner only produced a few of his bills to him for payment.

The Arbitrator views the "double recovery" argument as having potential merit as against the Fund, given the Fund's underlying purpose and the number of claimants seeking recovery from the Fund, but no merit as against Guzy, an individual who elected to employ a young person in a potentially hazardous trade without the benefit of workers' compensation coverage. The Arbitrator also notes that, via the analysis and award set forth below, Guzy is deriving a benefit from several treaters' charity write-offs. Guzy's other argument also fails. If anything, Guzy discouraged Petitioner from producing all of his bills, by telling Petitioner shortly after the accident that he could only "start" with the smaller bills. Petitioner presumably did not want to act too aggressively at that point since he wanted to resume working for Guzy. Moreover, Guzy acknowledged that Petitioner produced a variety of bills to him when Petitioner left his employment, years before the hearing.

The Arbitrator awards Petitioner the following medical expenses (PX 3):

Athletico:

6/21/11 – 8/29/11. Of the total charges of $4,433.00, Petitioner (via Guzy) paid $641.00 and United Healthcare paid $1,705.00. The Arbitrator awards the negotiated rate of $1,705.00.

Northshore University Healthsystem:

6/10/11 – 6/12/11 dates of service (initial hospitalization). The total charges are $29,580.84. The amount due per the fee schedule is $22,111.39. United Healthcare paid

$12,189.42 and there were other charity write-offs, leaving a balance of $4,347.85. The Arbitrator awards the negotiated rate of $16,537.27.

6/10/11 date of service (ER and chest X-ray). The total charges were $653.00. The Arbitrator awards the negotiated rate of $647.20.

6/10/11 date of service (Dr. Kay). The total charges are $7,879.00. The amount due per the fee schedule is $7,149.65. United Healthcare paid $6,280.00 and there were other charity write-offs, leaving a balance of $239.85. The Arbitrator awards the negotiated rate of $6,519.85.

6/10/11 date of service (Dr. Pimentel). The Arbitrator awards the group lien amount of $7,674.00.

6/15/11 date of service (X-rays). The total charges are $337.00. The amount due per the fee schedule is $256.12. United Healthcare paid $25.52 and there were other charity write-offs, leaving a balance of $77.87. The Arbitrator awards the negotiated amount of $103.39.

6/15/11 date of service (occupational therapy). The total charges were $381.00. Petitioner paid $30.00 but was reimbursed by Guzy. The Arbitrator awards the group lien amount of $351.00.

6/15/11 date of service (post-op visit and X-rays). The Arbitrator awards the group lien amount of $24.08.

7/11/11 date of service (X-rays). The Arbitrator awards the group lien amount of $206.00.

7/11/11 date of service (post-op visit and X-rays). The Arbitrator awards the group lien amount of $27.00.

8/8/11 date of service. The total charges are $337.00. The amount due per the fee schedule is $256.12. United Healthcare paid $168.50 and there were other charity write-offs, leaving a balance of $25.00. The Arbitrator awards the negotiated amount of $193.50.

8/8/11 date of service (post-op visit and X-rays). The Arbitrator awards the group lien amount of $28.00.

9/12/11 date of service (X-rays). The total charges are $337.00. The amount due per the fee schedule is $256.12. United Healthcare paid $168.50 and there were other charity write-offs, leaving a balance of $42.12. The Arbitrator awards the negotiated amount of $210.62.

9/12/11 date of service (X-rays). The Arbitrator awards the negotiated amount of $5.78.

What is the nature and extent of the injuries?

This case is pre-amendatory, since the accident occurred before September 1, 2011. In assessing permanency, the Arbitrator considers the treatment records and Petitioner's credible testimony concerning his current complaints. The Arbitrator also considers that the injury involved Petitioner's dominant right hand and that Petitioner's chosen occupation is hand-intensive. The Arbitrator notes that neither Guzy nor the Fund offered a Section 12 examination report or AMA impairment rating.

With respect to the right middle finger, the Arbitrator finds that Petitioner has established a 100% loss of the finger based on the statutory loss of "more than one phalanx." Dr. Levitz's operative report and final office note of September 12, 2011 establish that the surgical amputation involved the PIP joint. Dr. Levitz stated that Petitioner "essentially has no PIP joint." The 100% loss is equivalent to 38 weeks of benefits under Section 8(e) of the Act. The Arbitrator awards permanency at the rate of $292.34 per week based on the finding of an average weekly wage of $487.23.

The Arbitrator turns to the right first metacarpal injury, which required surgery, including insertion of a plate and other hardware. Dr. Levitz's records reveal that the first metacarpal surgery did not go exactly as planned in that two tabs which would typically have been removed, to allow for placement of screws in the resulting holes, were left in place. The records also reflect that the plate subsequently fractured. Dr. Levitz theorized that the plate failed to withstand the rigors of the strengthening exercises Petitioner performed during therapy. Petitioner opted not to have further surgery to replace the fractured plate. The Arbitrator views this option as reasonable, given the number of outstanding medical bills Petitioner faced. As of Petitioner's last visit with Dr. Levitz, on September 12, 2011, the grip strength in his dominant right hand was only 70 pounds compared with 125 pounds in his non-dominant left hand.

The Arbitrator, having considered the nature of the fracture, the ultimate surgical result, Petitioner's very young age, the fact that the injury involves the dominant hand and the hand-intensive nature of Petitioner's chosen occupation, awards additional permanency equivalent to 35% loss of use of the right hand, equivalent to 71.75 weeks, under Section 8(e) of the Act.

Is Respondent Mobile Digital liable for penalties and fees?

The Arbitrator finds that Respondent Guzy is liable for Section 19(k) penalties and Section 16 attorney fees on the undisputed right middle finger amputation. Guzy admitted he saw Petitioner very shortly after the accident and was aware of the amputation yet never made any payments toward this statutory injury. As of the hearing, more than four years had passed since the injury. Guzy stipulated to multiple issues, including employment, accident, causation and earnings, at the hearing. In Greene Welding and Hardware v. IWCC, 396 Ill.App.3d 754, 758 (4th Dist. 2009), the Appellate Court held, relying on Lester v. Industrial Commission, 256

Ill.App.3d 520 (1993), that "where there is no dispute regarding whether a claimant's amputation injuries arose out of and in the course of his employment, statutory benefits for amputation are to be paid no later than the time at which the employer reasonably knows the extent of the amputation and is capable of calculating the appropriate average weekly wage."

The Arbitrator, having considered the treatment records along with Guzy's stipulations and admission that he was aware of the amputation, finds that Guzy acted in an objectively unreasonable manner in failing to pay the statutory benefits.

With respect to the right middle finger, the Arbitrator has previously found that Petitioner established permanency equivalent to 100% loss, equivalent to 38 weeks of benefits. 38 weeks multiplied by the permanency rate of $292.34 equals $11,108.92. The Arbitrator finds Respondent Guzy liable for Section 19(k) penalties equivalent to 50% of $11,108.92, or $5,554.46, and Section 16 attorney fees equivalent to 20% of $11,108.92, or $2,221.78.

The Arbitrator clarifies that this award of penalties and fees is solely against Respondent Guzy.

Matthew Olson v. Lukasz Guzy, individually and as
President/Secretary d/b/a Mobile Digital and
Injured Workers' Benefit Fund
12 WC 20640

17IWCC0219

Arbitrator's Summary of Disputed Issues

Respondent Lukasz Guzy, the owner of Mobile Digital, appeared at the January 20, 2016 hearing and was represented by counsel. Guzy acknowledged Mobile Digital had no workers' compensation coverage as of Petitioner's June 10, 2011 accident. Guzy stipulated to all issues other than medical expenses, nature and extent and penalties/fees. Respondent Injured Workers' Benefit Fund [hereafter referred to as "IWBF"] placed all issues in dispute.

Arbitrator's Findings of Fact

Based on the certified NCCI records, to which neither Respondent objected, the Arbitrator made a preliminary finding that Mobile Digital lacked workers' compensation coverage as of June 10, 2011.

Petitioner testified he was born on March 22, 1989. As of the June 10, 2011 accident, he was 22 years old and single. He had no minor children as of that date.

Petitioner testified he is right-handed.

Petitioner described Mobile Digital as an installer of car electronics, including sound equipment, alarms and remote starts. Mobile Digital was located in Wheeling. Its business involved the use of sharp-edged instruments and power equipment.

Petitioner testified his first contact with Mobile Digital was as a customer. At some point in 2008, he went to Mobile Digital to pick up his car, after having work done, and spoke with the owner, Lukasz Guzy, about the training he was undergoing in car electronics. Guzy told Petitioner he could work for Mobile Digital once he had finished his training.

Petitioner testified he returned to Mobile Digital later in 2008 and again spoke with Guzy. At that point, he was working elsewhere. After Guzy reiterated his job offer, he provided his employer with two weeks' notice and began working part-time for Mobile Digital.

Petitioner testified that, when he first started working for Mobile Digital, he earned about $9 or $10 per hour. By 2011, he was earning about $12 hour and working full-time. Guzy paid him via checks and deducted taxes from his earnings. Petitioner identified PX 2 as the W2 tax form he received from Mobile Digital in 2011. PX 2 reflects earnings of $25,336 for that year.

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

Grazyna Marciniak,

Petitioner,

vs.

NO: 13 WC 5446

17IWCC0264

Mid City Plaza LLC,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions 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, causal connection, notice, 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).

The Commission corrects two scrivener errors in the Decision of the Arbitrator in the 'Findings' section of the Decision. The corrections reflect the actual findings of the Arbitrator in the body of the Decision. Line three in the 'Findings' section should state the following: "On this date, Petitioner did sustain an accident to the right shoulder that arose out of and in the course of employment, but did not sustain an accident to the left knee or left shoulder that arose out of and in the course of employment." Line four in the 'Findings' section should state the following: "Timely notice of this accident was given to the Respondent."

17IWCC0264

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 6, 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 $5,000.00. 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: APR 26 2017

Thomas J. Tyrrell

TJT/gaf
O: 3/7/17
51

Michael J. Brennan

DISSENT

I respectfully dissent from the decision of the majority. I maintain my position that the Arbitrator was correct in her original 19b decision when she found Petitioner's claim to be barred pursuant to Section 6(c). The Arbitrator's original review of the record was and still stands as thorough and contemporaneous with the testimony at arbitration. It remains persuasive on the issue of notice and I reassert my dissent and would bar the claim pursuant to Section 6(c) for failure to give timely notice as required.

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION
CORRECTED/ON REMAND

MARCINIAK, GRAZYNA
Employee/Petitioner

Case# **13WC005446**

MID CITY PLAZA LLC
Employer/Respondent

17IWCC0264

On 4/6/2016, 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 0.38% 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:

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CHICAGO, IL 60654

0507 RUSIN & MACIOROWSKI LTD
JOHN A MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

17IWCC0264

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION ON REMAND
19(b)

Grazyna Marciniak
Employee/Petitioner

Case # 13 WC 5446

v.

Consolidated cases:

Mid City Plaza LLC
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Arbitrator Deborah L. Simpson, Arbitrator of the Commission, in the city of Chicago, on 12/5/13 and 1/16/14. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment 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, 09-01-12, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was not given to Respondent.

In the year preceding the injury, Petitioner earned $32,344.00; the average weekly wage was $ 622.00.

On the date of accident, Petitioner was 53 years of age, married, with 0 children under 18.

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

Respondent shall be given a credit of $19,142.66 for TTD, $ 0 for TPD, $ 0 for maintenance, and $ _____ for other benefits, for a total credit of $ 0.

ORDER

Respondent shall pay Petitioner temporary total disability benefits commencing with October 25, 2012 through December 5, 2013 at the rate of $414.67 per week for a period of 58 1/7 weeks as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $19,142.10 for payments made. The Arbitrator finds that Petitioner failed to prove any causal relationship between a specific incident of September 1, 2012 and any condition of ill-being relative to the left shoulder or left knee. The Arbitrator finds that Petitioner did prove a causal relationship between the specific incident of September 1, 2012 and Petitioner's current condition of ill-being relative to the right shoulder.

Petitioner's request for prospective medical relative to the left shoulder and left knee is denied in light of the Arbitrator's finding as to lack of causality, as well as lack of medical necessity.

The Arbitrator finds that Respondent shall pay, in accordance with the fee schedule, any outstanding balance to Dynamic Physical Therapy for the therapy rendered to the right shoulder purported to be $4,021.19 under the fee schedule pursuant to Section 8(a) of the Act. The Respondent is responsible for any of the other bills submitted at trial that can be identified as relating to treatment for the right shoulder only, pursuant to the fee schedule in place at the time the bills were incurred in Section 8(a) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of temporary total disability, medical benefits, or compensation for a permanent disability, if any.

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

Deborah L. Simpson

Signature of Arbitrator

March 15, 2016

Date

APR 6 - 2016

17IWCC0264

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Grazyna Marciniak,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 13 WC 5446**
	)	
Mid City Plaza,	)	
	)	
Respondent.	)	
	)	

CORRECTED 19b DECISION AFTER REMAND FROM COMMISSION

PROCEDURAL HISTORY

This matter was heard by Arbitrator Deborah L. Simpson on December 15, 2013 and January 16, 2014. A record of the hearing was made. An Order was filed with the Commission on May 16, 2014. The findings and conclusions in that Order are now merged into this decision. The Arbitrator, after reviewing all the evidence and the testimony of the witnesses, found that the Petitioner's claim was barred under Section 6(c) for failure to give notice as required by law.

On May 19, 2015, the Commission issued a decision reversing the Decision of the Arbitrator with regard to notice and denies Petitioner's request to remand the case to enter additional evidence. The matter was remanded back to the Arbitrator with instructions to make findings with regard to all remaining issues. The decision of the Commission included a descent from Commissioner Lamborn, indicating that the Arbitrator's decision was well reasoned and should have been affirmed.

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

STATEMENT OF FACTS

The Commission found that the Petitioner reported her injury to her right shoulder to her supervisor, Anna Bartusiak, within 45 days of September 1, 2012, the date the Commission determined that the accident occurred.

The Commission having determined that the Petitioner sustained an accidental injury to her right shoulder on September 1, 2012, and that she reported same sometime before or after September 1, 2012, during conversations with her supervisor Anna Bartusiak, within the time period provided by the Act, remanded the matter back to the Arbitrator with instructions to make

findings with regard to all remaining issues. From the decision it appears that the issues that remain for the Arbitrator to determine are (1) causation; (2) medical expenses; (3) temporary total disability; and (4) prospective medical treatment. The Arbitrator, per the remand order will address these issues.

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987).

The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 Ill. 2d 214 (1969).

The burden of proving disablement and the right to temporary total disability benefits lies with the Petitioner who must show this entitlement by a preponderance of the evidence. *J.M. Jones Co. v. Industrial Commission,* 71 Ill.2d 368, 375 N.E.2d 1306 (1978)

It is not enough Petitioner is working when accidental injuries are realized; Petitioner must show the injury was due to some cause connected with employment. *Board of Trustees of the University of Illinois v. Industrial Commission,* 44 Ill.2d 207.

In other words, Petitioner must establish her employment subjected her to an increased risk of injury beyond that which the general public is exposed. *Holthaus v. Industrial Commission,* (1984) 127 Ill. App. 3d 732.

In support of the Arbitrator's decision with regard to whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions of law:

The Commission in its Decision found that Petitioner sustained a specific accident involving her right shoulder on September 1, 2012.

Petitioner's Application for Adjustment of Claim was signed by Petitioner on February 21, 2013 and filed with the Commission on the same date. It listed the part of body affected solely as the right shoulder (R. Ex. 1).

Petitioner's work duties included lifting wet towels and sheets from a large washing machine and placing them into a large drying machine. Petitioner was also required to fold large sheets by clipping a corner to a spring located above her head. The Arbitrator notes that all of these activities require Petitioner to lift items above her shoulders.

On September 1, 2012, Petitioner sought medical treatment from her family doctor, Dr. Nowak. At that time, she complained of severe right shoulder pain and less severe left shoulder

pain, which she began to notice a few days prior. Petitioner's pain increased while pulling heavy and wet laundry from a washing machine. Dr. Nowak noted that Petitioner's symptoms were getting progressively worse. Petitioner had decreased range of motion in both shoulders. Dr. Nowak's September 1, 2012 report indicates that the pain in both shoulders was related to an injury. (P. Ex. 2) A similar diagnosis was made at Petitioner's next visit, September 10, 2012, at which time Dr. Nowak indicated bilateral shoulder pain, right worse than left. A MRI on September 11, 2012 confirmed that Petitioner had suffered a full thickness tear of the supraspinatus tendon in her right shoulder.

Due to Petitioner's observable injury, she was referred to Dr. Dzwinyk, an orthopedic surgeon. At Petitioner's initial visit with Dr. Dzwinyk on November 3, 2012, Petitioner received a "patient status form," which established restrictions and noted that Petitioner's condition was work related. (P. Ex. 1) Dr. Dzwinyk performed a right rotator cuff repair on August 16, 2013. The Arbitrator notes that Petitioner stated she told Dr. Dzwinyk all of her complaints when seen between December 15, 2012 and May 4, 2013 (Tr. P. 87). Dr. Dzwinyk's notes, during this period of time, reference only a right shoulder condition with no reference of any left shoulder condition (R. Ex. 6). Dr. Dzwinyk's entries for September and October of 2013 do reference the left shoulder but indicate Petitioner had a full range of motion and normal strength (P. Ex. 2).

Petitioner was seen by two Section 12 examiners. The first examination, conducted by Dr. Verma in January 2013, was at the request of an insurance company that incorrectly believed that they insured Respondent on the date of Petitioner's injury. Dr. Verma's report indicates that Petitioner had been complaining of right shoulder pain in July and August 2012, which worsened with work activities in the end of August 2012. When the pain did not subside as expected, Petitioner sought medical treatment with her primary care physician. Dr. Verma also notes Petitioner claimed that, while working within the restrictions established by her doctors, she experienced pain in her left shoulder, caused by inflammation. Dr. Verma reviewed a job description that was consistent with Petitioner's testimony. At the time of the evaluation, Dr. Verma believed that Petitioner's left shoulder pain had resolved. After a physical examination, Dr. Verma diagnosed Petitioner with a right rotator cuff tear. Dr. Verma did not find any injuries to Petitioner's left shoulder. Dr. Verma believed that Petitioner's right shoulder condition was causally related to Petitioner's work activities and agreed with Dr. Dzwinyk's surgical recommendation and the need for post-surgical physical therapy. Dr. Verma gave Petitioner restrictions consistent with his diagnosis and recommendations. Dr. Verma noted the Petitioner stated her left shoulder was improved; with no further left shoulder complaints being voiced no left shoulder treatment was recommended. Relative to the left knee, Petitioner had no reports of ongoing problems in the left knee and no further treatment was recommended for the knee and no symptomatic requirements with regard to the knee. (R. Ex. 9, p. 2)

The second Section 12 examination also conducted at the Respondent's request was completed by Dr. Troy Karlsson of M&M Orthopedics on June 27, 2013 with benefit of an interpreter. Dr. Karlsson compiled a report of July 2, 2013. Dr. Karlsson's examination of the left shoulder revealed no positive objective findings with normal range of motion and strength. He reviewed the MRI of the left shoulder of November 8, 2012 and indicated that it showed no full thickness tear and degenerative cysts. He also reviewed an MRI of the left knee of November 8, 2012 which showed degenerative changes but no evidence of any type of tearing.

Dr. Karlsson found that there could exist a causality relative to Petitioner's right shoulder condition and her job duties. Possibility also existed that the right shoulder abnormality could be idiopathic or degenerative in nature. He noted that there were no positive objective physical findings relative to the left shoulder or left knee and that Petitioner was at maximum medical improvement relative to the left and right shoulder. He also opined, based upon the job video, that Petitioner's condition of the left knee and left shoulder bore no relationship to her work duties or any incident (R. Ex. 5).

The Arbitrator would therefore find that Petitioner established a causal relationship between the incident of September 1, 2012 and her current condition of ill-being in the right shoulder. The Arbitrator would find that Petitioner failed to establish a causal relationship between the specific incident of September 1, 2012 and any condition of ill-being in the left knee or left shoulder. The Arbitrator would adopt the opinions of Dr. Karlsson relative to the left knee and left shoulder and find that these conditions were unrelated to any specific incident of September 1, 2012 or sequela stemming there from.

In support of the Arbitrator's decision with regard to whether the medical services that were provided to Petitioner were reasonable and necessary and whether Respondent paid all appropriate charges for reasonable and necessary medical treatment, the Arbitrator makes the following conclusions of law:

The Arbitrator, having found no causal relationship between the accident of September 1, 2012 and any condition of ill-being relative to the left knee or left shoulder, hereby denies any medical services relative to same.

The Arbitrator awards medical services rendered to the right shoulder under the fee schedule or any preferred provider agreement that exists, whichever is less. The Arbitrator denies Petitioner's request under 8.2 (d) of the Act of interest of 1% on all unpaid medical bills. Section 8.2(d) requires for interest to be awarded that the carrier must be furnished all required data elements necessary to process a bill and only after receipt of such information after 30 days is interest awardable. Respondent objected to the bills as they were not furnished any itemized statements despite previously requesting same until the date of hearing of December 5, 2013 (Tr. P. 64). The Arbitrator also notes that the bills for which Petitioner requests payment (P. Ex. 2, Dr. Nowak), do not provide itemization as to what body parts treatment were rendered for. It is impossible for the Arbitrator, given the denial of causation relative to the left shoulder, to assess what portion, if any, of these bills relate to the right shoulder condition. The bills from Dynamic Physical Therapy (P. Ex. 3), in the amount of $5,209.00, with an alleged fee schedule analysis of $4,021.19 do relate to the right shoulder and are awardable in accordance with the fee schedule or any preferred provider agreement. Relative to the St. Mary and Elizabeth Medical Center bill of August 16, 2013, the date of the right shoulder surgery, the bill reflects a payment made by workers' compensation of $18,852.88; wherefore, Respondent would have already satisfied or exceeded the alleged fee schedule amount due and owing of $16,062.17. There is therefore no outstanding balance for said services. The bills of Dr. Dzwinyk of $612.15 lack sufficient proof or itemization that the alleged charges relate to the right shoulder as opposed to the left shoulder or left knee; wherefore, said claim for services is denied unless further information is provided establishing that the bills pertain to treatment for the right shoulder only.

Petitioner's request for reimbursement of $1,911.28 is also denied as these services were for payments made by Petitioner relative to treatment of the left shoulder.

Wherefore, Respondent shall pay, in accordance with the fee schedule, the Dynamic Physical Therapy statement, in the amount of $4,021.19, and any other bills which are properly attributed to treatment for the right shoulder only, per the fee schedule or prior agreement whichever is less, as provided in Section 8(a) of the Act.

In support of the Arbitrator's decision with regard to whether the Petitioner is entitled to TTD benefits, the Arbitrator makes the following conclusions of law:

The Arbitrator notes that Petitioner underwent right shoulder surgery on August 16, 2013 and had been authorized off work from October 25, 2012 for the right shoulder through the date of arbitration hearing of December 5, 2013. The Arbitrator therefore finds that Petitioner was temporarily totally disabled from October 25, 2012 through December 5, 2012, a period of 58 1/7 weeks and is entitled to receive for this period of time benefits at the rate of $414.67 per week.

Respondent shall be given credit for payments of $19,142.10.

In support of the Arbitrator's decision with regard to whether the Petitioner is entitled to Prospective medical treatment, the Arbitrator makes the following conclusions of law:

Petitioner's claim for prospective medical, relative to the left shoulder, is denied in light of the Arbitrator's finding as to lack of any causal relationship between the specific incident of September 1, 2012 and any condition of ill-being in the left shoulder.

The Arbitrator would also note that Dr. Verma, who examined Petitioner in January of 2013 (R. Ex. 4), had no positive objective findings relative to the left shoulder or left knee and opined that Petitioner was at maximum medical improvement relative to these conditions. Dr. Karlsson who examined Petitioner in July of 2013 also noted no positive objective findings relative to the left shoulder or left knee and found Petitioner to be at maximum medical improvement relative to these conditions. Dr. Karlsson also found that these conditions were not causally related to Petitioner's work activities or an incident of September 1, 2012.

The Arbitrator also notes that Dr. Dzwinyk's records from December 15, 2012 through May 4, 2013 make no reference of any left shoulder condition of ill-being (R. Ex. 6). Records from Dr. Dzwinyk from September, 2013 through October, 2013, relative to the left shoulder, note a full range of motion and normal strength. The Arbitrator would therefore find, in addition to lack of any causality relative to the left shoulder or left knee, that there is no objective clinical basis to support an award for prospective medical relative to either condition.

Petitioner's request for prospective medical relative to the left shoulder or left knee is hereby denied.

Respondent shall authorize and pay for any additional medical treatment recommended for or necessitated by the surgical intervention required to repair the Petitioner's right shoulder injury.

ORDER OF THE ARBITRATOR

Respondent shall pay Petitioner temporary total disability benefits commencing with October 25, 2012 through December 5, 2013 at the rate of $414.67 per week for a period of 58 1/7 weeks as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $19,142.10 for payments made. The Arbitrator finds that Petitioner failed to prove any causal relationship between a specific incident of September 1, 2012 and any condition of ill-being relative to the left shoulder or left knee. The Arbitrator finds that Petitioner did prove a causal relationship between the specific incident of September 1, 2012 and Petitioner's current condition of ill-being relative to the right shoulder.

Petitioner's request for prospective medical relative to the left shoulder and left knee is denied in light of the Arbitrator's finding as to lack of causality, as well as lack of medical necessity.

The Arbitrator finds that Respondent shall pay, in accordance with the fee schedule, any outstanding balance to Dynamic Physical Therapy for the therapy rendered to the right shoulder purported to be $4,021.19 under the fee schedule pursuant to Section 8(a) of the Act. The Respondent is responsible for any of the other bills submitted at trial that can be identified as relating to treatment for the right shoulder only, pursuant to the fee schedule in place at the time the bills were incurred in Section 8(a) of the Act.

Deborah L. Simpson

Signature of Arbitrator

March 15, 2016

Date

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Grazyna Marciniak,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 13 WC 5446**
	)	
Mid City Plaza,	)	
	)	
Respondent.	)	
	)	

19b DECISION AFTER REMAND FROM COMMISSION

PROCEDURAL HISTORY

This matter was heard by Arbitrator Deborah L. Simpson on December 15, 2013 and January 16, 2014. A record of the hearing was made. An Order was filed with the Commission on May 16, 2014. The findings and conclusions in that Order are now merged into this decision. The Arbitrator, after reviewing all the evidence and the testimony of the witnesses, found that the Petitioner's claim was barred under Section 6(c) for failure to give notice as required by law.

On May 19, 2015, the Commission issued a decision reversing the Decision of the Arbitrator with regard to notice and denies Petitioner's request to remand the case to enter additional evidence. The matter was remanded back to the Arbitrator with instructions to make findings with regard to all remaining issues. The decision of the Commission included a descent from Commissioner Lamborn, indicating that the Arbitrator's decision was well reasoned and should have been affirmed.

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

STATEMENT OF FACTS

The Commission found that the Petitioner reported her injury to her right shoulder to her supervisor, Anna Bartusiak, within 45 days of September 1, 2012, the date the Commission determined that the accident occurred.

The Commission having determined that the Petitioner sustained an accidental injury to her right shoulder on September 1, 2012, and that she reported same sometime before or after September 1, 2012, during conversations with her supervisor Anna Bartusiak, within the time period provided by the Act, remanded the matter back to the Arbitrator with instructions to make

findings with regard to all remaining issues. From the decision it appears that the issues that remain for the Arbitrator to determine are (1) causation; (2) medical expenses; (3) temporary total disability; and (4) prospective medical treatment. The Arbitrator, per the remand order will address these issues.

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987).

The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 Ill. 2d 214 (1969).

The burden of proving disablement and the right to temporary total disability benefits lies with the Petitioner who must show this entitlement by a preponderance of the evidence. *J.M. Jones Co. v. Industrial Commission,* 71 Ill.2d 368, 375 N.E.2d 1306 (1978)

It is not enough Petitioner is working when accidental injuries are realized; Petitioner must show the injury was due to some cause connected with employment. *Board of Trustees of the University of Illinois v. Industrial Commission,* 44 Ill.2d 207.

In other words, Petitioner must establish her employment subjected her to an increased risk of injury beyond that which the general public is exposed. *Holthaus v. Industrial Commission,* (1984) 127 Ill. App. 3d 732.

In support of the Arbitrator's decision with regard to whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions of law:

The Commission in its Decision found that Petitioner sustained a specific accident involving her right shoulder on September 1, 2012.

Petitioner's Application for Adjustment of Claim was signed by Petitioner on February 21, 2013 and filed with the Commission on the same date. It listed the part of body affected solely as the right shoulder (R. Ex. 1).

Petitioner's work duties included lifting wet towels and sheets from a large washing machine and placing them into a large drying machine. Petitioner was also required to fold large sheets by clipping a corner to a spring located above her head. The Arbitrator notes that all of these activities require Petitioner to lift items above her shoulders.

On September 1, 2012, Petitioner sought medical treatment from her family doctor, Dr. Nowak. At that time, she complained of severe right shoulder pain and less severe left shoulder

pain, which she began to notice a few days prior. Petitioner's pain increased while pulling heavy and wet laundry from a washing machine. Dr. Nowak noted that Petitioner's symptoms were getting progressively worse. Petitioner had decreased range of motion in both shoulders. Dr. Nowak's September 1, 2012 report indicates that the pain in both shoulders was related to an injury. (P. Ex. 2) A similar diagnosis was made at Petitioner's next visit, September 10, 2012, at which time Dr. Nowak indicated bilateral shoulder pain, right worse than left. A MRI on September 11, 2012 confirmed that Petitioner had suffered a full thickness tear of the supraspinatus tendon in her right shoulder.

Due to Petitioner's observable injury, she was referred to Dr. Dzwinyk, an orthopedic surgeon. At Petitioner's initial visit with Dr. Dzwinyk on November 3, 2012, Petitioner received a "patient status form," which established restrictions and noted that Petitioner's condition was work related. (P. Ex. 1) Dr. Dzwinyk performed a right rotator cuff repair on August 16, 2013. The Arbitrator notes that Petitioner stated she told Dr. Dzwinyk all of her complaints when seen between December 15, 2012 and May 4, 2013 (Tr. P. 87). Dr. Dzwinyk's notes, during this period of time, reference only a right shoulder condition with no reference of any left shoulder condition (R. Ex. 6). Dr. Dzwinyk's entries for September and October of 2013 do reference the left shoulder but indicate Petitioner had a full range of motion and normal strength (P. Ex. 2).

Petitioner was seen by two Section 12 examiners. The first examination, conducted by Dr. Verma in January 2013, was at the request of an insurance company that incorrectly believed that they insured Respondent on the date of Petitioner's injury. Dr. Verma's report indicates that Petitioner had been complaining of right shoulder pain in July and August 2012, which worsened with work activities in the end of August 2012. When the pain did not subside as expected, Petitioner sought medical treatment with her primary care physician. Dr. Verma also notes Petitioner claimed that, while working within the restrictions established by her doctors, she experienced pain in her left shoulder, caused by inflammation. Dr. Verma reviewed a job description that was consistent with Petitioner's testimony. At the time of the evaluation, Dr. Verma believed that Petitioner's left shoulder pain had resolved. After a physical examination, Dr. Verma diagnosed Petitioner with a right rotator cuff tear. Dr. Verma did not find any injuries to Petitioner's left shoulder. Dr. Verma believed that Petitioner's right shoulder condition was causally related to Petitioner's work activities and agreed with Dr. Dzwinyk's surgical recommendation and the need for post-surgical physical therapy. Dr. Verma gave Petitioner restrictions consistent with his diagnosis and recommendations. Dr. Verma noted the Petitioner stated her left shoulder was improved; with no further left shoulder complaints being voiced no left shoulder treatment was recommended. Relative to the left knee, Petitioner had no reports of ongoing problems in the left knee and no further treatment was recommended for the knee and no symptomatic requirements with regard to the knee. (R. Ex. 9, p. 2)

The second Section 12 examination also conducted at the Respondent's request was completed by Dr. Troy Karlsson of M&M Orthopedics on June 27, 2013 with benefit of an interpreter. Dr. Karlsson compiled a report of July 2, 2013. Dr. Karlsson's examination of the left shoulder revealed no positive objective findings with normal range of motion and strength. He reviewed the MRI of the left shoulder of November 8, 2012 and indicated that it showed no full thickness tear and degenerative cysts. He also reviewed an MRI of the left knee of November 8, 2012 which showed degenerative changes but no evidence of any type of tearing.

Dr. Karlsson found that there could exist a causality relative to Petitioner's right shoulder condition and her job duties. Possibility also existed that the right shoulder abnormality could be idiopathic or degenerative in nature. He noted that there were no positive objective physical findings relative to the left shoulder or left knee and that Petitioner was at maximum medical improvement relative to the left and right shoulder. He also opined, based upon the job video, that Petitioner's condition of the left knee and left shoulder bore no relationship to her work duties or any incident (R. Ex. 5).

The Arbitrator would therefore find that Petitioner established a causal relationship between the incident of September 1, 2012 and her current condition of ill-being in the right shoulder. The Arbitrator would find that Petitioner failed to establish a causal relationship between the specific incident of September 1, 2012 and any condition of ill-being in the left knee or left shoulder. The Arbitrator would adopt the opinions of Dr. Karlsson relative to the left knee and left shoulder and find that these conditions were unrelated to any specific incident of September 1, 2012 or sequela stemming there from.

In support of the Arbitrator's decision with regard to whether the medical services that were provided to Petitioner were reasonable and necessary and whether Respondent paid all appropriate charges for reasonable and necessary medical treatment, the Arbitrator makes the following conclusions of law:

The Arbitrator, having found no causal relationship between the accident of September 1, 2012 and any condition of ill-being relative to the left knee or left shoulder, hereby denies any medical services relative to same.

The Arbitrator awards medical services rendered to the right shoulder under the fee schedule or any preferred provider agreement that exists, whichever is less. The Arbitrator denies Petitioner's request under 8.2 (d) of the Act of interest of 1% on all unpaid medical bills. Section 8.2(d) requires for interest to be awarded that the carrier must be furnished all required data elements necessary to process a bill and only after receipt of such information after 30 days is interest awardable. Respondent objected to the bills as they were not furnished any itemized statements despite previously requesting same until the date of hearing of December 5, 2013 (Tr. P. 64). The Arbitrator also notes that the bills for which Petitioner requests payment (P. Ex. 2, Dr. Nowak), do not provide itemization as to what body parts treatment were rendered for. It is impossible for the Arbitrator, given the denial of causation relative to the left shoulder, to assess what portion, if any, of these bills relate to the right shoulder condition. The bills from Dynamic Physical Therapy (P. Ex. 3), in the amount of $5,209.00, with an alleged fee schedule analysis of $4,021.19 do relate to the right shoulder and are awardable in accordance with the fee schedule or any preferred provider agreement. Relative to the St. Mary and Elizabeth Medical Center bill of August 16, 2013, the date of the right shoulder surgery, the bill reflects a payment made by workers' compensation of $18,852.88; wherefore, Respondent would have already satisfied or exceeded the alleged fee schedule amount due and owing of $16,062.17. There is therefore no outstanding balance for said services. The bills of Dr. Dzwinyk of $612.15 lack sufficient proof or itemization that the alleged charges relate to the right shoulder as opposed to the left shoulder or left knee; wherefore, said claim for services is denied unless further information is provided establishing that the bills pertain to treatment for the right shoulder only.

Petitioner's request for reimbursement of $1,911.28 is also denied as these services were for payments made by Petitioner relative to treatment of the left shoulder.

Wherefore, Respondent shall pay, in accordance with the fee schedule, the Dynamic Physical Therapy statement, in the amount of $4,021.19, and any other bills which are properly attributed to treatment for the right shoulder only, per the fee schedule or prior agreement whichever is less, as provided in Section 8(a) of the Act.

In support of the Arbitrator's decision with regard to whether the Petitioner is entitled to TTD benefits, the Arbitrator makes the following conclusions of law:

The Arbitrator notes that Petitioner underwent right shoulder surgery on August 16, 2013 and had been authorized off work from October 25, 2012 for the right shoulder through the date of arbitration hearing of December 5, 2013. The Arbitrator therefore finds that Petitioner was temporarily totally disabled from October 25, 2012 through December 5, 2012, a period of 58 1/7 weeks and is entitled to receive for this period of time benefits at the rate of $414.67 per week.

Respondent shall be given credit for payments of $19,142.10.

In support of the Arbitrator's decision with regard to whether the Petitioner is entitled to Prospective medical treatment, the Arbitrator makes the following conclusions of law:

Petitioner's claim for prospective medical, relative to the left shoulder, is denied in light of the Arbitrator's finding as to lack of any causal relationship between the specific incident of September 1, 2012 and any condition of ill-being in the left shoulder.

The Arbitrator would also note that Dr. Verma, who examined Petitioner in January of 2013 (R. Ex. 4), had no positive objective findings relative to the left shoulder or left knee and opined that Petitioner was at maximum medical improvement relative to these conditions. Dr. Karlsson who examined Petitioner in July of 2013 also noted no positive objective findings relative to the left shoulder or left knee and found Petitioner to be at maximum medical improvement relative to these conditions. Dr. Karlsson also found that these conditions were not causally related to Petitioner's work activities or an incident of September 1, 2012.

The Arbitrator also notes that Dr. Dzwinyk's records from December 15, 2012 through May 4, 2013 make no reference of any left shoulder condition of ill-being (R. Ex. 6). Records from Dr. Dzwinyk from September, 2013 through October, 2013, relative to the left shoulder, note a full range of motion and normal strength. The Arbitrator would therefore find, in addition to lack of any causality relative to the left shoulder or left knee, that there is no objective clinical basis to support an award for prospective medical relative to either condition.

Petitioner's request for prospective medical relative to the left shoulder or left knee is hereby denied.

Respondent shall authorize and pay for any additional medical treatment recommended for or necessitated by the surgical intervention required to repair the Petitioner's right shoulder injury.

ORDER OF THE ARBITRATOR

Respondent shall pay Petitioner temporary total disability benefits commencing with October 25, 2012 through December 5, 2012 at the rate of $414.67 per week for a period of 58 1/7 weeks as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $19,142.10 for payments made. The Arbitrator finds that Petitioner failed to prove any causal relationship between a specific incident of September 1, 2012 and any condition of ill-being relative to the left shoulder or left knee. The Arbitrator finds that Petitioner did prove a causal relationship between the specific incident of September 1, 2012 and Petitioner's current condition of ill-being relative to the right shoulder.

Petitioner's request for prospective medical relative to the left shoulder and left knee is denied in light of the Arbitrator's finding as to lack of causality, as well as lack of medical necessity.

The Arbitrator finds that Respondent shall pay, in accordance with the fee schedule, any outstanding balance to Dynamic Physical Therapy for the therapy rendered to the right shoulder purported to be $4,021.19 under the fee schedule pursuant to Section 8(a) of the Act. The Respondent is responsible for any of the other bills submitted at trial that can be identified as relating to treatment for the right shoulder only, pursuant to the fee schedule in place at the time the bills were incurred in Section 8(a) of the Act.

Deborah L. Simpson

Signature of Arbitrator

February 3, 2016

Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Stephanie Juarez,

Petitioner,

vs.

NO: 13 WC 10090

Jewel/Osco,

17IWCC0239

Respondent.

DECISION AND OPINION ON REVIEW

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

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

17IWCC0239

The party commencing 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: APR 19 2017
TJT:yl
o 2/28/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

JUAREZ, STEPHANIE
Employee/Petitioner

Case# **13WC010090**

JEWEL/OSCO
Employer/Respondent

17IWCC0239

On 3/10/2016, 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 0.47% 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:

0000 BRISKMAN BRISKMAN GREENBERG
SUSAN E FRANSEN
175 W CHICAGO ST
JOLIET, IL 60432

0445 RODDY LAW LTD
PAUL A KRAUTER
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

17IWCC0239

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Stephanie Juarez
Employee/Petitioner

v.

Jewel/Osco
Employer/Respondent

Case # **13** WC **10090**

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 **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **January 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **December 26, 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.

In the year preceding the injury, Petitioner earned **$24,992.24**; the average weekly wage was **$480.62**.

On the date of accident, Petitioner was **45** years of age, ***single*** with **0** dependent children.

ORDER

The Petitioner failed to prove a compensable accident within the meaning of the Act. Benefits requested pursuant to Section 8 are therefore 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.

Deborah L. Simpson

Signature of Arbitrator

March 10, 2016

Date

ICArbDec19(b)

MAR 10 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Stephanie Juarez,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 13 WC 10090**
	)	
Jewel/Osco,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on December 26, 2012, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that the Petitioner gave the Respondent timely notice of the accidental injury that is the subject-matter of this dispute. They agree that in the year preceding the injuries, the Petitioner earned $24,992.24, and that her average weekly wage was $480.62.

At issue in this hearing is as follows: (1) Did an accident occur that arose out of and in the course of the Petitioner's employment with Respondent; (2) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (3) Were the medical services that were provided to the Petitioner reasonable and necessary and has the Respondent paid all appropriate charges for all reasonable and necessary medical services; (4) Is Petitioner entitled to TTD; and (5) Is Petitioner entitled to any prospective medical care.

This matter comes for hearing today on the Petitioner's motion for relief pursuant to Section 19b of the Act. There are two other cases, separate injuries and injury dates, which are consolidated with the case involved herein, but they are separated from this per stipulation and will remain open and pending. Petitioner sustained a back injury on 6/24/2010 and she is still treating for this and not making a claim for it in this hearing. Id. Petitioner also sustained a back and hip injury on 9/7/2011 and she is still treating for this and not making a claim for it in this hearing.

STATEMENT OF FACTS

The Petitioner began working for the Respondent in December of 1998; she was hired as a stocker for the Osco part of the Respondent. Suring the course of her employment, Petitioner was promoted to a supervisor/stocker. She remains in that position today. As a stocker/supervisor her job duties included stocking the shelves, changing tags for sales, breaking

down shipment loads, and bringing products from the stock room to the floor, using a u-boat (which is like a long rolling cart with two shelves on it), and restocking the shelves. Petitioner is responsible for re-stocking water, diapers, charcoal in the summer and rock salt in the winter. Petitioner stated that lifting is about 65 to 70 percent of her day and could be as heavy as 10-15 pounds over her head. She does ordering merchandise, if needed, as well.

Petitioner is left-hand dominant. She usually works the 2:00 pm to 10:00 pm shift. She had a day supervisor that she reported to, who left between 5:00 pm and 6:00 pm. In October, 2012, her supervisor was Tanya Young. Dan Tuttila, who was present in the courtroom for the hearing, was her supervisor in December, 2012. Ms. Young was different than Mr. Tuttila in that she did most of the ordering of the stock and Petitioner did the lifting. Ordering products involved going shelf to shelf, seeing what needed to be replenished, and using a scanning gun to do it. Petitioner identified Respondent's Exhibit 4, hereinafter referred to simply as "RX", 4, for demonstrative purposes only, as the scan gun that she used for the ordering. She also used the scanning gun for taking damaged products out of the system in the back.

While Ms. Young did 60 percent of the ordering with the scan gun, Petitioner would still order the diapers, the charcoal in the summer, the rock salt in the winter and the water. When using the scan gun, you gripped it like a gun, squeezed using the second and third finger, and held it until it registered. When this did not work the product numbers had to be punched in manually on the scanning gun. Petitioner demonstrated this procedure using her left hand.

In late 2012, Mr. Tuttila became Petitioner's supervisor. He gave more responsibility to the Petitioner, including ordering all of the Osco merchandise, 4-5 days a week, for most of each day , rather than the 3 days under Ms. Young's supervision. Petitioner testified that under Mr. Tuttlia, she would use the scan gun 200-300 times a day depending on which gun was available, as some worked better than others, they were all the same type of scan gun.

Petitioner testified that prior to this time she had never had pain or numbness or tingling to either hand and never had medical treatment to these areas. While working for Mr. Tutilla in December, 2012, Petitioner started to feel her fingers going numb and it felt like somebody was stabbing both hands. The left was worse and Petitioner stated she could not seem to wake up either one. Petitioner said that she did not realize that this was from the scan gun while it was happening.

On January 5, 2013 Petitioner sought medical treatment for the pain for the first time. She went to Palos Community Hospital. Although she was using the scan more often, she was still lifting when necessary. After going to the hospital, Petitioner reported the accident to the Respondent on January 7, 2013 in a formal report.

Petitioner was sent for a medical evaluation pursuant to Section 12 of the Act, at the request of the Respondent on April 8, 2013 with Dr. Michael Vendor, where it was determined that she had carpal tunnel syndrome. Petitioner testified that after this evaluation she wanted to have further medical care but treatment was denied by worker's compensation and she had no personal insurance.

On July 10, 2014 Petitioner was having so many problems with her hands she sought medical treatment at Little Company of Mary Hospital. PX 4. She stated that the delay in medical treatment was due to her lack of insurance.

She then started to treat with Dr. Irvin Wiesman of the Illinois Orthopedic Network. PX 3. Dr. Wiesman prescribed tests to confirm the carpal tunnel syndrome and then recommended surgery on Petitioner's left hand. PX 3. She could not recall whether or not Dr. Wiesman was the first physician to whom she attributed use of the gun as causing pain in her left hand. Petitioner has not had the surgery done to date as it has not been approved by the Respondent and she has no health insurance.

While Petitioner has been authorized off of work at various times over the last years for her back claims, she was only taken off of work for her CTS as of November 9, 2015. She is to remain off of work until surgery is completed. Petitioner wants to have the surgery. Although Petitioner had complaints in both hands, the left hand is really the main problem she has. Petitioner testified further that she wears a wrist splint all the time on the left wrist, except while sleeping. She was prescribed this splint from the Palos Community Hospital first and then Dr. Wiesman.

When Petitioner was returned to work at various times for her ongoing back claim, she did have restrictions as to her hands. These were accommodated by the Respondent. Petitioner was unable to use the scan gun as she could not manipulate it with her right hand and could not squeeze the trigger with her left hand.

On cross examination, Petitioner stated that she did not recall the history she gave to Palos Community Hospital on January 5, 2013. Nor did she specifically recall what she told Little Company of Mary Hospital or Dr. Wiesman.

Petitioner did recall working under Ms. Young prior to working for Mr. Tuttila. Petitioner had more responsibilities under Mr. Tuttila, who would leave between 5:00 pm and 6:00 pm depending on the day. She would be in charge of the store after he left and did not do one thing continuously throughout the day. Petitioner did have duties that she performed on a daily basis, including "facing" and "stocking" diapers and water, plus rock salt in the winter and charcoal in the summer. She did not do paperwork. When she was in charge of the store, there was only one other employee that would answer to her.

Petitioner identified RX 2, photographs of the scan gun involved herein, as being accurate. Petitioner's counsel confirmed that the description of the scan gun was accurate. The parties agreed that the scan gun weighed approximately 1.75 pounds; measured 3.5 inches by 9 inches looking at the display; 1.5 inches to 2.25 inches for the display part; and the handle is approximately 5.25 inches long and 5.5 inches round at the thickest part where the trigger is. The Arbitrator reviewed and handled the scan gun and it was agreed that there were more than this one particular scanner at the store, and they were all identical.

On redirect examination, Petitioner stated that she would move around while using the scan gun, including going up and down the shelves and all around. She would bend her wrist to extend it up higher or lower. She also agreed that back in January, 2013, she had no idea that the scanner gun had anything to do with her left hand problems.

Respondent called Dan Tuttila as a witness on their behalf. Mr. Tuttila was employed with Respondent since March, 2010, and is currently an assistant store director. His job duties included doing paperwork for the store, and overseeing the entire Osco side, currently he is responsible for overseeing the entire store.

Mr. Tuttila worked with Stephanie Juarez for approximately three years as her supervisor. He had used the scanner before. Mr. Tuttila is right-hand dominant and when using the scanner holds the gun in his left hand, to use it. He would have to hit the button to turn it on to get to the area where you need it and type in the UPC code if it did not scan right. He likened it to a calculator. Mr. Tuttila testified that he has not tried to use it with his left hand as he is predominantly right-handed.

On cross examination Mr. Tuttila admitted that there is no set rule on how to work the scanner as long as it works properly.

Petitioner was called as a witness on rebuttal. She testified that she used the scanner with her left hand as her right hand is weak. She never had problems utilizing the scanner when holding it in her left hand, or getting the job done.

On cross examination Petitioner testified that she rarely used her right hand at work except to hold the scanner with it to punch in the UPC codes with her left hand. She uses her left hand for ordering. Petitioner testified that when using her cellular phone she hits the necessary buttons and dials with her left hand as she is left-handed.

The records from Palos Community Hospital state that Juarez complained of pain to both hands with swelling for about three weeks which had gradually gotten worse. PX 12 The records note that Juarez worked in a store and stocked material. Whenever she moved, her left hand would hurt. PX 12

The records from Little Company of Mary indicate that she had left wrist and hand pain ongoing for months after she was diagnosed with carpal tunnel syndrome. In the last few days, it had become worse. PX 4

She provided Dr. Wiesman with a history of pain in her left hand that began after a few months of working as a tag changer. Dr. Wiesman diagnosed her with left carpal tunnel syndrome and prescribed an EMG/NCV. PX 3

She had the EMG/NCV performed by a chiropractor on August 7, 2014. The impression from the test results was consistent with bilateral carpal tunnel syndrome. PX 2

On September 8, 2014, Dr. Wiesman recommended that she have surgery to treat the carpal tunnel syndrome in her left hand. PX 3

Dr. Wiesman saw her again on April 29, 2015 and again recommended a left carpal tunnel release. PX 3

Petitioner returned to Dr. Wiesman on November 9, 2015, at that time he performed a cortisone injection to the left wrist. He again recommended a left carpal tunnel release. PX 3

The Petitioner offered the testimony of Dr. Wiesman via his evidence deposition. PX 9 Dr. Wiesman testified that he is board certified in general surgery and board certified in plastic surgery. He has a certificate of qualification for surgery of the hands. He is not an orthopedic surgeon. PX 9, He indicated that his practice is about 60% hand surgery and 40% plastic surgery. PX 9 His plastic surgery practice involves flap wound care, breast re-construction or augmentation, and nose jobs. PX 9 Dr. Wiesman stated that Petitioner had left carpal tunnel syndrome. He stated that it can be caused by repetitive forceful gripping. PX 9 He stated that anytime you are repetitively squeezing your hand open and closed, you are going to cause some changes in pressure. When the wrist is going up and down, the pressure is changing within the carpal tunnel. PX 9 The doctor stated that he inferred Petitioner was using her left hand for tag changing because it was her dominant hand. PX 9 He believed that she needed to have a persistent period of repetitive forceful gripping and tagging. Dr. Wiesman stated that his opinions regarding causation were based upon the understanding that Petitioner was using her left hand to operate the scan gun and that she was squeezing it 200 to 300 times day. PX 9 The doctor testified that he presumed the gun had a handle that she needed to squeeze closed to get to alarm pins or security pins. PX 9 The doctor also stated that opening and closing the fist, regardless of pressure, was enough to cause or aggravate carpal tunnel syndrome. PX 9

The Respondent offered the testimony of Dr. Michael Vender RX 1, the Section 12 examiner, also by way of deposition. He is a board certified orthopedic physician specializing in treatment of the body from the elbow to the hand. RX 1 He first performed a medical examination of the Petitioner, at the request of the Respondent, pursuant to Section 12 of the Act, on April 8, 2013. RX 1 Based upon that examination, Dr. Vender opined that Petitioner had bilateral carpal tunnel syndrome. RX 1 He did not believe that there was a causal relationship between her job duties and her bilateral carpal tunnel syndrome. RX 1 Dr. Vender noted that Petitioner had some personal factors that could contribute to carpal tunnel including age, body mass, and history as a smoker. He also noted that her work activities were varied. Most of her activities were handling objects and putting them on shelves which would not be considered a forceful activity. RX 1

Dr. Vender testified that he performed a second medical examination of Petitioner at the request of Respondent on November 24, 2015. (Rx. #1, D. 11) Dr. Vender stated that the results of the exam were the same. He still believed that she had carpal tunnel syndrome. The doctor opined that he did not believe the use of a scan gun was related to her carpal tunnel syndrome. RX 1 He noted that her use of the scan gun was a one handed activity and would not explain his diagnosis of bilateral carpal tunnel syndrome. He also noted that as Petitioner described it, the scanner was handled with the index and middle fingers. It was a well designed tool that did not require forceful gripping. RX 1 Dr. Vender did not believe that the activity of opening and closing one's fist would lead to the development of carpal tunnel syndrome. He testified that carpal tunnel syndrome is caused by forceful activities such as heaving lifting or tight squeezing. RX 1

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987).

Longstanding Illinois law mandates a claimant must show that the injury is due to a cause connected to the employment to establish it arose out of employment. *Elliot v. Industrial Commission*, 153 Ill. App. 3d 238, 242 (1987).

The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 Ill. 2d 214 (1969).

The burden of proving disablement and the right to temporary total disability benefits lies with the Petitioner who must show this entitlement by a preponderance of the evidence. *J.M. Jones Co. v. Industrial Commission,* 71 Ill.2d 368, 375 N.E.2d 1306 (1978)

In support of the Arbitrator's decision with regard to whether Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact as if fully restated herein.

The Arbitrator finds that Petitioner has failed to prove that she sustained an accidental injury to her hands that arose out of and was in the course of her employment. It is the Petitioner's burden to prove all elements of her claim by the preponderance of the evidence. *Nee v. Illinois Workers' Compensation Commission*, 28 N.E.3d 961, 390 Ill.Dec. 308, 2015 Ill.App.(1st) 132609WC. The Arbitrator has considered the testimony of the Petitioner, the medical records, medical expert opinions, and all other evidence submitted at trial in reaching this decision.

The Arbitrator has considered the expert medical testimony in this case and finds the opinions of Dr. Vender to be more credible that those of Dr. Wiesman. Dr. Vender is a board certified orthopedic physician, whose practice focuses on treatment from the elbow to the hand. Dr. Vender noted that Petitioner's job duties varied during the day, during the course of her employment. Dr. Vender had the opportunity to consider the scan gun that Petitioner alleged aggravated her hands. Dr. Vender testified that the scanner is handled with the index and middle fingers. He believed it was a well designed tool that does not require forceful gripping. The doctor explained that simply using the hands does not contribute to the development of carpal tunnel syndrome. Dr. Vender opined that carpal tunnel syndrome is caused by forceful activities involving such things as heavy lifting and tight squeezing.

The testimony of the Petitioner's treating doctor and expert, Dr. Wiesman, is not persuasive. Dr. Wiesman testified that he is a board certified plastic surgeon and general surgeon, who has a certificate in hand surgery. He is not an orthopedic surgeon. Dr. Wiesman's practice consisted of a wide range of treatment in the area of plastic surgery as well as hand surgery. Dr. Wiesman did not have an opportunity to handle or observe the scan gun that Petitioner attributes her carpal tunnel syndrome to. The Arbitrator finds that Dr. Vender is more qualified to render opinions on the subject of carpal tunnel syndrome than Dr. Wiesman.

Despite the issue of expert qualifications, the Arbitrator has still given consideration to the opinions of Dr. Wiesman in this case. He did testify that approximately 60% of his practice consists of treatment from the elbow to the hand. Therefore, the Arbitrator has taken his opinions into account. Dr. Wiesman testified that the basis of his opinions in this case was that Petitioner needed to squeeze the scan gun 300 times per day. PX 9 The doctor agreed that a change in the history might affect his opinions in this case. The doctor's testimony in this case makes it clear that he had little if any understanding as to the scan gun Petitioner used at the store. This is demonstrated by Dr. Wiesman's testimony on re-cross examination. When Dr. Wiesman was asked to describe his understanding of Petitioner's job duties relative to use of the scan gun, he testified as follows:

> I'm assuming it's some type of contraption with a gun with a handle that she had to squeeze closed to get those alarm pins, I think security pins most likely, or tags onto whatever items she is doing it for. So I think that, you know, if you taking your hand almost like when you are doing forearm exercise and squeezing, by doing that all these tendons are going through the carpal tunnel, all the tendons going to the fingers, and within that carpal canal is the median nerve. So by opening and closing it you are causing a lot of motion and friction within there along the nerve that can cause increased pressure on the nerve, which can cause carpal tunnel syndrome. PX 9

This testimony demonstrates that Dr. Wiesman did not understand the Petitioner's job duties and thus, did not provide a credible opinion addressing accident or causation. Dr. Wiesman appears to have been under the impression that the Petitioner was putting alarm pins onto items. That is not true. The Petitioner testified that she was scanning items in the store. There was no removal of pins and no force required to remove pins. Furthermore, the Arbitrator finds that Dr. Wiesman contradicted his own testimony. Following his testimony regarding the use of the gun, he was asked whether force in use of the hands was a contributing issue. He testified that just opening and closing a person's hands is sufficient to aggravate or cause carpal tunnel.

In addition to the doctor's testimony, the Arbitrator had the opportunity to review, hold and operate one of the scan guns that Petitioner used in her daily work activities. It is noted that minimal force was needed to squeeze the trigger on the gun.

Petitioner first sought medical treatment for her hands on January 5, 2013. The history that Petitioner gave to the medical personnel was that she worked in a store and stocked material. There was no mention of the use of a scan gun and Petitioner did not think she told them about the scan gun. This is significant because it appears that Petitioner's entire case is predicated upon the use of the scan gun allegedly causing her carpal tunnel syndrome. The accident date of December 26, 2012 as alleged by the Petitioner is not consistent with the medical records and evidence in this case. The Petitioner did not relate the use of the scan gun as being related to her hands until she sought treatment with Dr. Wiesman on July 10, 2014. No medical opinion or evidence was offered regarding whether the carpal tunnel syndrome was a pre-existing condition that was aggravated by the use of the scan gun. Although employment need only remain a cause, not the sole cause or even the principal cause, of a claimant's condition, *Rotberg v. Industrial*

Comm'n, 361 Ill.App.3d 673, 682, 297 Ill.Dec. 568, 838 N.E.2d 55 (2005) [a]n employer's liability for benefits cannot be based on guess, speculation or conjecture. *Illinois Bell Telephone* v. *Industrial Commission*, 265 Ill.App.3d 681, 638 N.E.2d 207 (1994).

In addition to this medical testimony, the Arbitrator also had the opportunity to use the scan gun and did not find that it required any significant force to pull the trigger. Therefore, the Arbitrator finds that the Petitioner failed to prove she sustained an accidental injury that arose out of and occurred in the course of her employment with the Respondent. All benefits requested under the Illinois Workers' Compensation Act are hereby denied.

In support of the Arbitrator's decision with regard to whether Petitioner's present condition of ill-being is causally related to the injury, whether Petitioner is entitled to any prospective medical care, whether Petitioner is entitled to TTD and the whether the medical services provided to the Petitioner were reasonable and necessary and whether the Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

Petitioner failed to prove that she sustained an accidental injury that arose out of and in the course of her employment with Respondent therefore the above listed issues are moot.

ORDER OF THE ARBITRATOR

The Petitioner failed to prove a compensable accident within the meaning of the Act. Benefits requested pursuant to Section 8 are therefore denied.

Deborah L. Simpson
Signature of Arbitrator

March 10, 2016
Date

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

Ruther M. Thomas-Duckett,
Petitioner,

vs.

NO: 13 WC 11374

City of Rockford Head Start Program,
Respondent,

17IWCC0217

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, 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 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: APR 11 2017
o033017
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

THOMAS-DUCKETT, RUTHER
Employee/Petitioner

Case# **13WC011374**

CITY OF ROCKFORD HEAD START PROGRAM
Employer/Respondent

17IWCC0217

On 8/2/2016, 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 0.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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STATE OF ILLINOIS)
)SS.
COUNTY OF WINNEBAGO)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

RUTHER THOMAS-DUCKETT
Employee/Petitioner

v.

CITY OF ROCKFORD, HEAD START PROGRAM
Employer/Respondent

Case # 13 WC 11374

Consolidated cases: N/A

17IWCC0217

An *Application for Adjustment 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 **6/10/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **1/19/13**, 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 **$30,063.28**; the average weekly wage was **$$791.13**.

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

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

Respondent is entitled to a credit of **$3,467.45** under Section 8(j) of the Act.

ORDER

Respondent shall be given a credit of $3,467.45 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner the sum of $474.68 per week for a further period of 37.5 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused 7-1/2% loss of use of the person as a whole.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained

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

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

Signature of Arbitrator

8/1/16
Date

AUG 2 - 2016

17IWCC0217

FINDING OF FACTS:

Petitioner was employed as a home teacher for the Head Start Program that was administered by the City of Rockford. She had performed this job for ten years. Her job was to go to the home of a child with special learning needs and spend a number of hours working with the child. She was normally assigned three (3) to four (4) homes during the course of a workday.

Petitioner provided that in order to perform the job, she would carry a number of teaching items with her into the child's home. These would include books and educational toys. She would carry the items in a canvas tote bag that measured approximately 2' x 2'. She estimated the weight of the loaded tote bag was between 30-40 pounds when full of items. She would carry the tote with two straps over the top of her shoulder and the tote bag under her armpit. Petitioner indicated she had to do this at least four times a day as she carried the materials from her vehicle into the child's home.

Petitioner testified that in the Fall of 2012, while carrying the materials in the home, she began noticing pain in her shoulder. Eventually the pain became so severe that she sought medical treatment with Dr. Tomacruz, her primary physician. On January 19, 2013, Dr. Tomacruz recorded that Petitioner presented with right shoulder pain for at least four (4) months. She described the pain as sharp, achy, non-radiating, and moderate to severe intensity. Petitioner reported no trauma. After performing an examination, the doctor diagnosed right shoulder pain with possible bursitis. Dr. Tomacruz prescribed oral steroids and a right shoulder MRI scan. The MRI when completed on February 4, 2013 demonstrated a high-grade chronic incomplete tear of the supraspinatous tendon without retraction and with only minimal fatty atrophy of the muscle. The radiologist also stated no fluid signal was seen and those findings were consistent with a chronic or repetitive injury rather than an acute event. (PX 3) On February 5, 2013, Dr. Tomacruz referred Petitioner to an orthopedic surgeon. (PX 3)

Petitioner returned to the offices of Dr. Tomacruz on April 9, 2013, when she was examined by David Finnegan, a physician's assistant. The physician's assistant recorded the history of onset of her right shoulder symptoms while carrying heavy bags weighing up to 50 pounds as a home-visit teacher. Following examination and review of the right shoulder MRI scan, Petitioner was diagnosed with a right rotator cuff syndrome. Additional medication and follow-up were prescribed. (PX 3)

Petitioner testified that she experienced little improvement in her right shoulder symptoms. She provided that although she had been referred to an orthopedic surgeon, she did not make an appointment with that physician for over five months because "I wasn't thrilled about having surgery."

Ultimately, Petitioner made an appointment and had a complete orthopedic evaluation with Dr. Steven Milos on September 9, 2013. The doctor's records show she presented with insidious right shoulder pain for a period of several months. The cause was recorded as repetitive lifting at work. An examination found right shoulder subacromial impingement and crepitus with range of motion. X-rays taken of the right shoulder were interpreted as showing mild degenerative arthritis. After reviewing the MRI, Dr. Milo assessed complete rupture of rotator cuff and recommended surgery in the form of right shoulder arthroscopic rotator cuff repair with subacromial decompression. (PX 2)

Petitioner testified that she declined going through with the surgery due to a fear of the procedure. She has not had any further care for her shoulder.

At Petitioner's request, she was seen by Dr. Jeffrey Coe for Section 12 examination on March 31, 2015. Dr. Coe recorded a history from Petitioner that she was a home visit schoolteacher and that she customarily visited three (3) to four (4) students per day. Petitioner provided that she was required to carry a heavy tote bag that included books and school materials. Petitioner indicated that over time, she began to experience increasingly severe pain that caused her difficulty lifting or reaching with the right arm. After performing an examination and reviewing medical documentation, Dr. Coe opined Petitioner suffered a repetitive compression/strain injury to her right shoulder in her work as a home visit schoolteacher. The doctor also opined that Petitioner was in need of ongoing treatment which would include right shoulder arthroscopic surgery as prescribed by Dr. Milos. (PX 4, Dep. Ex #2)

Dr. Coe testified also testified via deposition in this matter. Dr. Coe testified that he believed there was a causal relationship due to the act of carrying the teaching materials in such a matter that it placed pressure on the top of the shoulder. When testifying about the mechanism of injury, Dr. Coe stated, "…What she said she did at work on a regular basis, 12 visits a week, was carrying a heavy bag. Again, this bag is 50 pounds by her report on her right shoulder. Now, we talked a little bit about the anatomy of the shoulder, that there is an acromioclavicular joint. It's at the top of the shoulder. Carrying a bag on the right shoulder puts a 50 pound weight on top of the acromioclavicular joint on the structures on the top of the shoulder. Ms. [Thomas-]Duckett, based on the x-rays were taken and interpreted by Dr. Milos, has some arthritis of her acromioclavicular joint. It's degenerative arthritis. But the arthritis causes irregular swelling on the undersurface of the acromioclavicular joint . . . In a person that has this problem, putting on a lot of pressure on the top of the shoulder in this unique work activity, carrying a heavy bag, drives the undersurface of the acromioclavicular joint, that rough and thickened area, into the top of the rotator cuff. That's the supraspinatus in this area. And over time, it will cause abrasion and tearing of the rotator cuff. So, the mechanism, based on what she told me, is of a repetitive weighting or compression of the acromioclavicular joint causing abrasion and tearing of the underlying rotator cuff with an onset ultimately of symptoms." (PX 4, pp. 25-26)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Charles Carroll on July 29, 2015. Dr. Carroll recorded that in addition to obtaining a history and performing an examination, he also reviewed Petitioner's medical records as well as a provided job description. Dr. Carroll indicated Petitioner provided that carrying materials and tote bags of learning material on home visits caused and/or aggravated her bilateral shoulder bilateral shoulder complaints. Dr. Carroll opined that Petitioner may have a partial thickness tear of the right shoulder rotator cuff. The doctor expressed an opinion that he did not see evidence of an industrial injury as same appeared to be a degenerative condition. He provided that she had significant acromioclavicular changes as well. Dr. Carroll stated that he did not find the work as described would cause or aggravate impingement or rotator cuff disease. The doctor added that although he noted the lifting, he did not believe the lifting would likely cause Petitioner's condition. The doctor provided that the lifting was not highly repetitive and was at chest level and below. (RX 2, Dep. Ex.#2)

Dr. Carroll testified via deposition in this matter. Dr. Carroll testified that in his opinion, Petitioner's impingement was degenerative nature. When asked if he believed that Petitioner's job duties could have caused the injuries that he found during his examination, Dr. Carroll stated, "It didn't appear that way to me. I think it could depend on what the exact extent and nature of the lifting was. Lifting and getting things in and out of vehicles I didn't think would make a difference. If she was lifting at the chest level and above, which was not reflected really in her history or…the job description, then that might change my opinion." Dr. Carroll added that unless new information becomes available about Petitioner's job activities, he did not see a relationship between her work activities and her diagnoses. (RX 2, pp.14-15)

Petitioner testified that she subsequently retired from the Head Start Program. She has not undergone surgery to the rotator cuff nor has she had any additional care. She further testified that she has not re-injured the shoulder since the condition originally manifested itself in the Fall 2012. Petitioner testified that she still

has pain in the right shoulder and occasionally uses over-the-counter analgesic medication. She now has difficulty placing objects overhead and has modified the way that she does activities of daily living.

Ms. Kristine Holm testified on behalf of Respondent. Ms. Holm testified that she was a former supervisor of Petitioner at the Head Start Program. She testified that she is familiar with Petitioner's work duties. She estimated that a tote, when it did contain wooden puzzles and books, weighed no more than five (5) to eight (8) pounds. On cross-examination, Ms. Holm provided that she could not explain why the job description indicated that the home visitor teacher was required to lift 60 pounds occasionally.

In regard to issue "C", did an accident occur that arose out of or in the course of Petitioner's employment by Respondent and "F" is Petitioner's condition of ill being causally related to the injury, the Arbitrator finds the following:

Petitioner alleges a repetitive trauma injury to her right shoulder as a result of carrying heavy totes to and from her car when making home visits. Petitioner testified that the tote bag weighed between 35 and 40 pounds. She told Dr. Coe that she thought that it weighed up to 50 pounds. Petitioner offered a detailed job description of her position as a "Home Visitor Teacher." (PX 5) The description outlines all of the duties required in "...providing a comprehensive, developmentally appropriate early childhood program of curriculum and instruction." The description specifically describes the working condition and physical demands as follows:

> "Work is performed primarily in an office and home visits, involve traveling throughout the county. Ability to lift 60 pounds occasionally. Must be able to climb stairs and own and operate a personal vehicle independently."

Petitioner's testified that the only aspect that required heavy lifting was carrying the tote bag of teaching materials. Petitioner's supervisor, Ms. Holm, testified that the bag only weigh between 5-8 pounds. However, she could not explain why the job description indicated that the home visitor teacher was required to lift 60 pounds occasionally.

Petitioner first complained about her right shoulder to her primary care provider on January 19, 2013. She had no history of any prior treatment to the right shoulder. Dr. Tomacruz recommended an MRI of the right shoulder, which was performed on February 4, 2013. The radiologist diagnosed a high grade chronic incomplete tear of the supraspinatus tendon without retraction and with only minimal fatty atrophy of the muscle. He also stated no fluid signal is seen and these findings are consistent with a chronic or repetitive injury rather than an acute event.

On April 9, 2013, Petitioner saw David Finnegan, a physician's assistant, at OSF Rock Cut. Mr. Finnegan noted a history of severe right shoulder pain. He also noted a history of carrying heavy bags as a home visitor teacher "up to 50 pounds". Mr. Finnegan recommended that Petitioner follow with an orthopedic surgeon. Petitioner did not see a surgeon until September 2013. She testified that she put off seeing the surgeon because she was scared. Dr. Milos examined Petitioner on September 9, 2013. He noted that she had insidious development of right arm pain from repetitive lifting at work, along with a gradual worsening. He diagnosed a complete rupture of the rotator cuff and discussed conservative treatment versus surgery. Petitioner and the doctor agreed that surgery would be the best of action. Petitioner never followed through with the surgery, again because she was scared of the procedure.

Petitioner was seen by Dr. Jeffrey Coe at her attorney's request. She was also examined by Dr. Charles Carroll at the request of the City of Rockford. In reviewing the deposition testimony of the two physicians, the Arbitrator gives greater weight to the opinion of Dr. Coe. While Dr. Carroll is a highly qualified orthopedic surgeon, it appears that he was not given the same detailed history that Dr. Coe received. Dr. Carroll admitted

that a repetitive injury to the AC joint could lead to impingement and a subsequent rotator cuff tear. He also indicated that direct trauma to the AC joint could lead to the development of inflammation which would lead to impingement. (RX 2, p.25) Dr. Carroll noted a history of lifting and carrying materials. He also noted the job description indicating that she had to lift 60 pounds occasionally. It does not appear that he was given a specific history that Petitioner carried the tote bag with the straps on her shoulder. Nowhere in his deposition does he mention that specific history. In fact, he states that the lifting and carrying was "chest level and below".

In contrast, Dr. Coe was given a history of the tote straps being on top of Ms. Thomas-Duckett's right shoulder. Specifically, he stated as follows:

> "What she said she did at work on a regular basis, 12 visits a week, was carrying a heavy bag. Again, this bag is 50 pounds by her report on her right shoulder. Now, we talked a little bit about the anatomy of the shoulder, that there is an acromioclavicular joint. It is at the top of the shoulder. Carrying a bag on the right shoulder puts a 50 pound weight on top of the acromioclavicular joint on the structures on the top of the shoulder. Ms. Thomas-Duckett, based on the x-rays were taken and interpreted by Dr. Milos, has some arthritis of her acromioclavicular joint. . . . In a person that has this problem, putting on a lot of pressure on the top of the shoulder in this unique work activity, carrying a heavy bag, drives the undersurface of the acromioclavicular joint, that rough and thickened area, into the top of the rotator cuff. That's the supraspinatus in this area. And over time, it will cause abrasion and tearing of the rotator cuff. So, the mechanism, based on what she told me, is of a repetitive weighting or compression of the acromioclavicular joint causing abrasion and tearing of the underlying rotator cuff with an onset ultimately of symptoms."

The Arbitrator finds Petitioner credible when she testified that she carried heavy tote bags with straps over the top of her right shoulder. While Respondent's witness disputed this, there was no explanation of any activity, other than carrying tote bag, that would meet the job description indicating occasional lifting of up to 60 pounds. The Arbitrator also finds Dr. Coe's explanation of causation to be reasonable. It doesn't appear that Dr. Carroll had a clear understanding of the biomechanics of Petitioner's job and the force that was being placed upon the AC joint of the right shoulder.

Based upon all of the above, the Arbitrator finds in Petitioner's favor on the issue of accident and determines that she suffered a repetitive trauma injury that manifested itself on January 19, 2013. The Arbitrator further finds that a causal relationship exists between Petitioner's right shoulder condition of ill-being and the accident sustained.

In regard to issue "G" what were Petitioner's earnings, the Arbitrator finds the following:

The parties agreed that Petitioner received total annual earnings of $30, 063.06 for the year preceding the injury. The parties disagree on the calculation of average weekly wage. Petitioner was employed as a Head Start Teacher whose employment schedule coincided that of a regular teacher. The earnings record supplied shows that she worked 38 weeks during the year preceding the accident. School year breaks are not included in calculation of average weekly wage. Washington District 50 Schools v. Workers' Compensation Comm'n, 394 Ill.App.3d 1087, 917 N.E.2d 586 (3rd Dist. 2009). Dividing $30,063.06 by the weeks Petitioner was actually scheduled to work renders and average weekly was of $791.13.

In regard to issue "L" what is the Nature and Extent of the injury, the Arbitrator finds the following:

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

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party submitted an impairment rating. As such, the Arbitrator gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a home visitor teacher at the time of the accident and that she is able to return to work in her prior capacity as a result of said injury. The Arbitrator notes she has retired since the injury. Because of this, the Arbitrator therefore gives weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 59 years old at the time of the accident. Petitioner is an individual who is practically in her sixth decade of life and will live with his permanent disability for a shorter period that a younger individual, the Arbitrator gives lessor weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes no evidence was offered on future earning capacity. 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 Petitioner sustained a tear of her right supraspinatus tendon as a result of the repetitive trauma sustained at work. Surgery has been recommended to repair the rotator cuff, but Petitioner has declined the surgery. Petitioner testified that she still continues to have pain in the right shoulder especially if she has to reach overhead. Petitioner underwent two Section 12 examinations, Dr. Coe, on March 31, 2015, and Dr. Carroll, on July 29, 2015. During both of their examinations, Petitioner exhibited impaired range of motion as well as a positive impingement sign. In addition, there was associated weakness of the right shoulder girdle and rotator cuff musculature. As such, the medical records evidence ongoing disability. The Arbitrator, therefore, gives weight to this factor.

Based on all the above, the Arbitrator finds Petitioner is permanently disabled to the extent of 7-1/2% loss under § 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 Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JUAN DE LA ROSA,

Petitioner,

vs. NO: 13 WC 22016

BINDERYONICS,

17IWCC0263

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability (TTD), and permanent partial disability (PPD), and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that the Petitioner established that he sustained a work-related accident arising out of and in the course of his employment on June 17, 2013.

As a result of the accident, the Petitioner is entitled to TTD benefits from July 1, 2013 through October 1, 2014, representing 65 2/7 weeks. Respondent is entitled to a credit of $1,012.00 in TTD previously paid. The Petitioner is entitled to reasonable and necessary medical expenses totaling $107,955.90. The Commission finds the Petitioner sustained disability to the extent of fifteen percent loss of use of the man-as-a-whole pursuant to Section 8(d)(2) of the Act.

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.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings:

1. Petitioner testified through a Spanish interpreter at arbitration on February 25, 2016. (T.10). Prior to June 17, 2013, Petitioner worked approximately eight months for Respondent as a machine operator and mechanic. He ensured Respondent's machines were operating and performed set-ups. (T.12-13). Petitioner would change different-sized plates on the machines, such as "double gates" or "regular plates." (T.13-14). The plates folded paper of various sizes.

2. On Monday, June 17, 2013, Petitioner was injured while replacing double gates with regular plates:

> The plates that I had to replace were at the bottom, see; so I took them off . . . And then as I was putting it in, because you have to do it from below and set it up like on an angle, and that's when I felt the pain in my lower back. (T.15-16).

3. Prior to June 17, 2013, Petitioner did not have any injury, complaints, or treatment for the lower back. (T.28-29).

4. Petitioner testified the plate he was carrying when he was injured was approximately 36 inches wide by 86 inches in length, and it weighed 60 to 80 pounds. (T.43-44; T.50).

5. Petitioner reported the injury to Olivia on June 17, 2013. (T.16). Petitioner understood Olivia to be a second shift supervisor or some type of manager or person in control as she was the one who would give him the set-ups for the machine. He reported to Olivia because Angie Cervants, Respondent's plant manager, was not present at the time of the injury. (T.16; T.63; T.87).

6. Respondent called Ms. Cervants as a witness. She testified she had worked for Respondent for six years and she was Petitioner's supervisor. (T.20; T.63). On June 17, 2013, Ms. Cervants was on duty and she said Petitioner never reported any injury to her that day. (T.63).

7. Ms. Cervants acknowledged Olivia was a Production Monitor for Respondent who also worked on June 17, 2013. (T.64). She described the duties of a Production Monitor: "[C]hecks the jobs that are running, makes sure that the quality is good, make sure that we get the jobs done on time and that the next jobs are ready and available." (T.70-71). Although Olivia was not required to direct machine operators to fix certain machines, she could if a problem arose. (T.71).

8. Ms. Cervants stated she was not familiar with what machines or plates Petitioner used at work. (T.66-67). She had never changed any of the blades, or plates, herself. (T.68-69). She testified, "As far as I know, there's no need to change plates." (T.69). Then she added, "I do have seen them change the plate, but I've never done it myself." (T.75-76).

9. Ms. Cervants said Olivia was a Production Monitor, not a supervisor, and there was no reason for Petitioner to report an injury to her. (T.64; T.82). Neither party called Olivia as a witness. Ms. Cervants further testified Olivia never informed her Petitioner was injured. (T.64).

10. Ms. Cervants stated Respondent had an injury reporting policy. (T.64-65). Injured employees were to report accidents to Ms. Cervants, who reported it to Beth Caldwell in Human Resources. (T.65; T.77). Ms. Caldwell would complete an accident investigation report. (T.71). There were no accident reports completed for this injury. (T.73).

11. Beth Caldwell testified on behalf of Respondent. She had worked for Respondent since 1996 and agreed Respondent had an accident policy. (T.78). Respondent would complete an accident investigation form, pull footage from security cameras, if necessary, interview people, and send the injured worker to Alexian Brothers Clinic or Alexian Brothers Hospital. (T.78-79). Ms. Caldwell testified Petitioner did not report an injury to her on June 17, 2013, and neither did Ms. Cervants or Olivia. (T.80). The first notice she received was the Application for Adjustment of Claim filed July 8, 2013. (T.81).

12. Petitioner continued to work after the injury, but avoided any lifting. (T.17). Throughout the week, he noticed pain that worsened to the point where he could not walk. (T.17). He did not seek medical attention, but self-medicated at home with Ibuprofen. (T.18). The medication alleviated the pain a little bit. (T.18). Petitioner waited to seek treatment, hoping the pain was temporary. (T.46).

13. Petitioner's initial date of treatment was June 24, 2013 at Mount Sinai Hospital – one week after the accident. (T.18). He complained of pain in his lower back and he could not walk. (T.19). The hospital provided a muscle relaxer and two shots of steroids. (T.19). The hospital record stated: "Sts was carrying heavy bags yesterday and has had lower back pain since. Denies injury/trauma/urnary sx. Sts increase in pain when ambulating or sitting. No neuro deficits noted." The handwritten notes under "ED History & Physical Exam Worksheet" lists: "Acute low back pain s/p heavy lifting yesterday" and "Traumatic fall/injury." Petitioner was diagnosed with acute low back pain, given injections, and pain medication. (PX1).

14. On cross-examination, Petitioner testified the hospital record incorrectly stated the date and mechanism of his injury. (T.19; T.36). The hospital records do not indicate whether anyone (family/friend/translator) was with Petitioner during his visit. The hospital records also do not list any other mechanism of injury.

15. Following his discharge from Mount Sinai Hospital, Petitioner called Respondent "because they asked me to provide proof." (T.20). Petitioner testified, "I called to ask what type of papers they needed, Angie told me – transferred me to talk to Linda, the owner; and then that's when they told me that my services were no longer needed there and for me not to come back." (T.20). Angie Cervants confirmed Petitioner's last day of work was June 21, 2013. (T.65).

16. Thereafter, Petitioner applied for unemployment benefits. (T.29). During his unemployment proceedings, Petitioner said he learned for the first time why Respondent fired him. It was due to his inability to work the mandatory overtime following his injury. (T.33). Petitioner's unemployment benefits were approved and he received benefits for approximately eight months to a year. (T.34-35).

17. After his initial emergency room visit, Petitioner next sought treatment with Dr. Ravi Barnabas on July 1, 2013, at Herron Medical Center. (T.20). Petitioner complained of pain in his lower back and down his left leg. (T.21). The history documented in the medical records stated:

> The patient sets up machines, works for this company and was setting up a machine on the day mentioned [June 17, 2013] at the time mentioned [between 4 and 6]. He was finding a place to place something new on the machine. He lifted a blade that weights about 60-70 lbs. Then he put the blade down. He felt like there was some degree of pain and he felt as if his lower back was feeling very strained. He finished putting the blade and stretched out his lower back. The pain felt a little better but then got worse. (PX2).

18. Dr. Barnabas' records were consistent with Petitioner's testimony except it incorrectly noted Petitioner went to the hospital on June 21, 2013 instead of June 24, 2013. His medical records also stated Petitioner had an x-ray at the hospital, but he did not. Dr. Barnabas' examination revealed spasms, tenderness in the right and left SI joint at L4-5, limited range of motion, positive straight leg raise bilaterally, heel-to-toe was painful and Petitioner had an antalgic gait preferring the right leg. Petitioner reported a pain level of eight out of 10. Dr. Barnabas noted no prior history for the back. He diagnosed Petitioner with lumbago, lumbar sprain, thoracic or lumbosacral neuritis or radiculitis, and displacement of lumbar intervertebral disc without myelopathy. Dr. Barnabas took Petitioner off work and prescribed pain

medication, a back brace, a TENS unit, physical therapy, and an MRI for his lower back. (T.21; PX2).

19. Petitioner underwent an MRI at Delaware Place MRI on July 1, 2013. At L5-S1, there was a subligamentous left-sided disk herniation, with an extruded nucleus pulposus measuring approximately 4-5 mm, indenting the left side of the thecal sac with left-sided spinal stenosis and left lateral recess narrowing. (PX3).

20. Dr. Barnabas referred Petitioner to Dr. Michel Malek, M.D., a neurological surgeon. Petitioner's initial appointment with Dr. Malek was on July 24, 2013. (T.22). Dr. Malek's medical records provided a history consistent with Petitioner's testimony:

> [W]as setting up a machine while taking of plates to place new ones on the machine. The patient bent down in a twisted position with the left side lower than the right side holding onto the plate weighing 60-70 lbs. As he bent down and lifted the plate he had immediate onset of pain in his low back and could not bear weight on his left leg. (PX4).

21. Dr. Malek noted no prior history for back complaints. His exam revealed negative Waddell's signs, including superficial tenderness, nonanatomic tenderness, axial loading, pain on simulated rotation, distracted straight leg raise test, regional weakness, and sensory discordance. There was sensation deficit in the S1 distribution on the left compared to the right side. Dr. Malek reviewed the July 1, 2013 MRI of the lumbar spine. He noted desiccation at L5-S1, some modic type changes, and L5-S1 disc herniation compressing and distorting the descending S1 nerve root. Dr. Malek diagnosed Petitioner with lumbar musculoligamentous sprain/strain and left lumber radiculopathy, clinically in S1 distribution. He recommended a left-sided L5-S1 epidural steroid injection, an EMG/NCV, and ordered Petitioner to continue physical therapy and remain off work. (T.22; PX4).

22. Petitioner underwent a series of left L5-S1 transforaminal caudal epidural steroid injections on August 16, 2013, August 30, 2013, and September 20, 2013. (T.22-23; PX4). The medical records were consistent with Petitioner's testimony, in that he experienced improvement for a short time and then the pain returned. (T.23-24; PX4).

23. As of September 10, 2013, Dr. Malek had returned Petitioner to work light duty with a weight limit of 20 pounds. (T.24; PX4). Petitioner's physical exam remained positive for radiculopathy. Dr. Malek continued to recommend the EMG/NCV and perhaps a lumbar discography if Petitioner was not willing or capable of living with his symptoms. If Petitioner could tolerate his symptoms, Dr. Malek said he could proceed with a work conditioning program for two to four weeks followed by a functional capacity evaluation. (PX4).

24. On October 16, 2013, Petitioner had the EMG/NCV with Dr. Lenny Cohen, M.D., of Chicago Neurological Services, Ltd. The study showed mild acute L5 and S1 radiculopathy on the left. (T.24; PX4). Dr. Malek reviewed the results of the EMG/NCV on October 21, 2013, and recommended Petitioner proceed with left L5-S1 microdiscectomy. Petitioner had been in physical therapy, but as of this date, Dr. Malek put further therapy on hold. (T.25; PX4). Despite Petitioner's light duty status, he was not working.

25. Respondent sent Petitioner for a Section 12 examination on January 9, 2014 with Dr. Avi Bernstein, M.D., at the The Spine Center. Dr. Bernstein's history of the injury and subsequent treatment was consistent with Petitioner's testimony and the medical records. He noted Petitioner's prior history was negative. Dr. Bernstein's examination showed Petitioner had a minor limp on the left side and a minimally positive straight leg raise on the left side at 90 degrees. He indicated the July 1, 2013 MRI demonstrated a left L5-S1 disc herniation. Dr. Bernstein stated Petitioner suffered "a left L5-S1 disc herniation as the result of a work incident." He opined Petitioner would be at MMI six months from the accident date and he could return full duty. Dr. Bernstein stated Petitioner did not require surgery, but should instead consider a home conditioning and strengthening program. Dr. Bernstein mentioned in his report Petitioner was not interested in surgery. (RX1).

26. Petitioner returned to Dr. Malek on March 24, 2014. Dr. Malek noted Dr. Bernstein's report:

> He states however that given the level of the patient's symptomatology that no surgery is recommended. The patient stated he has not made that decision as the symptoms remain particularly with increased activity, and at this point I told him I will keep him on light duty, repeat an MRI scan of the lumbar spine and we can make a final decision after that is done. (PX4).

27. Petitioner proceeded with the MRI of the lumbar spine on March 27, 2014 at Lakeshore Open MRI and CT. The current MRI again demonstrated at the L5-S1 level a left-sided disk herniation with an extruded nucleus pulposus of approximately 5-6 mm. There was now an annular tear seen in this area. There was left-sided spinal stenosis and left neuroforaminal narrowing. (PX6).

28. On July 18, 2014, Dr. Malek performed a left L5-S1 partial hemilaminotomy, foraminotomy, lateral recess decompression, nerve decompression, and excision of herniated disc, transannular fragment. (PX5).

29. Petitioner began post-operative physical therapy on August 6, 2014 at New Life Medical Center. (T.27; PX7). The history given on that date was, "On 6/17/2013 he was taking out and putting heavy trays that weighed approximately 70 lbs. each under a machine when he felt sudden sharp pain in his low back." The rest of the history as to subsequent complaints and treatment was consistent with Petitioner's testimony. Petitioner underwent seven therapy sessions through August 15, 2014. (PX7).

30. Petitioner testified that post-surgery, "I was feeling better after that. You know, it soothed the pain. After that I didn't feel it." (T.26). He further stated, "Before I was not able to have a lot of strength and lean on this leg [left leg] here. I had to walk kind of sideways. And then after the surgery I started walking, you know, normally with both." (T.26-27).

31. Petitioner followed-up with Dr. Barnabas on October 1, 2014. He was "feeling fine" by this date. (T.28). Dr. Barnabas placed Petitioner at maximum medical improvement (MMI) and gave him a full duty release. (T.28).

32. On October 22, 2015, Respondent sent Petitioner for a second Section 12 examination with Dr. Jeffrey Coe, M.D., of Occupational Medicine Associates of Chicago, Ltd. Dr. Coe was board certified in occupational medicine. The history provided at this exam was, "Mr. de la Rosa states that he was at work for Binderyonics on June 17, 2013. He states that he lifted a heavy part (estimated weight, 60 to 70-pounds) and experienced pain in his lower back Mr. de la Rosa states that the pain in his back persisted." (RX2). No prior history was noted. Dr. Coe's report as to Petitioner's complaints was consistent with Petitioner's testimony. On examination, Dr. Coe noted slightly decreased range of motion on extension and left lateral bending, decreased sensation to light touch along the lateral border of the left thigh, calf and ankle as compared to the right. Dr. Coe noted Petitioner was able to heel and toe rise, but had slight limitation in prolonged left heel walking. Dr. Coe diagnosed Petitioner with L5-S1 intervertebral disc herniation, status post-surgery, with residual radiculopathy symptoms; he gave Petitioner an impairment rating of 10% MAW. He opined Petitioner was at MMI and he could return to full duty work. (RX2).

The Commission is not bound by the Arbitrator's findings, and may properly determine the credibility of witnesses, weigh their testimony, and assess the weight to be given to the evidence. R.A. Cullinan & Sons v. Indus. Comm'n, 216 Ill. App. 3d 1048, 1054 (3rd Dist. 1991). It is the province of the Commission to weigh the evidence and draw reasonable inferences therefrom. Niles Police Dep't v. Indus. Comm'n, 83 Ill. 2d 528, 533-34 (1981). Interpretation of medical testimony is particularly within the province of the Commission. A. O. Smith Corp. v. Indus. Comm'n, 51 Ill. 2d 533, 536-37 (1972).

For an injury to be compensable under the Act, "a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of

and in the course of his employment." Sisbro, Inc. v. Indus. Comm'n, 207 Ill. 2d 193, 203 (2003). "'In the course of employment' refers to the time, place and circumstances surrounding the injury." Id. "It is not enough, however, to simply show that an injury occurred during work hours or at the place of employment. The injury must also 'arise out of' the employment.'" Id. This element may be found "if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties." Caterpillar Tractor Co. v. Indus. Comm'n, 129 Ill. 2d 52, 58 (1989).

The Commission finds that Petitioner sustained an accident arising out of and in the course of his employment, and that his condition is causally related to the work accident.

In support of its finding, the Commission notes that the Arbitrator's denial of the claim was based, in part, upon her finding that Petitioner's testimony as to the accident was not corroborated by the emergency room records of Mount Sinai Hospital. The Arbitrator also stated the mechanism of injury varied depending on which doctor Petitioner reported to. The Arbitrator found the testimonies of Ms. Cervants and Ms. Caldwell to be credible and unrebutted.

Petitioner's unrebutted testimony was that he was a machine operator and mechanic for Respondent. He testified that his duties were to ensure machines operated properly, perform set-ups, and change different-sized plates on the machines. (T.12-14). Petitioner stated he worked with Olivia, a Production Monitor for Respondent. Olivia was the one who would give him the set-ups for the machine. (T.87). Petitioner testified that on June 17, 2013, he was setting up a machine to fold paper by replacing plates that were located at the bottom of a machine. The specific plate in his hands weighed 60 to 80 pounds. When he attempted to raise and place the 60 to 80 pound plate on the machine, he felt immediate pain in his back. (T.15-16; T.43-44; T.50).

The Commission finds that the only evidence to contradict Petitioner's testimony was: (1) Angie Cervant's testimony that as far as she knew, there was no need to change plates, and (2) the Mount Sinai Hospital records. Ms. Cervant's testimony carries no weight as to accident. She was not familiar with what machines or plates Petitioner used at work. She even testified that she had seen employees change plates on machines, she just never changed the plates herself. (T.68-69; T.75-76). This testimony does not negate the fact that as a machine operator and mechanic for Respondent, Petitioner was required to change various sized plates in order to set-up machines to perform specified tasks.

As to the Mount Sinai Hospital records, the Arbitrator relied heavily on the discrepancy contained therein to deny the claim. The Commission notes Petitioner required an interpreter at arbitration. (T.10). It is not clear whether Petitioner had an interpreter at Mount Sinai Hospital or subsequent medical appointments. The Commission finds that the history provided in the records of Mount Sinai Hospital, that Petitioner was carrying heavy bags on June 23, 2013, was the only history of that kind in the trial record. (PX1). Petitioner testified the hospital record incorrectly

stated the date and mechanism of his injury. (T.19; T.36). Every other history of the accident in evidence was consistent with Petitioner's testimony.

The only other issue the Arbitrator had was the interchanging use of plate, blade, gate, or tray. Again, interpretation issues cannot be ignored in this claim. The Commission finds that even at arbitration, Respondent's witnesses responded to questions where the attorneys interchanged the use of plate and blade. Such a dispute over semantics does not defeat Petitioner's claim that he was lifting a 60 to 80 pound part for a machine when he was injured. Petitioner was performing an act (performing a set-up/changing out plates), that was reasonably expected of him in the discharge of his duties.

Lastly, Petitioner testified that on the date of accident, he reported his injury to Olivia. (T.16). Both Respondent's witnesses acknowledged Olivia was an employee of Respondent and she was working on June 17, 2013. (T.64). However, Olivia was not called as a witness to testify as to accident.

The Commission also notes that the Arbitrator found the issue of causal connection moot as Petitioner did not prove accident. As the Commission finds Petitioner sustained a work-related accident arising out of and in the course of his employment on June 17, 2013, the Commission can address causality. Causal connection between an accident and an employee's condition has been found in instances where a chain of events demonstrate "a previous condition of good health, an accident, and a subsequent injury resulting in disability." Int'l Harvester v. Indus. Comm'n, 93 Ill. 2d 59, 63-64 (1982).

Petitioner was 32 years old on June 17, 2013, with no prior history of back complaints, injuries, or treatment. The Commission finds no evidence in the record that demonstrated Petitioner was unable to perform his work for Respondent without limitation leading up to the accident. Following his injury, Petitioner experienced severe pain in his lower back which affected his ability to walk. The emergency room physician had to administer muscle relaxants and steroid injections. (T.19; PX1). He was diagnosed with acute low back pain. The Commission finds the rest of the medical records in evidence were consistent with Petitioner's history as to his injury and subsequent complaints. (PX2; PX4). Respondent offered no evidence to contradict or rebut Petitioner's testimony. Two MRIs, taken on July 1, 2013 and March 27, 2014, showed a left-sided disc herniation at L5-S1, ranging from 4-6 mm, with left-sided spinal stenosis and narrowing. (PX3; PX6). The October 16, 2013 EMG/NCV revealed left L5-S1 radiculopathy. (PX4). Petitioner was also taken off work for the first time on July 1, 2013.

The Commission further notes that Respondent's own Section 12 examiner, Dr. Bernstein, opined Petitioner suffered "a left L5-S1 disc herniation as the result of a work incident." (RX1). A second Section 12 examiner on behalf of Respondent, Dr. Jeffrey Coe, did not rebut this opinion in his report. In fact, no opinion as to causal connection was offered by Dr. Coe.

Accordingly, the Commission finds that based upon Petitioner's testimony together with the medical records, Petitioner established that he sustained a work-related accident arising out of and in the course of his employment on June 17, 2013 and that his current condition of ill-being is causally related to said accident.

Consequently, Petitioner is entitled to TTD benefits for 65 2/7 weeks from July 1, 2013 through October 1, 2014. Respondent is entitled to a credit of $1,012.00 in TTD previously paid. Petitioner is also entitled to medical expenses totaling $107,955.90.

The Commission finds Petitioner is entitled to 15% loss of use of the man-as-a-whole pursuant to Section 8(d)(2) of the Act. Petitioner underwent a left L5-S1 partial hemilaminotomy, foraminotomy, lateral recess decompression, nerve decompression, and excision of herniated disc, transannular fragment. Petitioner was released to work full duty on October 1, 2014. However, on October 22, 2015, Dr. Coe noted Petitioner had residual radiculopathy symptoms; his range of motion was slightly decreased on extension and left lateral bending, there was decreased sensation to light touch along the lateral border of the left thigh, calf and ankle as compared to the right, and Dr. Coe noted Petitioner had slight limitation in prolonged left heel walking

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed on April 11, 2016, is hereby reversed as stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $476.40 per week for a period of 65 2/7 weeks (July 1, 2013 through October 1, 2014), that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $428.76 per week for a period of 75 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused the 15% loss of use of the person-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay medical expenses totaling $107,955.90 pursuant to Sections 8(a) & 8.2 of the Act.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all 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.

17IWCC0263

Michael J. Brennan

Thomas J. Tyrrell

DISSENT

I respectfully dissent from the Majority's opinion reversing the Arbitrator's Decision. I find Arbitrator Thompson-Smith's Decision to be thorough and well-reasoned. Particularly persuasive are the Arbitrator's numerous and detailed findings regarding Petitioner's credibility. I give great weight to Arbitrator Thompson-Smith's contemporaneous observations of Petitioner at trial and her analysis based on Petitioner's numerous conflicting medical records and histories. I would affirm and adopt this Decision.

Kevin W. Lamborn

DATED: APR 25 2017

MJB/pm
O: 2/28/17
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DeLaROSA, JUAN
Employee/Petitioner

Case# **13WC022016**

BINDERYONICS
Employer/Respondent

17IWCC0263

On 4/11/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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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

Juan De La Rosa
Employee/Petitioner

v.

Binderyonics
Employer/Respondent

Case # 13 WC 22016

Consolidated cases: _____

17IWCC0263

An *Application for Adjustment 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 February 25, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0269

FINDINGS

On **June 17, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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 $**24,296.40**; the average weekly wage was $**714.60**.

On the date of accident, Petitioner was **32** years of age, ***married*** with **3** dependent children.

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

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

Respondent shall be given a credit of $**1,012.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**1,012.00**.

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

ORDER

The Petitioner has not proven, by a preponderance of the evidence, that an accident occurred which arose out of and in the course of his employment by Respondent therefore, no benefits are awarded pursuant to the Illinois Workers' Compensation Act.

Respondent shall be given a credit of $1,012.00 for payment of temporary total disability 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.

17IWCC0263

Findings of Fact

The disputed issues in this matter are: 1) accident; 2) causal connection; 3) medical bills; 4) temporary total disability; and 5) the nature and extent of Petitioner's injuries. *See*, AX1.

Petitioner's testimony and medical treatment

Petitioner testified that he worked for Respondent for about eight (8) months as a machine operator. He worked on a folding machine and his job duties included machine maintenance. Petitioner testified that on June 17, 2013 he was setting up and had to replace the double gates and put regular plates on the machine. As he was raising the plate he felt an immediate burning and cramping in his lower back. He specifically testified that the plate weighed one hundred eighty (180) pounds. Petitioner testified that although he reported the incident to a co-worker, Olivia, he did not seek medical treatment. Instead, he testified that he tried to work through the pain. He did not lift anything any longer. Petitioner testified that he worked through his pain until June 21, 2013 when he was terminated. He testified that he took Ibuprofen that was prescribed to him by his dentist. Tr. pp. 12-18.

The medical records show that Petitioner first sought medical treatment on June 24, 2013, when he presented to Mount Sinai Medical Center, complaining of neck and back pain. The medical records document that Petitioner was diagnosed with acute low back pain and reported "heavy lifting yesterday", which would have been June 23, 2013. He did not report the injury as work-related. Petitioner testified that this history was wrong. X-rays were taken and he was given medication for pain. PX1 pp. 11; Tr. pp. 36-37.

On July 1, 2013, Petitioner came under the care of Dr. Ravi Barnabas of Herron Medical Center. By way of history of the accident, the records state that Petitioner reported that he experienced back pain while lifting "a blade" in machine set up weighing approximately fifty to sixty (50-60) pounds. Petitioner again testified that this history is wrong. He was given medication and recommended for physical therapy and a lumbar MRI scan. Petitioner underwent the lumbar MRI on that date and it was read to show an L5-S1 left-sided, disc herniation. Petitioner testified that he was referred to Dr. Michael Malek for a surgical consultation. PX2; PX3; Tr. pp. 38-39.

Petitioner was examined by Dr. Malek for a surgical consultation on July 24, 2013. Petitioner reported that he bent down in a twisted position with his left side lower than the right, while holding a plate weighing sixty-seventy (60-70) pounds. As he bent down and lifted, he felt pain in his lower back. After physical examination, Petitioner was diagnosed with a lumbar sprain with radiculopathy in the S1 distribution. Injections and an EMG were recommended. Petitioner was directed to continue physical therapy. PX4.

Petitioner received the first injection on August 16, 2013 and after a follow-up visit with Dr. Malek, received a second injection on August 30, 2013. He underwent a third on September 20, 2013 and Petitioner returned to Dr. Malek reporting mixed response to the injections. Dr. Malek recommended a microdiscectomy. PX4.

On January 9, 2014, Petitioner was seen by Dr. Avi Bernstein for an independent medical examination, ("IME") by request of Respondent. Petitioner reported a history of the accident as on June 17, 2013, he was removing plates from a machine and felt lower back pain. Petitioner testified that Dr. Bernstein did not perform a physical examination. However, the report indicates that Dr. Bernstein performed a physical examination and reviewed the MRI, then opined that Petitioner suffered from an L5-S1 disc herniation and had reached maximum medical improvement ("MMI") six (6) months after the time of the alleged incident. Petitioner had mild residual symptoms that Dr. Bernstein opined did not require surgical intervention; and he further opined that Petitioner could return to work at the level of his previous job, on an unrestricted basis. RX1.

On July 18, 2014, after an EMG and second lumbar MRI, Petitioner underwent surgery by Dr. Malek, consisting of a left-sided L5-S1 microdiscectomy. He also underwent a post-operative course of physical therapy. He was released to return to work, with no restrictions as of October 1, 2014. He has not had any medical treatment since. Petitioner did not testify as to any further complaints. PX2, 4 & 7.

Respondent's first witness

Ms. Angie Cervants, the plant manager for Respondent, testified that she worked overlapping shifts with Petitioner during the second shift on June 17, 2013. She testified that the Respondent has a strict accident reporting policy. Employees are to report an injury to her and she reports to Elizabeth Caldwell in Human Resources, who would prepare the necessary reports and documents. At no time did Petitioner report any type of injury to her, per company policy. Ms. Cervants testified that Olivia, the employee whom Petitioner alleged he reported an accident to, is a production monitor whose duties consisted of watching over production, not maintenance over the machines. She was Petitioner's co-worker and that neither Petitioner nor Olivia ever reported any injury to Petitioner to her, per the company policy. If an injury would have been reported, an accident report would have been documented.

She further testified that she had worked simultaneously with Petitioner during the week before Petitioner's June 21, 1013 termination and that he never mentioned an injury or complained to her. She was unsure when Respondent first learned Petitioner was alleging a work accident on but it was not until Petitioner was no longer working for Respondent.

Respondent's second witness

Elizabeth Caldwell, director of Human Resources for Respondent, also testified as to the specifics of Respondent's reporting policy. She testified that all injuries were to be reported to her by the employees or the manager. She testified that no injury to Petitioner was ever reported to her and that

if there had been an accident, a report would have been generated. She testified that Petitioner was let go on June 21, 2013 for cause and that Respondent did not receive notice that Petitioner was alleging a work accident until they received his Application for Adjustment of Claim sometime after July 8, 2013. Ms. Caldwell further testified that there were two women named Olivia, who worked the second shift and that they were both co-workers of Petitioner. Neither were supervisors and neither reported any incident or accident involving Petitioner on or around June 17, 2013.

Conclusions of Law

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

Petitioner bears the burden to establish all of the elements of his claim by the preponderance of credible evidence. *Ingalls Memorial Hospital v. Industrial Commission, 241* Ill.App.3d 710, 609 N.E.2d 775 (1993). His burden includes proving an accident that arose out of and in the course of his employment. *Parro v. Industrial Commission,* 630 N.E.2d 1084 (1995). His burden also includes proving a causal connection between the accident and his condition of ill-being. *Lee v. Industrial Commission,* 656 N.E.2d 1084 (1995). His burden of proof cannot be based on imagination, speculation, or conjecture. *Illinois Bell Telephone Co. v. Industrial Commission,* 265 Ill.App.3d 681, 638 N.E.2d 307 (1994).

A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission,* 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a causal connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v Industrial Commission,* 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

The 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).

The burden is on the petitioner to prove an accident "arose out of" and "in the course of" his employment with Respondent. Generally, an injury "arises out of " employment if, at the time of the occurrence, the employee was performing acts he was instructed by the employer to perform, those he might be reasonably expected to perform, or acts which he had a common law or statutory duty to perform. *Caterpillar Tractor Co. v. Industrial Comm'n,* 129 Ill.2d 52 (1989). The phrase "in the course of" refers to the time, place, and circumstances under which the accident occurred. *Orsini v. Industrial Comm'n,* 117 Ill2d. 38 (1987). Finally, an injury is received "in the course of" one's employment when it occurs within the period of employment, at a place the employee may reasonably be in the performance of his duties, and while he is fulfilling those duties or engaged in something incidental thereto. *Scheffler Greenhouses, Inc. v. Industrial Comm'n,* 66 Ill.2d 361 (1977).

The Arbitrator has carefully considered the testimony of all three witnesses and examined all of the evidence in the Record. The Arbitrator finds that Petitioner failed to show by a preponderance of the credible evidence that he sustained a work injury on June 17, 2013. The Arbitrator does not find Petitioner's testimony to be credible for several reasons.

First, Petitioner's testimony as to what happened on June 17, 2013, is not corroborated by the initial medical records and evidence; including the initial histories documented in the medical records of his treating physicians. The mechanism of injury of the accident varies, depending on which doctor Petitioner reported it to.

Secondly, Petitioner's testimony at trial is not supported by the initial medical records of Mount Sinai Medical Center, where he first sought treatment on June 24, 2013. The medical records state that Petitioner reported that he was injured while performing heavy lifting the previous day and had lower back pain since. Lastly, the Arbitrator finds the testimonies of Ms. Cervants and Ms. Caldwell to be credible and unrebutted.

17IWCC0263

The petitioner has not proven, by a preponderance of the evidence, that an accident occurred which arose out of and in the course of his employment by Respondent therefore, no benefits are awarded, pursuant to the Illinois Workers' Compensation Act. As the petitioner has not proven accident, the remaining disputed issues are moot and will not be addressed.

17IWCC0263

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
13WC22016
SIGNATURE PAGE

L Thompson

Signature of Arbitrator

April 11, 2016
Date of Decision

APR 11 2016

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

Theodore Lee,

Petitioner,

vs.

NO: 13 WC 29362

State of Illinois,

Respondent,

17IWCC0230

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 5, 2015 is hereby affirmed and adopted.

No bond or summons required for State of Illinois cases.

DATED: APR 13 2017

L. Elizabeth Coppoletti

LEC/mas
o:4/4/17
43

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LEE, THEODORE
Employee/Petitioner

Case# **13WC029362**

STATE OF ILLINOIS
Employer/Respondent

17IWCC0230

On 5/5/2015, 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 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

MAY 5 = 2015

RONALD A. RASHIA, 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

THEODORE LEE,
Employee/Petitioner

v.

STATE OF ILLINOIS,
Employer/Respondent

Case # **13** WC **29362**

Consolidated cases: _____

17IWCC0230

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **4/16/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **6/25/13**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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 **$81,590.47**; the average weekly wage was **$1,567.85**.

On the date of accident, Petitioner was **52** years of age, ***married*** with **1** dependent children.

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

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

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

ORDER

Petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury to her bilateral arms due to repetitive work activities, that arose out of and in the course of his employment by respondent and manifested itself on 6/25/13, and has failed to prove by a preponderance of the credible evidence that his current condition of ill-being is causally related to the alleged injury. Petitioner's claim for compensation is denied.

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

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

Signature of Arbitrator

5/1/15
Date

MAY 5 - 2015

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 52 year old CSC1, alleges he sustained an accidental injury to his bilateral hands/arms due to repetitive work activities that arose out of and in the course of his employment by respondent that manifested itself on 6/25/13.

Petitioner works in the Order Provisioning Department in the CMS department. He started working for respondent in 1995 and worked in the warehouse until 2001. At that time he moved over into the Order Provisioning Department where he handles IT telephone voice orders. Petitioner's job duties have been essentially the same since 2001, however his job title has changed. Petitioner's duties include scheduling phones or computers for all state agencies with the vendor. Petitioner does this by entering data into the computer. Petitioner testified that he works on the computer 6 to 6-1/2 hours of each day. Petitioner is right-hand dominant.

Each morning petitioner gets his orders out of his mailbox. About one half hour into his day he begins entering these orders into the computer. If there are requests for phone numbers petitioner will take time to get those phone numbers out of a book. His work on the computer includes entering data into text fields and doing some narrative writing. All orders do not take the same amount of time to complete. Some may be shorter, some may take longer. Petitioner will also take orders on the phone, typing them in while he is on the phone. Petitioner also spends about an hour day taking handwritten notes. Petitioner uses the copy fax machine throughout the day for a total of about 10 to 15 minutes on slow days. Petitioner has an hour lunch per day, and two 15 minute breaks.

Petitioner's workstation has a keyboard tray that he pulls out from underneath his desk that is adjustable. On the keyboard tray is his keyboard, a gel wrist pad, and a mouse. Petitioner also has an adjustable chair. Petitioner testified that while working his elbows and forearms rest on his chair arms, and his wrists rest on the wrist pad. Petitioner did not identify how many orders he processes per day.

On 6/26/13 petitioner presented to Dr. David Pittman, his primary care physician. His chief complaint was bilateral numbness and hand tingling, left worse than right, for about a month. Petitioner denied any similar problems. Petitioner reported that sometimes he has difficulty moving his middle fingers back and forth, and he has to almost do it manually with the right-hand. He denied any injury. Petitioner stated that he types on the keyboard and has been doing this for the last 15 years. He denied any weakness per se. Dr. Pitman noted a positive Tinel's sign. His assessment was hand pain and tingling. He ordered an EMG.

On 7/5/13 petitioner underwent an EMG/NCV of his bilateral upper extremities performed by Dr. Gelber. The impression was an abnormal EMG/NCV that suggested moderately severe bilateral carpal tunnel syndrome, and moderately severe right cubital tunnel syndrome. There was no evidence of ulnar neuropathy on the left side, radial neuropathy, peripheral neuropathy, brachial plexopathy, or cervical radiculopathy.

On 7/23/13 petitioner presented to Dr. Chris Wottowa's physician's assistant for evaluation of his bilateral hand pain, numbness, and tingling. He reported that he has had symptoms that have progressively gotten worse since about December 2012, and has gotten really bad over the past two months. Petitioner reported that his right side is slightly worse than his left side. He reported a lot of pain through the palmar region and numbness and tingling to both hands. He reported that he frequently gets numbness and tingling throughout the day with repetitive activity, especially with typing on the keyboard or using the mouse. Petitioner uses a headset to answer the phone. He also reported that driving seems to exacerbate the numbness and tingling, and he wakes up at night with numbness and tingling. Petitioner reported that his numbness and tingling is not constant. Following an examination and review of the EMG/NCV, petitioner was assessed with bilateral carpal tunnel syndrome and cubital tunnel syndrome of the right arm. Dr. Wottowa's physician's assistant recommended a sub muscular transposition of the ulnar nerve and right carpal tunnel release, followed by a left carpal tunnel release.

On 9/6/13 petitioner's Application for Adjustment of Claim was filed. The alleged accident date was identified as 6/25/13. Petitioner testified that the accident occurred from repetitive use of his hands/wrist, and right elbow using the computer. The parts of the body affected were identified as both hands/wrist and right elbow. The nature of the injury was also identified as both hands/wrist and right elbow related injuries. Petitioner signed this application on 8/26/13.

On 10/8/13 petitioner returned to Dr. Wottowa's physician's assistant complaining of significant numbness and tingling in both upper extremities. He reported that he had not had any significant improvement conservatively. Dr. Wottowa's physician's assistant again recommended surgery and prescribed Elavil.

On 1/23/14 petitioner underwent a Section 12 examination performed by Dr. James Williams, an orthopedic surgeon, at the request of the respondent. Petitioner stated that he worked as an information tech/com systems specialist for approximately 18 years for the State of Illinois. He stated that the first 4-5 years he worked in a warehouse, where he organized telephone materials. In this position he lifted, counted and used a computer to login telephone supplies, which were telephones and telephone systems. In doing a telecom job, petitioner writes orders to vendors to fill orders for phones for government agencies, which he then types into the computer. He uses a cordless headset to answer calls. Petitioner works on the computer every day and does data entry. He processes TSR orders, rewrites orders, and then types them into the system so that the express

mail service can get the order, so that it can be filled. Petitioner reported that he started noting symptoms around December 2012. He stated that around March 2013 he starting getting numbness and tingling in the right and left hands, worse on the right. He also reported pain, weakness, and that he would drop things. He reported numbness in his index, middle, and ring fingers of both hands. He complained of pain in both of his thumbs.

Petitioner drew a picture of his workstation. He showed a square desk. He stated that he used to staple and remove staples with his right hand, but now has an electric stapler. He stated that he has a wrist pad in front of his keyboard, and a mouse with a mouse pad. Petitioner demonstrated how he types. He did not rest his right or left wrist on the edge of the table. He kept his wrists in a neutral position. Dr. Williams noted that they were not in extreme flexion or extension while he typed. Petitioner also stated that he did not rest his elbows on the table. Dr. Williams performed a physical examination, reviewed medical records, and reviewed the position description of an Info Tech/Com Systems Specialist 1 from CMS. Dr. Williams went over the job description with petitioner, who found no significant discrepancies.

Following his examination and record review Dr. Williams' impression was right, as well as left carpal syndrome, and cubital tunnel syndrome. Dr. Williams did not feel that petitioner's carpal tunnel syndrome, nor his cubital tunnel syndrome were either aggravated and/or caused by his work duties. Dr. Williams noted that petitioner did not describe any poor ergonomics at his workstation. Dr. Williams believed the medical literature does not support a finding of carpal tunnel syndrome being related to and/or aggravated by typing, nor did he feel petitioner's cubital tunnel syndrome would be either aggravated and/or caused by his activity of typing. Dr. Williams found it significant that petitioner did not rest his wrists and/or his elbows on his workstation. As a result, Dr. Williams was of the opinion that petitioner's carpal tunnel and cubital tunnel conditions would not have been aggravated and/or caused by his intermittent data entry, and/or intermittent stapling and removal of staples. Dr. Williams felt that it was more likely that petitioner's confounding increased body mass index of 36, and his bilateral CMC joint arthritis, would more likely be the causative factor of his carpal tunnel syndrome. He was further of the opinion that petitioner's condition of hypertension and increased body mass index would be more likely the cause of his bilateral cubital tunnel syndrome.

On 2/17/14 petitioner saw Dr. Wottowa for the first time. Petitioner described his job as a CSC1 as being fairly hands on. He reported that he does a lot of data entry, and a lot a keyboarding. He reported at least a year or longer with symptoms of numbness and tingling and pain in both of his hands, and his elbow. He reported that initially it was just his hands, and a little bit on the elbows. Now, over the past few months, it has been getting a lot worse and both the hands and elbows have increased significantly. Petitioner stated that since he

underwent the EMG/NCV he has experienced increasing pain in both his elbows as well. Following a physical examination, and review of the EMG/NCV, and Dr. Williams and Dr. Gelber's report, Dr. Wottowa's clinical impression was that petitioner has bilateral cubital tunnel, bilateral medial epicondylitis, and bilateral carpal tunnel syndrome. He recommended surgical intervention that would consist of a sub muscular transposition of the ulnar nerve on the right and a right carpal tunnel release. He stated that he would hold off on doing the left side.

On 4/1/14 petitioner underwent a right sub muscular transposition of the ulnar nerve and right carpal tunnel release. This procedure was performed by Dr. Wottowa. Petitioner followed up postoperatively with Dr. Wottowa. On 4/14/14 petitioner followed up with Dr. Wottowa and stated that he had almost no pain with surgery, and his right hand was already much better in terms of his numbness and tingling. On 5/14/14 petitioner reported to Dr. Wottowa that his hand on the right side was doing very well. He stated that he still gets some mild numbness to the right thumb, but the rest of his numbness and tingling had abated. He noted a nodule over the radial pillar which was tender, but was getting better. Dr. Wottowa was of the opinion that petitioner had done very well with the right side, and that the numbness in petitioner's thumb would abate over the next month or two.

On 6/26/14 petitioner underwent a left cubital tunnel release, and left carpal tunnel release. This procedure was also performed by Dr. Wottowa. Petitioner followed-up postoperatively with Dr. Wottowa. On 7/7/14 he reported improvement in his left hand. He stated that he had very little numbness in his fourth and fifth fingers, and improved numbness in his thumb, index, and long finger. Petitioner demonstrated full range of motion. On 9/8/14 petitioner stated that he has had decreased pain, but an increased electrical feelings shooting into his fingertips. Dr. Wottowa was of the opinion that this was actually a good sign. He believed that petitioner was just experiencing normal carpal tunnel type stuff and would continue to get better. He prescribed vitamin E cream.

On 12/15/14 petitioner returned to Dr. Wottowa for the last time. Dr. Wottowa was of the opinion that petitioner had done splendidly with his bilateral upper extremity procedures. He noted no numbness or tingling, and no weakness. Dr. Wottowa noted normal two-point discrimination to all of the fingertips, less than 5 mm. He also noted normal intrinsic strength and normal thenar musculature, and normal intrinsic musculature. In short, Dr. Wottowa was of the opinion that petitioner had done spectacularly well. He noted full range of motion, full strength, and no numbness. Dr. Wottowa released petitioner to full duty without restrictions. He also released him from his care. He was of the opinion that petitioner had reached maximum medical

improvement for both of his upper extremities. Petitioner had been authorized off work from 4/1/14 through 12/18/14 by Dr. Wottowa.

On 1/7/15 Dr. Wottowa drafted a letter to petitioner's attorney, Steven Berg, in response to his request for narrative on petitioner and whether or not his work activities caused or aggravated petitioner symptoms of carpal and cubital tunnel syndrome. Dr. Wottowa noted that clerical work has not been linked to carpal tunnel and cubital tunnel in terms of causation. However, he was of the opinion that petitioner's symptoms were significantly aggravated by his activities at work by his own description. Because of this aggravation, Dr. Wottowa was of the opinion that petitioner's work activities played a role in his carpal tunnel and cubital tunnel syndrome.

Theresa Starling, Public Service Administrator 3 (Telecommunication Service Desk Manager – Bureau of Communication and Computer Services – CMS), was called as a witness on behalf of petitioner. Petitioner has worked with Starling for 15 years. She stated she knew petitioner when he worked in the warehouse. Starling was petitioner's supervisor on the alleged date of accident. She testified that she was familiar with what petitioner did. She testified that petitioner types on the computer 90% of his day. She stated that she received productivity reports on the staff, including petitioner. She testified that petitioner would type data in fields and type narratives. Starling testified that the typing petitioner did was continuous. Petitioner did not offer into evidence any of his productivity reports.

Respondent offered into evidence a worksheet that they created regarding medical payments they had made on behalf of petitioner from 6/26/13 through 1/20/14. None of the actual bills associated with these payments were included.

Respondent also offered into evidence the Worker's Compensation Employees Notice of Injury that was completed by petitioner on 7/25/13. Petitioner noted that he went to the doctor for pain in his hands on 6/26/13. The duties he was performing at the time of the injury were identified as "accumulative". With respect to the place where the injury occurred, petitioner indicated "work" hands aching and paining daily.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?
F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

As a general rule, repetitive trauma cases are compensable as accidental injuries under the Illinois Worker's Compensation Act. In Peoria County Belwood Nursing Home v. Industrial Commission (1987) 115 111.2d 524, 106 Ill.Dec 235, 505 N.E.2d 1026, the Supreme Court held that "the purpose behind the Workers' Compensation Act is best serviced by allowing compensation in a case … where an injury has been shown to be

caused by the performance of the claimant's job and has developed gradually over a period of time, without requiring complete dysfunction.." However, it is imperative that the claimant place into evidence specific and detailed information concerning the petitioner's work activities, including the frequency, duration, manner of performing, etc. It is also equally important that the medical experts have a detailed and accurate understanding of the petitioner's work activities.

Since petitioner is claiming an injuries to his bilateral hands and arms, in Illinois, recovery under the Workers' Compensation Act is allowed, even though the injury is not traceable to a specific traumatic event, where the performance of the employee's work involves constant or repetitive activity that *gradually* causes deterioration of or injury to a body part, assuming it can be medically established that the origin of the injury was the repetitive stressful activity. In any particular case, there could be more than one date on which the injury "manifested itself". These dates could be based on one or more of the following, depending on the facts of the case:

1. The date the petitioner first seeks medical attention for the condition;
2. The date the petitioner is first informed by a physician that the condition is work related;
3. The date the petitioner is first unable to work as a result of the condition;
4. The date when the symptoms became more acute at work;
5. The date that the petitioner first noticed the symptoms of the condition.

Petitioner is alleging a manifestation date of 6/25/13. Given the fact that petitioner presented to Dr. Pittman on 6/26/13, the arbitrator reasonably infers that 6/25/13 could have been the date petitioner's symptoms became more acute at work.

In order for the petitioner to prove by a preponderance of the credible evidence, it is imperative that the claimant place into evidence specific and detailed information concerning the petitioner's work activities, including the frequency, duration, manner of performing, etc. It is also equally important that the medical experts have a detailed and accurate understanding of the petitioner's work activities.

Although Dr. Williams reviewed petitioner's job description as part of his evaluation, no job description for petitioner was entered into evidence. When petitioner testified at trial he stated that the first thing he does each morning is gets his orders out of his mailbox. About one half hour into his day he begins entering these orders into the computer. While doing this, if there are requests for phone numbers, petitioner will stop typing and take time to get those phone numbers out of a book. Petitioner testified that his work on the computer

includes entering data into text fields and doing some narrative writing. He noted that all orders do not take the same amount of time to complete. Some may be shorter, some may take longer. Petitioner did not testify as to how long it takes to process an order. Petitioner will also take orders on the phone, typing them in while he is on the phone. The arbitrator finds it significant that petitioner did not indicate how many orders he processes each day. Petitioner also testified to additional tasks that he performs each day that do not include typing. These include about an hour an day taking handwritten notes, as well as using the copy/fax machine throughout the day for a total of about 10 to 15 minutes on slow days. He did not indicate how often he used the copy/fax machine on busy days. Additionally, petitioner has an hour lunch per day, and two 15 minute breaks.

In support of petitioner's testimony regarding his activities, Starling testified that petitioner types on the computer 90% of the day. She based this on productivity reports that she received. However, Starling did not offer these productivity reports into evidence. Given petitioner's testimony regarding the various activities he performs each day, the arbitrator reasonably infers that petitioner could not be typing 90% of the day.

Petitioner's testimony related to his desk setup shows that he has an adjustable keyboard tray that holds his keyboard and mouse, as well as an adjustable chair. There is nothing in Dr. Pittman's or Dr. Wottowa's records that indicate petitioner discussed his work station set up with them. In the alternative, Dr. Williams did asked petitioner about his work station set up. In response, petitioner stated that he not only had an adjustable keyboard tray with a keyboard, gel wrist pad, mouse and mouse pad, but also had an adjustable chair. He also demonstrated to Dr. Williams that he did not rest his right or left wrist on the edge of the table, and kept his wrists in a neutral position. Dr. Williams noted that when petitioner demonstrated his wrist positions there was no extreme flexion or extension while he typed. Dr. Williams also noted that petitioner did not rest his elbows on the table. Dr. Williams also had an opportunity to review petitioner's job description for an Info Tech/Com Systems Specialist I, which petitioner found no significant discrepancies with.

When petitioner presented to Dr. Pittman, the only description of his job duties he provided was that he has been typing on a keyboard for the past 15 years. He did not describe any of the other work duties he testified to at trial or reported to Dr. Williams. Dr. Pittman did not review his official job description. Additionally, petitioner did not provide a detailed description of his work duties to Dr. Wottowa, that was consistent with his testimony at trial., and Dr. Wottowa did not have an opportunity to review petitioner's official job description. However, when petitioner presented to Dr. Williams, he provided a more detailed explanation of his job duties. Dr. Williams also had an opportunity to review petitioner's official job description.

Based on the above, the arbitrator finds that although the claimant placed into evidence, through his testimony, specific and detailed information concerning his work activities, he did not include the frequency with which he performed his tasks, the duration of each task, and the manner in which he performed each task. Additionally, the arbitrator finds the petitioner failed to provide a consistent job duty history to Dr. Pittman and Dr. Wottowa that was as detailed as the job history he provided at trial. As a result, the arbitrator finds Dr. Wottowa and Dr. Pittman did not have a detailed and accurate understanding of the petitioner's work activities. The arbitrator finds the only doctor that had a detailed and accurate understanding of petitioner's job duties was Dr. Williams, who went over petitioner's job duties with him, and had the opportunity to review his actual job description.

With respect to the causality between petitioner's alleged work activities and his current condition of ill-being, the arbitrator first addresses petitioner's cubital tunnel syndrome. Based on the credible evidence, the arbitrator finds it significant that petitioner made absolutely no complaints related to his elbows until after he underwent diagnostic testing that showed evidence of ulnar neuropathy on the right side, retained counsel, and filed his Application of Adjustment of Claim on 9/6/13. The arbitrator finds such claims at this point without any credible medical evidence to support any complaints associated with this condition prior to this date, suspect at best. The arbitrator finds the complaints petitioner reported to Dr. Wottowa on 2/17/14, that the symptoms in his elbow had been present for over a year, unpersuasive, and unsupported by the complaints he reported to Dr. Pittman on 6/26/13, and Dr. Wottowa's physician's assistant on 7/23/13. In all medical records offered prior to 9/6/13, the arbitrator finds it significant that there is no mention of any elbow complaints by the petitioner to any healthcare provider. Therefore, the arbitrator gives lesser weight to the opinions of Dr. Wottowa as they relate to petitioner's cubital tunnel, since they are based on an incorrect medical history, as well as an incomplete job duty history. In the alternative, the arbitrator gives greater weight to the opinions of Dr. Williams based on the fact that Dr. Williams had a detailed description of petitioner's job duties and workstation setup, and was given complaints that were consistent with all other complaints provided prior to 9/6/13.

With respect to the causality between petitioner's claim for bilateral carpal tunnel and his work duties, the arbitrator finds both Dr. Wottowa and Dr. Williams offered opinions. In a narrative Dr. Wottowa sent to petitioner's attorney on 1/7/15, Dr. Wottowa noted that clerical work has not been linked to carpal tunnel and cubital tunnel in terms of causation. He then goes on to contradict this opinion, and opines that petitioner's symptoms were significantly aggravated by his activities at work, which petitioner only described to Dr. Wottowa as being related to data entry and keyboarding. Based on the inconsistencies in these two opinions,

and the incomplete description of petitioner's job duties Dr. Wottowa had, the arbitrator gives lesser weight to the opinions of Dr. Wottowa.

In the alternative, the arbitrator gives greater weight to the opinions of Dr. Williams who was of the opinion that neither petitioner's carpal tunnel syndrome, nor his cubital tunnel syndrome were either aggravated and/or caused by his work duties. Dr. Williams noted that petitioner did not describe any poor ergonomics at his workstation. He also was of the opinion that the medical literature does not support a finding of carpal tunnel syndrome being related to and/or aggravated by typing. He was also of the opinion that petitioner's cubital tunnel syndrome would not be aggravated and/or caused by his activity of typing. Dr. Williams found it significant that petitioner did not rest his wrists and/or his elbows on his workstation, and kept his wrists in a neutral position, that were not in extreme flexion or extension while he typed. He was of the opinion that petitioner's carpal tunnel and cubital conditions would not have been aggravated and/or caused by his intermittent data entry, and intermittent stapling and removal of staples. Dr. Williams felt that it was more likely that petitioner's confounding increased body mass index of 36, and his bilateral CMC joint arthritis, would more likely be the causative factor of his carpal tunnel syndrome. He was also the opinion that petitioner's condition of hypertension and increased body mass index would be more likely the cause of his bilateral cubital tunnel syndrome.

Based on the above, as well as the credible evidence, the arbitrator adopts the findings and opinions of Dr. Williams, as set forth herein, and finds the petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury to his bilateral hands and arms, due to repetitive work activities that arose out of and in the course of his employment by respondent, that manifested itself on 6/25/13, and that petitioner has failed to prove by a preponderance of the credible evidence that his current condition of ill-being is causally related to the alleged injury.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?
K. WHAT TEMPORARY TOTAL BENEFITS ARE IN DISPUTE?
L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

Given the fact that the petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury to his bilateral arms due to repetitive work activities, that arose out of and in the course of his employment by respondent and manifested itself on 6/25/13, and that petitioner has failed to prove by a preponderance of the credible evidence that his current condition of ill-being is causally related to the alleged injury, the arbitrator finds these remaining issues moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Don McConnell,

Petitioner,

vs. No. 13 WC 32700

17IWCC0256

Fred Lavigne d/b/a Capital City Bus Service,

Respondent.

DECISION AND OPINION ON REVIEW

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

On review, we give no weight to the medical examination conducted by the Arbitrator. Having carefully considered the entire record, the Commission otherwise affirms and adopts the Arbitrator's Decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 11, 2016, is hereby expanded as stated herein, and otherwise affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $36,600.00. 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: APR 24 2017
o-03/09/2017
SM/sk
44

Stephen Mathis

David L. Gore

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McCONNELL, DON
Employee/Petitioner

Case# **13WC032700**

FRED LAVIGNE D/B/A CAPITAL CITY BUS SERVICE
Employer/Respondent

17IWCC0256

On 4/11/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4494 SGRO, HANRAHAN, & DURR LLP
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SPRINGFIELD, IL 62703

0000 RUSIN & MACIOROWSKI LTD
R MARK COSIMINI
2506 GALEN DR SUITE 108
CHAMPAIGN, IL 61821

D. McConnell v. Fred Lavigne, etc., 13 WC 032700

17IWCC0256

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

Don McConnell
Employee/Petitioner

v.

Fred Lavigne d/b/a Capital City Bus Service
Employer/Respondent

Case # 13 WC 032700

An *Application for Adjustment 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 **Springfield**, on **12/18/15**. 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?

FINDINGS

On **December 12, 2011,** Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$26,000.00**; the average weekly wage was **$500.00.**

On the date of accident, Petitioner was **44** years of age, ***married*** with **0** dependent children.

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

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

To date, Respondent has paid **$62,525.16** in TTD and/or for maintenance benefits, and is entitled to a credit for any and all amounts paid

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

ORDER

Respondent shall pay Petitioner **temporary total disability benefits** of **$333.34/week** for **183-2/7** weeks, commencing **12/13/2011 through 6/29/2015,** as provided in **Section 8(b) of the Act.**

Respondent shall pay reasonable and necessary medical services of **$130.00,** as provided in **Sections 8(a) and 8.2 of the Act.**

Respondent shall pay Petitioner **permanent partial disability benefits** of **$300.00/week** for **125.9 weeks,** because the injuries sustained caused the **30% loss of the left arm,** as provided in **Section 8(e) of the Act** and the **10% loss of the person as a whole,** as provided in **Section 8(d)2 of the Act.**

Respondent shall pay Petitioner all benefits that have accrued form 12/12/2011 through 12/18/2015 in a lump sum and shall pay the remainder of the award, if any in weekly payments.

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

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

Signature of Arbitrator

April 11,2016
Date

APR 11 2016

FINDINGS OF FACT

Petitioner was employed by Respondent since 2001. Petitioner testified that he was the general manager, driver, and mechanic, and he basically ran the business.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on December 12, 2011. Petitioner was working on a bus. He was inflating a tire, and the wheel exploded into two pieces. Petitioner testified he was blown backwards. He was disoriented and his ears were ringing. He also testified he had rust in his eyes. Petitioner's arms were hurting, and his left arm was bloody. Petitioner testified that his back was also hurting him at that time.

Petitioner was taken to St. John's Hospital. Petitioner testified he had a compound fracture, and Dr. Pineda performed surgery consisting of the placement of a plate and four screws. The medical records from St. John's Hospital reflect Petitioner was diagnosed with an open fracture of the left ulna. X-rays of the left arm were said to show a comminuted fracture of the left mid to distal ulnar shaft. Dr. Pineda performed an irrigation and debridement of the open ulnar fracture and an open reduction internal fixation of the left ulnar fracture on December 12, 2011. At the emergency room, Petitioner also complained of right arm and wrist pain. X-rays of the right forearm and right hand did not reveal any abnormalities. Petitioner denied any other injuries. (PetEx. 1)

Petitioner continued on a course of follow up care with Dr. Pineda. On February 28, 2012, Dr. Pineda noted Petitioner's complaints of diffuse pain and aching as well as swelling in both palms and hands as well as the fingers. Dr. Pineda stated he could not correlate Petitioner's symptoms with any specific entity. He thought the fractured bone was healed. Dr. Pineda referred Petitioner to a neurologist for a neuropathic evaluation, as there was a concern for RSD. He also noted Petitioner has a significant fear of needles which could pose a problem with his treatment. (PetEx. 2)

Dr. Fortin, a neurologist at Springfield Clinic, evaluated Petitioner March 6, 2012. Petitioner provided a history of excessive sweating of his hands and swelling in both hands. He also complained of pain in both hands and fingers especially with ulnar deviation of the wrist. Petitioner commented he had excessive sweating to the point where he had to hold a washcloth to capture the sweat. On exam, Dr. Fortin noted slight discoloration of the hands, but Petitioner denied any discoloration in his hands at that time. Dr. Fortin did not document the presence of sweating, temperature changes, hair growth changes, fingernail changes, or changes to the texture of the skin at this visit. Dr. Fortin diagnosed Petitioner with reflex sympathetic dystrophy. He prescribed Gabapentin and Prednisone. He also ordered a nerve conduction study performed. The nerve conduction study, performed March 6, 2012, was noted to be unremarkable with no evidence for a neurogenic lesion including a median neuropathy at the wrist or forearm or an ulnar neuropathy at the elbow or wrist. (PetEx. 3)

As of March 27, 2012, Dr. Pineda thought the left forearm fracture was healed. He thought Petitioner was at MMI for the left forearm fracture, but he scheduled a follow-up visit four months later. (PetEx. 2)

The treatment for the diagnosed RSD condition included an evaluation by Dr. Narla on April 3, 2012. Petitioner was referred to Dr. Narla by Dr. Fortin for a possible sympathetic nerve block. The subjective portion of Dr. Narla's note indicates Petitioner had temperature and color changes in his left hand as well as blotchiness and profuse sweating. However, the objective portion of the note indicates Dr. Narla did not find any temperature or color changes in Petitioner's hands. He did note very minor swelling in the dorsum of the left hand as compared to the right. There were no color or temperature changes noted on either side. Dr. Narla also noted Petitioner's sensation was intact and there was no touch allodynia in either hand. Dr. Narla agreed with the diagnosis of chronic regional pain syndrome, but he also thought Petitioner may have sustained some bruising of the ulnar nerve which would explain Petitioner's symptomatology particularly in the left hand. (PetEx. 3)

On August 14, 2012, Petitioner told Dr. Fortin he had gained about 40 pounds and was complaining of back pain. However, according to Dr. Fortin's notes from March 6, 2012 and August 14, 2012, Petitioner only gained about 20 pounds and that was attributed to the medications he was taking. On September 25, 2012, Petitioner indicated the sweating spells of his arm were decreased as was his pain. Petitioner again complained of his weight gain, but his weight was actually less than it was August 14, 2012. (PetEx. 3)

Petitioner returned to see Dr. Pineda September 25, 2012. Dr. Pineda noted Petitioner's ulnar fracture was completely healed. He concluded that Petitioner did not have any restrictions as a result of the forearm fracture. He also noted Petitioner has RSD, and he would defer to Dr. Fortin with respect to any restrictions relating to the RSD diagnosis. (PetEx. 2)

Dr. Fortin indicated in his treatment note dated January 28, 2013 that Petitioner had been gaining weight on steroids and had a recurrence of some low back pain. Petitioner's weight was listed as 249 pounds, which is less than Petitioner's documented weight in August and September of 2012. Petitioner advised Dr. Fortin on January 28, 2013 that he decided to forego a stellate ganglion block, due to his phobia of needles and an interval improvement of his upper extremity pain since taking Lyrica. On exam, Dr. Fortin noted a severely antalgic gait with significant guarding and limping due to left leg and low back pain. No hyperpathia was identified on Petitioner's arm. Additionally, no discoloration was noted. Dr. Fortin did find some swelling in the left hand. Dr. Fortin ordered an MRI of the lumbosacral spine, and he also ordered a Functional Capacity Evaluation. (PetEx. 3)

At the request of Respondent, Petitioner was seen for a §12 exam by Dr. Joshua Warach, a neurologist from Springfield. Following his exam of Petitioner January 31, 2013, Dr. Warach noted Petitioner had monoparetic weakness of the entire left arm from the shoulder down with giveaway weakness, gait difficulty with a variable limp, and otherwise non-focal findings. Dr. Warach agreed with the Complex Regional Pain Syndrome diagnosis, and he noted psychogenic factors may be highly contributory to Petitioner's symptoms. The treatment to date had been appropriate. An FCE may define functional limits. Dr. Warach did not believe there was any relationship between Petitioner's low back or leg pain and the work accident. He also did not believe there was any connection between Petitioner's alleged increase in weight and the December 12, 2011 work accident. (PetEx. 6)

Dr. Fortin's final evaluation of Petitioner took place April 9, 2013. Petitioner's primary issues at that time were with his lower back. Petitioner reported his upper extremity symptoms were improved with Lyrica. The diagnosis regarding Petitioner's upper extremities was RSD/CRPS. (PetEx. 3)

Also on April 9, 2013, Petitioner underwent a Functional Capacity Evaluation. The therapist noted Petitioner arrived at the office sitting in a wheelchair. Petitioner moved himself in the wheelchair with both upper extremities with his feet on the footrest from the waiting room into the therapy room. The therapist noted Petitioner moved both upper extremities without any observable difficulty. The therapist commented Petitioner was able to hold a water cup, scratch his head, and shake the therapist's hand. When asked if Petitioner could use his feet, he lifted the footrest with each hand and then used his feet to move throughout the clinic. Following the FCE, Petitioner was observed walking from the office to the parking lot. During the FCE, Petitioner was noted to have full sensation in his left hand and fingers. He did have some lack of sensitivity in the middle and ring fingers of the right hand. The results of the grip strength testing revealed a lack of effort on Petitioner's part. Petitioner did demonstrate an ability to perform fine motor tasks by using tweezers to place small pegs into holes and by threading and unthreading plastic bolts. The therapist concluded that despite Petitioner's discussion of his RSD condition, the therapist did not observe the condition to the degree anticipated. This was based upon Petitioner's observed use of his upper extremities. The therapist concluded Petitioner's demonstrated functional tolerances were not an accurate reflection of his functional levels. (ResEx. 1)

An MRI of the lumbar spine was performed March 15, 2013. The report reflects the presence of a herniated disc at the L4-5 level which was compressing the L5 and S1 nerve roots. Petitioner had a lumbar ESI on April 30, 2013. He subsequently developed cauda equina symptoms and Dr. William Payne, a spine surgeon at Springfield Clinic, performed emergent surgery on Petitioner's lower back on May 4, 2013. The procedure consisted of the removal of a massive herniated disc at L4-5 and a fusion at the L4-5 level. (PetExs. 1, 4)

Following the back surgery, Petitioner developed a blood clot in his left leg. He was admitted to St. John's Hospital for DVT treatment from June 18, 2013 to June 29, 2013. (PetEx. 1)

Petitioner did not have a good result from the spinal surgery and the DVT. Petitioner still takes blood thinning medication.

At trial, Petitioner testified to ongoing issues with his bladder and bowel function. He does not need to wear a diaper, but he testified he generally tries to stay close to a bathroom. He feels pressure on his spine. The fractured bone in his arm has healed. His left arm swells and shakes. It is sensitive. There is discoloration. His right arm bothers him as well. He feels like he has no dexterity. He couldn't use a torque wrench or perform other physical aspects of his job.

The Arbitrator examined Petitioner's right and left upper extremities. Petitioner's hands looked puffy and swollen. There was some red coloration. There did not appear to be any loss of mass and the strength appeared appropriate.

Petitioner is right handed, per Bob Hammond's report. (PetEx. 5)

Petitioner testified that he has not received any treatment for his upper extremities since April of 2013. He testified the only medication he is currently taking consists of blood thinners. He is not taking any pain medications because of the impact they have with his bowel movements.

Petitioner was seen for another §12 exam at the request of Respondent by Dr. Michael Vender June 29, 2015. Both Dr. Vender and Dr. Fortin testified by way of evidence deposition.

Dr. Fortin testified on October 13, 2015. He testified Petitioner was suffering from Complex Regional Pain Syndrome, which he believed to be causally related to the work accident. On cross examination, Dr. Fortin acknowledged he did not document any classic symptoms of complex regional pain syndrome such as temperature changes, hyperpathia, skin texture changes, hair or nail growth changes, or atrophy in Petitioner's hands. Dr. Fortin testified that over time, the complex regional pain syndrome would result in bony changes, skin changes and atrophy due to disuse. Dr. Fortin also acknowledged Petitioner's observed use of his hands during the Functional Capacity Evaluation would be inconsistent with the Complex Regional Pain Syndrome diagnosis. He further acknowledged that the RSD/CRPS condition can resolve over time. Dr. Fortin had not seen Petitioner since April of 2013, so he testified he was not able to say what Petitioner's current condition is as of the time of his deposition. He did not have an opinion regarding causation as to Petitioner's low back condition. (PetEx. 3)

Dr. Vender testified on November 16, 2015. He confirmed his IME report, and he concluded Petitioner was not suffering from any trophic changes at the time of his exam. Dr. Vender explained that when a person has complex regional pain syndrome, he develops changes in the tissues of the hand. This would include the pattern of hair on the fingers, the nature of the cuticles and the nails themselves. The tissues in the fingertips become more thin and there will be changes in color and temperature. Petitioner was not suffering from any of those findings. Dr. Vender testified that Petitioner was not suffering from CRPS at the time of his exam. He indicated that if Petitioner had suffered from complex regional pain syndrome, there would be residual findings expected, but Petitioner's tissues were all normal and his range of motion findings were all normal. There was no indication Petitioner had any type of contracture or loss of motion of the fingers. Additionally, x-rays taken by Dr. Vender did not identify any disuse phenomenon such as osteoporosis. Dr. Vender determined Petitioner was at maximum medical improvement for his work injuries and he also testified Petitioner did not need any type of restrictions or limitations regarding his upper extremities as a result of the work injuries. Dr. Vender testified that sweating and temperature changes in the limbs are very non-specific and could be caused by numerous reasons. He further explained the diagnosis of Complex Regional Pain Syndrome cannot be made based upon one or two findings. There must be an overall comprehensive presentation consistent with the diagnosis. He did not believe the findings noted in the medical records were sufficient for the diagnosis of CRPS. Dr. Vender further noted Petitioner's ability to propel himself with a wheelchair by using his upper extremities is inconsistent with a diagnosis of Complex Regional Pain Syndrome. (ResEx. 2)

At trial, Petitioner's wife, Kristy McConnell, testified. She has been married to Petitioner for 26 years. She testified that Petitioner never had any problems before the accident. He was very active prior to the accident, but he has not been active at all following the accident.

Petitioner also presented the testimony of Bob Hammond, a vocational counselor. Mr. Hammond testified that Petitioner's limitations prevent him from returning to work in a stable labor market. Hammond testified his opinion was based upon his interpretation of the medical records provided to him by Petitioner's attorney. He did not have any specific restrictions upon which to base his opinions. Mr. Hammond determined Petitioner was able to function at a less than sedentary level, and there was no stable labor market for Petitioner. Mr. Hammond noted Petitioner was a high school graduate with no significant training after that time. It is noted that Petitioner had two years of vocational study following high school. The vocational study was obviously related to mechanic type activities. Mr. Hammond indicated one of Petitioner's limitations was his dexterity, and he believed Petitioner would not be capable of performing fine motor activities with his fingers. Mr. Hammond was not aware that Petitioner used tweezers to place small pegs into holes during the FCE. Mr. Hammond was also not aware Petitioner was capable of maneuvering a wheelchair with his hands, which is inconsistent with Petitioner's claim of his hands being sensitive to touch. Mr. Hammond acknowledged Petitioner's lack of effort on the grip strength test during the FCE could impact his opinion on Petitioner's capabilities.

Petitioner denied experiencing burning painful discomfort and dexterity problems in his hands and arms before the accident. He also denied back related problems with his bowel and bladder and sensation prior to the accident. The Arbitrator notes that the medical records contain several references by Petitioner to prior low back pain and problems. After the accident of December 12, 2011, there is no mention of a back injury or low back pain complaints at the ER, and there is no documentation of low back pain in the medical records until August of 2012.

TTD benefits were paid through July 28, 2015.

Petitioner's Exhibit No. 7 was claimed bills.

CONCLUSIONS OF LAW

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

WITH RESPECT TO ISSUE (F), IS 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 upper extremities (status post bus tire/wheel explosion resulting in an open fracture of the left ulna with subsequent I & D and ORIF procedure with a plate and 4 screws and later development of RSD/CRPS with disability and treatment as documented in the records of Dr. Fortin and Dr. Pineda, along with a right arm contusion and subsequent development of right upper extremity RSD/CRPS condition as documented in the records, with the fracture healed well and no treatment for the RSD/CRPS condition after April 9, 2013 and the current upper extremity

conditions as noted by the Arbitrator at trial and by Dr. Vender in his examination of Petitioner on June 29, 2015) to be causally related to the injury, based upon the testimony of Petitioner and the medical records. Dr. Fortin's opinion on causation and his diagnosis of the RSD/CRPS condition are found to be credible and persuasive. Dr. Narla, Dr. Pineda and Dr. Warach supported the diagnosis of CRPS/RSD. To the extent that Dr. Vender opines that Petitioner did not have RSD/CRPS at all based upon the lack of some findings by the treating physicians while Petitioner was undergoing treatment in 2012 and 2013 and the lack of objective findings upon examination in June of 2015, the Arbitrator finds this opinion to be not persuasive.

The Arbitrator finds that Petitioner has failed to prove that there is a causal connection between the accident and Petitioner's current condition of ill-being regarding his low back and left leg. First, Petitioner had a long history of prior low back problems. Second, it is specifically documented that Petitioner denied injuries other than his left arm fracture and the right arm contusion at the St. John's ER on the date of accident. The first documented back complaints are given to a PA in August of 2012. Finally, there is no medical opinion supporting causation regarding the low back.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner's claimed bills were submitted as Exhibit 7. Most of the bills are associated with Petitioner's low back condition and are denied based upon the Arbitrator's finding above regarding causation. There is one bill from Dr. Fortin for RSD/CRPS related treatment (Dos: 4/9/2013, $130.00) and that bill is awarded.

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:

Petitioner's testimony establishes that he received no further treatment for his upper extremities after April 9, 2013. Unfortunately, the Record in this case does not establish that Petitioner was at MMI at that time. MMI can be established based upon the examination of Petitioner by Dr. Vender on June 29, 2015 and his opinions thereafter. Thus, the award for TTD is from December 13, 2011 through June 29, 2015. See: Interstate Scaffolding v. Workers' Compensation Comm'n, 236 Ill.2d 132 (2010)

The award of TTD is 183-2/7 weeks at the rate of $333.34 per week.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

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

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records.

No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

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

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 general manager/mechanic/driver at the time of the accident and that he is not able to return to work in his prior capacity, possibly partially as a result of said injury. This factor is given some weight in determining PPD. The Arbitrator notes that the primary medical condition that prevents Petitioner from returning to his regular occupation is Petitioner's low back and left leg condition, which has been found to be not causally related to the injury. Dr. Pineda released Petitioner to regular work regarding the ulnar fracture, but deferred regarding the RSD/CRPS condition. Dr. Fortin did not have an opinion regarding the extent of Petitioner's RSD/CRPS condition in 2015. Dr. Vender found Petitioner to be capable of working regular duty regarding his upper extremities on June 29, 2015.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 44 years old at the time of the accident. This factor is given more weight in determining PPD, as Petitioner will likely have to live with his disability for a long period of time.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner is likely disabled from all work due to his current medical condition, age,

prior work experience and level of education. The medical disability is not causally related to the injury, so this factor is given no weight in determining PPD.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the last treatment that Petitioner had for his left arm/RSD/CRPS condition was in April of 2013 by Dr. Fortin. Dr. Fortin had no opinion regarding petitioner's current condition at the time of his deposition in October of 2015. Petitioner did have disability related to the left ulnar fracture and the RSD/CRPS condition as of the last visit with Dr. Fortin. The Arbitrator does believe that Petitioner has residuals from the RSD/CRPS condition. Petitioner's current complaints regarding his upper extremities are, unfortunately, not corroborated by records of current treatment. Therefore, this factor is given less weight in determining PPD.

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 30% loss of use of the left arm, pursuant to §8(e) of the Act regarding the left ulna fracture and 10%loss of use of a person as a whole pursuant to §8(d)2 of the Act regarding the RSD/CRPS condition.

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

Brenda James,

Petitioner,

17IWCC0220

vs.

NO: 13 WC 32717
14 WC 38119

Chicago Transit Authority,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary disability, medical expenses, causal connection, prospective medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 4, 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: APR 12 2017
o3/30/17
DLS/rm
046

David L. Gore

Stephen J. Mathis

DISSENT

I must respectfully dissent from the majority's decision affirming the Arbitrator's finding that Petitioner's need for a right total knee replacement is causally connected to a work-related condition. Petitioner had a history of osteoarthritis in both hips and knees prior to the date of accident. She underwent surgery to repair a right torn meniscus and bilateral hip replacements. Petitioner admitted that prior to the accident she had asked Respondent about driving only the newer-model busses due to her knee complaints. I would find that the accidental injury of April 3, 2013 did not cause or accelerate Petitioner's right knee end-stage osteoarthritis or her need for a knee replacement.

With respect to the mechanism of injury, it is notable that Petitioner testified that she did not initially believe she was injured. She did not immediately have any pain and she continued working. Over an hour later, Petitioner called for medical attention. She testified that her neck and her right knee began to hurt while she was driving and that she felt weak. The paramedics took Petitioner's history of tripping on a rug and hitting her *right side*. At the emergency room, Petitioner again reported falling onto her *right side*. She complained of pain in the right side of her neck, and pain in her right elbow, knee, and thigh. A right pelvis and femur x-ray was obtained, but the emergency room doctor did not order an x-ray of her right knee. Petitioner was diagnosed with a right hip contusion and neck strain and discharged. On an injury report completed later that day, Petitioner did not mention falling on her right knee nor did she describe or identify what if any injuries she sustained.

The following day, Petitioner was examined at Concentra Occupational Health Center. She complained of pain in the right hip, right knee, and left arm after falling the day before. She reported that she tried to continue working but she developed pain and went to the emergency room. Dr. Cole noted full range of motion of the right knee and no swelling or instability. He diagnosed contusions to the right knee, hip, left elbow, and a neck strain, and he released Petitioner to modified duties. Petitioner indicated that she would follow-up with her primary care doctor.

On April 8, 2013, she was examined by Dr. Munoz at WorkCare Occupational Medicine Center. She gave a history of falling forward onto her right side, striking her right knee, thigh, and right side of her body. This is the first time Petitioner specifically reported striking her right knee. She also described an immediate onset of pain in her right knee and hip after the incident, which is not consistent with the prior medical records or her testimony. Dr. Munoz took Petitioner off of work and referred her to Dr. Giannoulias, an orthopedic surgeon.

On July 1, 2013, Petitioner saw Dr. Giannoulias and gave a history tripping and falling, landing on her right knee. Dr. Giannoulias noted that Petitioner had previous problems with her knee and had an arthroscopy several years earlier. Dr. Giannoulias interpreted the MRI from June 10, 2013 as showing significant tricompartmental arthrosis with a *degenerative* meniscus tear. Dr. Giannoulias concluded that Petitioner was "doing pretty well" at that time and that her pain was improving with physical therapy. Dr. Giannoulias discussed with Petitioner that "the only cure for this is a knee replacement given the severity of the arthritis."

At Petitioner's follow-up evaluation on August 26, 2013, Dr. Giannoulias noted that Petitioner was doing great and had no significant complaints. He noted no tenderness over the medial or lateral joint line and normal range of motion. Dr. Giannoulias concluded that "Things have resolved nicely. From my standpoint, she can return to her activities as tolerated. I will see her in the future as needed."

Two days later, however, Petitioner returned to Dr. Munoz and indicated that she was awaiting knee injections by Dr. Giannoulias and complained of throbbing and swelling in the right knee. Dr. Munoz found that Petitioner remained unfit for duty and he kept her off of work. When Petitioner returned to Dr. Giannoulias over a month later on October 7, 2013, he noted that she was wondering if she could have Hyalgan injections of both knees, noting "She has taken a little bit of turn for the worse[.]" Dr. Giannoulias injected both knees, noting "the right one is work related and the left one is not."

It is a factual decision whether a work-related injury exacerbated Petitioner's pre-existing condition. I would find that Petitioner failed to meet her burden of proof on this issue. The causal opinion of Dr. Giannoulias that the accident hastened Petitioner's need for a total knee replacement is not persuasive as it relies entirely on Petitioner's subjective history. Dr. Giannoulias admitted that he did not review any prior medical records or those contemporaneous

17IWCC0220

with the accident. Dr. Giannoulias agreed that knee replacement was the only permanent treatment for Petitioner's advanced tricompartmental osteoarthritis; he also agreed symptoms wax and wane over time.

The conclusion that Petitioner sustained a temporary aggravation of her pre-existing condition is supported by a preponderance of the evidence. On August 26, 2013, Dr. Giannoulias found that Petitioner's knee had resolved nicely. Respondent's §12 examiner, Dr. Mash, also opined that the accident of April 3, 2013 did not cause or accelerate Petitioner's need for a total knee replacement. Based on the above, I must respectfully dissent from the decision of the majority.

Deborah L. Simpson

Deborah L. Simpson

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

17IWCC0220

JAMES, BRENDA
Employee/Petitioner

Case# **13WC032717**

14WC038119

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

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

If the Commission reviews this award, interest of 0.47% 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:

0996 WILLIAM BUDDY MEYERS & ASSOC
NICHOLAS A RUBINO
100 W KINZIE ST SUITE 325
CHICAGO, IL 60654

0515 CHICAGO TRANSIT AUTHORITY
DEREK L FALLSTROM
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

17IWCC0220

☐	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

BRENDA JAMES
Employee/Petitioner

Case #13 WC 32717
#14 WC 38119

V.

CHICAGO TRANSIT AUTHORITY
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 March 3, 2014. 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 April 3, 2013, 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 $63,065.60; the average weekly wage was $1,212.80.
- At the time of injury, the petitioner was 59 years of age, single with no children under 18.
- The petitioner agreed that the respondent paid $48,511.80 in temporary total disability benefits.
- The respondent agreed that the petitioner is entitled to temporary total disability benefits for 60 weeks, from April 4, 2013, through May 28, 2014.

ORDER:

- The petitioner is awarded further medical care, therefore, her request for permanent partial disability benefits at this time is denied.
- The medical care rendered the petitioner for her cervical spine, arms, and right knee and hip was reasonable and necessary and is awarded. The medical care rendered the petitioner for her left knee 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 is entitled to have from the respondent the reasonable and necessary cost for a right total knee replacement.

- 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

April 1, 2016

Date

APR 4 - 2016

FINDINGS OF FACTS:

On April 3, 2013, the petitioner, a bus operator, tripped and fell over a rolled-up rug at the respondent's training room and landed on her right side. After driving her bus for a while, she sought emergency care at Northwestern Memorial Hospital for right lateral neck pain, right elbow pain, right knee pain and right hip pain. The doctor noted a normal gait with some pain limitations and a full ROM of her hip, knee and elbow. X-rays of her right hip and femur were negative for fractures. The diagnosis was a hip contusion and neck strain.

The petitioner received care at Occupational Health Centers of Illinois on April 4th and reported pain in her right hip and knee and left arm. The doctor noted tenderness in the petitioner's left upper arm, wrist and palm and pain with ROM of her right knee. The petitioner was treated with medication, physical therapy and work restrictions. On April 8th, the petitioner saw Dr. Munoz at WorkCare Occupational Medicine Center and reported pain in her right knee, left arm and wrist/hand and right hip and thigh, and discomfort in her right cervical spine. Dr. Munoz recommended physical therapy, medication, home exercises and no work for his assessment of right knee, left wrist/hand, cervical spine and right hip-thigh contusions and sprains. The petitioner reported continuing symptoms on April 17th and May 22nd. A right knee MRI on June 10th, revealed tricompartmental degenerative joint disease, most advanced in the lateral compartment where broad areas of full-thickness chondral loss were present, a diffuse tear/maceration of the lateral meniscus with a partial lateral extrusion of the body, a mucinous degeneration in the posterior horn of the medial meniscus with mild fraying along the free edge, an interstitial partial-thickness tear of the posterior cruciate ligament

and a small to moderate-sized joint effusion with synovitis, debris and intra-articular bodies.

On June 19th, Dr. Munoz opined that the MRI revealed a partial PCL tear and meniscal defects and noted that the petitioner was slowly progressing with rehab. The petitioner saw Dr. Giannoulias on July 1st and reported previous right knee problems and an arthroscopy several years earlier. Dr. Giannoulias' impression was a knee contusion with aggravation of her arthrosis. Physical therapy was continued for her right knee. The petitioner reported continuing right knee pain and swelling to Dr. Munoz on July 24th and improved neck and thigh symptoms but continued neck stiffness. The petitioner reported doing great with no complaints with her right knee to Dr. Giannoulias on August 26th. His physical examination revealed no effusion, no tenderness over her medial or lateral joint lines and a normal ROM with some crepitation. She was allowed to resume her activities as tolerated.

Dr. Munoz noted improved neck and thigh symptoms but continued neck stiffness and right knee throbbing and swelling on August 28th and September 12th and worsening cervical symptoms on September 15th but improvement on September 25th. On October 7th, the petitioner complained of bilateral knee pain and requested Hyalgan injections for both knees, which was provided by Dr. Giannoulias. She received additional injections in both knees on October 21st and 28th. Dr. Munoz noted improvement with the petitioner's right thigh on October 30th and November 30th, but continued right knee pain and neck stiffness and soreness. The petitioner reported improvement with her cervical spine on February 5, 2014, and March 5th. Dr. Giannoulias noted on February 24, 2014, that the petitioner was doing pretty well without much knee pain. On April 7th, Dr. Giannoulias

gave the petitioner a cortisone injection in her right knee. Dr. Munoz noted continued right knee swelling, weakness and motion limitations on May 1st and cervical spine discomfort with side-to-side motion. She reported continued right knee and cervical symptoms to Dr. Munoz at monthly follow-ups from June 1, 2014, through February 11, 2016. The petitioner saw Dr. Ivankovich at Chicago Musculoskeletal Institute on January 25, 2016, who noted tenderness to palpation of her cervical and lumbar spine, a good cervical ROM, an excellent bilateral hip ROM and a valgus alignment of both knees with crepitation and lateral compartment tenderness.

The petitioner began receiving duty disability from the respondent in November of 2013. At the request of the respondent, the petitioner was evaluated on March 13, 2014, by Dr. Steven Mash. Dr. Mash opined that the petitioner sustained a temporary aggravation of her right knee condition and a cervical strain and may have suffered an acute PCL tear on April 3, 2013.

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

The medical care rendered the petitioner for her cervical spine, arms, and right knee and hip was reasonable and necessary and is awarded. The medical care rendered the petitioner for her left knee 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 the current condition of ill-being with her cervical spine and right knee is causally related to the work injury. The petitioner has consistently complained of cervical and right knee symptoms since her initial medical care on April 3, 2013, and has treated continuously

for her neck and left knee through January 25, 2016. Dr. Giannoulias opined that the petitioner needs a right total knee replacement. Dr. Mash's opinion that the petitioner sustained a temporary aggravation of her right knee condition and a cervical strain does not provide a sufficient medical basis to negate the petitioner's consistent and continuous right knee and cervical complaints. The petitioner sustained more than a temporary aggravation of her pre-existing left knee arthrosis.

FINDING REGARDING PROSPECTIVE MEDICAL CARE:

The petitioner proved that the right total knee replacement recommended by Dr. Giannoulias is reasonable medical care necessary to relieve the effects of the work injury. The petitioner is entitled to have from the respondent the reasonable and necessary cost for a right total knee replacement.

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jerry Wilder,

Petitioner,

vs. NO: 13 WC 32840

Abbate Screw Products, Inc./QBE Insurance Co.,

Respondent.

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DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses and nature and extent, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner, a 44 year old machinist, testified that he worked for Respondent as a working supervisor from early 2011 until September 2013. (T.7-8). He testified that on 9/16/12 he was having a problem with a multi-spindle machine and had to beat on it with a steel bar, weighing approximately 35 to 40 pounds and measuring 3.5' to 4' long, in order to remove a carrier. (T.8-10). He noted that it was a very big machine weighing approximately 17,000 pounds. (T.10). He indicated that while he was beating on the carrier to remove it he felt a little soreness in his right arm around his right elbow. (T.10). Petitioner is right handed. (T.11).

Petitioner testified that he continued working, but that his pain "... progressively kept getting worse. Pain radiating from [his] elbow down through [his] fingers. Pain, numbness, tingling. It became very sore." (T.11). He reported the injury to his supervisor, Jerry Suerth, who recommended that he go to Alexian Brothers to be examined. (T.11-12).

Petitioner testified that he visited Alexian Brothers on 10/16/12 with complaints of pain,

numbness radiating from his elbow to his hand and center two fingers, and difficulty using his right arm and hand. (T.12). Alexian Brothers personnel gave him ibuprofen and a brace and recommended light duty, or what he thought was a 5 to 10 pound restriction with his right arm. (T.13). He noted that Respondent was able to accommodate his restrictions. (T.13).

Alexian Brothers Medical Group records dated 10/16/12 contains the following history: "... [patient] reported that on 9/16/2012 while he was trying to break apart an old heavy machine with a bar weighing approximately 40 pounds back in the machine with the bar several times he started to have pain at the left [sic] elbow with irradiation to proximal forearm and wrist, he denies any tingling or numbness sensation. The pain is reported as a dull pain, on a scale from 0-10 a 5. However, he reports normal muscle strength or gripping and pinching." (PX1). Petitioner later testified that he did not injure his left elbow; thus, the above reference would appear to be in error. (T.30). The impression was left lateral epicondylitis. (PX1). Petitioner was prescribed ibuprofen and given work restrictions of no lifting, pushing or pulling anything over 20 pounds and limited repetitive movement with the right upper extremity, principally with flexion/extension of the elbow. (PX1).

Petitioner indicated that in November of 2012 he visited Alexian Brothers and was prescribed oral steroids, which did not help. (T.15). He agreed that on 11/9/12 he was released from his restrictions by Alexian Brothers and resumed full-duty work at Abbate. (T.15-16). Petitioner continued to work full-duty for Respondent from November of 2012 to February of 2013. (T.16). He noted that during that period he continued to have radiating pain from his elbow through his hand which were aggravated by "... anything where [he] had to lift anything heavy or carry things with [his] right hand." (T.16-17). He indicated that at home he would take ibuprofen when the pain got too bad. (T.17).

Petitioner testified that he returned to Alexian Brothers for ongoing right elbow pain in February of 2013. (T.17). He believed that they recommended work restrictions again and referred him to Dr. Donohue who recommended a course of physical therapy as well as a splint for his right elbow. (T.17-18). Petitioner believed he attended 24 therapy sessions from February through April of 2013, and that he was discharged from therapy on 5/2/13. (T.18).

Petitioner noted that in March of 2013 he was referred to Dr. Jeffrey A. Murray at Core Orthopedics in Schaumburg whom he saw on 4/1/13. (T.19). He indicated that at that time he was "... very sore, very sore. Pain [in the right elbow through the hand] was hard to deal with on a daily basis." (T.20). Dr. Murray recommended a steroid injection, for which he received temporary relief for one or two weeks. (T.20-21).

In a report dated 4/3/13, Dr. Murray recorded a history of "... beating a machine apart with a 40 pound bar" and that "[t]he pain started building slowly over a period of a couple of days." (PX2). Dr. Murray noted that "[t]he onset of the symptoms occurred on 08-15-2012. The injury is work related." (PX2). Petitioner denied suffering any injury to his right elbow in August of 2012. (T.30). He also denied experiencing any problems with or receiving treatment for his right elbow prior to the 9/16/12 incident, nor was he having any radiating pain from his elbow down into the two center fingers of his right hand prior to that date. (T.30-31). In addition, he did not have any restrictions regarding his right elbow that affected his ability to

work as a lead supervisor machinist prior to September of 2012, and he denied suffering another accident to his right elbow since the incident in question. (T.31). Dr. Murray found that Petitioner was suffering from lateral epicondylitis and administered a cortisone injection. (PX2).

Petitioner indicated that he returned to Dr. Donohue in May of 2013 at which time he was released to full duty. (T.21). He noted that he resumed full-duty work at Abbate in May of 2013. (T.21). He stated that he believed he left Abbate in September of 2013, after which he began working as a CNC machinist at Camcraft, his present employer. (T.21-22). Petitioner testified that "Abbate was old mechanical machines, cam driven machines where Camcraft is CNC computer and numerically controlled machines. Instead of physical pounding, beating, turning on the machines at Camcraft [he] [is] able to push buttons on a control panel. Significant difference." (T.22). He stated that "[a]t Abbate to make an adjustment to the machine there was always involved a hammer and a wrench. At Camcraft to make an adjustment to the machine [he] press[es] a button." (T.23). As a result, he agreed that the work is "significantly" less demanding at Comcast. (T.23).

Petitioner noted that he returned to Dr. Murray in December of 2013 with complaints of right elbow pain radiating through the right hand and fingers. (T.23). He testified that "[a]t that point [Dr. Murray] said there is no other conservative treatment, that he would recommend surgery." (T.23). However, prior to surgery, Dr. Murray gave him a PRP injection, or platelet rich plasma injection in February of 2014. (T.24). Petitioner noted that the results of this injection "... w[ere] temporary. It lasted a little bit longer than the steroid injection, but it was temporary, a few weeks to a month." (T.24).

In an office note dated 12/9/13, Dr. Murray recorded that Petitioner "... had a cortisone injection 8 months ago which gave him short term relief for only 2 months. Right side pain is severe with a rating of 9/10 with certain movements. Since the last visit there ha[ve] been no additional treatments ... [or] testing... He has switched jobs, but states doing repetitive motion activity certainly exacerbate his underlying pain... Symptoms are very similar to that he was experiencing months ago." (PX4). Following his examination, Dr. Murray noted that he felt Petitioner's symptoms "... are consistent with recurrent lateral epicondylitis picture. We discussed options, including cortisone injection or platelet Rich plasma injection... We also discussed the role of surgical management, but we will defer that at this time." (PX4).

Petitioner saw Dr. Murray on 2/5/14 at which time he received the previously recommended platelet rich plasma injection. (PX4).

Petitioner indicated that he returned to Dr. Murray in March of 2014. (T.24). In a report dated 3/5/14 Dr. Murray noted "... slight improvement in the symptoms since the last visit. He rates his pain 3/10... He did have his PRP injection on his last visit that gave him partial relief of symptoms. He had ongoing pain about the lateral aspect [of] the elbow. Pain does seem the [sic] worsened by activities... He is frustrated with his lack of improvement. Of note, he has recently changed jobs, doing less heavy lifting, pushing, and pulling. Feels this may have helped him, but as stated, his symptoms do persist..." (PX4). Following his examination, Dr. Murray noted that Petitioner's condition "[d]oes seem to be limiting him significantly from a functional standpoint. He has had significant pain despite conservative measures. I do feel that based upon the nature

of his symptoms, he would benefit from consideration of right elbow lateral condyle debridement, with dermal grafting. Had good success with this procedure for persistent symptoms, such as he is [sic] been experiencing... He will remain on the same work restrictions at this time." (PX4). Petitioner testified that he is still awaiting approval for this procedure. (T.25).

Currently, Petitioner noted that "[w]ith work today, if [he] pick[s] up anything too heavy or if [he] [is] not very careful in modifying the way [he] do[es] everything, the pain will still come back and radiate through [his] hand." (T.25). When asked what is too heavy, he noted "30, 40 pounds or more [he] begin[s] to feel pain and pulling." (T.25-26). As far as any changes are concerned with respect to his activities, Petitioner testified that "[e]very day it's a constant thought to how [he] can do something – [he's] right-handed, so without using [his] right arm for everything. [He] lean[s] more toward using [his] left hand to do most work." (T.26). He noted that he "... use[s] [his] left arm a lot more than [he] used to." (T.27). He indicated when he does household chores with his right arm such as "... working the flower beds, picking up a [filled] mug with [his] right arm [it] hurts. When [he] pick[s] up [his] granddaughter." (T.27). He noted that his granddaughter is a little over three years old and weighs 25 to 30 pounds. (T.27). Petitioner stated that "[e]ven shaking the water out of a toothbrush, [he] feel[s] pulling through [his] arm..." (T.27-28). He indicated that he continues to experience radiating pain from the elbow into the hand and into the two center fingers, and that he experiences this "[p]robably weekly to biweekly." (T.28). He noted that if the pain is significant he'll take ibuprofen. (T.28).

On cross examination, Petitioner indicated that he had worked for Abbate as a machinist for maybe 22 years. (T.32). He stated that he had immediate pain after the accident on 9/16/12 and that the pain was the result of "... pounding on the machine, that part of the machine to remove it, that one event..." (T.32-33). He noted that the "... pain had started while [performing that activity], but it wasn't a significant pain until later while [he] was doing it later on." (T.33). He indicated that it was not one particular strike where he felt immediate pain, but that he knew immediately in his mind what caused the pain. (T.33).

Petitioner testified that the increase in pain that he complained about to his doctor at the time of his visit in February of 2013 was caused by "[j]ust using [his] arm." (T.33-34). He indicated that he felt the increase in pain while using his arm "with everything", including at home and at work. (T.34). He agreed that he continued to work full-duty for Respondent after his release by Dr. Donohue in May of 2013, and that he started working for his current employer in September. (T.34). He noted that his wages are more at his current employer and that the job is less physical in comparison to the job with Respondent. (T.35-36). Petitioner indicated that his medical bills were not paid while he worked for Respondent, but that he has not received any bills in the mail recently, specifically in 2015. (T.35-36).

Petitioner believed that he last saw Dr. Murray in March of 2014. (T.36). He indicated that he has not seen any other treaters for his elbow since that time. (T.36). However, he did see Dr. Vender at the insurance company's request on 10/27/14. (T.36). When asked whether his symptoms have been constant since the accident, Petitioner responded: "[t]he pain is always there. Sometimes it gets stronger, sometimes it gets less pain." (T.37). He noted that "... if [he] pick[s] up anything too heavy like picking up [his] granddaughter, if [he] [is] not careful how

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[he] pick[s] her up. Anything where [he] ha[s] to use a lot of strength in [his] hand [he] can feel pain going through [his] elbow into [his] fingers." (T.37). He stated that the radiating pain he feels is in "[t]he middle two fingers mainly", and that he sometimes experiences numbness and tingling in those fingers. (T.37-38). Petitioner also reiterated that he did not lose any time from work as a result of the accident. (T.38). On re-direct, Petitioner agreed that when he returned to Dr. Donohue in February of 2013 he was working for Abatte. (T.38-39).

At the request of Respondent, Petitioner visited Dr. Michael Vender on 10/27/14 for purposes of a §12 examination. (RX1). Dr. Vender testified that he is board certified orthopedic surgeon with an added qualification in surgery of the hand. (RX1, p.5). Following his examination and review of the records, Dr. Vender diagnosed Petitioner with residuals of right elbow lateral epicondylitis. (RX1, p.9). Dr. Vender noted that "[t]he way [he] understood [Petitioner's] symptoms is that when [he] saw him in October of 2014 it was just an ongoing remnants [sic], so to speak, of his injury in September of 2012" and that Mr. Wilder had reached MMI. (RX1, pp.9-10). Dr. Vender indicated that Petitioner "... was at a stable level. He was at a satisfactory level and [he] did not think [Mr. Wilder] needed further treatment." (RX1, p.10). In addition, Dr. Vender stated that he did not think Petitioner would be a surgical candidate. (RX1, p.10). When asked about the treatment to date, Dr. Vender indicated that he thought "... it was reasonable... and necessary, though, [he] d[id]n't necessarily agree with the use of platelet injections, which is why [he] recommended [he] wouldn't use them again in the future... [b]ecause there is no scientific basis for using them. [He] should say no scientific basis, there is theoretical scientific basis, but it has never been shown to be of any benefit." (RX1, pp.10-11).

Dr. Vender testified that "[w]hen I saw [Petitioner] he had a low-level of symptoms. The surgical treatment for lateral epicondylitis is very unpredictable. There are many conditions we treat in the upper extremity that are very predictably successful, things like carpal tunnel and trigger fingers... Lateral epicondylitis in the best of hands, that is, hand surgeons, people who do this for a living, have unpredictable results. Some people do great, some people do badly, most people are in between. So to get a good result it could take somebody, I'm just going to make up some numbers, somebody who is suffering at a level of eight out of ten pain, and their life is truly impaired, if you can bring that person down to a three or four, that's a good result. Now, a three out of four for someone like you who has no symptoms, that would be annoying. But for someone who is an eight out of ten to end up at three or four, that's a big improvement. Well, where he is now is already at a level that I would consider good for surgery. So he's got little margin for improvement and little likelihood of improvement, but actually a potential down side. Or to say it another way, the risks outweigh the benefits." (RX1, pp.11-12).

On cross, Dr. Vender indicated that it "appears" Petitioner's condition of right lateral epicondylitis was proximately caused by the accident in September of 2012. (RX1, pp.21,23-24). He also noted that "relatively speaking", compared to other upper extremity injuries that he sees, Petitioner's prognosis was more guarded. (RX1, p.21). He also agreed that this is the type of injury that can wax and wane, and that it's common to have improvement in the condition followed by exacerbations. (RX1, pp.21-22). Likewise, he agreed that the condition can be chronic and difficult to completely eradicate, and that the ongoing symptoms he would experience would principally be pain in the extremity. (RX1, pp.22-23). As far as future treatment recommendations, Dr. Vender testified that Petitioner "... may go through another

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course of occupational therapy. He may want to use a forearm band for support. He may want to take some anti-inflammatory medication. He may have a steroid injection." (RX1, p.30).

Based on the above, and the record taken as a whole, the Commission modifies the award of the Arbitrator to find that Petitioner was permanently partially disabled to the extent of 10% loss of use of the right arm pursuant to §8(e)10 of the Act. In support of this holding the Commission notes the following with respect to the five (5) factors enumerated in §8.1b of the Act:

1) Neither party submitted an AMA impairment rating;

2) Petitioner's occupation continues to be that of a machinist, albeit for a different employer working on newer, computer-controlled machines which he noted were "significantly" less physically demanding than the machines he used while working for Respondent;

3) Petitioner was 44-years-old at the time of the injury;

4) Petitioner earns more in his current position than he did for Respondent, and otherwise presented little if any evidence to show that his future earning capacity has been diminished or adversely impacted as a result the injury;

5) Petitioner has been diagnosed with right lateral epicondylitis and underwent conservative treatment in the form of splinting, physical therapy and injections, including a cortisone injection as well as a platelet rich plasma injection, with only short-term relief of his symptoms; Dr. Murray recommended possible surgical intervention consisting of right elbow lateral condyle debridement with dermal grafting which Dr. Vender questioned and which the Arbitrator ultimately denied; Petitioner was released to return to full-duty work in May of 2013 and has continued to work in that capacity since that time; currently, he complains of pain when he picks up items that are too heavy and notes that he now finds himself using his left arm more in order to perform everyday activities, both at home and at work; he also noted that he continues to experience radiating pain from the elbow of his right arm into his right hand and into the two center fingers, and that he experiences this weekly to bi-weekly; Petitioner has not treated with any physician for his right elbow condition since he last saw Dr. Murray on 3/5/14; he indicated that he currently takes ibuprofen when the pain is significant.

Based on the above, and the record taken as a whole, the Commission finds that Petitioner sustained the loss of use of 10% of his right arm pursuant to §8(e)10 of the Act.

Furthermore, the Commission finds Petitioner is entitled to reasonable and necessary medical expenses as set forth in PX5 and PX6 pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act. The Commission removes from the Arbitrator's decision references to balances due as a basis for this award, and notes that Respondent's liability rests instead on the fee schedule amounts relating to services provided by each provider, with a credit to Respondent for any and all amounts paid on account of this injury.

Finally, the Commission notes a clerical error on the first page of the Arbitrator's decision wherein the assigned county is shown as "Cook." The Commission hereby corrects this reference to show the assigned county as "Kane."

All else is otherwise affirmed and adopted.

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IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 12/8/15 is modified as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 per week for a period of 25.3 weeks, as provided in §8(e)10 of the Act, for the reason that the injuries sustained caused the loss of use of 10% of the right arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical expenses as set forth in PX5 and PX6 pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $22,000.00. 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: APR 4 - 2017
o:11/1/16
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILDER, JERRY
Employee/Petitioner

Case# **13WC032840**

ABBATE SCREW PRODUCTS INC QBE INSURANCE CO
Employer/Respondent

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On 8/20/2015, 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 0.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1876 PAUL W GRAUER & ASSOC
CZAPLA, EDWARD ADAM
1300 E WOODFIELD RD SUITE 205
SCHAUMBURG, IL 60173

0210 GANAN & SHAPIRO PC
JOSEPH P BRANCKY
210 W ILLINOIS ST
CHICAGO, IL 60654

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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- [ ] 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

JERRY WILDER
Employee/Petitioner
v.
ABBATE SCREW PRODUCTS, INC.;,
QBE INSURANCE CO.
Employer/Respondent

Case # 13 WC 32840

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable JESSICA A. HEGARTY, Arbitrator of the Commission, in the city of ELGIN, on April 24, 2015. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [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: Prospective Medical Treatment?

FINDINGS

On **9/16/12**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**72,800** the average weekly wage was $ **1,400**.

On the date of accident, Petitioner was **44** years of age, ***married*** with **1** dependent children.

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

Respondent 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.

FINDINGS OF FACT AND CONCLUSIONS OF LAW ARE ATTACHED.

ORDER

- Respondent is ordered to pay Petitioner permanent partial disability benefits, as provided in Section 8(e)(10) of the Act in accordance with the Arbitrator's finding that the Petitioner has suffered a **20%** loss of an arm.

- The Arbitrator finds the medical treatment, including the PRP injection, administered to the Petitioner and contained in Px. 5 and Px. 6 was reasonable and necessary. The Arbitrator finds that Respondent shall pay the reasonable and necessary medical expenses (Px. 5 and Px. 6) incurred in the care and treatment of Petitioner's right elbow pursuant to the medical fee schedule and Section 8 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

7/11/15
Date

AUG 2 0 2015

IN THE WORKERS' COMPENSATION COMMISSION
OF THE STATE OF ILLINOIS

JERRY WILDER, Petitioner,	)	**17IWCC0202**
v.	)	
	)	
	)	Case No: 13 WC 32840
ABBATE SCREW PRODUCTS, INC.,	)	Arbitrator Hegarty
QBE INSURANCE CORP.	)	
Respondent.	)	

ADDENDUM TO THE DECISION OF ARBITRATOR

This matter proceeded to hearing pursuant to §19B of the Illinois Workers' Compensation Act (the "Act") on April 24, 2015, before Arbitrator Jessica A. Hegarty in Elgin, Illinois.

The issues in dispute are:

- Causal connection;
- Unpaid medical bills;
- Prospective medical treatment;
- Nature and extent of the injury. (Arb. 1).

STATEMENT OF FACTS

Petitioner was employed by the Respondent as a machinist beginning in 2011.

On September 16, 2012, Petitioner was involved in an undisputed accident while operating a 17,000 pound, multi-spindle machine which began locking up. In an effort to free up the machine, Petitioner employed a 3 ½ foot long, 40 pound steel bar and began beating on the machine. Petitioner testified that during the course of this activity, he noticed soreness in his right elbow. As he continued working, his elbow pain increased, accompanied by numbness, tingling and radiating pain.

Following the accident, Petitioner continued working his full duty position. He testified that he eventually reported his accident to his supervisor, Jerry Suerth, who instructed him to report to Alexian Brothers for evaluation.

On October 16, 2012, Dr. William Sandoval noted Petitioner's reports of left elbow pain that radiated to his proximal forearm. He denied any numbness or tingling. (PX1). On exam, the doctor noted tenderness on the lateral epicondyle

at the insertion of the extensor muscle of the forearm. Dr. Sandoval diagnosed Petitioner with left lateral epicondylitis, issued light duty work restrictions and advised to take ibuprofen. (PX. 1).

On October 19, 2012, Alexian Brothers medical records note Petitioner's complaints of right elbow pain. He was issued a splint with modified work restrictions of 3-5 pounds lift, carry, push, pull and was advised to undergo occupational therapy. (PX. 1).

On October 25, 2012, Alexian Brothers medical records note Petitioner's right elbow pain complaints ranging between 1-7 on a 10 point scale with difficulty gripping and grabbing. (PX. 1). A Prednisone Dose Pak was prescribed and the work restrictions were continued. (Id.).

On November 2, 2012, Alexian Brothers records reflect that Petitioner presented with continued right elbow complaints ranging between a 0-2/10. (Id.).

On November 9, 2012, Petitioner was released from medical care and advised to return to full duty work. (PX1).

Petitioner testified that Respondent accommodated his work restrictions and that he returned to full duty work after his November 9, 2012, release,

Petitioner testified to experiencing another onset of right elbow pain with work and home activities in early 2013.

On February 4, 2013, Alexian Brothers records note Petitioner's reports of an onset of right elbow pain 4 weeks prior. Petitioner was issued light duty work restrictions. (Id.). The next day, Petitioner was seen by Dr. Donohue at Alexian Brothers who issued a prescription for Naprosyn, and advised that Petitioner begin physical therapy. (Id.).

On February 7, 2013, Petitioner began a course of physical therapy at ATI (PX. 3). Petitioner reported pain at a 9/10 during activity. He also reported decreased grip ability and an inability to accomplish the following tasks: pick up and drink a glass of water, turning/twisting tools, lifting over 30 pounds, clicking a mouse, computer work, sleeping, brushing his teeth, cutting food and opening/closing drawers. The physical therapist noted grip strength deficit in the right elbow at 90 degrees.

On March 21, 2013, the physical therapist from ATI completed a progress note, noting pain complaints at a 6/10. Petitioner reported that he still had difficulty gripping, turning/twisting tools, lifting over 30 pounds, clicking a mouse, brushing his teeth and opening/closing heavy doors. (Id.). It was noted that Petitioner had completed 19 physical therapy visits to date. (Id.).

On March 28, 2013, ATI completed a discharge summary noting that Petitioner had shown improvement in his strength and grip but that he continues to have pain during gripping and wrist extension. (Id.). Pain level with activity was reported at a 6/10 with activity. Current limitations were noted to be: gripping, picking up more than 10 pounds, turning/twisting tools, lifting over 30 pounds, clicking a mouse, computer work, brushing his teeth and opening and closing heavy doors. The therapist recommended that Petitioner wear his brace at work. Petitioner reported that if he did so, the brace would become saturated with oil. Petitioner was discharged from physical therapy for "further investigation of symptoms." (Id.).

On April 1, 2013, Petitioner consulted with Dr. Jeffrey Murray at Core Orthopedic who noted complaints of "intermittent, constant, burning, sharp, stabbing and aching" pain at 9/10. (PX4). Upon exam, Dr. Murray noted "marked lateral epicondyle tenderness" as well as "restriction of elbow motion." (Id.). The doctor further noted Petitioner tested "positive for resisted wrist test and that dorsiflexion wrist causes pain in the area of the lateral epicondyle." (Id.). Dr. Murray's impression was lateral elbow epicondylitis. The doctor injected Petitioner's right lateral epicondyle with cortisone and advised him to resume physical therapy. (Id.).

On April 8, 2013, Petitioner resumed physical therapy at ATI who noted his report of improvement after the cortisone injection. Petitioner reported his pain was at 0/10 at rest, and 1/10 with activity. (PX. 3).

On May 2, 2013, Petitioner was discharged from ATI after he reported that he was pain free. (Id.).

On May 8, 2013, Petitioner returned to Dr. Donohue and reporting he was "100% better." (PX2).

On December 9, 2013, Petitioner presented to Dr. Murray with right elbow pain complaints at a 9/10. The doctor noted that Petitioner "had a cortisone injection 8 months ago which gave him short term relief for only two months." (PX 4). Dr. Murray noted that Petitioner had no treatment or care since the cortisone injection in April of 2013. Dr. Murray diagnosed "recurrent lateral epidcondylitis" and recommended a platelet rich plasma ("PRP") injection (Id.).

On February 5, 2014, Dr. Murray performed a PRP injection to Petitioner's right elbow. (Id.).

On March 5, 2014, Petitioner presented to Dr. Murray reporting ongoing pain about the lateral aspect of the elbow especially with activity. Petitioner reported partial improvement after the PRP injection with lingering symptoms. (Id.) The doctor noted that Petitioner had recently changed jobs and was doing less heavy lifting, pushing and pulling and that Petitioner felt this change in jobs may have helped him. (Id.). Petitioner rated his pain at a 3/10. (Id.) On exam, Dr. Murray

noted restriction in elbow range of motion, positive resisted wrist test and pain in the lateral epicondyle with dorsiflexion. (Id.). Dr. Murray recommended an open lateral condyle debridement or lateral fasciotomy based on the fact that Petitioner was still experiencing pain despite conservative measures. (Id.). Petitioner last saw Dr. Murray on March 5, 2014. (Id.).

Petitioner testified that he continued working full duty for Respondent until September of 2013 when he left for a higher paying job as a CNC machinist at CamCraft. According to Petitioner's testimony, CamCraft uses newer computer-operated machines in contrast to Respondents older, manual machines. He testified that operating the newer machines involved pushing buttons and was less physical than his job with Respondent.

Petitioner still works full time, full duty, as a machinist at CamCraft. He testified he earns more now than when he was employed by the Respondent

According to Petitioner, he did not miss any work as a result of his accident.

He testified that currently, his pain increases if he lifts greater than 30-40 pounds. He has numbness that radiates to his two middle fingers. He further testified that picking up a mug, shaking out a toothbrush and picking up his granddaughter causes pain to his right arm. According to his testimony, he constantly thinks about how to avoid using his right arm in his activities of daily life. He takes ibuprofen for pain and performs home exercises consisting of stretching.

Petitioner testified he wants the surgery recommended by Dr. Murray.

Dr. Vender's IME and Evidence Deposition

On October 27, 2014, Petitioner presented to Dr. Michal Vender of Hand to Shoulder Associates for a Section 12 Independent Medical Examination ("IME") at the request of Respondent. (RX 2). Upon exam, Dr. Vender noted normal range of motion in Petitioner's right elbow. Further exam revealed lateral elbow pain with firm grip, only with the elbow extended. The doctor also noted minor tenderness to palpitation of the extensor origin adjacent to the lateral condyle. *(Id.)*

Dr. Vender diagnosed Petitioner with right elbow lateral epicondylitis. (Id.). Dr. Vender's report further notes:

> *Mr. Wilder was appropriately diagnosed with lateral epicondylitis. The prognosis for lateral epicondylitis is more guarded than many types of conditions treated in the upper extremity. As noted above, it can persist for a very long period of time. However, very frequently the symptoms can be controlled to a satisfactory level. (Id.).*

With respect to whether Petitioner's current condition is related to the September, 2012 work accident, Dr. Vender opined that Petitioner's "current condition can be considered a remnant or continuation of his initial diagnosis of lateral epicondylitis." (Id.).

On the issue of whether Petitioner was at maximum medical improvement ("MMI), the doctor opined that "he could be considered as having reached maximum medical improvement. However, it is possible that his low level of symptoms noted now may increase in the future." (Id.).

With respect to prospective medical, Dr. Vender did not agree that Petitioner was a surgical candidate given his current level of symptoms. (Id.). The doctor did not recommend PRP injections in the future as there "are no indications that this type of treatment will provide benefit." (Id.). The doctor was of the opinion that Petitioner does not need any further treatment. (Id.).

The parties took the evidence deposition of Dr. Vender on January 16, 2015. (RX 1). The doctor testified he examined Petitioner on October 27, 2014, and noted pain with a firm grip and with his elbow fully extended. (Id. at 8). Petitioner related to Dr. Vender that he had significant improvement in his symptoms since the onset, and that he only had occasional pain in the lateral aspect of the right elbow. (Id. at 7). Dr. Vender diagnosed Petitioner with residuals of right elbow lateral epicondylitis. He testified it is common for someone with that diagnosis to have exacerbations and remission, or to have a separate episode in the future. (Id. at 9). Dr. Vender testified lateral epicondylitis can have a traumatic, repetitive, or unknown onset. (Id. at 13).

According to Dr. Vender's testimony, Petitioner is not a surgical candidate. (Id. at 10). Dr. Vender opined that surgery to address lateral epicondylitis has unpredictable results even in the care of the best orthopedic hand surgeon. (Id. at 12). According to the doctor, surgery can cause nerve damage and/or injury to the lateral collateral ligament. (Id. at 27-8). He testified that surgery is indicated where someone has a high level of pain complaints, such as 8/10, as the risk of surgery is outweighed by the reward of potentially reducing the pain to 3-4/10. (Id. at 12). As Petitioner has a low level of pain, the doctor does not believe the benefits outweigh the risks. (Id.).

With respect to non-surgical, prospective care, the doctor recommended conservative measures (i.e., occupational therapy, forearm band for support, or anti-inflammatory medications) to treat an increase in symptoms. (Id. at 30). The doctor opined that Petitioner had reached MMI as a result of his work accident given the current level of his symptoms. (Id. at 10).

On the issue of whether the medical care and treatment that Petitioner had received to date was reasonable and necessary Dr. Vender testified that the physical therapy that Petitioner received at ATI was reasonable and necessary. (Id. at 29). Although the doctor did not agree with the use of PRP injections and

would not recommend them for Petitioner's future care, he did agree that the PRP injections administered by Dr. Murray were reasonable and necessary. (Id.). He further agreed to the overall reasonableness and necessity of Petitioner's care and treatment with Dr. Murray at Core Orthopedic. (Id.)

Dr. Vender further testified that pain is the principal symptom that a patient with lateral epicondylitis would experience and that complaints of numbness, loss of range of motion, and swelling are inconsistent with the condition. (Id. at 22).

CONCLUSIONS OF LAW

Causal Connection

It is undisputed that Petitioner injured his right elbow while working for the Respondent on September 16, 2012. The Arbitrator notes there is no evidence contained in the record of a right elbow injury or complaints of right elbow pain prior to the work injury at issue. Petitioner was working full duty as a machinist at the time of the injury. Petitioner treated for one month and after a three month remission, began treating again from February of 2013 to May of 2013. After a seven month remission, he began treating again in December of 2013 to March of 2014. Since that time, Petitioner has not sought any care, has worked his full duty job, but remains symptomatic.

Dr. Vender opined that Petitioner's right lateral epidcondylitis was proximately caused by the September 16, 2012, work injury and that his current condition is a continuation of that initial lateral epicondylitis injury. (Rx. 1, p.21 and 24). On the issue of whether Petitioner was at MMI the doctor opined in his report that although he could be considered as having reached maximum medical improvement although "it is possible that his low level of symptoms noted now may increase in the future". (Id.). Dr. Vender testified that Petitioner's symptoms will wax and wane over time and can be chronic and difficult to completely eradicate. (Rx. 1, p8, 21-22). According to Dr. Vender, the prognosis for Petitioner remains "guarded". (Id. p.21-22).

Based on the credible medical evidence contained in the record, including Dr. Murray's treating records as well as Dr. Vender's IME report and evidence deposition, the Arbitrator finds that Petitioner's right elbow condition, diagnosed as lateral epicondylitis, is causally related to his September 16, 2012, work injury.

Medical Bills

Petitioner's Exhibit 5 consists of certified records, dated November 21, 2013, from ATI Physical Therapy. Contained therein is a multi-page document entitled "Patient Statement Inquiry" that lists dates of service from February 7, 2013, through March 28, 2013. CPT codes for various physical therapy treatments are

listed for each date along with the units and the amount charged for the various services. The Arbitrator cross-referenced Petitioner's Exhibit 5 with Petitioner's Exhibit 3, which are the certified treatment records from ATI Physical Therapy. Both exhibits evidence treatment and billing for 22 physical therapy sessions between February 7, 2013 and March 28, 2013, after which he was discharged.

Petitioner's Exhibit 5 indicates:

Total charges on the account:	$12,012.94
Total payments on the account:	$5,605.11
Total discounts on the account:	$4935.48
Balance due:	**$1472.35**

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Petitioner's Exhibit 5 contains another list of charges for care at ATI from April 8, 2013 through May 2, 2013. Petitioner's Exhibit 3 establishes that Petitioner attended 8 physical therapy sessions during this time period. For that time period, Petitioner's Exhibit 5 indicates a balance due of:

$734.88

Petitioner's Exhibit 6 contains certified treatment records from Core Orthopedics. Contained therein is a "Transaction History Report," printed on April 23, 2014, indicating charges for dates of services from April 1, 2013, through March 5, 2014. Exhibit 6 indicates a balance due of:

$2,550.80

Based on the Arbitrator's finding of a causal connection and Dr. Vender's testimony that the physical therapy and medical treatment at Core Orthopedics, including the PRP injection, was reasonable and necessary, the Arbitrator finds that Respondent is liable and shall pay the medical expenses contained in Px. 5 and Px. 6 that were incurred in the care and treatment of Petitioner's right elbow pursuant to the medical fee schedule and Section 8 and 8.2 of the Act.

Prospective Medical Treatment

On March 5, 2014, Petitioner last saw Dr. Murray. (PX4). At that time, Dr. Murray recommended an open lateral condyle debridement or lateral fasciotomy as Petitioner "had significant pain despite conservative measures." (Id.). The Arbitrator notes that Dr. Murray noted Petitioner had pain at only 3/10 that day. (Id.). Although Petitioner had frequently treated in the past when he had only low levels of pain, Petitioner sought no further care beyond this date and has continued to work full duty.

Dr. Vender noted there are two types of surgery typically used to treat serious cases of lateral epicondylitis: arthroscopy or open debridement. (RX1 at 26). Dr. Vender testified there is greater risk of nerve injuries with an arthroscopy, and greater risk injuring the lateral collateral ligament with an open debridement. (RX1 at 28). According to the doctor, surgery to address lateral epicondylitis has

unpredictable results even in the care of the best orthopedic hand surgeon. (RX1 at 12). He further explained that surgery can cause nerve damage or injury to the lateral collateral ligament. (RX1 at 27-8). He testified that surgery is indicated where someone has a high level of pain complaints, such as 8/10, as the risk of surgery is outweighed by the reward of potentially reducing the pain to 3-4/10. (RX1 at 12). However, as Petitioner already had a low level of pain, the risks of such a surgery were not justified. (Id.).

Based on the above, the Arbitrator finds Petitioner is not a candidate for surgery as he does not exhibit the condition of ill-being that would warrant surgical intervention. The Arbitrator finds Dr. Vender's explanation credible, especially in conjunction with Petitioner's low level of pain complaints.

Nature and Extent of Petitioner's Injury

Petitioner testified that when he lifts weights he experiences pain in his right arm, he cannot lift more than 30 pounds without significant pain. Petitioner further testified that activities such as picking up a mug, shaking out a toothbrush and picking up his granddaughter causes pain to his right arm. According to his testimony, he constantly thinks about how to avoid using his right arm in his activities of daily life. He takes ibuprofen for pain and performs home exercises consisting of stretching.

The Arbitrator carefully scrutinized the Petitioner during his testimony and found him to be a credible witness. His demeanor at the hearing appeared relaxed, unaffected, open and earnest.

On the issue of permanency the Arbitrator founds Dr. Vender's testimony compelling. The doctor testified he examined Petitioner on October 27, 2014, and noted pain with a firm grip and with the elbow fully extended. Dr. Vender diagnosed Petitioner with residuals of right elbow lateral epicondylitis and testified that it is common feature of that condition is that an individual can have exacerbations and remission, or to have a separate episodes in the future. He further testified that symptoms will wax and wane over time and can be chronic and difficult to completely eradicate. (Rx. 1, p8, 21-22). According to Dr. Vender, his prognosis for Petitioner remains "guarded". (Id. p.21-22).

5 Factors of Section 8.1b

Pursuant to Section 8.1b of the Act, the following criteria and factors must be considered in assessing permanent partial disability:

> *(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally*

appropriate measurements of impairment that include, but are not limited to: loss of range of motion, loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:

(i) The reported level of impairment as assessed pursuant to the current edition of the 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.

The Act provides that no single enumerated factor shall be the sole determinant of disability.

With respect to Section 8.1b(i), the Arbitrator notes that neither party submitted a report regarding the level of impairment pursuant to the AMA guidelines.

Regarding factor (ii), the Arbitrator finds that the Petitioner is employed as a machinist working for a different employer at a less physically demanding level than he was pre-injury. The Arbitrator therefore gives less weight to this factor.

Regarding factor (iii), the Petitioner's age, the Arbitrator notes that the Petitioner was 44-years-old at the time of the injury. The Arbitrator finds that because of Petitioner's relatively young age at the time of this injury, greater weight should be accorded to this factor.

In terms of factor (iv), the employee's future earning capacity, the Arbitrator notes Petitioner's testimony that he earns more at Camcraft than he did for Respondent. The Arbitrator finds no evidence that the Petitioner's disability has had any impact upon his future earning capacity and therefore gives this factor no weight.

Regarding factor (v), the record reveals that Petitioner was diagnosed with lateral epicondylitis which has been treated conservatively with physical therapy and injections. The Arbitrator notes that Petitioner participated in 22 physical therapy visits between February 7, 2013 and March 28, 2013. Also noted were his reports of an inability to turn/twist tools, lift over 30 pounds, click a mouse,

brush his teeth and open and close heavy doors were noted. Petitioner was noted to wear a brace which the physical therapist recommended he wear at work. Petitioner reported that he could not wear the brace at work because it would become saturated with oil. Petitioner reported his pain during activities to be a 6/10 at his March 28, 2013, discharge appointment.

Petitioner then began treating with Dr. Murray (on April 1, 2013) who noted complaints of "burning, sharp, stabbing, aching pain". The doctor found marked tenderness at the lateral epicondyle and advised him to resume physical therapy. Between April 8, 2013, and May 2, 2013, Petitioner participated in 8 physical therapy sessions. He was discharged after he reported significant improvement following a cortisone injection administered by Dr. Murray.

Seven months following that cortisone injection, Petitioner returned to Dr. Murray with pain complaints at a 9/10. Petitioner reported that the cortisone injection had only provided relief for two months. Dr. Murray diagnosed Petitioner with recurrent lateral epicondylitis and performed a PRP injection on February 5, 2014 after which, Petitioner continued to report ongoing pain causing Dr. Murray to issue a surgical recommendation.

Because the treating medical records contain findings corroborative of Petitioner's disability, the Arbitrator therefore gives greater weight to this factor.

Based on the foregoing, and the record considered as a whole, the Arbitrator finds that Petitioner is entitled to permanency in the amount of loss of use of **20% of the right arm.**

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

MANUEL HERNANDEZ,

Petitioner,

vs. NO: 13 WC 33408

SOUTHWEST AIRLINES,

17IWCC0204

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of an evidentiary ruling regarding the AMA impairment rating raised at the deposition of Dr. Frank Phillips, Respondent's Section 12 examiner, as well as the issue of nature and extent, 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.

Specifically, the Commission writes to clarify the Arbitrator's Decision relative to the AMA impairment rating report. In admitting the AMA impairment rating report of Dr. Phillips, the Arbitrator reviewed his deposition testimony and the objections raised therein. The Arbitrator had no issue with the thoroughness of the history or format of the report and admitted said report into evidence. She did not specifically comment on Petitioner's objection.

17IWCC0204

Petitioner filed timely review and a Statement of Exceptions wherein he argued he was disadvantaged because he was not provided with the foundational basis of Dr. Phillips' impairment rating. His argument was subsequently raised during oral arguments on March 7, 2017. Accordingly, the Commission writes to address the arguments raised.

Petitioner contends that the Arbitrator erred in admitting Dr. Phillips' report because it did not comply with the alleged mandatory provisions of the AMA Guidelines in assessing an impairment rating, namely Chapter 2, page 28, Section 2.7 of the AMA Guides. (RX1, Petitioner's Deposition Exhibit #5). Section 2.7 of the AMA Guides provides a three-step process in order to estimate impairment: (1) clinical evaluation, (2) analysis of the findings, and (3), a discussion of how the impairment rating was calculated. Under the third criteria, the rater is required to explain "each impairment value with reference, including pages and table number, to the applicable criteria of the *Guides*."

The Arbitrator admitted the report into evidence relying, in part, on the wording in Section 8.1(b) of the Act, and noted any AMA impairment rating was but one factor in determining the nature and extent of Petitioner's condition. Section 8.1(b)(a) of the Act states:

> 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. 820 ILCS 305/8.1(b)(a).

Dr. Phillips' report stated the following as to the impairment rating:

> Impairment Rating (AMA 6th Edition)
>
> Diagnosis: Lumbar radiculopathy with surgery
> Class 1 Default Rating 7%
> FHA: Pain with normal activity: Grade 2 Modifier
> PEA: No tension signs: Grade 0 Modifier
> CSA: Degenerative changes clinically significant: Grade 2 Modifier
> (2-1) + (0-1) + (2-1) = +1
> IR: 8% (RX1, Respondent's Deposition Exhibit #2).

Dr. Phillips' report and testimony are consistent with the criteria set forth in the AMA Guides as well as in Section 8.1(b)(a), except the report lacks page and table numbers. Dr. Phillips' report and his testimony showed he relied on the Sixth Edition of the AMA Guides. (RX1, pg. 18; RX1, Respondent's Deposition Exhibit #2). Dr. Phillips explained in detail how he used the AMA Guides to reach his impairment rating. (RX1, pgs. 19-26). He also explained the lack of page and table numbers. "[T]his is obviously all taken directly from the AMA, Sixth Edition book. I don't have the ability to memorize this. Every time I do it I'm using the tables we just went through, otherwise I'd have no way of doing this or even remembering these numbers or ratings." (RX1, pgs. 24-25).

Petitioner also argued he was "surprised and disadvantaged" because he was not provided with the foundational basis of Dr. Phillips' impairment rating. Petitioner relied on the so-called "48-hour rule," found in Section 12 of the Act, as well as Ghere v. Indus. Comm'n, 278 Ill. App. 3d 840 (4th Dist. 1996), in support of his position. Section 12 of the Act states:

> In all cases where the examination is made by a surgeon engaged by the employer, and the injured employee has no surgeon present at such examination, it shall be the duty of the surgeon making the examination at the instance of the employer to deliver to the injured employee, or his representative, a statement in writing of the condition and extent of the injury to the same extent that said surgeon reports to the employer and the same shall be an exact copy of that furnished to the employer, said copy to be furnished the employee, or his representative as soon as practicable but not later than 48 hours before the time the case is set for hearing. 820 ILCS 305/12.

Petitioner acceded at oral arguments before the Commission that Dr. Phillips' report was timely tendered to him at least a month prior to Dr. Phillips' deposition. Therefore, Petitioner's argument is injudicious.

In Ghere, the Appellate Court found that the "48-hour rule" applied to the claim and struck the physician's deposition testimony, wherein the physician testified to circumstances outside his records. The Appellate Court stated:

> It appears from the record that the employer in the present case had Dr. Climaco's medical reports more than 48 hours before the arbitration hearing. However, the portion of Dr. Climaco's testimony to which the employer objected was Dr. Climaco's opinion regarding whether the decedent's work activities and the work environment could or might have precipitated the decedent's heart attack. Dr. Climaco's opinion on whether the decedent's work

> activities and the work environment could have precipitated the decedent's heart attack goes well beyond what is in his records. There is absolutely no mention in Dr. Climaco's records of his opinion regarding whether the decedent's activities or the work environment could have precipitated the decedent's heart attack. Dr. Climaco's records do not mention that he ever treated the decedent for a heart condition. There was nothing in Dr. Climaco's records to put the employer on notice that Dr. Climaco had an opinion regarding causal connection which the employer could have requested. Therefore, the arbitrator was correct in sustaining the employer's objection to Dr. Climaco's testimony regarding the above matters. Ghere v. Indus. Comm'n, 278 Ill. App. 3d 840, 846 (4th Dist. 1996).

The Commission finds that Dr. Phillips' deposition testimony was well within what was contained in his report. The Commission further notes that the impairment rating report listed everything Dr. Phillips considered to determine the impairment rating, including the medical records offered by Petitioner at arbitration and the AMA, Sixth Edition book. Petitioner was not surprised or disadvantaged, but instead, had ample notice as to the basis of Dr. Phillips' impairment rating. Further, and more importantly, Petitioner's counsel had the opportunity to cross-examine Dr. Phillips as to his findings and conclusions, and did so extensively. (RX1, pgs. 77-86).

For example, at Dr. Phillips' deposition, Petitioner's counsel and Dr. Phillips had the following exchange:

> Q: Doctor, in your AMA report I assume you utilized Table 17-4 on page 570 and you chose Class 1, which gave you a default value of 7 percent.
>
> A: Correct.
>
> Q: We're going to mark this one as – It's page 570 through 574. It's going to be marked as No. 8. Now that you have that in front of you again, can you please show me why you put number 7, 7 percent? (RX1, pgs. 77-78).

In another example:

> Q: So the grade modifiers, I assume you used Table 17-6, page 575?
>
> A: Yeah.

Q: And you gave him a Grade 2 modifier for functional history assessments since he had pain with normal activity, correct?

A: Yep. (RX1, pgs. 79-80).

Petitioner's claim that he was surprised and disadvantaged is without merit as he not only had the basis for Dr. Phillips' AMA impairment rating prior to Dr. Phillips' deposition, but was able to reference exact page and table numbers from the AMA Guides and conduct a thorough cross-examination. Therefore, this Commission finds Petitioner's objection as to Dr. Phillips' report was properly overruled.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed February 3, 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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $33,100.00. 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: APR 5 – 2017

MJB/pm
O: 3/7/17
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HERNANDEZ, MANUEL
Employee/Petitioner

Case# **13WC033408**

SOUTHWEST AIRLINES
Employer/Respondent

17IWCC0204

On 2/3/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1993 ROMANUCCI & BLANDIN LLC
FRANK A SOMMARIO
321 N CLARK ST SUITE 900
CHICAGO, IL 60654

0766 HENNESSY & ROACH PC
DANIEL S WELLNER
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
NATURE AND EXTENT ONLY

Manuel Hernandez
Employee/Petitioner

v.

Southwest Airlines
Employer/Respondent

Case # **13** WC **33408**

Consolidated cases: **D/N/A**

17IWCC0204

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 **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **1/14/16**. By stipulation, the parties agree:

On the date of accident, **12/30/12**, 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 $**38,169.56**, and the average weekly wage was $**734.03**.

At the time of injury, Petitioner was **27** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $**35,303.11** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $**35,303.11**.

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 **$440.42**/week for a further period of **75** weeks, as provided in Section **8(d)(2)** of the Act, because the injuries sustained caused **15% loss of use of a man as a whole**.

Respondent shall pay Petitioner compensation that has accrued from **12/30/12** through **1/14/16**, 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.

Molly C Mason

Signature of Arbitrator

2/3/16
Date

FEB 3 - 2016

Manuel Hernandez v. Southwest Airlines
13 WC 33408

17IWCC0204

Arbitrator's Summary of Disputed Issues

The only disputed issue is nature and extent. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified he began working for Respondent in 2007. As of his undisputed work accident of December 30, 2012, he worked as a ramp agent. His duties included lifting and transferring luggage, loading and offloading airplanes and operating a belt loader vehicle.

Petitioner testified the bags he lifted ranged in weight from 2 to 99 pounds. He handled approximately 250 pieces of luggage per plane and typically loaded/unloaded six planes per day. He is a member of a union.

Petitioner testified that, on December 30, 2012, he lifted a bag that was heavier than he had anticipated. The bag weighed about 65 pounds. When he lifted the bag, he felt a sharp pain running down his left leg. He immediately reported the injury to his supervisor, who directed him to MacNeal Hospital. The hospital records reflect that Petitioner complained of left-sided lower back pain radiating to his left buttock since lifting a bag at work two hours earlier. The records also reflect that Petitioner denied any history of significant back problems. A physician's assistant examined Petitioner and administered a Toradol injection. She prescribed Naproxen, Hydrocodone and Flexeril and released Petitioner from care with instructions to seek follow-up care in a day or two. PX 1.

On December 31, 2012, Petitioner saw Dr. Jafri at Occupational Health Centers. The doctor recorded a consistent history of the accident and noted complaints of non-radiating left-sided back pain and numbness in the back of the thigh, calf and heel. On examination, he noted positive straight leg raising on the left at 35 degrees and a tendency to "partially drop the heel on the left side" when walking. He prescribed physical therapy and imposed work restrictions of no lifting over 10 pounds and no pushing/pulling over 20 pounds. He directed Petitioner to return in two days. PX 2, pp. 124-126.

Petitioner testified he remained off work because Respondent was not able to accommodate his restrictions.

On January 2, 2013, Petitioner returned to Occupational Health Centers and saw Dr. Paloyan. The doctor noted that Petitioner was still experiencing moderate left-sided lower back pain radiating into his left posterior thigh and down into the lateral aspect of the left foot. He described Petitioner as walking with a moderate limp and exhibiting a decreased range of motion. He described Waddell's signs as negative. He diagnosed a lumbar strain and lumbar radiculopathy. He directed Petitioner to continue therapy. He released Petitioner to light duty

with no lifting over 15 pounds, no pushing/pulling over 20 pounds and no bending, squatting or kneeling. He directed Petitioner to return to him in one week. PX 2, pp. 145-146.

Petitioner continued attending therapy and returned to Dr. Paloyan on January 9, 2013. The doctor noted some improvement but indicated Petitioner was still experiencing pain in his left lower back with extension to the posterior calf and lateral aspect of the foot. He described these symptoms as "characteristic [of] an L5-S1 possible nerve impingement." On re-examination, he noted positive straight leg raising on the left at 45 degrees, a decreased range of motion and negative Waddell's signs. He prescribed a lumbar spine MRI and additional therapy. He continued the previous work restrictions. PX 2, pp. 156-157.

The lumbar spine MRI, performed without contrast on January 22, 2013, showed disc desiccation and decreased disc height with a broad-based central disc protrusion at L4-L5 and compression of the ventral thecal sac at L4-L5 and disc desiccation and decreased disc height with endplate spondylosis and a diffusely bulging disc with focal left paracentral superior disc extrusion/herniation indenting the ventral thecal sac at L5-S1. PX 6, pp. 46-47.

On January 25, 2013, Dr. Payolan reviewed the MRI results and noted ongoing complaints of moderate pain extending down the posterior left leg and foot. The doctor discussed the MRI with Petitioner, continued the previous work restrictions and recommended that Petitioner see a neurosurgeon as soon as possible. PX 2, pp. 133-135.

Petitioner saw Dr. Cerullo, a neurosurgeon, on February 13, 2013. The doctor's note of that date reflects a referral from Dr. Payolan and sets forth a consistent history of the work accident and subsequent care. Dr. Cerullo indicated that Petitioner reported experiencing worsening of his left leg symptoms during the previous week.

On examination, Dr. Cerullo noted slight weakness of left foot plantar flexion, positive straight leg raising on the right at 80 degrees and positive straight leg raising on the left at 30 degrees.

After reviewing Petitioner's MRI scan, and "in view of [Petitioner's] young age," Dr. Cerullo recommended a very conservative approach. He prescribed continued therapy and an epidural steroid injection at L5-S1 on the left. He directed Petitioner to remain off work. PX 2, pp. 103-104.

At Respondent's request, Petitioner saw Dr. Martin Lanoff, a physiatrist, for purposes of a Section 12 examination on February 26, 2013. In his report of that date, Dr. Lanoff recorded a consistent history of the work accident and subsequent treatment. He noted he reviewed records from Respondent and Concentra, as well as the MRI report and images, but indicated he had not been provided with Dr. Cerullo's records. He interpreted the MRI as showing "an extruded disc herniation at L5-S1 into the left lateral recess." He indicated this finding corresponded to Petitioner's leg symptoms "very classically."

On examination, Dr. Lanoff noted 0/5 Waddell's findings, positive straight leg raising on the left in the seated position, negative crossed straight leg raising, positive supine straight leg raising on the left at 40 degrees, difficulty toe walking on the left, no frank evidence of atrophy and a normal gait.

Dr. Lanoff found Petitioner to have "classic left S1 radiculopathy with a significant disc herniation and an extruded fragment in the left lateral recess compressing the left S1 nerve root." He viewed this condition as related to the accident, based on the abrupt onset of symptoms. He recommended one or two epidural steroid injections. He found Petitioner capable of light duty with sitting/standing as needed, no lifting over 10 pounds and no climbing, pushing, pulling or overhead work. He recommended that therapy be placed on hold, indicating Petitioner could resume therapy if he responded well to the injections. He indicated that Petitioner might require surgery if he failed to respond to the injections. He stated this surgery should consist of a simple laminectomy discectomy at L5-S1. He did not view L4-L5 as the cause of any of Petitioner's symptoms. He characterized the treatment to date as reasonable and necessary. PX 8.

Petitioner continued attending therapy during this time period, despite Dr. Lanoff's recommendation that therapy be placed on hold. A therapy note dated February 28, 2013 reflects that Petitioner was still awaiting authorization of the recommended injection. PX 7, p. 209. A subsequent note, dated April 5, 2013, reflects that Petitioner complained of left buttock and leg pain and had not yet obtained authorization for the injection. PX 7, p. 233. On April 17, 2013, the therapist indicated Petitioner was holding off on the injections because his back was progressing. PX 7, p. 240. On April 29, 2013, the therapist noted Petitioner complained of pain down his leg with bending and "continued numbness in heel." PX 7, p. 251.

Petitioner returned to Dr. Cerullo on May 8, 2013, with the doctor noting the following interval history:

> "I saw the patient last on 2/13/13. At that time, I recommended an epidural steroid injection. The patient was doing well with his physical therapy and decided not proceed with the injection. At present, however, he reports that his left numbness on the left in the S1 distribution persists. It is aggravated by bending. He has not been working, but has been exercising religiously and attending physical therapy 2-3 times per week."

On re-examination, Dr. Cerullo noted a moderate limitation of range of motion in the back in flexion, trace weakness of left foot plantar flexion, trace weakness of left foot dorsiflexion and positive straight leg raising on the left at 80 degrees. He imposed a 20-pound lifting restriction and again recommended an epidural steroid injection at L5-S1 on the left. PX 2, p. 138.

On May 23, 2013, Petitioner's therapist noted that Petitioner was neither worsening nor improving and was "still awaiting his injection." PX 7, p. 275.

Petitioner returned to Dr. Cerullo on July 31, 2013. The doctor noted he had last seen Petitioner in May. He indicated that Petitioner had undergone two injections but that they had little effect other than "aggravating his back pain." He stated that Petitioner was still experiencing numbness in the S1 distribution on the left, as well as cramping in the calf and foot muscles. On examination, he noted trace weakness of left foot plantar flexion and positive straight leg raising on the left at 60 degrees. He told Petitioner he viewed him as a surgical candidate since he had failed conservative measures. He recommended that Petitioner remain off work and undergo a repeat MRI. PX 2, p. 139.

The repeat MRI, performed on August 15, 2013, showed mild dehydration and mild/moderate loss of disc height at T11-T12, severe dehydration, moderate loss of disc height and arthropathy causing central stenosis at L4-L5 and numerous changes at the L5-S1 level producing "moderate, asymmetric left anterolateral central spinal canal stenosis and moderate/severe bilateral neural foraminal narrowing, worse on the left." PX 2, pp. 107-109.

On September 18, 2013, Petitioner returned to Dr. Cerullo. The doctor compared the repeat MRI with the original one and saw no change. He indicated Petitioner remained symptomatic. He recommended that Petitioner undergo an EMG and see Dr. Mkrdichian to discuss surgical options. PX 2, p. 140.

On September 30, 2013, Petitioner saw Dr. Mkrdichian, a neurosurgeon. Dr. Mkrdician recorded a consistent history of the work accident and subsequent treatment. He noted that Petitioner described his previous radicular pain as "improved" but that he was still experiencing numbness in his left posterior thigh, calf, heel and lateral foot.

On lumbar spine examination, Dr. Mkrdichian noted a slight paraspinal muscle spasm, a slightly limited range of motion, tenderness in the left paraspinal area and grossly normal motor and sensation with the exception of the reported decreased sensation.

After reviewing the recent MRI and examining Petitioner, Dr. Mkrdichian informed Petitioner that, in his opinion, it was unlikely that surgery would relieve the persistent numbness. He recommended an EMG of the left leg and a functional capacity evaluation. PX 5, p. 9.

The EMG, performed by Dr. Minieka on October 30, 2013, was negative, with the doctor indicating that the "absence of electrophysiologic findings does not exclude a diagnosis of radiculopathy as electrodiagnosis is only about 80% sensitive for active radiulopathy." PX 5, pp. 15-16.

On November 11, 2013, Petitioner saw Dr. Deutsch for a second opinion. The doctor noted that Petitioner experienced acute back and left leg pain on December 30, 2012, while

working as a baggage handler for Respondent. He also noted that Petitioner was still experiencing severe back and left leg pain despite having undergone several epidural injections.

Dr. Deutsch described Petitioner's gait as normal. On examination, he noted negative straight leg raising bilaterally, flexion up to 90 degrees, extension up to 20 degrees and negative Waddell's.

Dr. Deutsch interpreted the January 2013 MRI as showing a "very large L5/S1 disc herniation related to the job accident." He also noted bulging at L4-L5. He indicated that surgery should be considered, based on the failure of conservative care and Petitioner's persistent symptoms. He directed Petitioner to remain off work pending surgery. PX 6, pp. 17-18., 22.

On December 5, 2013, Dr. Deutsch performed a posterior left lumbar microdiscectomy at L5-S1. PX 6, p. 77. Petitioner was discharged from the hospital the same day, with directions to follow up with Dr. Deutsch. PX 6, p. 78.

At a follow-up visit, on January 15, 2014, Dr. Deutsch described Petitioner as having "no real leg complaints but some foot numbness, unchanged from pre-op." On examination, he noted 5/5 strength and negative straight leg raising. He directed Petitioner to stay off work and start physical therapy in two weeks. PX 6, pp. 189-190.

Petitioner began attending therapy at ATI in late January 2014. The therapist noted complaints of numbness in the left thigh radiating to the foot. PX 6, p. 197.

On February 26, 2014, Dr. Deutsch described Petitioner's leg pain as "gone." He noted that Petitioner was still experiencing back tightness. His examination findings were unchanged. He recommended one month of work hardening and released Petitioner to light work with no lifting over 20 pounds. PX 6, p. 207-209.

At the next visit, on April 9, 2014, Dr. Deutsch noted that Petitioner had completed four weeks of work hardening. He also noted that Petitioner had been off work for about a year and had a "lot of anxiety about returning to activities." He indicated that the last work hardening note placed Petitioner at a medium level. He recommended two more weeks of work hardening. PX 6, pp. 225-226. PX 7, p. 49.

Petitioner continued attending work hardening thereafter. In a progress note covering the period April 21-27, 2014, a therapist noted that Petitioner appeared to have progressed from the medium to the heavy physical demand level but that he expressed concerns about being able to resume working due to his persistent back pain. The therapist recommended one to two weeks of additional work hardening. PX 7, p. 62. It appears that Petitioner last attended work hardening on April 29, 2014. PX 7, pp. 60-61.

On May 19, 2014, Dr. Deutsch noted that Petitioner had completed work hardening. He described Petitioner's gait, strength and sensory examination as normal and straight leg raising as negative. He described Waddell's signs as absent. He found Petitioner to be at maximum medical improvement and released him to full duty as of the following day. PX 6, pp. 240-242.

Petitioner testified he resumed his regular ramp agent duties on May 20, 2014.

On July 24, 2014, Petitioner returned to Dr. Buvanendran. In his report of that date, the doctor noted that Petitioner reported some improvement secondary to surgery but was still experiencing 5/10 low back pain radiating down the back of his right leg into his right foot. He also noted that Petitioner resumed full duty in May 2014 but was still taking Norco several times daily to manage his pain.

On examination, Dr. Buvanendran noted tenderness to palpation over the left sacroiliac joint but no tenderness to palpation over the lumbar spine. He noted strength of 4/5 and negative straight leg raising bilaterally. He described Petitioner as "doing quite well" but indicated he would give consideration to a repeat injection if Petitioner continued to have a high narcotic requirement. He directed Petitioner to return in three months. PX 4, p. 17.

At Respondent's request, Petitioner saw Dr. Frank Phillips on September 11, 2014 for purposes of a Section 12 examination and impairment rating. See below for a summary of the doctor's opinions and deposition testimony.

Petitioner returned to Dr. Buvanendran on December 5, 2014. The doctor noted that Petitioner was performing full duty but still complaining of back and leg pain. He described Petitioner's left leg pain as minimal. He indicated Petitioner was taking Norco as needed and Gabapentin two to three times weekly. On examination, he again noted negative straight leg raising bilaterally. He administered a trigger point injection and refilled Petitioner's medication. PX 4, pp. 36-41.

Petitioner denied injuring his back before or after the accident of December 30, 2012.

Petitioner testified his back remains "very sore." Bending aggravates this soreness. He experiences constant numbness in his left leg, from his buttock down to his heel. Dr. Deutsch told him this numbness would likely persist. At rest, he experiences pain at a level of 4-6/10 with extended sitting. At the end of a workday, his low back pain can get up to 7/10 and his leg pain can get up to 5/10. He no longer takes any prescription pain medication. He regularly takes over the counter medication, including Tylenol, Aleve and Advil. He applies ice and heat "almost every day." He continues to perform home exercises, which consist of various stretches.

Petitioner testified that, before the accident, he used to do some running and he belonged to a softball league. He has not resumed these activities since the accident, primarily because of his persistent back pain.

Petitioner testified he is now 30 years old. He was hoping to work until age 65. He hopes he will be physically able to continue performing his current job up to this age but he is not sure.

Under cross-examination, Petitioner testified he does not feel comfortable with the ides of resuming playing softball in a league setting. He has not returned to Dr. Deutsch or Dr. Buvanendran. Nor has he seen any other doctor for his back/leg complaints. He still has pain in his left leg. He injured both of his legs in 2010. The pain he now experiences in his left leg is very different than the pain he experienced secondary to the 2010 injury. When he saw Dr. Phillips, he was truthful about his complaints. He is still working full time, full duty. He works at least 40 hours per week and sometimes a little overtime. During a typical 8-hour day, he is allotted two 15-minute breaks and a 30-minute lunch.

Petitioner testified he has received a raise since 2012.

Petitioner testified his job involves directing incoming planes, driving a belt loader vehicle, which attaches to a plane for purposes of luggage removal, going inside planes to offload luggage and driving the belt loader vehicle to other locations. Sometimes he works inside planes and sometimes he drives vehicles. His duties vary with each flight. He has no other employment.

On redirect, Petitioner testified he did not follow up with either Dr. Deutsch or Dr. Buvanendran because they both told him there was nothing more they could do. He wanted to return to work and asked Dr. Deutsch when he would be able to do so.

Respondent offered into evidence Dr. Phillips' deposition testimony of May 12, 2015. RX 1.

On direct examination, Dr. Phillips testified he is a fellowship-trained, board certified orthopedic surgeon. He specializes in spine surgery. He is a professor of orthopedic surgery at Rush University Medical Center. His very lengthy CV reflects that he has co-authored a number of articles relating to spine surgery. Phillips Dep Exhibit 1.

Dr. Phillips testified that 10 or 15% of the individuals he sees are seen for purposes of independent medical examinations and/or impairment ratings. RX 1 at 6-7. He has been performing impairment ratings for about 1 ½ or 2 years. He attended a CME-accredited course in AMA Guides impairment ratings at a hotel in Chicago or Oak Brook. He was unable to recall who sponsored this course. RX 1 at 8-9. The course consisted of a day of lectures followed by a test. The individuals who sat for the test had to achieve a certain score in order to be certified to perform impairment ratings. RX 1 at 9-10.

Dr. Phillips testified he examined Petitioner on September 14, 2014. He did not recall whether Petitioner signed a consent form prior to the examination but he requires examinees to complete certain paperwork. RX 1 at 10.

Dr. Phillips acknowledged he has no independent recollection of Petitioner. RX 1 at 10.

Dr. Phillips testified he reviewed certain records in connection with his examination. He issued a report of his findings. He identified Phillips Dep Exhibit 2 as his report. RX 1 at 11. [The Arbitrator overruled Petitioner's foundational and Ghere-based objections to this report.]

Dr. Phillips testified that Petitioner provided a history of the lifting-related work accident and complained of 5-7/10 pain in his back, buttock and posterior thigh, as well as persistent numbness in the left foot and ankle and weakness in the left calf. Dr. Phillips testified that Petitioner denied any pain radiating down his leg distal to the knee. RX 1 at 14-16.

Dr. Phillips testified that, on examination, he noted Petitioner had normal posture and was able to walk on his heels and toes. Petitioner exhibited an "almost normal" lumbar range of motion. Strength and motor examinations were normal, as was straight leg raising, but Petitioner "had some diminished sensation on the outside of his left foot." RX 1 at 15. Dr. Phillips testified he did not note any atrophy in his report. If he had observed atrophy, he would have documented it. RX 1 at 16. He reviewed a report of the lumbar spine MRI taken on August 15, 2013. RX 1 at 16.

Based on the information Petitioner provided and the records review, Dr. Phillips opined that Petitioner "presented with what seemed to be radiculopathy in the left leg that, based on the nature of his complaints, . . . was causally related to the incident in question." RX 1 at 17.

Dr. Phillips found Petitioner to be at maximum medical improvement. He felt he had sufficient information to make an impairment rating based on the AMA Guides, 6th Edition. RX 1 at 17-18. He has read the AMA Guides and has used them in making impairment ratings in the past. RX 1 at 18.

Dr. Phillips testified his final impairment rating was 8%. He arrived at this rating after making an initial "default" rating of 7%, based on Petitioner's diagnosis of "lumbar radiculopathy with surgery." He then applied a Grade 2 modifier, based on Petitioner's reporting of pain with normal activities, and a physical examination adjustment modifier of zero. He used a zero examination modifier because Petitioner "had no objective nerve tension findings on examination." Petitioner only exhibited some "non-specific sensory loss." Straight leg raising was negative and strength was normal. RX 1 at 20-22. Finally, he applied the "CSA," or "Clinical Studies Adjustment." He gave Petitioner "the benefit of the doubt" on this, despite the non-specific findings on MRI. The MRI was "at least consistent" with the examination findings so he used a Grade 2 modifer. RX 1 at 22-24. Using the formula set forth in the AMA Guides, he arrived at 8% as follows: "it's 2 minus 1 for the history plus 0 minus 1 for the exam

plus 2 minus 1 for the clinic studies." That comes out to a net score of "plus 1." He thus added 1 to the 7% default rating to arrive at 8%. RX 1 at 24.

Dr. Phillips testified he is not aware of any other impairment ratings concerning Petitioner. RX 1 at 25. He is aware that impairment differs from disability. RX 1 at 25-26.

Under cross-examination, Dr. Phillips testified his records are electronic and he thus has no paper file. RX 1 at 26. He reviewed Dr. Lanoff's report of February 26, 2013. RX 1 at 27. He typically takes notes by hand during an examination and then transcribes them. His original notes would be included in his electronic records. RX 1 at 28. He does not recall reviewing a job description. RX 1 at 28. Of the examinations he performs, the majority are for respondents. RX 1 at 29. He performs six to eight surgeries per week. RX 1 at 29. He charges around $1000 for an independent medical examination. He has been performing such examinations for at least ten years. RX 1 at 30. He performs impairment ratings once or twice weekly. He charges a couple of hundred dollars more for an examination if an impairment rating is requested. RX 1 at 30. He gives about one deposition per week. RX 1 at 31. He recognizes the name of Respondent's counsel's firm and thus suspects he has done work for this firm in the past. RX 1 at 31-32. He is not personally acquainted with Respondent's counsel or any of the firm's partners. RX 1 at 32. He received a letter from Respondent's counsel in connection with the examination. He does not recall whether he reviewed this letter prior to examining Petitioner. Typically, he would examine the patient first and then review the letter to see whether he has to respond to any specific questions. RX 1 at 33-34. Physicians, regardless of their specialties, can have different opinions. RX 1 at 37. In terms of surgical technique, there is no difference between orthopedic surgeons and neurosurgeons. RX 1 at 37. He reviewed the radiographic reports but not the actual studies. RX 1 at 38.

Dr. Phillips acknowledged he has never worked as a ramp agent for Respondent or undergone any training to be a ramp agent. RX 1 at 38.

Dr. Phillips testified he did not undergo any training in AMA impairment rating other than the course he attended. He obtained the requisite score on the test and has been performing impairment ratings ever since. RX 1 at 38-39. He is certified by the American Board of Orthopaedic Surgery. He is not aware of any board certification for impairment rating. RX 1 at 39.

Dr. Phillips could not recall how much he paid to take the AMA impairment ratings course. RX 1 at 39. He has no idea whether a non-physician such as an attorney can obtain certification to perform such ratings. The course he attended lasted an entire day, eight to ten hours. RX 1 at 40. He was not provided with mock examinations. There was definitely no section of the course devoted to "writing winning reports." RX 1 at 42. There was a substantial fail rate because he was quite concerned until he learned he had passed. RX 1 at 42. A lot of people from his practice attended the same course and "there were people who failed, for sure." RX 1 at 43. He does not know whether the American Board of Medical Specialists does not recognize AMA Guides certification. RX 1 at 43-44. He documented range of motion

findings in his report but such findings are not a criteria for spine impairment ratings, since they are "very subjective." RX 1 at 44. He documented 5/5 strength on lower extremity motor examination. RX 1 at 45.

Dr. Phillips acknowledged that a person can have significant activity limitations in the absence of demonstrable impairment. He also acknowledged that the process of defining impairment is not perfect. RX 1 at 47. He admitted that the AMA Guides are not to be used to determine work restrictions and that an impairment rating is one of several determinants of disability. In a spine case, a "Pain Disability Questionnaire," or "PDQ," and a functional assessment are not required in order to make an impairment rating. RX 1 at 50. In Petitioner's case, he went beyond a functional assessment and relied on the subjective complaints Petitioner relayed to him. RX 1 at 50-51. He does not use "PDQ" forms when rating spine-related impairments because the form is general and "not very useful for spine" conditions, as a disclaimer on the form states. RX 1 at 51-53. Petitioner received "probably the highest modifier he could have received," based solely on his reporting so the fact the form was not used probably worked in Petitioner's favor. RX 1 at 53. He was not the only physician who found Petitioner to be at maximum medical improvement. Petitioner's surgeon, Dr. Deutsch, made the same finding. RX 1 at 54. It would not affect his opinion if he learned that Petitioner returned to Dr. Buvanendran in December 2014 for another injection. RX 1 at 55. He does not view his impairment rating as premature. RX 1 at 56. He did not include the page and table numbers in his report, although it would be "very obvious" to anyone reading the report where he arrived at the numbers. RX 1 at 58. The report he issued does not resemble the sample report included in Figure 2-3 on page 30. RX 1 at 59. A claimant can have subjective complaints which are disabling. Pain is real and cannot be objectively measured. RX 1 at 60. Regardless, pain is used in arriving at an impairment rating. RX 1 at 60. Since a rating is diagnosis-based, a rating could be incorrect if the underlying diagnosis is incorrect. RX 1 at 60-61. He agrees with Dr. Deutsch's diagnosis of a herniated disc. RX 1 at 62-63. He has never performed an impairment rating on any of his patients. RX 1 at 63. No one has requested this of him. Dr. Deutsch did not perform an impairment rating. RX 1 at 63. Each examinee he sees has to sign a consent form but he does not know whether he has the form Petitioner signed. RX 1 at 65. Every time he examines someone, he tells that person he is not there for the purpose of treatment. RX 1 at 65. He reviewed Petitioner's records before conducting the examination but he did not review these records with Petitioner. RX 1 at 67. In general, an impairment rating does not automatically equate to loss of function. RX 1 at 68. The AMA Guides follow a "rule of liberality," meaning that, of available methods, the method providing the higher rating must be used. He adhered to this rule in rating Petitioner's impairment. RX 1 at 70. The AMA Guides system is medically based in the sense it is based on diagnosis but it is not scientifically based. RX 1 at 71. He does not agree with the proposition that an impairment rating is a mathematical formula concocted to reach a predetermined outcome. RX 1 at 72. He finds that proposition to be ridiculous. RX 1 at 72. He was not aware that the authors of the AMA Guides received funding to produce their ratings. RX 1 at 72. An AMA rater can reject a functional history set forth in medical records assuming the patient is obviously malingering. RX 1 at 76. He used Table 17-4 on page 570 in choosing Class 1, which resulted in a default value of 7%. He did not choose Class 2 because, on examination and in the records, Petitioner did not exhibit

radiculopathy. Petitioner's radicular symptoms had resolved postoperatively. RX 1 at 79. If Petitioner had an injection postoperatively, that would not prompt him to choose Class 2. He used a Grade 2 rather than a Grade 3 modifier based on Petitioner's history of increased symptoms with sitting and bending. He views those activities as normal rather than less than normal, or minimal. RX 1 at 80. He has no idea whether the use of a PDQ, depending on the score, would have prompted him to use a Grade 3 modifier. RX 1 at 80. He knows that Petitioner's job involves heavy lifting. He does not know the extent of Petitioner's current symptoms. RX 1 at 81. The fact that Petitioner underwent an injection in December does not necessarily mean he has radicular symptoms. RX 1 at 81. He adhered to the "rule of liberality" in using a Grade 2 modifier. RX 1 at 82. He chose Grade 2 based on the MRI. As for the physical examination modifier, he used a Grade 0 modifier because Petitioner had no active radiculopathy. Straight leg raising was negative and his motor examination revealed normal strength. RX 1 at 83. Petitioner did have diminished sensation but, when you put that together with everything else, he did not have active radiculopathy. RX 1 at 83. The diminished sensation in a small area of the foot, in and of itself, would not push Petitioner to a Grade 1 modifier. RX 1 at 84. If a rater used higher values than he used, he could theoretically arrive at a 12% rating. He believes his rating is accurate. In Petitioner's case, ten different doctors might arrive at the same rating. RX 1 at 85.

On redirect, Dr. Phillips testified that the questions he was asked on cross-examination further confirmed the rating he arrived at. RX 1 at 86.

Arbitrator's Credibility Assessment

Petitioner came across as a hard-working individual. None of the physicians who treated or examined him noted any positive Waddell's signs. The Arbitrator found him credible.

The reliability of Dr. Phillips' AMA impairment rating is at issue in this case. The Arbitrator has considered Petitioner's counsel's lengthy cross-examination of the doctor. The Arbitrator has also considered Petitioner's argument that the doctor's report is, at least potentially, technically deficient in that it lacks numerical values and was not based on a Patient Disability Questionnaire, or "PDQ." The doctor ably responded to questions concerning the latter, indicating that "PDQs" are not useful in spine cases such as Petitioner's. As for the former, the report reflects that the doctor obtained information as to which activities (i.e., sitting and bending) tended to increase Petitioner's symptoms. Where the Arbitrator had some difficulty was not with the thoroughness of the doctor's history or the format of his report. Instead, the Arbitrator questions the doctor's reliance on an MRI report generated off of an admittedly "somewhat limited" study of August 2013. See page 4 of the doctor's report (Phillips Dep Exhibit 2), which the Arbitrator admitted into evidence over Petitioner's foundational objection. There is no evidence indicating the doctor reviewed the actual images of either of Petitioner's two lumbar spine MRIs. Regardless, the doctor's finding of negative straight leg raising bilaterally correlated with that of Dr. Deutsch in May 2014 and that of Dr. Buvanendran in July and December 2014. This consistent finding supports Dr. Phillips' conclusion that Petitioner did not have active radiculopathy as of the latter part of 2014.

The Arbitrator, in reliance on the wording of Section 8.1b(v) of the Act, views any AMA impairment rating as only one piece of the permanency puzzle. Impairment does not equal disability, as Dr. Phillips readily acknowledged.

Arbitrator's Conclusions of Law

What is the nature and extent of the injury?

This is a post-amendatory case, since Petitioner's undisputed work accident occurred after September 1, 2011. As previously noted, the Arbitrator looks to Section 8.1b of the Act for guidance in determining nature and extent. This section sets forth various factors to be considered in assessing permanency, with no single factor to be given more weight than any other. As for the first factor, any AMA Guides impairment rating, the Arbitrator considers Dr. Phillips' methodology and ultimate rating of 8%. For the reasons stated above, the Arbitrator finds Dr. Phillips' September 2014 examination findings, which were a basis for the rating, to be largely consistent with the 2014 examination findings of Petitioner's treating physicians, Drs. Deutsch and Buvanendran. No other impairment rating is in evidence. Turning to the next two enumerated factors, the Arbitrator notes that Petitioner was only 27 years old at the time of the accident and that there is consensus that his occupation, i.e., baggage handler, is heavy in nature. With respect to the next factor, future earning capacity, the Arbitrator notes that Petitioner resumed working as a baggage handler in May 2014 and that he was earning more money as of the hearing than as of the accident. The Arbitrator also notes that, while Petitioner expressed some doubt as to whether he will be physically capable of performing his current job into his sixties, no physician opined that Petitioner's condition will prevent this. The Arbitrator also notes that Petitioner remained symptomatic after returning to work and that Dr. Phillips viewed Petitioner's reported complaints as valid. In fact, Dr. Phillips testified he relied on those complaints in arriving at a value that factored into his overall impairment rating. That doctors could differ, rating-wise, as to the significance of Petitioner's reported decreased sensation in part of one foot is not lost on the Arbitrator. As for the last factor, evidence of disability corroborated by the treating medical records, the Arbitrator notes the positive lumbar spine MRIs and Dr. Minieka's cautionary comments about the negative EMG. Dr. Phillips did not dispute Dr. Deutsch's diagnosis of a disc herniation. Nor did he disagree with the need for surgery.

The Arbitrator, having considered all of the foregoing, along with Petitioner's credible testimony concerning his lingering complaints and regular use of over the counter pain medication, finds that Petitioner is permanently partially disabled to the extent of 15% loss of use of the person as a whole under Section 8(d)2 of the Act, equivalent to 75 weeks of benefits.

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Byron Ward,

Petitioner,

vs.

NO. 13WC35567

PMR (RMR) Construction,

17IWCC0241

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review under §19b having been filed by the parties herein and proper notice given, the Commission, after considering the issues of medical expenses, causal connection, prospective medical care, maintenance benefits, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 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 $40,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 19 2017
SJM/sj
o-4/6/17
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

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

WARD, BYRON
Employee/Petitioner

Case# **13WC035567**

PMR (RMR) CONSTRUCTION
Employer/Respondent

17IWCC0241

On 5/16/2016, 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 0.38% 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:

0536 RON D COFFEL
PO BOX 366
502 W PUBLIC SQUARE
BENTON, IL 62812

0000 RUSIN & MACIOROWSKI LTD
SARAH TRIPP
231 W MAIN ST SUITE 2E
CARBONDALE, IL 62901

17IWCC0241

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

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

BYRON WARD
Employee/Petitioner

v.

PMR (RMR) CONSTRUCTION
Employer/Respondent

Case # **13** WC **35567**

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 **Mt. Vernon**, on **February 5, 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 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 **$35,360.00**; the average weekly wage was **$680.00**.

On the date of accident, Petitioner was **50** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$54,661.83** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$54,661.83**.

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

ORDER

The Petitioner's current lumbar spine condition **is causally related** to the April 1, 2013 accident.

The Petitioner **failed to prove** that his current cervical spine condition is causally related to the April 1, 2013 accident.

Respondent shall pay Petitioner temporary total disability benefits of **$455.33** per week for **109-3/7 weeks**, commencing **June 1, 2013 through July 6, 2015**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of **$455.33** per week for **30-4/7** weeks, commencing **July 7, 2015 through February 5, 2016**, as provided in Section 8(a) of the Act.

Respondent shall be given credit of **$54,661.83** for temporary total disability and/or maintenance benefits paid under Sections 8(a) and 8(b) of the Act.

Respondent shall pay the reasonable and necessary medical services contained in Petitioner's Exhibit 20, as provided in Section 8(a) of the Act, and subject to the medical fee schedule provided in Section 8.2 of the Act, with the exception of the medical expenses incurred with Dr. Corzine after May 9, 2013. The expenses of Dr. Corzine after May 9, 2013 are denied. Respondent shall also reimburse the Petitioner for his out-of-pocket medical expenses totaling $1,247.12.

Respondent shall be entitled to a credit for any of the medical expenses submitted in Petitioner's Exhibit 20 which have been paid by Respondent prior to hearing.

The Petitioner has **failed to prove** that he the lumbar fusion surgery recommended by Dr. Ray is reasonable and necessary pursuant to Section 8(a) of the Act.

Ward v. RMR (PMR) Construction, 13 WC 35567

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 12, 2016
Date

ICArbDec19(b)

MAY 16 2016

STATEMENT OF FACTS

Petitioner was employed as a heavy equipment/bulldozer operator for the Respondent. He testified that on April 1, 2013, around 11:30 a.m., he was backing up a large bulldozer, and wearing a lap seatbelt, when he hit an approximately 6 to 8 foot deep and 30 foot wide trench. He testified: "it just slammed me, banged my head, and I just stopped suddenly." He noted his head hit a metal roll bar in the bulldozer, and his body was jerked around while his waist was held with the belt. He testified that when the dozer came to a stop he immediately felt back and neck pain. He finished the remainder of his shift and sought treatment the following day.

Petitioner presented to the Family Health Care Clinic at Franklin Hospital on April 2, 2013 with back pain, reporting that he hit a big hole the day prior on his bulldozer, felt something hurt in between his shoulder blades, and by night time had pain at the end of the thoracic spine "where he couldn't bend." The report also states: "he has been also hurting for a long time in his cervical spine just before this happened." A separate portion of the report states: "Neck pain (pain originated in the neck area first a day or so ago...but is now down into the lower back)." As to back pain, the report notes: "Back pain (states he has had back pain for a long time.....but was jarred yesterday in the bulldozer and could hardly get out of bed this am.)." Interestingly, the report states: "Patient words: states this is not workman's comp." Examination indicated pain with bending and twisting and positive straight leg raising bilaterally. X-rays of the lumbar and thoracic spine were obtained, which revealed mild scoliosis, early degenerative endplate/disc changes in the mid-to-lower thoracic spine, and early degenerative endplate changes in the mid lumbar spine with associated facet arthropathy at the lumbosacral junction. Petitioner was assessed with chronic back pain, returned to regular duty as of April 6th, and prescribed Flexeril, Naproxen and Norco. He was instructed to keep a previously scheduled visit with his new primary care provider in 2 weeks. (Px3; Rx2). At trial, Petitioner denied reporting to FHCC that he was having prior problems with his cervical or lumbar spine.

Petitioner next sought treatment with chiropractor James Corzine on April 9, 2013. (Px4; Rx3). Petitioner reported complaints involving his neck bilaterally, radiating into both shoulders and arms, upper back pain bilaterally, aching and tingling in both hands, low back pain radiating into both hips, aching and tingling in both legs and both feet. A diagnostic ultrasound was noted to have been performed on the lumbar spine, and one for the cervical spine was scheduled. Dr. Corzine recommended that Petitioner see his medical doctor, Dr. Elizabeth Cox, for medication, while he continued to treat at Corzine's office. Petitioner treated with Dr. Corzine from April 9 to September 16, 2013, and his records indicate virtually no improvement during that time. There were moments of improvement, which inevitably were followed by essentially a return to baseline pain level. The doctor's records note over and over again that the Petitioner's objective findings had been virtually unchanged from exam to exam. Various testing was performed, including SEMG and computerized balance tests. Noting slow progress, on May 9, 2013 Dr. Corzine recommended cervical and lumbar MRIs and referred Petitioner to neurosurgeon Dr. Joel Ray, as well as continued restrictions from Petitioner's normal work duties. The Arbitrator notes that his review of the records, which are extensive in terms of the number of pages to review, indicated no recommendations from Dr. Corzine regarding Petitioner's work status prior to May 9th. On May 10, 2013 Dr. Corzine indicated Petitioner's condition was exacerbated and he should be off work until further notice. On May 30th and August 20th, Dr. Corzine noted he was still recommending that Petitioner see Dr. Ray. (Px4; Rx3). The Petitioner testified that Dr. Corzine's treatment provided temporary relief.

Petitioner sought treatment with Dr. Cox on April 19, 2013. Petitioner reported a 3 week history of neck and low back pain at work when he hit a hole with his bulldozer and had a "slam" sensation. He thought he was okay at the time, but unable to work by the next morning. The low back pain was now worse, and constant with shooting pains into his arms and legs and numbness in both legs and feet. Chiropractic treatment involving

acupuncture had provided only temporary relief. Petitioner reported no back problems prior to this with the exception of an occasional ache in the back over the years from concrete work, but nothing like his current problem, and that he had no prior numbness and tingling in his legs and feet. He reported pain in his neck for approximately one month prior to April 1, 2013, but it was not as severe. He reported that he had numbness and tingling in his bilateral 4th and 5th fingers for a month, and Dr. Cox noted this was also prior to the accident. Examination noted decreased range of motion of the neck and pain with range of motion. Petitioner had pain to palpation of the lower cervical spine and upper lumbar spine. Straight leg raise increased his side muscle pain in the lumbar region. Dr. Cox's assessment was low back pain and neck pain, and she recommended an MRI of the neck and spine. Petitioner was prescribed Gabapentin, a Medrol dosepak and was to follow up in a week. Nothing was indicated regarding work status, and the only other note of Dr. Cox indicated Petitioner was a no show on May 8, 2013. (Px2; Rx4).

On May 24, 2013, Petitioner underwent lumbar and cervical MRIs at Franklin County Hospital. The reports do not indicate the requesting physician. Impression of the lumbar MRI noted mild lumbar degenerative spondylosis and no disc herniation. There was mild left and minor right foraminal stenosis at L3/4 due to a mild disc bulge, mild bilateral facet arthropathy and ligamentum flavum hypertrophy; minor bilateral foraminal stenosis at L4/5 due to mild bilateral facet arthropathy; and, mild left and moderate right foraminal stenosis at L5/S1 due to a mild disc bulge and mild bilateral facet arthropathy. A small far right annular tear was also noted at L5/S1. Impression of the cervical MRI noted mild degenerative spondylosis and a small central disc protrusion at C4-5. No stenosis was noted from C2/3 to C4/5 or C6/7 to C7/T1. At C5/6 there was a minor disc bulge and minor bilateral uncovertable hypertrophy with mild left foraminal stenosis. (Px19). The Arbitrator notes that the lumbar report also identified a partially duplicated left kidney and probable collecting system with mild atrophy, and some level of compensatory hypertrophy of the right kidney. (Px19).

On May 31, 2013, Petitioner sought treatment with neurosurgeon, Dr. Ray. The Petitioner reported going into a 3 to 4 foot ditch with his bulldozer at high speed and being thrown about. The Petitioner reported numbness from the waist down associated with excruciating low back pain, and numbness and intermittent blanching of the 4th and 5th digits of both hands and associated excruciating neck pain. On exam, Dr. Ray noted that when getting out of the chair Petitioner appeared crippled, and indicated his exam was limited due to Petitioner's complaints of pain. Dr. Ray indicated that the MRIs did not show a significant compressive lesion of the cervical or lumbar spine, and he did not see a basis for surgery. He indicated that Petitioner had profound pain, neurologic symptoms, but not a specifically attached compressive lesion. His diagnosis was extremely complex pain and Dr. Ray recommended pain management and neurology consultations, including EMG/NCV testing. He indicated the Petitioner was incapacitated for work until he returned after the consults. (Px5)

At the request of Respondent, Petitioner was seen for a Section 12 examination with neurosurgeon, Dr. Robert Bernardi on July 13, 2013. Dr. Bernardi testified via evidence deposition on September 11, 2015. (Rx1). Dr. Bernardi noted that Petitioner's complaints were similar to what he described to Dr. Ray. He testified that Petitioner's symptom diagram was unusual in that he was essentially marking symptoms involving his entire body. He indicated that Petitioner's diagnostic studies revealed very mild degenerative disease in both the neck and low back, but nothing acute, post-traumatic or not age appropriate. Dr. Bernardi had no structural explanation for the cause of Petitioner's pain. He felt it was reasonable to conclude that Petitioner's acute symptoms were related to the accident, but it was difficult to attribute his chronic symptoms. Dr. Bernardi testified that he recommended flexion and extension x-rays to look for evidence of instability, followed by physical therapy and work conditioning if the scans looked okay. He opined that following work hardening it would be in Petitioner's best interest to try to return to work regular duty, and if he did not feel he was capable of doing so a functional capacity evaluation (FCE) would be appropriate. (Rx1)

Petitioner presented for a follow-up with Dr. Ray on September 27, 2013. Dr. Ray reviewed the IME report of Dr. Bernardi and noted that they both seemed to be of the opinion that there was not a surgical indication. However, Dr. Ray again recommended pain management and neurology consults before making a final determination as to a treatment plan. He also continued Petitioner's off work status pending that determination. (Px5).

On November 7, 2013, Petitioner underwent flexion/extension x-rays of the lumbar and cervical spine. The reports note Dr. Ray to be the requesting physician, while Dr. Ray's records note no such prescription on September 27, 2013. Lumbar films revealed no evidence of spondylolisthesis or instability, and the disc spaces were within normal limits. Cervical films noted stable grade 1 anterolisthesis of C5 on C6 and minimal osteophyte formation. Disc heights and spaces appeared well maintained at both the lumbar and cervical levels. (Px5).

Petitioner underwent formal physical therapy at NovaCare from November 12 through December 23, 2013. (Px8). The initial report indicated Petitioner complained of constant diffuse cervical pain, paresthesia and coldness in the hands (last two digits), severe lower lumbar pain and paresthesia from the iliac crests to the feet and throughout the entire legs. He noted he had no symptomatic improvement with chiropractic treatment. Minimal improvement was noted in therapy, with the therapist noting an inability to reproduce the Petitioner's symptoms leaving the differential diagnosis inconclusive, he was self limiting with material handling, and he indicated anger and frustration with seeing several different doctors and having ongoing pain. The last report noted he had 12 visits, and 5 cancelation/no shows. (Px8).

On November 25, 2013, Dr. Rupert, a pain specialist, initially saw Petitioner in consultation. Petitioner reported neck and low back pain since his April 1, 2013 bulldozer accident. Petitioner indicated his cervical issues were 70% neck pain and 30% bilateral arm pain, and his lumbar issues were 70% low back pain and 30% bilateral leg pain. The Arbitrator notes that here the Petitioner indicated that not only did chiropractic treatment not help him, but it increased his pain. Following examination and a review of Petitioner's films, Dr. Rupert diagnosed Petitioner with cervical spondylosis without myelopathy, lumbar spondylosis, degenerative lumbar lumbosacral disk, and peripheral neuropathy. He performed diagnostic bilateral L4/5 and L5/S1 facet injections. Petitioner reported his back and buttock pain reduced to 2 out of 10, and he was about 50% improved. (Px9; Rx5).

On December 10, 2013, Dr. Rupert performed diagnostic medial branch block injections at the left C3 through C6 facet joints. Petitioner reported a pain decrease after the injection. On January 9, 2014, Petitioner reported to Dr. Rupert that the injections helped for three days. Dr. Rupert wanted to see Petitioner's MRIs to determine if new films were needed, and he continued Norco 6 times per day and Zanaflex once a day, as well as sedentary work restrictions.

On December 5, 2013, Petitioner's therapist noted he had low back improvement with cortisone injections, but by December 9th he indicated his low back pain had increased. (Px8).

The cervical branch blocks provided only very temporary relief and the Petitioner's level of pain was 8/10 at his follow-up visit on January 9, 2014. (Px10). The December 13, 2013 report of NovaCare indicated Petitioner did not have much relief from cervical injections. On December 19th the therapist indicated there had been minimal improvement. The assessment noted subjective symptoms consistent with nerve root impingement along the lower cervical spine and along L5/S1, and that his symptoms were not consistent with available MRI and x-ray findings. The last note of December 23, 2013 indicated Petitioner was to return to his physician for recheck. (Px8).

A January 27, 2014 lumbar MRI report requested by Dr. Rupert indicated mild multilevel spondylosis, coexistent slight retrolisthesis at L5/S1, and moderate right and mild left foraminal stenosis. The cervical MRI noted moderate left facet osteoarthritis and mild degenerative disc disease (DDD) at C3/4 with mild left foraminal stenosis, and otherwise mild multilevel cervical spondylosis/DDD. (Px9 & Px19; Rx5).

Dr. Rupert's January 27, 2014 report indicated his review of the MRIs noted an L5/S1 bulge with facet arthropathy and a posterior annular tear and left greater than right C5/6 and C6/7 bulges. He added the diagnoses of degenerative lumbosacral disc ("At L5/S1 with a posterior annualar (sic) tear which may account for his LBP") and idiopathic progressive polyneuropathy, and took the Petitioner completely off work indefinitely. Repeat medial branch blocks were prescribed at L3 to S1 to establish the validity of the first injection, noting a possibility of a radiofrequency procedure. (Px9; Rx5)

He testified that his reading of the lumbar films reflected a small peripheral annular tear at L5-S1, right foraminal and left paracentral, but no focal disc herniation; slight retrolisthesis and L5-S1 and mild bilateral facet OA at L3-4 through L5-S1. (Px10) Dr. Rupert testified that even after the 2nd MRI he was still trying to figure out the facet joints, and so he performed bilateral L3, L4 and L5 medial branch blocks on January 31, 2014. His February 26, 2014 report indicated that the Petitioner reported 7% improvement, but that the pain then "came back plus more." The report further stated both that he was on short term disability indefinitely, as well as that he needed to find a light duty job to work at, noting he was not a surgical candidate at that time. He believed Petitioner's low back pain was discogenic and the annular tears were caused by the injury, recommending discogram to verify how many bad discs he has. (Px9; Rx5).

Petitioner was evaluated by neurologist, Dr. Lori Guyton on February 24, 2014. Petitioner provided a consistent history of accident. He reported complaints of low back pain, neck pain, numbness and tingling in his extremities, his feet and fingers turning purple, pain radiating down his extremities and that his left leg gives out. He reported headaches occurring 4 or 5 times per week, and difficulty walking. He stated that his pain extended down his left side, but also down the bilateral legs, including numbness and shooting pains. Petitioner advised Dr. Guyton that he had received 3 injections, which did not help. On exam, Dr. Guyton noted decreased response to pain and temperature stimulation of his feet, decreased response to tactile stimulation, normal muscle strength in the upper and lower extremities but only with reinforcement, and low back tenderness. Dr. Guyton opined that Petitioner had significant neck pain and arm discomfort that was likely related to the accident, and that the accident likely produced significant musculoskeletal pain given that the MRI revealed only mild degenerative disease. From a clinical perspective in such case, she would expect Petitioner's pain to improve, not worsen. She believed this indicated that deconditioning and lack of activity, coupled with the use of frequent narcotics, can sensitize the pain receptors. His headaches were likely rebound from narcotic use. She stated: "It would be difficult to relate his leg pain and numbness (peripheral neuropathy)" to the work accident, and she opined that the peripheral neuropathy was unlikely related to a traumatic event. She recommended that he increase activity, reduce narcotic use and develop a more routine lifestyle. (Px11; Rx7).

Respondent submitted additional medical records to Dr. Bernardi for review in early 2014. Dr. Bernardi testified that he issued an addendum report on February 24, 2014, indicating that upon review of the additional records he could not provide insight as to the cause of Petitioner's ongoing symptoms. He testified there was no medical explanation as to why Petitioner was continuing to report such high levels of pain that far out from the work injury. Dr. Bernardi noted there was no neurophysiological explanation for how the trauma could produce the diffuse symptoms Petitioner described. He consistently rated his pain as 8-9/10 despite the absence of any objective abnormalities on exam or any post-traumatic abnormalities on imaging studies. (Rx1).

On March 19, 2014, Dr. Rupert continued Petitioner off work, noting he believed the back pain was discogenic and the leg pain was due to peripheral neuropathy, and that Petitioner was going to consult with his surgeon. (Px9; Rx5).

On March 31, 2014, Petitioner returned to Dr. Guyton and underwent EMG/NCV studies of the lower extremities which revealed mild peripheral neuropathy, mainly impacting Petitioner's motor components. Petitioner followed up with Dr. Guyton on May 8, 2014. Her office note indicated Petitioner noted no change in his condition, other than increased severity of his neck pain. He continued to take 6 narcotics per day, and he noted he didn't sleep well and sometimes stayed in bed until noon. Dr. Guyton noted she offered Petitioner Neurontin, but he said it didn't work, and he did not want to try Cymbalta out of fear regarding side effects. He also told Dr. Guyton that he didn't feel he could be active without his medications. She made the same recommendations to Petitioner that she had on February 24th, and indicated she had no further treatment to offer Petitioner as he did not wish to try other products and he did not feel he needed to be more active. Dr. Guyton noted the arthritis in Petitioner's spine was mild, and much of his discomfort was musculoskeletal. He had mild findings of peripheral neuropathy, but "this is unrelated to trauma.". (Px11; Rx7).

On May 14, 2014, Petitioner returned to Dr. Ray, who noted that Petitioner had become progressively miserable, and that he was using a cane. He indicated that Dr. Guyton felt part of his problem was a non-work related peripheral neuropathy, and Dr. Rupert felt a significant part of the problem was discogenic. Dr. Ray strongly recommended that Petitioner follow-up with Dr. Rupert for a discogram to determine if there was a discogenic pain generator, given that he otherwise did not think the Petitioner had a neurosurgical issue. He continued the Petitioner's off work status through June 27, 2014, noting that if Petitioner ultimately was determined not to be a neurosurgical candidate following the discogram, Dr. Rupert would be in charge of the Petitioner's chronic pain situation that was work related, in terms of medications, disability, limitations, etc. (Px5).

A May 19, 2014, toxicology report indicated the Petitioner tested positive for cocaine. (Px9; Rx5). Dr. Rupert testified that he advised Petitioner that if he tested positive again he would be discharged from pain management. He also testified that Petitioner admitted to drug use in the past. (Px10). Petitioner testified, and reported to Dr. Rupert, that he does not use cocaine, and had not done so in 25 years. (Px9; Rx5 – 7/16/14 report).

Dr. Rupert performed a lumbar discogram on May 30, 2014. The report indicated it was performed at four levels, right L2 through S1, and noted that pain was concordant only at L5/S1. A post-discogram CT Scan indicated mild multilevel DDD with an L5/S1 annular tear, paracentral but more so right-sided, with mild foraminal stenosis, slight retrolisthesis, mild bilateral facet arthritis and no herniation. (Px9; Px19; Rx5). At a July 16, 2014 follow up, Dr. Rupert indicated he believed the Petitioner's pain was coming from the L5/S1 level, and recommended he follow up with Dr. Ray. He also noted that he again told the Petitioner to stop smoking, and that "he just needed to lay down the cigarettes and quit." (Px9; Rx5).

On July 23, 2014, Dr. Ray noted that he had discussed the discogram results with Dr. Rupert, who felt that Petitioner should be treated surgically. Dr. Ray noted Petitioner continued to use a cane, and stated: "He has been evaluated by multiple specialists and feel that the secondary aspects of is injury are now severely incapacitating him due to disuse atrophy and lack of activities and so we should move forward with this expeditiously." Apparently due to the positive drug test, "on top of my other concerns", Dr. Ray referred Petitioner for a neuropsychological evaluation with Dr. Steven Jordan. One of the concerns he expressed was Petitioner's ongoing smoking. Dr. Ray recommended an L5-S1 posterior lumbar interbody fusion (PLIF). (Px5).

Petitioner underwent the recommended neuropsychological evaluation with Dr. Jordan on August 12, 2014. Dr. Jordan cleared Petitioner from a psychological standpoint to proceed with surgery. He noted a low risk for noncompliance and opioid misuse. Petitioner stated he intended to stop smoking at that time, and agreed to avoid any other type of nicotine use. As to the positive drug test, Petitioner reported: "He stated that he had one urine drop which was negative for cocaine in the office, but came back from the lab positive for cocaine." He denied ever using illicit drugs and stated that he has had otherwise negative tests. Based on PHQ-SADS testing, Dr. Jordan noted results indicating minimal somatization, mild anxiety and mild depression. (Px7).

Utilization review was conducted by orthopedic surgeon Dr. Clarence Fossier on September 10, 2014, and this appears to have been performed at the request of the Respondent (see Px17). After reviewing Petitioner's medical records and diagnostic studies, his opinion was that the recommended fusion surgery was reasonable and necessary. However, he indicated that the Petitioner had to quit smoking and dipping tobacco, and he needed to avoid e-cigarettes. It does not appear that Dr. Fossier reviewed the discogram from May 2014. (Px16).

Additional records from Franklin Hospital were submitted in Respondent's Exhibit 2. On September 16, 2014, Petitioner appeared at the ER complaining of anxiety, headache and back pain. Increased blood pressure was noted, and it was noted that he was out of Lisnoprol/Percocet. A history of chronic back and neck pain was noted. It appears he also complained of chest pain, and underwent a heart protocol. Clinical impression was chest pain, and Lisnoprol was prescribed. (Rx2).

Petitioner treated with Dr. Harrison for smoking cessation between October 14, 2014 and January 23, 2015. The initial report indicated he was a heavy tobacco user via both cigarettes and chewing tobacco. Chantix was prescribed. An October 20th note indicates Petitioner took the wrong dose and was advised to go to the ER. The last report of January 23rd notes Petitioner's levels were still a little high and he needed to follow up after surgery. It is unclear what levels this refers to as the records also indicate that the Petitioner was supposed to be nicotine free prior to surgery. The records note increased anxiety for Petitioner with smoking reduction or cessation. (Px12). The Petitioner continued to follow up with Dr. Rupert for medications, with the doctor noting on November 25, 2014: "Surgery may be scheduled in a few weeks – he is not sure if surgeon will cover pain meds – lives 2 hours away."

Petitioner returned to Dr. Ray on January 7, 2015. He noted that Dr. Jordan found Petitioner to be an excellent surgical candidate. He went over all the films again, and identified a right sided foraminal stenosis: "and so in this situation where it was primarily by discogram that we have identified the concordant pain," he recommended proceeding with a right L5-S1 transforaminal lumbar interbody fusion (TLIF), noting this would be less invasive than the previously prescribed PLIF. He believed the likelihood of getting Petitioner to return to work as a bulldozer operator was questionable, but that Petitioner was "of good heart", and desperately wanted to return to work. Given that he hadn't had an MRI in almost a year, he requested repeat films. (Px5).

An updated lumbar MRI was performed on January 21, 2015, and the report notes a small right-sided T11/T12 herniation with no significant central canal stenosis, a small right L5/S1 disc protrusion causing moderate right L5 foraminal stenosis, and mild bilateral foraminal stenosis at L3/4 and L4/5. When compared to May 24, 2013 films, no significant interval changes were noted. (Px5; Px19).

The Petitioner continued to follow up with Dr. Rupert for medications through November 5, 2015. (Px9; Rx5). The last report noted that the Respondent would not approve a spinal cord stimulator, but there was no indication of a prior prescription for such a stimulator. Dr. Rupert testified he didn't recall prescribing it, but that it could be used for both failed back syndrome or peripheral neuropathy. (Px10). The Arbitrator also notes

that on August 24, 2015, Dr. Rupert reported that Petitioner had an epidural steroid injection which did not work. The Arbitrator did not find any reports in evidence indicating that an ESI had been performed.

Petitioner underwent an FCE on October 27, 2015 at Joyner Therapy Services. The Arbitrator notes that an April 29, 2014 letter from the Respondent's nurse consultant, Donna Hilliard, had been sent to the Petitioner stating that an FCE had been scheduled for him on May 5, 2014 at Pro Rehab, but it doesn't appear this was ever completed. (Px14). The FCE indicated that Petitioner had the ability to perform 85.1% of the physical demands of his job as a heavy equipment operator. The therapist felt Petitioner was unable to return to his previous job as a heavy equipment operator, mainly due to his inability to sit for a consistent basis, and that he was at the light physical demand level. The limitations noted were based on increased pain, limited range of motion, mechanical changes and mechanical deficits. The Petitioner was noted to have provided full and consistent effort, and thus the testing was considered by the therapist to be valid. There were notations indicating biomechanical inconsistencies between floor to waist and shoulder height lifting, and an Oswestry Low Back Disability Questionnaire was determined to represent unreliable pain reports. (Px9; Px15; Rx5; Rx6).

Petitioner testified that he currently has pain in his lower back on both sides constantly that shoots down both butt cheeks down into his legs and feet. He testified he was still having numbness in his feet, but it was better with Gabapentin. Petitioner testified that his neck constantly hurts on both sides. Petitioner presented at hearing with a cane, and testified that he uses the cane when driving long distances and it helps him feel more comfortable.

Respondent submitted surveillance footage from April 22 and April 23, 2015. The first day the Petitioner was filmed leaving his house, driving a short distance to buy various items and to visit a medical facility before returning home. The Petitioner walked relatively slowly with a bit of a forward hunch, but he was able to walk, lift a few items in a plastic bag into the bed of his pick up truck, and he ambulated without a cane. On the second day the Petitioner was filmed getting into his car, and that was about it. The associated investigator's report indicated he drove to another residence about 30 minutes away and later returned home. (Rx8).

The Petitioner submitted a September 8, 2015 letter into evidence from the Respondent indicating that, based on the determination of Dr. Bernardi, the Petitioner had reached maximum medical improvement, and TTD benefits were being terminated. (Px13).

The Petitioner submitted the medical expenses that are alleged to be causally related to the accident as Petitioner's Exhibit 20, and these total $33,797.03. The Petitioner also claims that he is owed reimbursement for various medications totaling $1,247.12. (Px21).

Dr. Ray testified via deposition on September 9, 2015. (Px6). The Arbitrator notes that much of the doctor's direct testimony was in response to leading questions. When he initially saw the Petitioner, he knew this was going to be an "extremely complicated" case. He had doubts at different times as to whether he could help the Petitioner, noting concern that the Petitioner did well if he had to perform surgery. He testified the May 24, 2013 lumbar MRI showed a small far right lateral annular tear at L5/S1 with bilateral foraminal stenosis, and he didn't believe the Petitioner was a surgical candidate at that point. Because of the complicated nature of the Petitioner's condition, he wanted to obtain pain, psychological and neurology consults to get input from doctors who he trusted and who had assisted him in reasonably good outcomes on other cases. He referred the Petitioner specifically to Dr. Jordan, but did not recall if he initiated the consultations with Dr. Guyton or Dr. Rupert. (Px6).

While Dr. Ray testified that he does not routinely refer patients for discograms, he does in certain circumstances as an independent verifier concept to locate a pain generator. Dr. Ray's review of the January 21, 2015 lumbar MRI identified a diffuse L5/S1 bulge with left paracentral and right posterolateral annular changes with mild to moderate left foraminal stenosis. (Px6).

Dr. Ray opined that trauma can cause annular tears. He further opined that the accident at issue caused or aggravated the Petitioner's lumbar and cervical conditions based on the chain of events: a lack of symptoms, the accident, and ongoing symptoms subsequent to the accident. He testified that some of the Petitioner's other chronic/complex pain issues and "diffuse, obscure, hard to treat pain syndromes" could have resulted as well, in that "what he has can effervesce over into initiating other parts of the diagnosis." (Px6, p. 28, 32-33). He believed the annular tears, problems at L5/S1 and the recommendation of surgery were all related to the accident. He based his recommendation for surgery on the MRI films, physician consultations, the psychological evaluation, the utilization review, and the discogram. He testified the recommendation was not based on the discogram alone. However, on cross exam he testified that, if the discogram hadn't give him guidance, he didn't know what he was going to do for the Petitioner. He added: "So if you don't believe in discograms, I can give you reasons not to believe in them.", though he noted that is why they have to be performed by someone he has a track record with. (Px6, p. 56).

Dr. Ray testified: "I think that if the patient walked in today and said, looking at the risk benefit ratio, I don't want this surgery, I'd go along with him. If he walked in today and said, I've looked at all the information, you're my doctor, would you please just help me out? I think we vetted this case as well as I can. It's just not a super clean case. That's all there is to it." (Px6, p. 19).

In discussing future surgical outcomes, Dr. Ray testified as follows: "I talk to them about it, like in this case, every single piece of paper I have says I don't know if I can help you. So when you look at this patient, if you wanted to talk about your future-scope, I'm saying, I would say that I'm saying to the guy, I am really uncertain if you're going to do well. His response to me is I am doing incredibly poorly so if there is anything you can do that might help me, I want you to consider and then I want you to do that." (Px6, p. 26-27). He later testified, "I am not going to tell you he's going to do well." (Px6, p. 27-28). Further, Dr. Ray testified that he wouldn't even say his primary goal with surgery was getting the Petitioner back to work, noting: ". . . if I could say to him, hey, you know, don't go back to work and you don't have to have surgery and you'll live within the confines of your life. That would be a perfectly acceptable alternative answer in this case." But if the Petitioner feels he needs a better quality of life, the recommended surgery would provide him with a means of stabilization and improved quality of life. (Px6, p. 31).

On cross examination, Dr. Ray testified that while he reviewed multiple scans and consulted with his friends in trying to take care of the Petitioner, that: "This is a very complex case. I am not saying that if I were to do this surgery, I'd even get a good outcome." (Px6, p. 38). Asked if what makes this a complicated case includes a review of initial MRI films and noting relatively mild findings, Dr. Ray responded: "I would say if I can use my own adjectives, I would agree with you. It's stated in my report. I didn't see this guy as absolutely a surgical candidate" He further noted that in asking whether to operate on Petitioner, he did a lot of "hand wringing". (Px6, p. 39). He went on to testify that the Petitioner's accident started a "whole string of things", and "it's moved into this literally spreading pathology of whatever nature. Chronic pain, fibromyalgia, complex pain syndromes, etc." (Px6, p. 40). In a long response to a question, Dr. Ray included the following: "If there's one thing that decent about my documentation, it's the humility with which I say, I don't know exactly what is going to help this patient. So if the court wants to say I don't have the right to work through it and try and help him in this situation, the court is going to determine that." (Px6, p. 44). Dr. Ray also made it very clear how

emotionally and passionately he had invested himself into determining whether to operate on the Petitioner. (Px6).

Dr. Ray agreed that the blanching in the Petitioner's hands could be related to Raynaud's phenomenon, which is where the sympathetic system isn't working properly, and that "it could be emotional." (Px6, p. 47). At one point he testified that, in seeking other opinions on the Petitioner, he was looking for someone to tell him why he shouldn't operate on the Petitioner. (Px6).

He agreed that the Petitioner was diagnosed with peripheral neuropathy, and also agreed that the numbness and tingling in the extremities can spread into extreme sensitivity to touch and muscle weakness, which Petitioner displayed. He also agreed that the flexion and extension x-rays obtained by Dr. Bernardi did not demonstrate any lumbar spine instability. Dr. Ray agreed that smoking and hypertension could hinder a good fusion outcome. However, he did not agree that ongoing smoking prevented the Petitioner from being a surgical candidate. (Px6).

Essentially, Dr. Ray's testimony indicated he wanted to attempt the lumbar fusion as a kind of "thorn in the foot" removal, such that once the thorn is removed, you can move on to the other problems the Petitioner is having, with hope that the surgery resolves some of all of them: "It begins to let us concentrate on more specifically knowing if there are other mechanical pain generators immediately due to the injury or developing as secondary to the injury." (Px6).

Dr. Rupert testified via evidence deposition on January 27, 2016. (Px10). Dr. Rupert testified that Dr. Ray wanted his consultation with regard to diagnosis, identification of a pain generator and whether the Petitioner was a surgical candidate. He opined that MRIs taken in southern Illinois were of "poor, poor quality", and they "under-evaluate" what the problem is, so he always repeats them. (Px10, p. 7-11). He testified that the repeat May 24, 2013 films reflected L3/4 and L5/S1 degenerative disc disease, with facet arthritis he and an L5/S1 disk bulge. Dr. Rupert testified that he kept the petitioner off work throughout the course of his treatment, as he was limited to sedentary duty. (Px10).

Dr. Rupert noted that the symptoms of peripheral neuropathy occur in a "stocking / glove" distribution, as opposed to following any specific dermatome or pattern. (Px10).

The Petitioners improvement in back and buttock pain following December 3, 2013 facet injections indicated to Dr. Rupert that the facets were a component of his pain. However, he also testified that the Petitioner did not have improvement with repeat injections on January 31, 2014, and thus that the lumbar problems were not due to the facets but rather were discogenic. He testified that the Petitioner had decreased pain with cervical nerve blocks on December 10, 2013, but couldn't say how much of a decrease. (Px10).

Dr. Rupert testified that annular tears allow the chemical inside of the disc to leak out and irritate the tissues and nerves, causing pain. (Px10, pp. 22-23).

Dr. Rupert requested yet another lumbar MRI on January 13, 2014, with the January 27, 2014 report indicating an annular tear and retrolisthesis at L5/S1. He opined that retrolisthesis can cause pain due to laxity – "you get disc pain and you get posterior element pain", similar to facet joint pain. (Px10, p. 23). He testified that moderate right foraminal stenosis at L4/5 and L5/S1 was consistent with Petitioner's complaints of bilateral leg pain. (Px10).

The Petitioner's peripheral neuropathy he made it difficult to diagnose the location of his problem. Dr. Rupert indicated the peripheral neuropathy he did not stop him from walking in functioning, "it's the back pain and the associated leg pain that is causing him to have his loss of function". (Px10, pp. 31-33).

Based on his determination of discogenic pain, Dr. Rupert recommended a discogram. He testified that they are accepted tests in the Illinois medical community to determine pain generators, but agreed it has a subjective element to it. Interestingly, he noted that surgeons who want to obtain a discogram should not perform them themselves: "It's like having a fox in the hen house. Of course it's positive, you know, so - - I usually do them, in my general workup, because it gives me better information on the disk." He testified he was also using it in this case to determine if fusion was contraindicated by multiple bad discs, and that it is accurate when he performs them because he uses a manometer to measure disc pressure. (Px10, p. 35-37).

Dr. Rupert testified that the Petitioner told him that Dr. Ray had recommended surgery, and Dr. Rupert, based on his testing, indicated agreement with this recommendation. (Px10, pp. 47-48). He noted the January 21, 2015 lumbar MRI showed a right sided L5/S1 herniation. Dr. Rupert testified "Well, before, before, if you look at the - - if you looked at the previous MRI, it didn't say there was any herniations. So if you look at the CT discogram, you're starting to see it was central and to the right. And now, with this MRI, you're starting to see it's to the right." He believed this disc was causing right leg pain in an L5 dermatome. Taking the annular tears and the disc together, he believed this was consistent with back and bilateral leg pain. (Px10, pp. 48-51).

Dr. Rupert initially testified that he was not aware of Dr. Bernardi recommending an FCE with validity testing, but also testified that he prescribed one to address Bernardi's concerns about nonorganic pain issues, and that he relied on it in giving his opinions in this case. The FCE report noted Petitioner gave consistent effort 95.2 percent of the test, so he testified the test was reliable and noted as valid. (Px10, pp. 51-53).

Dr. Rupert opined that, beyond surgery, there was nothing more he could do for Petitioner from a pain management perspective other than medication. Dr. Rupert agreed that the Petitioner needed to stop smoking before undergoing a fusion surgery – "we all know that you can't have a fusion if you don't." (Px10).

Dr. Rupert's diagnoses were cervical facet joint pain, discogenic L5/S1 pain with herniated disc and annular tear, and peripheral neuropathy. He noted that as to discogenic pain, he "might as well include L4/5." He opined that these conditions were all causally related to the April 1, 2013 accident. He testified he hadn't worked up the cervical spine, other than the medial branch blocks, because the lumbar spine was the primary issue, but that the Petitioner was not at MMI as to the cervical spine. Dr. Rupert opined that the annular tears were due to the shearing effect on the spine from the Petitioner's bulldozer accident. He disagreed that the tears were degenerative, testifying if that were the case there should have been tears at the upper lumbar levels as well, and that "usually you see annular tears associated with trauma" at the L4 to S1 levels. He further testified, however, that "you're going to get people on both sides of the argument." (Px10, pp. 59-65).

Dr. Rupert opined that the Petitioner was not functioning or improved, and thus that he had nothing to lose with surgery. The FCE was the best picture of his functional abilities, with Dr. Rupert indicating he would not be able to return to work as a heavy equipment operator, and is likely limited to sedentary duty. He believed that concerns about nonorganic issues was a "smokescreen", given the FCE and neuropsych evaluations. (Px10, pp. 68-71).

On cross examination, Dr. Rupert was asked when he had prescribed an FCE and a spinal cord stimulator, but could not say when he had. He agreed that the Petitioner had peripheral neuropathy, and that it was not related to the April 1, 2013 accident. When asked if Petitioner's numbness and tingling complaints in the arms, legs and

feet were due to the peripheral neuropathy or the lumbar spine, Dr. Rupert testified it was related to both. He agreed that the peripheral neuropathy made it difficult to determine whether there was a dermatomal pattern to his symptoms coming from the lumbar spine, but that the positive straight leg raising test as support for a radiculitis. Asked if Dr. Ray recommended the discogram, Dr. Rupert indicated he was the one that recommended it, not Dr. Ray. (Px10, pp. 77-83).

Dr. Rupert testified that it was the discogram result that "turned my opinion that he needed disc - - needed surgery." He further testified that if a degenerated disc that is causing no pain is highly pressurized, it can create pain, but that he took care to perform the Petitioner's test with proper pressures, which is why the test wasn't concordant at all tested levels. Again, he agreed it is a subjective test, but that the patient is blind to which disc is being pressurized. (Px10, pp. 84-88).

Dr. Rupert was aware that the North American Spine Society recommended that the term "annular tear" not be used in diagnostic testing because of the implication that the finding is traumatic or painful. He agreed that an annular tear, in and of itself, does not mean it is acute, but he disagreed that it is a degenerative fissure, noting the disc can be torn in an injury, indicating that Petitioner did not have his pain until after the accident, which relates it to the accident. Initially Dr. Rupert testified the Petitioner did not have a cane when he first saw him, but after reviewing his November 25, 2013 report, he indicated Petitioner did always have his cane, "He's been consistent with that". (Px10, pp. 89-92).

Dr. Rupert agreed that Petitioner has consistently complained of significant pain regardless of the treatments he received, and that his chronic pain hasn't responded to anything. (92-93). He agreed Petitioner tested positive one time for cocaine, and indicated he had done it at some point in the past, but Dr. Rupert indicated that another positive test would result in terminating their relationship, and Petitioner never tested positive again. (Px10, pp. 92-94). The EMG/NCV being negative didn't tell him anything, as this test is generally negative unless there is a physical nerve injury. Radiculitis can occur with nerve irritation and can result in pain down the leg. Petitioner's radiating pain was reportedly mainly on the sides and back of the leg, indicating L5 or S1 – he couldn't be more specific because of the interrelation of the peripheral neuropathy. Dr. Rupert agreed that the branch blocks ruled out lumbar facet issues as the source of pain, and at that time he indicated his belief that peripheral neuropathy was a lot of his pain. He was not treating the Petitioner's peripheral neuropathy, though he noted that some of the medications he took could be used to treat that condition as well. (Px10, pp. 94-97). Dr. Rupert indicated that Petitioner had a listhesis, and therefore some sort of instability, and that the fusion would be performed to fix the instability, while Dr. Ray would also likely remove the painful disc. (98-101). He further testified that peripheral neuropathy would not be repaired by surgery, and that the condition cannot be fixed, and that the neuropathic pain would likely not go away. He believed that any risks of surgery did not outweigh the benefits, noting Petitioner is not improving otherwise. (Px10, pp. 101-105)

Neurosurgeon Dr. Bernardi gave a deposition on September 11, 2015. (Rx1). He saw Petitioner for a Section 12 examination at Respondent's request on July 30, 2013. Petitioner completed three pain-based questionnaires, noting abnormally high scores on two of them which could suggest non-organic contributions to Petitioner's physical symptoms. Dr. Bernardi noted an essentially normal neurological examination, and that his review of the lumbar and cervical MRI scans indicated very mild degenerative disc disease, nothing acute or post-traumatic. He did not believe that the various lumbar MRIs that were performed in this case were significantly different, other than that they were performed on different machines and thus some may show some things others didn't. (Rx1, pp. 13-16).

Dr. Bernardi diagnosed multi-level degenerative disc disease in the cervical and lumbar spines, and diagnosed back and neck pain, numbness and paresthesias in the legs and numbness and blanching of the hands, all of

uncertain etiology. He had no objective basis to explain the source of the Petitioner's severe pain throughout his whole body. While he believed that Petitioner's acute symptoms were causally connected to the work accident, he could not explain the ongoing chronic symptoms four months out, noting such acute symptoms would normally have abated after about 6 weeks. Dr. Bernardi recommended x-rays to verify a lack of ligamentous injury, as none was indicated on MRI, a course of physical therapy followed by work conditioning/hardening and then full duty or a functional capacity evaluation (FCE). He believed that some level of non-organic issues existed with Petitioner. The purpose of the FCE would first be to determine what, if any, permanent restrictions Petitioner required, and second to determine whether non-organic or non-physiological issues were contributing. (Rx1, pp. 17- 20).

Dr. Bernardi testified that patients with a history of tobacco, pending litigation, age over 50 and psychological morbidity were the three biggest factors which are predictors of the development of chronic pain. He opined Petitioner could work with restrictions and that he had not reached maximum medical improvement at that point, though he had no objective basis for work restrictions. He believed that there had to be "more than meets the eye" with Petitioner, and that there were likely non-organic signs given he noted Waddell signs on exam, elevated pain questionnaire scores, and pain in multiple body areas that did not appear to be in a physiologic pattern. (Rx1).

In a 2014 addendum report, Dr. Bernardi testified that he noted Petitioner had not been compliant with physical therapy, missing about a third of his scheduled visits. He believed that a lack of compliance raises questions about a patient's desire to improve. He again felt that an FCE was appropriate. (Rx1).

On July 6, 2015, Dr. Bernardi prepared a third report. Testifying about same, he opined that discogram was not a subjective test that was not an appropriate basis for determining whether surgery was indicated: "I do not believe there is a shred of evidence to support the utility of discography as a diagnostic test." He added that all diagnostic testing, even objective tests like MRI, are not accurate at determining the cause of back pain. He opined that the surgery proposed by Dr. Ray gave the Petitioner a significantly greater chance of ending up worse than ending up better. Dr. Bernardi testified that he recommends lumbar fusion surgery in two situations: where a patient has bone on bone degenerative disc disease at one level and refractory pain, and where the patient has a significant spondylolisthesis. The vast majority of spine surgeries are elective, in terms of them being done to relieve subjective pain. Given the lack of any pattern to the Petitioner's indicated symptoms and pain, he could not understand why a surgeon would recommend surgery in this case. (Rx1, pp. 27-33).

The flexion and extension x-rays Dr. Bernardi recommended did not reflect any instability in the lumbar spine. Citing recent medical studies, Dr. Bernardi noted less than optimal outcomes based on work injury litigation, chronic opioid use, age over 50 and people with significant depression. Noting that several of these factors were applicable to the Petitioner, he reiterated that the chance of Petitioner having a good fusion outcome was "dismal". Given the lack of instability in the films, and no objective basis to support a spinal problem, Dr. Bernardi felt he had reached MMI. (Rx1, pp. 34-37).

On cross examination, Dr. Bernardi testified that he was not aware of the opinion of orthopedic surgeon Dr. Fossier that surgery was reasonable. He agreed that there are guidelines on when to do fusion surgery that come from multiple sources, noting "there are a lot of different studies out there that can only support any conclusion you want." Dr. Bernardi agreed that three other doctors (Ray, Rupert and Fossier) indicated that surgery was reasonable versus his opinion, and stated: "I didn't know it was a matter of numbers, but okay." (Rx1, pp. 45, 51-52).

Dr. Bernardi agreed he is fairly conservative in terms of the surgical management of back pain. He agreed that a neurosurgical recommendation is a judgment call, and that fusions can be "predictably unpredictable", noting: "In the best of circumstances it's a coin toss. And sometimes it's considerably less than a coin toss." (Rx1, pp. 56-59). He agreed that a surgeon's determination regarding the reasonableness of a surgery is influenced by the outcomes they have experienced with their own patients, and this can be different from surgeon to surgeon, but that is why he references articles that objectively look at a large group of patients, not just his own anecdotal experience. He believed that the Petitioner's chance of a successful outcome was less than 50%, and that the odds were greater that he could end up worse. (Rx1).

Dr. Bernardi testified that he did not believe that even a majority of surgeons in the St. Louis area used discograms to assist in surgical determinations, noting "it is very infrequently used outside the Workers' Compensation arena." He did agree that the procedure is used by some spine surgeons in making surgical decisions (Rx1, pp. 65-68).

Dr. Bernardi reiterated on cross exam that the current recommendations from the Radiology and the North American Spine Society is to discontinue using the term "annular tear" because of the implication that the finding is traumatic or painful, and that they are degenerative fissuring of the disc. He noted these guidelines were published by three different journals. He noted that people who tend to be aggressive in dealing with axial back pain are the ones who really like to use the term, annular tear. 50% of the population has annular tear findings and they are unaware of it. When it was noted that Dr. Rupert opined Petitioner's annular tears could be acute, Dr. Bernardi testified: "I would challenge anyone to show me any article, ever, ever, in the medical literature, that proves an annular tear is acute. I have never seen it." (Rx1, pp. 68-70).

Dr. Bernardi testified that the Petitioner's lumbar MRI findings of mild to moderate foraminal stenosis was not clinically significant, noting Petitioner didn't have symptoms that correlated with such findings, and also noted that it was not clear to him that Dr. Ray believed the foraminal stenosis was symptomatic. (Rx1).

Dr. Bernardi admitted he never reviewed Dr. Jordan's neuropsychologist report or the FCE prior to the deposition. As to the psych report, he questioned Dr. Jordan's findings that there was nothing abnormal about Petitioner having pain levels of 9 out of 10 two years after an accident, not associated with any acute objective findings on physical and neurological exam, and "if he does not find that unusual, I don't know what he would find unusual." He agreed not every report noted 9/10 pain, but that they all indicated high pain levels and no "good" days. He also questioned how Dr. Jordan could determine that there was no active litigation impact when he was testifying in a deposition for Petitioner's case. He further testified that the single biggest risk factor for the Petitioner having a poor surgical report is the fact he has a workers' compensation claim. He testified this was not his opinion, but rather is a fact similar to the fact that smoking is a risk factor for a failed fusion, and that Petitioner also is a smoker. (Rx1, pp. 84- 91).

Dr. Bernardi testified that he did not agree with Dr. Rupert, that L5-S1 was the pain generator. He testified that a discogram is a completely subjective test, the accuracy of which is unproven. Dr. Bernardi testified there was no objective evidence in the medical records, films or on examination to support the need for surgery. Dr. Bernardi testified that the MRI of the lumbar spine from January 21, 2015, showed some mild snugness of the right L5 foramen. He testified this was early degenerative narrowing of the foramen, but not enough to be clinically significant. He testified it was obviously not clinically significant as Petitioner did not have right symptoms for foraminal stenosis. Dr. Bernardi testified that Petitioner's leg pain did not correlate with the distribution of any known nerve, and he was at a loss as to why someone would consider operating on Petitioner. Dr. Bernardi testified that assuming there was no instability on the x-rays and pending the results of an FCE he felt Petitioner has reached maximum medical improvement. (Rx1).

Ultimately, based on all the factors he has noted, Petitioner had a less than 50% chance of success with lumbar fusion. He referenced underlying depression, psychological issues, signs of non-organic findings on exam, nonphysiological complaints, and "very, very soft" findings on imaging studies. Petitioner's complaints of pain did not correlate with any known nerve distribution, and he was at a loss to understand why a surgeon would consider operating on the Petitioner. (Rx1).

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

With regard to the cervical spine, the Arbitrator finds that the Petitioner has failed to prove by a preponderance of the evidence that his current condition is causally related to the April 1, 2013 accident.

The Petitioner's initial visit to the Family Health Care Clinic at Franklin Hospital on April 2, 2013 indicated he felt something hurt in between his shoulder blades, and by night time had pain at the end of the thoracic spine "where he couldn't bend." Additionally, the report states: "he has been also hurting for a long time in his cervical spine just before this happened." A separate portion of the report states: "Neck pain (pain originated in the neck area first a day or so ago...but is now down into the lower back)." The initial report of Dr. Cox on April 19, 2013 stated that the Petitioner reported a one month history of neck pain prior to the accident, and that this included numbness and tingling in his bilateral 4th and 5th fingers. He did indicate that the prior pain was not as severe.

Dr. Ray and Dr. Rupert, in the Arbitrator's view, had ample opportunity to treat the Petitioner's cervical spine had they deemed it necessary. While both Dr. Ray and Dr. Rupert have testified that they essentially had put the Petitioner's neck condition on the back burner while they focused on the low back condition, the Arbitrator does not find this persuasive. The idea that the cervical spine would simply be ignored in favor of the lumbar spine for two years makes no logical sense unless the condition was not significantly complained of by the Petitioner. The Arbitrator further notes that the presence of unrelated peripheral neuropathy makes any cervical diagnosis suspect at this point. Given the notes of two different doctors indicating the condition had begun just a month prior to the accident, that it included complaints of numbness into the fingers prior to the accident, and that no treatment was rendered to the Petitioner for the cervical spine for almost two years indicates that any current cervical condition is no longer causally related to the accident. The Petitioner may have sustained an initial temporary aggravation of the cervical spine in the accident, but the preponderance of the evidence does not support an ongoing causal relationship.

The Arbitrator finds that the Petitioner's lumbar condition remains causally related to the April 1, 2013 work accident. There was no evidence of recent prior low back pain before the accident, and the mechanism of injury supports a potential low back injury. The Arbitrator believes, however, that the existence of radiculopathy remains questionable in this case given a negative EMG for radiculopathy, and the fact that peripheral neuropathy appears to make it very difficult if not impossible to determine of the Petitioner's symptoms are in a dermatomal pattern or not. Additionally, Dr. Bernardi's point is well taken that the Petitioner is essentially complaining of pain throughout his body: the upper spine, the lower spine, both arms, both legs and headaches.

The Arbitrator notes that both Dr. Guyton and Dr. Rupert have opined that the Petitioner's peripheral neuropathy is not related to the accident at issue in this case, and the Arbitrator accepts and adopts those

opinions in this case. As such, the parties may need to determine, if possible, what FCE restrictions may be due to the Petitioner's lumbar condition as opposed to the denied cervical condition, and the unrelated peripheral neuropathy.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner has failed to prove that the lumbar fusion surgery proposed by Dr. Ray is reasonable and necessary under the Act.

The surgical recommendation was made by Dr. Ray in this case, however he had indicated that the Petitioner was not a surgical candidate prior to a discogram being performed. The discogram was determined by Dr. Rupert to be concordant at the L5/S1 level, and based on the discogram identification of this level as a pain generator, he recommended fusion surgery to Dr. Ray. While both doctors have made it clear that the surgical recommendation was not solely based on the discogram results, it is clear to the Arbitrator that the discogram results changed the treatment path in this case. Dr. Ray had indicated that after he initially reviewed the report of Dr. Bernardi, they both seemed to be of the opinion that there was not a surgical indication. The problem in this case is that this positive result is questionable in the face of the other evidence in this case.

As to the discogram itself, the Arbitrator found Dr. Rupert's testimony interesting. He indicated that surgeons should not perform them for their own patients, as that would be "like having a fox in the hen house" because they would essentially get the result they were looking for. The Arbitrator takes this as an indication that the test has the potential for some level of subjectivity and/or potential manipulation. It is unclear if this would occur consciously or subconsciously, but from the Arbitrator's perspective this impacts the reliance that should be placed on the test in this case in determination if the Petitioner needs surgery. While there is no indication in any way that the performance of the test by Dr. Rupert was invalid, and Dr. Rupert testified as to how he ensures that the test is accurate, it was noted by Dr. Ray that he discussed with Dr. Rupert what he was looking for in this test. Once Dr. Rupert knows this, for example if Dr. Ray indicated the lumbar level he was concerned about, how docs that not place Dr. Rupert in a similar position as the surgeon? And if that is the case, is that not the fox being in the hen house? It is abundantly clear to the Arbitrator that, but for the discogram and surgical recommendation from Dr. Rupert, Dr. Ray was not planning to recommend surgery.

Also indicating the subjective nature of the test, Dr. Bernardi testified that discograms are not used by the majority of local surgeons, and questioned its reliability entirely with regard to the value of the test in determining the location of a spinal pain generator. He specifically testified: "I do not believe there is a shred of evidence to support the utility of discography as a diagnostic test."

It is difficult, based on the totality of the evidence in this case, for the Arbitrator to determine that a major surgery determination should be based so significantly on a test with this much uncertainty attached to it.

Dr. Rupert performed the initial lumbar facet injections and determined that Petitioner's improvement indicated that he had facet issues. Repeat injections did not result in improvement, and his impression was that the Petitioner did not have facet problems, and therefore he had disc pain. The Arbitrator believes this adds further questionability as to what the pain generator is in this case for the Petitioner's lumbar complaints.

There is a question, based on the evidence, as to whether annular tears can be caused by trauma, and whether they are pain generators. The testimony of Dr. Ray and Dr. Bernardi was significant. When he was initially asked if annular tears could be traumatic, Dr. Ray testified: "Well, let's just look at it from a common sense

perspective. At one point its normal, at the next point, its not normal. So at some point it changes. So if you look at calculus and differential calculus, at some point it changes." He then was asked again, and responded: "My opinion is that it can and that there are variations in how I do it", without further explanation of how he does it. How this answered the question is unknown to the Arbitrator. Dr. Ray later testified that the mechanism of the Petitioner's injury was such that there was a shearing effect that likely caused the annular tears, noting this made sense in that the Petitioner did not have his current pain and symptoms prior to the accident. Dr. Rupert testified similarly with regard to this shearing effect. Dr. Bernardi, on the other hand, testified that there are no studies which prove that an annular tear is a pain generator, and when asked about a traumatic cause for such tears, stated that he would "challenge anyone to show me any article ever, ever, in the medical literature, that proves an annular tear is acute. I have never seen it." The Arbitrator finds that the opinion of Dr. Bernardi in this regard was more persuasive than the opinions of Dr. Ray and Dr. Rupert. Again, this puts into question the reliance on the existence of annular tears in this case as a basis for a surgical determination.

There are pieces of evidence in this case that the Arbitrator had a difficult time putting significant reliance upon. With regard to Dr. Jordan's neuropsychological evaluation, Dr. Bernardi countered that some of the findings in the report did not make any sense, particularly in terms of their being a lack of litigation involved in this case. Unfortunately, the report of Dr. Jordan is significantly conclusory in nature, and does not explain very well how he came to the conclusions he did. Dr. Ray, when he was asked about Dr. Jordan's finding that the Petitioner was a low risk surgical candidate, noted that Dr. Jordan "is not perfect", and that his input is only one piece of the puzzle for him.

The utilization review report of surgeon Dr. Fossier was admitted into evidence over the Respondent's objection as an admission against the Respondent's interests. However, in reviewing the report, as with Dr. Jordan, the report is highly conclusive and does not sufficiently explain the basis for the doctor's findings. The fact that the opinion may be against the Respondent's interest does not absolve the report from being scrutinized for credibility and weight. Here, the report is minimal and simply does not explain why a fusion is reasonable and necessary given the known facts of the case.

An FCE was performed in this case which was indicated to be significantly valid. However, in reviewing the entire report, there appeared to be some internal inconsistencies with regard to the validity of the findings regarding the Petitioner's limitation. There were notations indicating biomechanical inconsistencies between floor to waist and shoulder height lifting, and an Oswestry Low Back Disability Questionnaire was determined to represent unreliable pain reports. Part of the basis for the limitations of the Petitioner were his pain levels.

Dr. Rupert's records also show inconsistencies that should, in the Arbitrator's view, raised red flags. For example, on November 25, 2013, his report indicates that the Petitioner indicated that he had increased pain with chiropractic therapy (see page 3). On January 13, 2014, his report notes that the chiropractic treatment helped his pain. As noted above, the Petitioner complained of virtually every part of his body in some way following the April 1, 2013 accident, much of it complained of as being very severe.

The Respondent presented surveillance video of the Petitioner. The time length of the footage was very minimal. Nothing was depicted which would indicate that the Petitioner was exceeding the limitations indicated in his FCE in any way. However, it is also true that on two different occasions in April, 2015, the Petitioner was ambulating without a cane, and the video appears to indicate that there was nothing abnormal about the Petitioner walking without a cane. He did not move rapidly, but he also did not appear to be in excruciating pain, as some of his records have indicated. The Arbitrator does not believe that the Petitioner is intentionally malingering or being disingenuous about his complaints. However, his reliability as a historian is somewhat questionable.

Multiple times during his deposition, Dr. Ray alluded to or inferred that the Petitioner may have some type of sympathetic system pain syndrome. Essentially, his testimony is, once the Petitioner had this accident, the dominoes started to fall, and the initial trauma or insult breaks down the body, and then the body starts breaking down, apparently into such pain syndromes. In the Arbitrator's experience, these pain syndromes are difficult to diagnose, and in this case, we have no evidence of testing or medical work-up which would support a diagnosis of such a pain syndrome. Additionally, no evidence was not presented as to whether Dr. Ray has the expertise to diagnose such conditions, or what the basis of such diagnosis would be. Again, the doctor seems to be basing much of his opinion on this case on a chain of events analysis. No such pain syndrome has been diagnosed in this case within a reasonable degree of medical certainty.

The treaters' reliance on straight leg raising as indicative of a lumbar problem is difficult to accept in this case. A review of all of the medical records in this case shows varying findings with regard to this test. There is a subjective component to this test on the part of the patient, as well as the physician. As such, this also appears to be a weak basis to determine if a significant surgery like a lumbar fusion is reasonable in this case.

Overall, Dr. Ray made it clear in his testimony that he simply does not know exactly what is causing the Petitioner's symptoms, that it is a very complicated case, and that the Petitioner has a multitude of complaints. For this reason he really could not say with any reasonable degree of medical certainty, in the Arbitrator's view, that the proposed surgery has a reasonable likelihood of resulting in symptomatic improvement. His position appears to be that he doesn't know exactly what will help the Petitioner, that the recommended fusion is his best guess based on a lot of scrutiny of findings from multiple sources, and that he would perform the surgery because the Petitioner can't live with his current condition and is seeking anything that might give him relief. Dr. Ray has quite clearly testified that he simply does not know whether the recommended lumbar fusion surgery will help the Petitioner, in whole or in part, or not. He believes the Petitioner's pain picture is complicated and, as a neurosurgeon, that the recommended fusion surgery is the best course of action given the information he has available to assist him in making this determination. However, Dr. Ray's uncertainty about the specific cause of the Petitioner's pain, and whether the surgery will help him, is palpable in reviewing his deposition.

This has to be taken in the context of Dr. Bernardi's very strong recommendation against fusion surgery. The doctor goes so far as to say he basically could not contemplate how someone would recommend surgery in a case like this given the objective findings of mild degenerative cervical and lumbar changes, and that it was opinion that the Petitioner had a greater chance of being worse than being better following surgery.

The Arbitrator appreciates Dr. Ray's expressions of passion and concern for the Petitioner and what is best for his health. The Arbitrator shares that passion and concern, however the role of the Arbitrator is to review all of the evidence and to determine whether, in this case, a particular procedure is, based on a reasonable degree of medical and surgical certainty, reasonable and necessary. Here, the Arbitrator has an examining neurosurgeon, Dr. Bernardi, who makes it very clear he think this surgery not only is not reasonable and necessary, but that it would be a bad idea in this case and has a greater chance of making the Petitioner worse than it does of making him better. He also has a treating neurosurgeon, Dr. Ray, essentially testifying that the Petitioner's case is very complicated, that because of this he has sought as much information as he can from multiple sources, and that he has determined that, while he is recommending a fusion surgery, he cannot really say whether it will help the Petitioner or not.

On balance, analyzing the case by the preponderance of the evidence standard, the Arbitrator believes these two opinions indicate that the surgery is not reasonable and necessary pursuant to the Act. It appears to the

Arbitrator that there is a significantly stronger chance that the surgery will either not help the Petitioner, or will make him worse, than it will of helping him. There are simply too many other things that appear to be going on with this Petitioner, whether it be a pain syndrome, peripheral neuropathy or some level of nonorganic issues, to allow the Arbitrator to determine that it is reasonable to perform a major surgery like a lumbar fusion. The Arbitrator in this case sought to determine if, based on a review of all of the evidence available in the record, the surgery is reasonably required to cure the effects of the Petitioner's injury. That simply hasn't been made clear here sufficiently under the standard of proof.

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:

With regard to the treatment of Dr. Corzine, the Arbitrator finds that the records reflect no improvement in the Petitioner's condition despite months of treatment. The Petitioner's indication of his response to these treatments per various medical records range from very temporary improvement to making him worse. The Arbitrator thus finds that all treatment subsequent Dr. Corzine's May 9, 2013 referral to Dr. Ray was excessive and not necessary treatment pursuant to Sections 8(a) and 8.2(e) of the Act. The Arbitrator believes it was unnecessary and excessive for Dr. Corzine to continue to provide ongoing ineffective treatment to the Petitioner after May 9, 2013. When treatment so clearly, as in this case, provides no lasting improvement, it is unreasonable for a provider to continue to provide, and charge for, the ongoing treatment, especially given the significant number of treatments provided in that span. Section 8.2(e) of the Act states that a provider shall also not bill or otherwise attempt to recover from the employee for services or treatment determined by the Commission to be excessive or unnecessary. As such, pursuant to the findings of the Arbitrator and the law, neither the Petitioner nor the Respondent are liable for the charges of Dr. Corzine subsequent to May 9, 2013.

The Respondent is liable for the causally related medical expenses contained in Px20, except for the medical expenses of Dr. Corzine that were incurred after May 9, 2013. As the expenses of Dr. Corzine after May 9, 2013 were denied based on the treatment being excessive and unnecessary, pursuant to Section 8.2(e) of the Act, neither the Petitioner nor the Respondent are liable for those expenses.

The Respondent shall also reimburse the Petitioner $1,247.12 for his out of pocket medical expenses. (Px21).

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 Petitioner is entitled to TTD from June 1, 2013 through July 6, 2013, the date upon which Dr. Bernardi determined the Petitioner had reached maximum medical improvement (MMI).

The Arbitrator finds that the Petitioner reached MMI on July 6, 2015, based on the opinion of Dr. Bernardi. The Petitioner had been treating for almost three years after his injury as of the date of hearing. Dr. Rupert has indicated he has nothing to offer Petitioner beyond medication if there is no surgery. Dr. Ray has made it clear that he really does not know what will help the Petitioner. However, the Petitioner remained under restrictions pursuant to the FCE. Dr. Bernardi had recommended an FCE, but his testimony indicated he was not aware of the results of that test at the time he testified. No evidence was presented to indicate that the Respondent had employment available to the Petitioner within the FCE restrictions. As such, the Petitioner is also entitled to maintenance from July 7, 2015 through the February 5, 2016 date of hearing.

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

Jessica Caron,
Petitioner,

vs.

Advocate Eureka Hospital,
Respondent.

17IWCC0252

NO: 13 WC 38066

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 21, 2016, is hereby affirmed and adopted.

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

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

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

DATED: APR 21 2017
o4/6/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0252

CARON, JESSICA
Employee/Petitioner

Case# **13WC038066**

ADVOCATE EUREKA HOSPITAL
Employer/Respondent

On 1/21/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.37% 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
SEAN D OSWALD
3100 N KNOXVILLE AVE
PEORIA, IL 61603

2461 NYHAN BAMBRICK KINZIE & LOWRY
CHRISTOPHER GIBBONS
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

17IWCC0252

STATE OF ILLINOIS)
) SS.
COUNTY OF MCLEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JESSICA CARON,
Employee/Petitioner

Case # **13 WC 38066**

v.

Consolidated cases:

ADVOCATE EUREKA HOSPITAL,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS MCCARTHY**, Arbitrator of the Commission, in the city of **BLOOMINGTON**, on **December 18, 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 **8/20/2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***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 $**25,361.44**; the average weekly wage was $**487.72**.

On the date of accident, Petitioner was **34** years of age, ***married*** with **2** dependent children.

Petitioner N/A received all reasonable and necessary medical services.

Respondent N/A paid all appropriate charges for all reasonable and necessary medical services.

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

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

ORDER

Denial of benefits

No benefits are awarded. Petitioner has failed to prove an accident arising out of her employment as alleged.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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

Signature of Arbitrator

1/11/21016

Date

JAN 21 2016

STATE OF ILLINOIS)
) ss.
COUNTY OF MCLEAN)

17IWCC0252

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jessica Caron,

Petitioner,

v.

Advocate Eureka Hospital,

Respondent.

Court No. 13 WC 38066

STATEMENT OF FACTS

Petitioner alleges that she sustained accidental injury arising out of and in the course of her employment on August 20, 2013. Specifically, Petitioner testified that while attempting to help a patient move while using lifting equipment and twisting that lifting equipment, she sustained a sudden onset of back pain. She testified that while performing a twisting motion, a burning pop occurred in her lumbar spine. She testified she was in pain and knew that she had injured herself.

Petitioner testified that following her accident, she reported it to her supervisor that day, Jane Patterson. Ms. Patterson was her charge nurse. The Petitioner said that her regular supervisor was Ron Bartlett, and he was not at work that day. Mr. Bartlett later testified that he didn't remember if he was at work on the date in question, but that if he was absent, the charge nurse would be acting in his place. The Petitioner said that she filled out an accident report, offered into evidence by both parties as PX 2 and RX 1. She said that Nurse Patterson assisted her in completing the report. In the report, the Petitioner's description of the accident basically matched her description given at arbitration. She said that she took the report with her when leaving work that day, and then took it to her doctor, Dr. Hughes, when she first saw him for treatment several days later. She acknowledged that she signed the report, but did not recall when it was signed. Next to the Petitioner's signature, the report is dated. It appears that the date of September 5, 2013 has been written over the date of August 21, 2013. The Petitioner did not say whether she ever dated the report, but said that she did not change it, as she would have initialed any changes.

She did not seek immediate medical treatment and continued to work her regular schedule until August 29, 2013 when she sought treatment from her personal physician, Dr. Hughes. She gave Dr. Hughes a history of having lower back pain and nausea for two weeks. She noted she had had similar pain on the left side about 10 years earlier, prior to her previous lumbar laminectomy. Dr. Hughes diagnosed Claimant with a "overuse/muscle strain". (PX 4) His note indicates that Petitioner and Dr. Hughes discussed Claimant's work duties and the fact that her job involved significant bending and stooping at times. According to Claimant, she specifically testified she gave Dr. Hughes a history of her alleged workplace accident. Dr. Hughes' notes do not contain this history.

Claimant returned to Dr. Hughes on September 4, 2013. She noted her back pain continued to give her trouble and that she had been "hollering out in pain while sleeping". Dr. Hughes suspected a disc herniation as the Petitioner presented with more radicular complaints. The office note contained no reference to the Petitioner's work duties or any specific accident. Claimant underwent an MRI at Dr. Hughes' direction of her lumbar spine on September 10, 2013.

That study was positive for post-surgical changes and noted no recurrent disc herniation. On September 11, 2013, the Claimant returned to Dr. Hughes who reviewed the MRI study and took a history of her ongoing complaints and symptoms. At no point did Dr. Hughes' records indicate Claimant gave a history of the workplace accident. Dr. Hughes recommended Claimant try an epidural steroid injection which she underwent on September 16, 2013.

Claimant's supervisor, Ron Bartlett, testified in this matter. He is the Medical Services and Clinical Manager at Eureka Hospital. He testified that he hired the Claimant and supervised her work. He testified that all employees go through training in relationship to workers' compensation and reporting workplace injuries. He testified the accident report is available to all employees online through their company website and that he has both inter-office mail, his desk, and another internal procedure for receiving communication from his employees. Claimant testified Mr. Bartlett was on vacation on the date of accident. Mr. Bartlett testified he did not know whether or not he was on vacation. He testified that he received the accident report from the Claimant on September 19, 2013, and signed it that day which was his normal practice. He also said that he spoke with the Petitioner on several occasions at work between the alleged accident date and September 19. He said that she did tell him that her back was hurting, but did not recall her telling him about her accident. He said that if she did, he would have followed up.

Mr. Bartlett also testified about two e-mails sent to him from the Petitioner which were entered into evidence as RX 2. In the e-mails, sent on September 3 and September 9, 2013, the Petitioner talked about her work schedule, interaction with co-employees

and her need for her schedule to accommodate a doctor's appointment she had scheduled. Neither e-mail mentions the Petitioner's alleged accident of August 20, though in the e-mail of September 9, the Petitioner states "I have been very upfront with you and everyone else on what's been going on with me and my back." On cross examination, the Petitioner did not answer the question of whether she had sent the e-mails.

Claimant began physical therapy in September of 2013 and continued to treat with Dr. Hughes for several visits in October of 2013. She also continued to work during this time period.

On November 29, 2013, the Claimant saw Dr. Tracy, the surgeon who did her previous surgery. She gave him a history of specifically injuring herself on August 20, 2013 while lifting a heavy patient who weighed 350 pounds. Dr. Tracy recommended conservative care. This was the first time any medical records recorded a specific history of the alleged accident. The Claimant underwent additional injections, therapy and conservative measures and continued to work. Claimant came under the care of Dr. Kube in February of 2015. Dr. Kube ordered an EMG and then a discogram and has recommended a lumbar fusion. Claimant attended an independent medical evaluation at the request of Respondent with Dr. Frank Phillips. He agreed with the recommendation for surgery. He further noted that if Claimant sustained injury as she described, it would be related to the accident in this case. He further noted Claimant's medical records did not have an initial history of accident.

Conclusions of Law

The issue in this case is whether or not Claimant sustained accidental injury arising out of and in the course of her employment on August 20, 2013.

At trial, Claimant described a specific onset of pain while moving heavy patient and using lifting equipment. She then testified that she filled out the aforementioned accident report and took it with her when she saw her doctor.

Dr. Hughes' notes of his first and second examinations of the Petitioner are very thorough and complete. In neither note is there any mention of the accident which is clearly described on the Petitioner's accident report which she said she took to the doctor. In the initial e-mail to Ron Bartlett, sent five days after her first doctor's visit, the Petitioner does not reference any recent accident involving her back. Accordingly, none of those documents serve to corroborate the Petitioner's claim of a specific injury on August 20, 2013.

Based on the above sequence of events, it appears to the Arbitrator that the Petitioner decided at some point after sending the first e-mail, perhaps on September 5,

to claim she'd had a specific accident. If that weren't the case, Nurse Patterson could have been subpoenaed to verify the Petitioner's version of events.

Mr. Bartlett testified with a great deal of credibility that reports could be easily delivered to him through a variety of sources and that he received a report on September 19, 2013. Furthermore, Mr. Bartlett testified and Respondent's Exhibit No. 2 demonstrates that the Claimant was comfortable communicating via e-mail with Mr. Bartlett regarding any supervisory issues such as scheduling

Therefore, the Arbitrator does not find it credible that Claimant sustained an accident as she described at trial and finds Claimant failed to prove she sustained accidental injury arising out of and in the course of her employment. All benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

☒ Affirm and adopt (no changes)	☐ 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

David Dover,
Petitioner,

vs. NO: 13 WC 39972

M. L. Vasquez, Inc.
Respondent.

17IWCC0227

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 15, 2016 is hereby affirmed and adopted.

The party commencing 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: APR 13 2017

Joshua D. Luskin

o-04/05/17
jdl-wj
68

Charles J. DeVriendt

Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DOVER, DAVID
Employee/Petitioner

Case# **13WC039972**

M L VASQUEZ INC
Employer/Respondent

17IWCC0227

On 1/15/2016, 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 0.47% 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:

2261 WILLIAMS CAPONI & FOLEY PC
KIRK CAPONI
30 E MAIN ST
BELLEVILLE, IL 62222

0299 KEEFE & DePAULI PC
GREGORY S KELTNER
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

17IWCC0227

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

David Dover
Employee/Petitioner

v.

M. L. Vasquez, Inc.
Employer/Respondent

Case # **13** WC **39972**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Collinsville**, on **11/24/15**. 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 **Did Petitioner exceed his two choices of physician?**

FINDINGS

On **4/5/13**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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 **$1,530.06**; the average weekly wage was **$765.03**.

On the date of accident, Petitioner was **54** years of age, *married* with **0** dependent children.

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

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

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

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

ORDER

Because Petitioner failed to notify Respondent of his alleged accident within 45 days of its occurrence as required by Section 6(c), benefits are denied. Benefits are also denied because Petitioner did not sustain an accident arising out of and in the course of his employment with Respondent and because his current condition of ill-being is not causally related to the alleged accident.

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

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

Michael K. Nowak, Arbitrator

1/2/16
Date

ICArbDec p. 2

JAN 15 2016

FINDINGS OF FACT

On April 3, 2013 Petitioner began working for Respondent as a Laborer out of the union hall. Petitioner's job involved driving a tractor, making mortar, shoveling block and erecting scaffolding. Petitioner denied any right shoulder problems prior to the alleged accident.

Petitioner testified that on April 5, 2013 at approximately 10:00 a.m. he was asked to get a cube of block. He drove the tractor to the block storage area. As he approached the block he encountered a piece of scaffolding lying on the ground. He dismounted the tractor and as he attempted to move the scaffolding on the ground, other pieces of scaffolding which were leaning against a dumpster began falling toward him in a domino-like fashion. He estimated that the scaffolding pieces were approximately seven feet tall. Petitioner testified that he lifted his arms to protect himself and was struck on the superior aspect of the right shoulder along the clavicle by the falling scaffolding. Petitioner testified that the scaffolding pushed him down and ultimately came to rest on the tire of the tractor with him between the tire and the scaffolding.

Petitioner testified that approximately three minutes after the incident he encountered Respondent's President and owner, Rodney Vasquez, who inquired as to whether Petitioner was ok. Petitioner responded that he did not know.

Petitioner testified that immediately after the alleged accident he experienced a searing burn in his right shoulder. Petitioner completed his shift but did not seek any medical treatment. The alleged accident occurred on Friday. Petitioner was off for the next two days. He did not obtain any medical treatment over the weekend. He returned to work the following Monday and continued working until April 11, 2013 when he was laid off. He underwent no medical treatment prior to his layoff. Petitioner testified that prior to his layoff his shoulder progressively worsened to the point that he could not lift his arm above his head. Petitioner testified that he was laid off because he could not perform his job duties.

Petitioner did not contact the union hall after the layoff and request reassignment to another job. He applied for unemployment and in so doing certified that he was able and willing to return to work. Petitioner estimated that he applied for unemployment benefits within a month of his layoff.

Petitioner first received medical treatment for his right shoulder on May 16, 2013 at Union County Hospital. He testified that although his right shoulder symptoms continued to worsen subsequent to the layoff he delayed treatment because he thought that he would get better.

The Union County Hospital records of May 16, 2013 reflect that Petitioner presented with complaints of right shoulder, neck and back pain which began on April 9, 2013. (RX8, p. 9) Petitioner reported on an intake form that his symptoms were due to an accident on April 9, 2013. He did not provide any description of the mechanism of injury or indicate that it occurred at work. (*Id.*, at 14) Under the workers' compensation section of another intake form Petitioner indicated an injury date of April 9, 2013 and provided Respondent's name as a contact. (*Id.*, at 19) This same form indicates he was employed by Charles Masonry. (*Id.*)

Plain film x-rays of the right shoulder taken on May 16, 2013 revealed apparent widening of the AC joint space representing chronic separation and minor degenerative changes in the glenohumeral joint.

Discharge diagnosis was right shoulder pain and neck pain. Petitioner was released with no restrictions. He was not referred elsewhere for treatment or further testing.

On May 21, 2013, Petitioner contacted Vasquez and advised that he needed authorization for medical treatment.

On May 24, 2013, Petitioner saw his primary care physician, Dr. Lori Moyers of Cape Family Practice. The history recorded by Dr. Moyers reflects that Petitioner complained of chronic joint pain and issues related to his right rotator cuff. Examination of the extremities revealed decreased right shoulder range of motion with pain over the supraspinatus and biceps insertion. Dr. Moyers record does not reflect that Petitioner was referred elsewhere for treatment or testing. There is no notation that any restrictions were placed on his activities or that he was excused from work. (PX9).

Petitioner returned to Union County Hospital on May 31, 2013 and saw Dr. Everett Shaw. Dr. Shaw ordered a cervical MRI and a right shoulder MRI. Those studies were performed at Union County Hospital on May 31, 2013. (P.8). The right shoulder MRI revealed marked rotator cuff tendinosis, a full thickness and full width tear of the supraspinatus, full thickness and partial thickness tears along the infraspinatus, a near full thickness tear involving the subscapularis and rotator cuff atrophy. Moderate sized glenohumeral joint effusion with fluid in the subacromial/subdeltoid and subcorticoid bursa was noted as was a tear involving the intra-articulation and proximal bicipital groove segments of the longhead of the biceps tendon. Also observed was a degenerative type tear involving the superior glenoid labrum and mild glenohumeral joint osteoarthrosis. The Union County Hospital records do not reflect that Petitioner was referred elsewhere for further treatment, that his activities were restricted or that he was excused from work. Petitioner testified that Dr. Shaw referred him to Dr. Wood.

On September 18, 2013 Petitioner saw orthopedic surgeon John Wood. Dr. Wood's records do contain a referral form from Union County Hospital. The intake form completed by Petitioner on September 18, 2013 does not that Petitioner was being seen in conjunction with a workers' compensation claim. The upper right hand corner of the intake form contains the notation "not WC". (PX10). However, the doctor's note from that visit indicates "he initially filed this under work comp but work comp has denied it so this is not a work comp claim currently. (*Id.*) The intake form reflects that Petitioner was injured in April 2013 when scaffold jacks fell on him. He told Dr. Wood that he experienced immediate pain and weakness in the shoulder thereafter. Petitioner denied any previous problems with the shoulder. Dr. Wood reviewed the May 31, 2013 MRI and noted that it revealed a large rotator cuff tear.

On September 26, 2013 Dr. Wood performed a right shoulder arthroscopy with rotator cuff debridement and open rotator cuff repair. Postoperative diagnosis was a massive right rotator cuff tear, impingement, chronic biceps tendon rupture and extensive synovitis. Dr. Wood testified that he excused Petitioner from work as of the surgery date. (P. 11 at 9).

On March 19, 2014 Petitioner presented to Dr. Wood and advised that his right shoulder condition was 100 percent better and that he was pleased with the outcome. Petitioner contacted Dr. Wood on April 8, 2014 and requested a full duty release effective April 14, 2014. Dr. Wood issued the release.

Dr. Wood opined that, based on Petitioner's history of symptom onset and lack of history of right shoulder problems prior to the alleged accident, that there was a causal relationship between the alleged injury and the right shoulder pathology. (P.11 at 11). Dr. Wood testified that his causation opinion was predicated on the accuracy of the information provided by Petitioner insofar as the mechanism of injury and symptom onset were concerned. (P.11 at 14). He agreed that if the onset of symptoms or the mechanism of injury was different than reported by Petitioner his causation opinion could be affected. (P.11 at 15).

Dr. Wood agreed that the pathology found intraoperatively was of a relatively serious nature and was not of a type that would typically improve with the passage of time. (P.11 at 15-16). He testified that he would expect the onset of symptoms contemporaneously with the injury and that it was unlikely that Petitioner would have been completely asymptomatic subsequent to the trauma. (P.11 at 17). Dr. Wood testified that he assumed that Petitioner's symptoms started in conjunction with the alleged incident.

Petitioner testified that after Dr. Wood's release he returned to work as a laborer. Petitioner testified that his right shoulder is currently "limited but workable".

Rodney Vasquez testified that he is Respondent's President. He was present during Petitioner's testimony. He had no recollection of Petitioner advising him of a work injury involving falling scaffolding during Petitioner's tenure from April 3, 2013 through April 11, 2013. He recalled Petitioner's foreman, Matt Baker, advising that Petitioner was favoring his right arm and that Petitioner told Baker that he had injured his shoulder elsewhere. Vasquez questioned Petitioner about this on April 4 or April 5, 2013. Petitioner advised that his shoulder problems were unrelated to his employment with Respondent.

The first notice that Vasquez had of an alleged work injury was on May 21, 2013 when Petitioner called him. Vasquez testified that Petitioner was laid off because he worked in an unsafe manner and repeatedly drove the forklift at a high rate of speed. Vasquez testified that had Petitioner reported an injury or had he witnessed an accident, a report would have been completed and Petitioner would have been sent for medical treatment. Vasquez testified that he was unaware of any incident such as described by Petitioner.

Matt Baker testified that he was Petitioner's foreman between April 3 and April 11, 2013. Within a day or so of Petitioner's hiring, Baker noticed that Petitioner was favoring his right shoulder and was frequently holding the shoulder. Baker testified that he asked Petitioner about the shoulder on several occasions to make sure that there had not been a work injury. Petitioner reported that his right shoulder condition was related to an altercation at a bar. Baker testified that each time he inquired of Petitioner about the shoulder Petitioner's response was that his problem did not begin at work. Baker testified that at no time between April 3 and April 11 did Petitioner report that he had been injured at work. Baker testified that had Petitioner done so, an accident report would have been completed and medical treatment offered.

Baker testified that Petitioner was laid off because he worked in an unsafe manner. Baker advised Petitioner of his layoff and when he did so Petitioner said nothing about an alleged work injury.

On February 24, 2014 §12 exam was performed by Dr. George Paletta. Dr. Paletta testified that in conjunction with his evaluation Petitioner completed an intake form on which he indicated that he was injured on either April 8 or April 9, 2013 when scaffolding fell on him. (RX1, p. 10) In conjunction with the evaluation

Dr. Paletta reviewed a number of Petitioner's medical records and imaging studies including the May 31, 2013 right shoulder MRI. Dr. Paletta testified that Petitioner described the injury as having occurred when scaffolding struck him where the collar bone and the acromion intersect. Petitioner demonstrated to Dr. Paletta that his right arm was at his side against his body when he was struck by the scaffolding. (*Id.*, at 12-13).

Dr. Paletta interpreted the MRI as showing a complete tear of the supraspinatus and infraspinatus tendons. He characterized the tear as "massive". He noted significant atrophy of the rotator cuff. He explained that the foregoing pathology is most typically seen with an older or longstanding tear. Dr. Paletta interpreted the film as showing a massive tear of the rotator cuff with retraction and atrophy that suggested an older chronic tear. He explained that the degree of retraction and muscle atrophy that appeared on the MRI would be inconsistent with an injury six weeks prior and would typically develop over the course of six to twelve months at a minimum, if not longer. (*Id.*, at 17) Dr. Paletta explained that if the pathology shown on the MRI occurred in early April 2013, one would still expect to see edema or inflammation from the initial injury and a minimal degree of retraction and muscle atrophy on an MRI performed six weeks later. (*Id.*) Dr. Paletta explained that the MRI also showed poor tissue quality. He explained that Petitioner's shoulder tissue appeared to be a combination of gray, black, white and was thin and without uniform thickness. He explained that this appearance is typically seen with a chronic rotator cuff condition. (*Id.*, at 17-18)

Dr. Paletta opined that there was no causal relationship or aggravation of the underlying condition based on the reported work injury. He testified that the pathology was inconsistent with the mechanism of injury which Petitioner described to him. (*Id.*, at 19) Dr. Paletta testified that Petitioner demonstrated that his arm was at his side in a neutral position at the time of the alleged impact and that the impact occurred on the top of the shoulder. Dr. Paletta testified that this would not cause any threat to the rotator cuff. (*Id.*). He explained that a tear of the magnitude shown on Petitioner's MRI would cause significant pain, dysfunction and inability to continue working. (*Id.*, at 19-20)

CONCLUSIONS OF LAW

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

The Arbitrator finds the testimony of Rodney Vasquez and Matt Baker more persuasive and credible than that of Petitioner regarding the occurrence of the alleged accident. The Arbitrator notes the inconsistency between Petitioner's testimony that the accident occurred on April 5, 2013 and the medical records of Union County Hospital and the history provided to Dr. Paletta that the injury occurred on April 8 or April 9, 2013.

The Arbitrator finds Rodney Vasquez's testimony that he was not aware of an alleged accident until May 21, 2013 and had no recollection of an accident such as described by Petitioner having occurred until he received Petitioner's phone call credible. The Arbitrator also finds Baker's testimony credible that Petitioner repeatedly denied having injured himself at work when Baker questioned him after noticing that Petitioner was favoring his right shoulder

The Arbitrator finds it significant that Petitioner did not seek any medical treatment until May 21, 2013. In the Arbitrator's view, this strongly suggests that Petitioner was not injured during his employment with

Respondent. The Arbitrator's conclusion is also supported by the fact that Petitioner continued to work for several days after the alleged accident and ultimately left Respondent's employment because he was laid off due to safety issues. The Arbitrator notes that both Dr. Wood and Dr. Paletta agree that if the incident alleged by Petitioner caused the shoulder pathology, Petitioner would have had significant symptoms immediately after the accident. The Arbitrator does not find Petitioner's explanation that the delay in treatment was because he thought his condition would improve with time to be credible.

Finally, the Arbitrator notes that although Petitioner alleged that he was laid off by Respondent because he could not perform his work duties, he applied for unemployment within a month of his layoff and certified that he was able and willing to return to work. He presented to Union County Hospital on May 16, 2013, almost six weeks after the alleged accident.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner failed to prove that he sustained an accident which arouse out of and in the course of his employment with Respondent on April 5, 2013.

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

Petitioner's unequivocal testimony on both direct and cross-examination was that his alleged injury occurred on April 5, 2013. He offered no testimony that his injury occurred on April 8 or April 9, 2013. If the injury occurred on April 5, 2013, Petitioner would have been required to notify Respondent of the alleged accident by May 20, 2013. The Arbitrator finds Vasquez's testimony as to the date that he became aware of Petitioner's alleged injury more credible than Petitioner's and finds that notice was not provided until 46 days after the alleged accident.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner did not provide Respondent with notice of the alleged accident within 45 days as required by Section 6(c) of the Act.

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

The Arbitrator finds Dr. Paletta's opinion regarding causation more persuasive than that of Dr. Wood. Dr. Paletta testified that the mechanism of injury described by Petitioner would not cause the type of rotator cuff pathology shown on the MRI or found intraoperatively. Although Dr. Wood opined that there was a causal relationship between the alleged accident and Petitioner's shoulder pathology, he did not offer any testimony explaining why Dr. Paletta's opinion that the mechanism of injury could not have caused the pathology was incorrect. The Arbitrator also notes that unlike Dr. Paletta, Dr. Wood did not address the significance of the position of Petitioner's right arm at the time he was allegedly struck by the falling scaffolding. The Arbitrator also notes that none of the medical records (including those of Dr. Wood) reflect that Petitioner's right arm was extended above his head at the time of the alleged accident.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner failed to prove that his current condition of ill-being is causally related to the alleged accident of April 5, 2013.

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): **What temporary benefits are in dispute?**

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

Consistent with the Arbitrator's findings with regard to accident/causation and notice, Petitioner's claims for medical expenses, TTD and PPD are denied.

Issue (O): **Did Petitioner exceed his two choices of physician?**

The Arbitrator finds that Petitioner did not exceed his 2 physician choices. The Arbitrator finds that Union County Hospital was Petitioner's physician choice #1 and that Dr. Moyers was choice #2. Petitioner testified that Dr. Shaw at Union County Hospital referred him to Dr. Wood at the Orthopedic Institute of Southern Illinois. Dr. Wood's records reflect a referral from the Union County Hospital Convenient Care 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	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rene Ruano,

Petitioner,

vs.

NO: 14 WC 3027

Hienie's Chicken,

17IWCC0255

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 14, 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.

17IWCC0255

The party commencing 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: APR 24 2017
TJT:yl
o 4/11/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RUANO, RENE
Employee/Petitioner

Case# **14WC003027**

HIENIE'S CHICKEN
Employer/Respondent

17IWCC0255

On 11/14/2016, 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 0.53% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1920 BRISKMAN BRISKMAN & GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

1295 SMITH AMUNDSEN LLC
LESLIE T JOHNSON
150 N MICHIGAN AVE SUITE 3300
CHICAGO, IL 60601

17IWCC0255

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

Rene Ruano
Employee/Petitioner
v.
Hienie's Chicken
Employer/Respondent

Case # **14 WC 03027**

An *Application for Adjustment 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 **6/21/2016 & 7/29/2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☒ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 **9/22/2013**, 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 ***was 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 **39** years of age, with **2** dependent children.

Petitioner received all reasonable and necessary medical services.

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

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

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

ORDER

Petitioner failed to prove he was an employee of Respondent and therefore is not entitled to Workers' Compensation benefits. All other issues are moot.

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

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

Signature of Arbitrator

November 14, 2016
Date

NOV 14 2016

INTRODUCTION

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

Petitioner testified live at the two hearings. Manny Garcia testified by evidence deposition.

FINDINGS OF FACTS

Petitioner testified that in September of 2013 he had been employed by Connor's Transportation as a truck driver. Petitioner and Respondent Hienie's witness Manny Garcia testified that since December of 2012 he also delivered food for Respondent. As a deliveryman Petitioner was given $14.00 for gas at the start of his shift, which sometimes did not cover his expenses, as well as $3.00 per delivery. Petitioner used his own vehicle. Petitioner was paid in cash. Respondent neither withheld income or other taxes nor issued IRS W-2s or 1099's. Petitioner did not declare this cash on any state or federal tax documents. At the June 21, 2016 hearing Petitioner presented federal income tax returns for 2012, 2013, 2014, and 2015, all dated June 16, 2016.

When he delivered for Respondent Petitioner would pick up the food order at the restaurant, contained in a bag with Respondent's name on the ticket attached to the bag. Petitioner would arrive at the restaurant and the orders for delivery were already prepared and placed in a warmer. Petitioner did not take the phone orders. Deliveries were made according to first-in-first-out. Petitioner testified that he could not take a route he wanted when making a delivery. Respondent's manager Manny Garcia testified that the deliverymen knew the streets/routes better than he did and did not rely upon him for route directions. Petitioner testified that the owner Larry was aware of his employment at Connor's since Larry would cash Petitioner's paycheck from Connor's Transportation.

Petitioner testified that he could not, and did not refuse to make any deliveries. He testified that he was unaware of other delivery drivers refusing deliveries to certain addresses. Mr. Garcia testified that Petitioner could refuse any delivery and in fact, had to be cajoled several times to make the delivery to the address where the assault occurred. Additionally Mr. Garcia testified that any driver could (and had in the past) refuse any delivery even up to the point of arrival at the residence; if it looked dangerous, they could leave without completing the delivery. Petitioner and Mr. Garcia both testified that certain addresses were on a posted no delivery list, sometimes because of bad credit/payment issues and sometimes due to robberies.

Petitioner testified that on September 22, 2013, he had completed his delivery shift at 10:30, and then went to 10836 Ave. M, where he was staying at the time. Petitioner testified that about 10:45 p.m., Mr. Garcia called him to request that he return to make a delivery to 9918 Paxton. Petitioner testified that he told Mr. Garcia this address was on the no delivery list. He further testified that he had delivered food there before, and was robbed, or "short changed". Petitioner testified that he had spoken to the owner Lawrence about this previously. Petitioner testified that Mr. Garcia requested that he return to the restaurant and make the delivery as a "favor" and that he would make it "worth his while." Petitioner further testified that Mr. Garcia stated the order was paid by credit card, so he would not have a concern about being robbed.

Petitioner testified that he returned to the restaurant at about 10:50 p.m., and after repeating the same conversation with Mr. Garcia, he proceeded to make the delivery. Petitioner then testified that when he got to the location, he notified the customer he was in front. Petitioner then got out of the car, and when the customer opened the door, he saw 3 or 4 guys scrambling in back. These people then came to the front porch and shot Petitioner in the pelvis, chest, buttocks and right leg. Petitioner was transported to Northwestern Memorial Hospital.

Petitioner was admitted to Northwestern on September 22 through September 29, 2013. Petitioner underwent an exploratory laparotomy, ileocectomy primary stapled anastomosis, primary small bowel enterosrothy repair, retrograde urethogra and castocopy, after multiple gunshot wounds to the abdomen, buttocks and lower extremity. Petitioner had gunshot wounds in the chest, right anterior thigh, and bilateral buttocks. Petitioner had an open abdominal wound, which resulted in infections and debridement on October 23, 2013. Petitioner underwent physical therapy and ongoing wound checks. Petitioner was released to return to work without restriction on March 19, 2014, and was last seen on June 25, 2014 (PX #1 & PX #2).

On cross-examination Petitioner testified that he did not keep records of his earnings from delivering food for Respondent. When asked how he calculated his earnings reported on the 2012 and 2013 IRS Schedule Cs, Petitioner responded "ballpark." He further testified that he thought he did not have to pay taxes on cash income.

Petitioner testified that he has had no other accidents. He has no feeling from the right knee down, and continues to have an open abdominal wound. Petitioner testified he continues to have severe pain, cannot sleep on his side, and that his sleep is disrupted by his pain. Petitioner continues to take medications for his pain.

CONCLUSIONS OF LAW

B: Was there an employee-employer relationship?

The Arbitrator finds that Petitioner failed to prove that an employee-employer relationship existed with Respondent.

There are numerous factors which may establish whether an employer-employee relationship existed. The essential test in determining an employee-employer relationship is the direction and control over the employee's work activities by the employer. Other factors include the method of payment, the right to choose routes, whether the respondent provides tools, equipment, uniforms, signage, or materials necessary for the work, income or other tax withholding, the right to discharge, and the intent of the parties. Additionally, the nature of the claimant's work in relationship to the respondent's business purpose is a factor.

The evidence here established that Respondent did not have the actual or implicit right to control the manner of Petitioner's delivery activities. Petitioner could refuse any delivery if he felt it was dangerous. He chose his own route after picking up an order. He did not have to remain on Respondent's premises between deliveries and did no other work for the restaurant. Petitioner conferred with Larry, the owner, on his availability for deliveries. He drove his own car, sometimes having friends accompany him. Petitioner did not wear a Respondent's uniform or mark his private car with Respondent's name or insignia. Respondent paid Petitioner in cash without withholding income taxes, Medicare taxes, or social security taxes. Respondent did not issue IRS W-2s or 1099s.

The method of payment reflects a typical independent contractor relationship. Respondent paid Petitioner in cash without withholding income taxes, Medicare taxes, or social security taxes. Respondent did not issue IRS W-2s or 1099s. Payment was not on an hourly basis, instead based totally upon the number of deliveries. Petitioner presented federal income tax returns for 2012 and 2013, along with returns for 2014 and 2015, all dated June 15, 2016. The returns for 2012 and 2013 each had IRS Schedule C (Profit or Loss from Business [Sole Proprietorship]) attached, setting forth income and expenses from his deliveries for Respondent. Petitioner's declaration of profit and loss as a sole proprietor deliveryman can be a factor supporting a finding of independent contractor.

Clearly, Petitioner controlled whether he made the Paxton address delivery the night of the attack. He testified that he had already gone home when Mr. Garcia called him numerous times and begging him to make the delivery, stating Petitioner would be doing him a "favor" and that he "would make it worth his while". Petitioner clearly had the control over whether to make the delivery. Petitioner admitted that he did not feel threatened by Larry or Manny that he could be fired for refusing the delivery. Mr. Garcia testified without rebuttal that he could not have discharged Petitioner for refusing a delivery. Also, Petitioner's testimony that Respondent directed the routes or other means of delivery was not credible.

The parties clearly intended a cash-based, non-employment relationship. Petitioner's testimony about his other employment clearly indicates that he understands the nature of standard employment particularly with respect to insurance benefits and tax obligations. The benefits of avoiding tax obligations with this non-employment cash basis relationship did not escape either Petitioner or Respondent.

Finally, Petitioner testified that he did not keep records of his earnings from delivering food for Respondent. When asked on cross-examination how he calculated his earning reported on the 2012 and 2013 Schedule Cs, Petitioner responded "ballpark." The entire scenario of the concocted tax returns showed that Petitioner was not credible.

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

The Arbitrator has found that no employee-employer relationship existed between Petitioner and Respondent. Therefore, this issue is moot.

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

The Arbitrator notes that Petitioner sustained serious and life-threatening injuries. However, the Arbitrator has found that no employee-employer relationship existed between Petitioner and Respondent. Therefore, this issue is moot.

G: What were Petitioner's earnings?

The Arbitrator has found that no employee-employer relationship existed between Petitioner and Respondent. Therefore, this issue is moot. However, the Arbitrator notes that Petitioner's testimony and evidence of the earnings claimed was not credible. Further, income stated on IRS Schedule C (Profit or Loss from Business [Sole Proprietorship]) is not wages, see *Mansfield v. IWCC*, 2013 IL App (2d) 12090 WC.

J: Were 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 medical care provided was reasonable and necessary to treat Petitioner's life-threatening injuries. However, due to the finding that no employee-employer relationship existed between Petitioner and Respondent this issue is moot.

K: What temporary benefits are in dispute? TTD

The Arbitrator has found that no employee-employer relationship existed between Petitioner and Respondent. Therefore, this issue is moot.

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

The Arbitrator has found that no employee-employer relationship existed between Petitioner and Respondent. Therefore, this issue is moot.

November 14, 2016

Steven J. Fruth, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Francisco Ramirez,

Petitioner,

vs. NO: 14WC 6005

Reynolds Services, Inc., Pactiv, LLC.,

17IWCC0213

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, 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 July 8, 2016, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $14,000.00. 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: APR 6 - 2017
o033017
SM/jrc
044

Stephen Mathis

David L. Gore

Deborah Simpson

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

RAMIREZ, FRANCISCO
Employee/Petitioner

Case# **14WC006005**

PACTIV
Employer/Respondent

17IWCC0213

On 7/8/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0243 JAMES ELLIS GUMBINER & ASSOC
EDUARO SALGADO
180 N MICHIGAN AVE SUITE 2100
CHICAGO, IL 60601

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

17IWCC0213

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)

Case # 14 WC 6005

FRANCISCO RAMIREZ
Employee/Petitioner

v.

PACTIV
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **February 29, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **November 10, 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 lumbar condition of ill-being *is not* causally related to the accident.
Petitioner's current left knee condition of ill-being is causally related to the accident.

In the year preceding the injury, Petitioner earned **$69,680.00**; the average weekly wage was **$1,340.00**.

On the date of accident, Petitioner was **39** 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 **$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 $ 893.33/week for 15.429 weeks, commencing 11-13-15 through 02-29-16, as provided in Section 8(b) of the Act.

Respondent shall pay the outstanding medical bills related to the Petitioner left knee condition.

Respondent has no liability under the Act for the Petitioner's lumbar spine condition.

Petitioner is entitled to additional medical care prescribed by Dr. Iftikar for his left knee condition.

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

07-07-16
Date

ICArbDec19(b)

JUL 8 - 2016

ARBITRATOR'S DECISION

I. PETITIONER'S TESTIMONY

Petitioner was employed by Respondent, at the time of the alleged accident, and described his job as helping machine operators when they have problems with the machine. He described his job as walking from one side of machine to another and involving pulling and pushing a lot including pushing a cart which would weigh 50-80 pounds and pulling plastic out of the machine. The job classification is heavy.

On or about November 10, 2013, the petitioner was walking up steps, on a machine, when he slipped on the first step. He felt pain immediately in his left knee.

After the accident he was given ice. He testified that he was sent to MacNeal where he told them about his left knee. He underwent therapy to his left knee but could not tell or tolerate the pain which was 10/10 so an MRI was done and then he was referred to Dr. Seymour.

Dr. Seymour performed an arthroscopic repair of the medial meniscal tear on or about December 24, 2013. Petitioner indicated that after the surgery he felt a little better, the pain diminished but he still had some swelling and had trouble walking and was using a cane.

Because of his continued complaints, Petitioner decided to seek a second opinion so he saw Dr. Harsoor. On March 20, 2014. Petitioner indicated that he told the doctor about the pain in his left knee as well as his low back. He told her that the pain in the low back was because he couldn't walk correctly because of his left knee injury. Under the care of Dr. Harsoor, he had three injections into his back. He also underwent therapy for both conditions. He did not have any neck pain. While treating at the therapy facility he was not provided with transportation by the facility except on a couple of occasions. They also would give him a $25 gas card when he was seen.

Ultimately, he was put into work hardening which helped with his knee but didn't really build up the strength. Dr. Harsoor then had him undergo a functional capacity evaluation and after which he was given restrictions of not climbing a ladder, not walking a lot and not kneeling.

Petitioner testified that he returned to work on or about October 12, 2014 and worked modified duty for three months in a mostly seated position. He was then switched to the mold department where he had to switch blades on the machine and his restrictions were no longer being honored. He had to perform all aspects of his job duties. Petitioner was working 12 hour shifts. The pain became worse with regular duty. His knee would buckle at work, particularly when he was under a machine or when he was on a ladder.

The petitioner did not see Dr. Iftikhar again until November 4, 2015. At that time, he prescribed a new left knee MRI was ordered and petitioner described his job duties to the doctor. Dr. Iftikhar, according to petitioner, told him that he had a new tear of the medial meniscus and recommended surgery, which the Petitioner want to undergo. He is currently off work as Respondent is not honoring Dr. Iftikar's crurrent restrictions of 8 hours of light duty, no climbing, kneeling or squatting.

A. CROSS EXAMINATION

Petitioner was shown respondent's exhibit number one, the application for adjustment of claim that he had filed in this matter. Petitioner acknowledged that the description on the application for adjustment of claim, of how the accident occurred , and specifically that he was climbing a ladder to feed a machine when he lost his footing and felt a sharp pain, was accurate. He also agreed that he did put that only his left knee was injured when he filed the application for adjustment of claim on or before February 24, 2014 without any mention of the low back. This was despite the fact that he testified at one point that he almost immediately, after the accident, had low back pain and at another point, indicated that the low back pain began three or four months after the accident.

II. MEDICAL RECORDS

1) MACNEAL/CLEARING CLINIC (PX. 1)

Petitioner was first seen at the Cearing Clinic on November 15, 2013. At that time, his primary complaint was pain located in the left knee. He was seen on November 18 and referred for physical therapy after the physician noted the range of motion was guarded. He was given a knee support and released to return to work at regular duty.

By November 25, 2013 due to no improvement in his left knee an MRI was ordered and he was continued on regular duty.

An MRI was done on February 10, 2013 which showed a medial meniscal tear as well as a medial collateral ligament sprain-grade 2.

On December 20, 2013 the MRI was reviewed and he was referred to and orthopaedic surgeon

2) DR. SEYMOUR (PX. 2)

Petitioner was first seen by Dr. Seymour on December 16, 2013. At the time of that visit, he filled out a patient information sheet indicating that the reason for the visit was an injury to his knee. Dr. Seymour recommended an arthroscopic procedure and this was scheduled for December 24, 2013.

Surgery was performed on December 24, 2013. Postoperatively, on December 30, 2013, Dr. Seymour indicated that he should undergo physical therapy at the Clearing Clinic. By January 27, 2014, Petitioner was noted to be improving but had some discomfort, swelling and stiffness of the left knee. Range of motion was noted to be good although there was some mild quad weakness. Petitioner was instructed to continue with physical therapy.

When seen on February 24, 2014, Dr. Seymour indicated that three weeks prior thereto, the petitioner's knee took a turn for the worse and he developed popping in the front of his knee and pain in the waist and chest. Petitioner was noted to have good range of motion but was wincing with any movement. Dr. Seymour described this as atypical symptoms, injected the knee and ordered a venous study which was found to be normal.

Dr. Seymour's notes indicate that he expected the petitioner to be at MMI by March 3, 2014.

3) ILLINOIS PAIN MANAGEMENT/DR. HARSOOR (PX. 5)

Petitioner was first seen by Dr. Harsoor, on March 20, 2014, at which time he gave a history of pain in the left knee, left shoulder, left backside which had been symptomatic for last four months. The pain did not radiate in the dermatomal distribution. Associated symptoms included numbness. He told the Dr. that he was there for a second opinion, the pain in his left knee was persistent and that he also had pain in his left shoulder left side of his back. Diagnoses included cervicalgia, radiculopathy, myofascial pain and pain in the shoulder joint. Physical therapy was ordered. He was taken off work. On June 10, 2014 the records reflect that he was seen for low back and left knee pain as well as tingling in his left toes. The petitioner was noted to have multiple annular disc bulges and hypertrophy in the lumbar spine. The doctor recommended work conditioning for the left knee and a lumbar epidural steroid injection.

An MRI was done on June 27, 2014 which showed diffuse lumbar spondylosis with multilevel annular disc bulging.

Dr. Harsoor performed two lumbar epidural steroid injections on September 2, 2014. Her notes reflect, on September 9, 2014, that petitioner was complaining of popping when standing up from a sitting position and that he was working full duty.

The functional capacity evaluation was done on October 9, 2014 and showed that Petitioner could work in the light to medium level. Subsequent thereto, he had another two lumbar epidural steroid injections on October 9. On November 25, 2014 Dr. Harsoor noted that Petitioner had pain in the left knee of 1/10. She placed Petitioner at maximum medical improvement for the left knee. The doctor reiterated that the petitioner was at maximum medical improvement for the left knee when seen on January 6, 2015.

4) MIDWEST REHAB/ELITE PHYSICAL THERAPY (PX. 3)

Petitioner underwent work conditioning after the functional capacity evaluation of June 11, 2014, beginning on June 13, 2014 and was seen approximately 41 times, ending on or about October 8, 2014.

5) AMERICAN DIAGNOSTIC MRI (PX. 4)

A lumbar MRI was performed on June 2, 2014 which showed diffuse lumbar spondylosis with multilevel annular disc bulging and hyper trophy of posterior elements.

6) ASSOCIATED MEDICAL CENTER (PX. 6)

A valid functional capacity evaluation was done on October 2, 2014. The recommendations were that Petitioner was able to work in the light-medium category and should limit lifting to occasionally 30 pounds, frequently 15 pounds and 6 pounds constantly.

7) **DR. GARCIA (PX. 8)**

There is a slip from Dr. Garcia, dated October 30, 2015, referring the petitioner for a left knee pain evaluation.

8) **DR. IFTIKHAR (PX. 9)**

Petitioner was seen by Dr. Iftikhar on November 4, 2015 with a complaint of left knee pain, swelling, locking and giving out. Petitioner denied any sensory symptoms in the left lower extremity. The left knee had evidence of mild effusion and the McMurray's sign was positive medially. He ordered an MRI which revealed a new oblique tear of the periphery of the medial meniscal body.

Subsequent thereto, the petitioner was seen on November 13, 2015 at which time the doctor indicated that the petitioner had been working regular duties which included squatting, kneeling and climbing frequently and those activities were becoming more and more difficult with the passage of time. He believed that the petitioner had a torn cartilage due to the work-related injury. He recommended arthroscopic repair.

When Petitioner was seen, on January 19, 2016, Dr. Ifthikar indicated that the petitioner remained symptomatic in his left knee but that the back was causing a considerable amount of problems with radiation of pain into his left leg. The left knee symptoms were not noted to be interfering with activities to any significant level. The back problem and radiation was the main limiting factor.

9) **DR. WEBER – RESPONDENT'S IME (RX. 2)**

The petitioner was evaluated at the request of the Respondent on May 11, 2015. At that time petitioner told the doctor that on the date of the accident that he noted left knee pain and some low back pain.

On examination the petitioner had decreased sensation on the left in a non-dermatomal pattern. The left knee had no effusion. The left knee also had a negative Lachmann and a negative McMurray's test.

Dr. Weber indicated that the petitioner was status post left knee medial meniscal/partial menisectomy was some underlining findings of chondromalacia at the time of the procedure. She indicated that while he continued to complain of knee pain, he had no findings that could localize his discomfort. He also had no effusion and good range of motion. In summary, she indicated Petitioner had no objective findings and/or a current active left knee diagnosis. Similarly, he had no positive objective findings in the lumbar spine and the MRI was felt to reveal only age-related changes.

She opined that his current condition of ill being, as it pertained to the left knee, was not substantiated by the objective evidence. She also opined that the low back complaints were not causally related to the accident as the incident described would not result in a back injury and he did not complain or mention

any back complaints for four months from the date of injury. The doctor added that the care for the lumbar spine was not work-related she also believe that he was capable of working at full duty and found that he had a 1% permanent partial impairment.

FINDINGS

The Arbitrator after having heard the testimony of the petitioner and evaluated the evidence finds as follows:

1. Petitioner sustained a medial meniscal tear as a result of the accident of November 10, 2013 and that although it appeared that he had reached maximum medical improvement for that injury on November 25, 2014, the Respondent failed to honor his permanent work restrictions and the left knee condition deteriorated.

2. Petitioner's low back condition is not causally related to the accident of November 2013 as the medical evidence and specifically the lack of any reference to the low back complaints until three or four months after the occurrence make any causal connection to be too remote in time and place.

3. The current condition of ill-being for the left knee is related to original accident, surgery and the failure of Respondent to honor the Petitioner's work restrictions. The arbitrator assigns greater weight to the medical opinions of Dr. Iftikhar.

4. All medical bills related to the Petitioner's left knee condition should be paid pursuant to the fee schedule, including the FCE.

5. Respondent has no liability for the medical bills related to the Petitioner's low back condition. The Petitioner's first complaints of low back pain are too remote in time and place to be related to the work accident.

6. Respondent has no liability for the nonemergency transportation tax of $80 for each visit, nor the ground mileage fee of $450 per visit.

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

Melody Vogler,
Petitioner,
vs.
State of Illinois/Vienna Correctional Center,
Respondent,

NO: 14 WC 13485

17IWCC0231

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 what is the nature and extent of Petitioner's permanent disabilityand being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 12, 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 required for State of Illinois cases.

DATED: APR 13 2017

L. Elizabeth Coppoletti
L. Elizabeth Coppoletti

Charles J. DeVriendt
Charles J. DeVriendt

Joshua D. Luskin
Joshua D. Luskin

LEC/mas
o:4/5/17
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

VOGLER, MELODY
Employee/Petitioner

Case# **14WC013485**

ST OF IL/VIENNA CORRECTIONAL CENTER
Employer/Respondent

17IWCC0231

On 10/12/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

OCT 12 2016

RHARALD A. HASBIA, Acting Secretary
Illinois Workers' Compensation Commission

17IWCC0231

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Melody Vogler
Employee/Petitioner

v.

State of Illinois/Vienna Correctional Center
Employer/Respondent

Case # 14 WC 13485

Consolidated cases: N/A

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **August 17, 2016**. By stipulation, the parties agree:

On the date of accident, **March 5, 2014**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$40,356.00**, and the average weekly wage was **$776.08**.

At the time of injury, Petitioner was **48** years of age, ***married,*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner the sum of **$465.65**/week for a further period of **100** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **20% loss of use of the person-as-a-whole.**

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

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

Melinda M. Rowe-Sullivan

Signature of Arbitrator

10/10/16

Date

OCT 12 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Melody Vogler
Employee/Petitioner

Case # 14 WC 13485

v.

Consolidated cases: N/A

State of Illinois/Vienna Correctional Center
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner sustained injuries to her left shoulder and cervical spine when she slipped and fell on ice in Respondent's parking lot. (PX13; RX1). The matter was previously tried on a 19(b) Petition, and findings were rendered in favor of Petitioner after which no appeal was taken. *Id.*

Petitioner testified that she proceeded with the recommended surgical interventions. She testified that the surgeries and post-operative therapy improved her condition, but also testified that she continues to have difficulties with her neck and left shoulder. She testified that she has lost range of motion in her neck and has at times significant pain in her left shoulder and is unable to lift anything with her left hand over five pounds. She testified that she cannot golf anymore, that she can no longer shotgun or bow hunt, that it is very difficult for her to fish and that she can no longer ride a motorcycle or 4-wheeler.

The Medical Bills List was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Medical Records List was entered into evidence at the time of arbitration as Petitioner's Exhibit 2.

The medical records of Herrin Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on March 5, 2014, at which time it was noted that she was getting out of the truck, slipped on the ice and fell, hitting her head. Petitioner underwent a CT of the cervical spine on March 5, 2014, which was interpreted as revealing no acute post-traumatic abnormality of the cervical spine. The CT of the head performed on the same date was interpreted as revealing no acute intracranial abnormality. The x-rays of the left forearm performed on the same date were interpreted as revealing no fracture or dislocation, as were x-rays of the left humerus performed on the same date as well. The x-rays of the left shoulder also performed on the same date were interpreted as revealing (1) no acute fracture or subluxation; (2) suggestion of chronic osteolysis versus previous resection of the distal clavicle; (3) minimal glenohumeral osteoarthritis. The final diagnoses were that of fall, contusion to left upper extremity, cervical strain and hematoma of the scalp. (PX3).

The records of Herrin Hospital reflect that Petitioner was seen on March 14, 2014, at which time it was noted that she stated that she fell and hit her head on March 5th and had nausea and vomiting yesterday, that she passed out twice the night before and that she also complained of left hand redness. A CT of the head performed on March 14, 2014 was interpreted as revealing no acute intracranial abnormality. The x-rays of the left shoulder performed on the same date were interpreted as revealing (1) no new fracture or dislocation; (2) old fracture versus post-surgical change of the distal end of the left clavicle. The final diagnoses were that of (1) syncope; (2) cellulitis; (3) left shoulder strain. (PX3).

The medical records of Dr. Jodi Fox-Altug/Southern Illinois Medical Care Associates were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on March 7, 2014 at which time the chief complaint was that of an injury sustained to the left shoulder, elbow and back of head when she fell on work property. It was noted that Petitioner fell at work on March 5th and was reaching out to grab ahold of the door while falling on the ice, that her left arm was extended and twisted, that she was having pain and difficulty with movement and that she had weakness and tingling in her fingertips. The assessment was that of (1) shoulder joint pain, suspect injury to rotator cuff; (2) post-concussion syndrome. Petitioner was recommended to undergo an MRI of the left shoulder. At the time of the March 19, 2014 visit, it was noted that Petitioner was seen in follow-up, and that on March 5th Petitioner fell at work in the parking lot which scratched her right thumb. The assessment was that of Staphylococcal infectious disease. (PX4).

The records of Dr. Jodi Fox-Altug reflect that Petitioner was seen on March 21, 2014, at which time it was noted that her left shoulder was still very painful, that she had slightly more range of motion but that she still had significant pain. The assessment was that of shoulder joint pain, and it was noted that they were awaiting approval of the MRI. It was also noted that Petitioner would get the name of the orthopedic physician that was recommended to her given that she had a history of left rotator cuff tear. (PX4).

The medical records of Dr. Nathan Mall were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on March 31, 2014 for a chief complaint of left shoulder, elbow and hand pain. It was noted that on March 5, 2014 Petitioner was getting out of a truck and hit some ice, and that her left hand reached behind her to grab ahold of the truck so that she would not fall. It was noted that Petitioner fell and landed on her left shoulder and shoulder blade and her head hit a truck bumper. It was noted that Petitioner had some neck pain initially as well, and that she also had a scratch on her hand which had developed a staph infection. The assessment was that of (1) left partial thickness versus full thickness rotator cuff tear; (2) biceps tendinitis/proximal superior labral tear. An MRI of the left shoulder was recommended, as well as an ultrasound guided biceps injection. (PX5).

The records of Dr. Mall reflect that Petitioner was seen on April 4, 2014 at which time it was noted that Petitioner was seen in follow-up after her MRI and that she stated that her shoulder continued to bother her. It was noted that the MRI demonstrated a partial thickness rotator cuff tear, and that there was one area that may actually be a full thickness tear of the anterior aspect of the supraspinatus. It was noted that Petitioner also had what appeared to be a superior labral tear. The assessment was that of (1) left shoulder superior labral tear; (2) left shoulder partial thickness rotator cuff tear and very small full thickness tear. Petitioner was recommended to undergo a cortisone injection into the biceps tendon sheath as well as an intraarticular injection for the superior labral tear. Petitioner was also recommended to undergo physical therapy. At the time of the April 29, 2014 visit, it was noted that Petitioner stated that her pain was getting worse and that she had 2-3 hours of relief from the injection she had been given. It was noted that Petitioner had worsening pain in both the shoulder and in the neck area, and that she was also describing some radicular-type pain as well into the thumb and index fingers. The assessment was that of (1) high grade partial thickness rotator cuff tear with an area of likely full thickness rotator cuff tearing at the anterior insertion of the supraspinatus; (2) superior labral/biceps pathology. It was noted that Dr. Mall thought a lot of the pain was related to the shoulder, and that there was also potentially a component related to the neck. An MRI of the neck was recommended. (PX5).

The records of Dr. Mall reflect that Petitioner was seen on May 27, 2014 for left shoulder and neck complaints, and it was noted that she was getting increasing headaches. The assessment was that of (1) high grade partial thickness rotator cuff tear with an area of full thickness rotator cuff tearing at the anterior supraspinatus; (2) superior labral/biceps pathology. Petitioner was recommended to undergo a left shoulder arthroscopy, rotator cuff debridement and possible rotator cuff repair and biceps tenodesis,

and it was noted that Dr. Mall thought that the vast majority of her pain was coming from the shoulder given her response to the Lidocaine aspect of the injection. It was noted that Petitioner would be referred to Dr. Gornet for her neck. At the time of the June 30, 2014 visit, it was noted that Petitioner stated that she was having some burning and pulling type of pain in the anterior aspect of her elbow, and that she had coughed hard and had some burning pain in her left shoulder. The assessment was that of (1) left shoulder, partial thickness, rotator cuff tear with a small area of full thickness tearing anteriorly in the supraspinatus; (2) superior labral tear; (3) bicipital tendinitis; (4) AC joint arthrosis. Petitioner was recommended to undergo left shoulder arthroscopy, possible rotator cuff repair depending on intraoperative appearance and biceps tenodesis. (PX5).

The records of Dr. Mall reflect that Petitioner was seen on August 11, 2014, at which time it was noted that she continued to have significant discomfort. It was noted that Petitioner stated that her headaches were worse, and that she had an episode in which the side of her face went numb. It was noted that Petitioner had trouble picking up objects with her left side, and that left thumb and index finger numbness was present as well as significant left shoulder pain. The assessment was that of (1) left shoulder partial thickness rotator cuff tear with small area of full-thickness tear anteriorly in the supraspinatus; (2) superior labral tear; (3) biceps tendonitis; (4) AC joint arthrosis. Petitioner was again recommended to undergo surgical intervention. It was noted that Dr. Mall explained that Petitioner's headaches and the numbness into her thumb and index finger were not coming from the shoulder and were likely coming from her cervical spine and that this was her major complaint, although the left shoulder was worsening in terms of its pain and symptoms as well. Petitioner was recommended to undergo a work-up of her cervical spine and treatment of the cervical spine prior to the shoulder, as it seemed like her headache and cervical spine symptoms were somewhat greater than her left shoulder complaints. (PX5).

The records of Dr. Mall reflect that Petitioner was seen on September 22, 2014, at which time it was noted that she was extremely sore and that she stated that over the weekend, she became extremely more painful with pain that radiated down her neck, down her right arm in addition to her left arm and down into her back and down her right leg. The assessment was that of (1) left shoulder high-grade, partial-thickness rotator cuff tear with a small area of full-thickness superior labral tear; (2) cervical spine pathology; (3) lumbar discomfort. Petitioner was recommended to see her spine surgeon, Dr. Gornet. At the time of the November 3, 2014 visit, it was noted that Petitioner continued to have significant symptoms down the left arm and shooting from her neck. The assessment was that of (1) cervical spine disc herniation; (2) high-grade, partial-thickness versus full-thickness rotator cuff tear; (3) possible superior labral tear. It was noted that Petitioner was recommended to hold physical therapy for a while as it was making her neck worse. At the time of the January 26, 2015 visit, it was noted that Petitioner continued to have left shoulder pain without any resolution of her discomfort and that she also continued to have significant neck pain. The assessment was that of (1) left shoulder high-grade, partial-thickness rotator cuff tear with an area of full-thickness tearing, possible superior labral tear, AC joint arthrosis and biceps tendonitis. Petitioner was again recommended to undergo surgery. (PX5).

The records of Dr. Mall reflect that Petitioner was seen on February 23, 2015, at which time it was noted that she continued to have left shoulder pain and some stiffness in the shoulder as well that was preventing her from returning to full duty work. It was noted that Petitioner stated that the shoulder was about the same as it had been without any resolution of her symptoms, and that she also continued to have neck pain. The assessment was that of (1) left shoulder high-grade, partial-thickness rotator cuff tear with an area of full-thickness tearing, possible superior labral tear, AC joint arthrosis and biceps tendinitis. Petitioner was again recommended to undergo surgery. At the time of the June 19, 2015 visit, it was noted that Petitioner had undergone cervical surgery by Dr. Gornet that had improved some of her pain, but that she had persistent pain in some distributions of the left shoulder and had also developed some right shoulder pain due to overuse of the extremity attempting to make up for the loss of use of the right

shoulder. The assessment was that of (1) left shoulder high-grade, partial-thickness rotator cuff tear with an area of full-thickness tearing; (2) superior labral tear; (3) biceps tendinitis. Petitioner was again recommended to undergo surgery, but it was noted that given that the AC joint was non-tender Dr. Mall would not proceed with AC joint resection. (PX5).

The records of Dr. Mall reflect that Petitioner was seen on July 31, 2015 in follow-up of her left shoulder labral repair, biceps tenodesis and subacromial decompression. It was noted that Petitioner was doing well and was making some improvements in terms of her pain. Petitioner was recommended to begin physical therapy. At the time of the August 28, 2015 visit, it was noted that Petitioner was making improvements, that her pain was improving and that her range of motion was improving. Petitioner was recommended to continue physical therapy. At the time of the September 25, 2015 visit, it was noted that Petitioner continued to make some improvements, that her pain was definitely improving with physical therapy and that she continued to complain of some numbness into the ulnar two digits. Petitioner was recommended to use an ulnar nerve night splint and to continue physical therapy. At the time of the October 23, 2015 visit, it was noted that Petitioner continued to have some numbness and tingling into the two ulnar digits and that she was improving her strength. Petitioner was recommended to continue physical therapy for the shoulder, and it was noted that if she did not make much progress in terms of the left elbow, Petitioner may need to undergo surgery. (PX5).

The records of Dr. Mall reflect that Petitioner was seen on November 20, 2015, at which time it was noted that she continued to have numbness and tingling in the ulnar digits and also had pain to palpation and pain laterally, but that it was improved from the injection given at the last visit. It was noted that the right upper extremity was having some symptoms over the medial epicondyle as well. Petitioner was recommended to undergo an injection to the right elbow, and she was recommended to continue physical therapy for the left shoulder. At the time of the December 18, 2015 visit, it was noted that Petitioner was back to work full duty and was tolerating it well. It was noted that Petitioner had some soreness at the end of the day, but otherwise the elbows had improved somewhat. Petitioner was recommended a home exercise program for the elbows, and it was noted that Dr. Mall would continue to monitor the ulnar nerve symptoms. It was noted that Dr. Mall believed that Petitioner would likely benefit from a cubital tunnel decompression and transposition of the ulnar nerve. (PX5).

The records of Dr. Mall reflect that Petitioner was seen on February 12, 2016 for follow-up of her bilateral elbows, right greater than left, in terms of her ulnar nerve compression symptoms in the right elbow and bilateral medial epicondylitis. Petitioner was recommended to undergo a left elbow ulnar nerve decompression and transposition. At the time of the March 25, 2016 visit, it was noted that Petitioner had also developed some left shoulder symptoms in the posterolateral distribution and had been somewhat sore to do various activities. The assessment was that of (1) cubital tunnel syndrome bilaterally; (2) medial epicondylitis bilaterally; (3) left shoulder rotator cuff tendinitis, status post left shoulder surgery. Petitioner was recommended a cortisone injection in the subacromial space followed by physical therapy. It was noted that Petitioner was to proceed with right elbow surgery in the upcoming weeks. At the time of the April 8, 2016 visit, it was noted that Petitioner stated that on Sunday she woke up with extraordinary pain in the posterior aspect of the shoulder in the trapezial area and superior aspect of the scapula. The assessment was that of scapulothoracic bursitis and rotator cuff tendinitis. Petitioner was recommended to continue physical therapy. It was noted that if Petitioner had persistent pain and symptoms, then Dr. Mall would recommend getting an MRI of the left shoulder for further evaluation. Petitioner underwent an injection on that date. (PX5).

The records of Dr. Mall reflect that Petitioner was seen on April 22, 2016, at which time it was noted that she continued to have some pain in the left shoulder in the superior aspect of the shoulder and in the rotator cuff distribution. The assessment was that of rotator cuff tendinitis. An MRI of the left shoulder was recommended. At the time of the June 8, 2016 visit, it was noted that Petitioner's left shoulder was doing well and that she had minimal complaints. It was also noted that the right elbow was

also doing well status post ulnar nerve transposition and that her numbness and tingling had resolved. Petitioner was recommended a home exercise program for the left shoulder for maintenance, and she was placed at maximum medical improvement for the left shoulder. Petitioner was recommended to continue physical therapy for range of motion and strengthening of the right elbow. (PX5).

The medical records of Heartland Regional Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner underwent physical therapy for the timeframes of April 3, 2014 through April 23, 2014; October 7, 2014 through November 4, 2014; December 23, 2014 through January 27, 2015; August 7, 2015 through October 26, 2015; November 2, 2015 through November 23, 2015; and April 4, 2016 through April 28, 2016. (PX6).

The medical records of MRI Partners of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner underwent an MRI of the left shoulder on April 4, 2014, which was interpreted as revealing (1) no evidence of rotator cuff tear, though there is mild undersurface irregularity or minimal partial tearing at the insertion of the supraspinatus tendon; (2) acromioclavicular irregularity with mild widening, perhaps due to previous injury, but no acute edema or fracture. Petitioner underwent an MRI of the cervical spine on August 21, 2014, which was interpreted as revealing (1) C5-6 level: mild disc dessication; minimal diffuse annular disc bulge, as well as a mild broad-based left foraminal disc protrusion which contributes to mild to moderate left neural foraminal exit stenosis; no central canal stenosis or right neural foraminal exit stenosis; (2) otherwise, no other significant disc profile abnormality, central canal stenosis or neural foraminal exit stenosis throughout the remainder of the cervical spine. Petitioner underwent an MRI of the cervical spine on April 15, 2015 as well, which was interpreted as revealing (1) central broad-based herniations at both C4-5 and C5-6 with left greater than right foraminal stenosis at both these levels; no central canal stenosis is observed. Petitioner underwent an MRI arthrogram of the left shoulder on May 4, 2016, which was interpreted as revealing (1) the rotator cuff is intact; (2) no discrete labral tear; (3) tenodesis of the long head biceps tendon; (4) Grade I AC separation, age indeterminate and likely chronic. (PX7).

The medical records of Dr. Matthew Gornet were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that Petitioner was seen on July 17, 2014 at the referral of Dr. Mall, and it was noted that the chief complaint was that of neck pain, headaches to the left trapezius, left shoulder and down her left arm to her elbow with numbness and tingling into her left thumb and left scapula. It was noted that during the course of the fall on March 5, 2014, Petitioner stepped out of her car, she slipped, her feet went out from under her and she twisted rapidly to try and protect herself but in doing so her head struck the bumper of the car next to her. It was noted that Petitioner readily admitted to a history of a small rotator cuff tear and shoulder problems in 2009 but did not recall any previous neck problems. It was noted that Petitioner's symptoms were constant and worse with turning to the left, flexion/extension and better with turning to the right. Petitioner was recommended to undergo an MRI of the cervical spine, and the current working diagnosis was that of disc injury at C5-6. At the time of the August 21, 2014 visit, it was noted that Petitioner's main complaint was that of neck pain and muscle tension into her left trapezius and left shoulder. It was noted that Petitioner's MRI revealed a fragmented disc out onto the left foramen at C5-6. It was noted that from Dr. Gornet's standpoint, Petitioner should begin with treatment of her shoulder with Dr. Mall followed by treatment of her cervical spine. It was noted that if her symptoms increased significantly from the shoulder surgery, they could forego cervical spine intervention. It was noted that Petitioner was recommended to undergo one selective injection at C5-6 on the left, for which she was referred to Dr. Granberg. (PX8).

The records of Dr. Gornet reflect that Petitioner was seen on September 22, 2014, at which time it was noted that Dr. Mall would prefer that Petitioner's neck issue be addressed first. It was noted that the current plan was disc replacement and bilateral foraminotomy at C5-6, and that Petitioner was having significant neck pain and headaches in addition to her left shoulder symptoms. It was also noted that she was having some low back issues into her right buttock and right hip. At the time of the November 10,

2014 visit, it was noted that Petitioner had a CT myelogram which showed some subtle arthritis on the left side at C4-5. It was noted that Dr. Gornet believed Petitioner had a small disc herniation and foraminal fragment on the left at C5-6, which correlated best with her symptoms. It was noted that Petitioner wished to proceed with surgery. At the time of the December 8, 2014 visit, it was noted that Petitioner was set for surgery but had limited off work time and felt she could not move forward until she had more sick time. (PX8).

The records of Dr. Gornet reflect that Petitioner was seen on March 9, 2015, at which time it was noted that they continued to wait for approval for treatment. At the time of the April 15, 2015 visit, it was noted that the new MRI showed a small disc fragment out in the foramen at C5-6 on the left, which correlated with Petitioner's symptoms. At the time of the May 28, 2015 visit, it was noted that Petitioner was two weeks out from surgery and clinically was doing very well. It was noted that Petitioner felt a dramatic improvement in her pain and symptoms. At the time of the June 18, 2015 visit, it was noted that Petitioner continued to do well and had some intermittent headaches. Petitioner was recommended a home exercise program. At the time of the September 10, 2015 visit, it was noted that Petitioner continued to do well but still had intermittent headaches. It was noted that Petitioner recently had shoulder surgery, and that her exam was non-focal. Petitioner was released back to work full duty with no restrictions regarding her cervical spine. (PX8).

The records of Dr. Gornet reflect that Petitioner was seen on December 10, 2015, at which time it was noted that she was still having intermittent headaches, that her pain was more to the right side of her neck and base of her neck with headaches that came over the top of her head to her forehead which was probably consistent with a problem at C4-5, an area that was noted as part of her injury but not treated. It was noted that Dr. Gornet did not recommend any further treatment but was reluctant to place her at maximum medical improvement. It was noted that the working diagnosis was continued discogenic pain from annular tear at C4-5. At the time of the March 8, 2016 visit, it was noted that Petitioner was doing relatively well and still had some pain at the adjacent level issue at C4-5. At the time of the May 23, 2016 visit, it was noted that Petitioner continued to do exceedingly well with her neck and was very pleased. It was noted that Petitioner recently had right elbow surgery and shoulder surgery by Dr. Mall. It was noted that overall Petitioner was very pleased and had no focal neurological complaints. Petitioner was placed at maximum medical improvement regarding the neck. (PX8).

The medical records of Dr. Steven Granberg were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The records reflect that Petitioner was seen on September 8, 2014, at which time she underwent a cervical multi-level transforaminal epidural injection at left C5 and left C6. (PX9).

The medical records of CT Partners of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The records reflect that Petitioner underwent a CT myelogram of the cervical spine on November 10, 2014, which was interpreted as revealing (1) there is mild multilevel bilateral facet arthropathy throughout the cervical spine; (2) there is no significant disc profile abnormality, central canal stenosis or neural foraminal exit stenosis throughout the cervical spine; (3) bilateral C7 cervical ribs; (4) mild bilateral carotid atherosclerotic disease. Petitioner underwent a CT of the cervical spine on September 10, 2015, which was interpreted as revealing (1) decompression and disc replacement at C5-6 with a low profile disc replacement prosthesis in satisfactory position; no residual central canal or foraminal stenosis is detected; (2) circumferential disc bulge at C4-5 resulting in dural displacement but no significant central canal stenosis, essentially unchanged. Petitioner underwent another CT of the cervical spine on May 23, 2016, which was interpreted as revealing (1) anterior decompression and disc replacement at C5/6 with hardware in stable satisfactory position; no new central canal or foraminal stenosis is detected. (PX10).

The medical records of St. Louis Spine & Orthopedic Surgery were entered into evidence at the time of arbitration as Petitioner's Exhibit 11. The records reflect that Petitioner underwent surgery on

May 5, 2015 for a pre- and post-operative diagnosis of discogenic neck pain, and that the procedures performed were that of (1) placement of Garnder-Wells tongs; (2) disc replacement at C5-6. (PX11).

The medical records of Orthopedic Ambulatory were entered into evidence at the time of arbitration as Petitioner's Exhibit 12. The records reflect that Petitioner underwent surgery on July 16, 2015 for post-operative diagnoses of (1) left shoulder involvement of the middle glenohumeral ligament insertion; (2) partial-thickness rotator cuff tear involving only about 5% of the rotator cuff, posterior extension of the superior labral tear; (3) os acromiale and subacromial spur; (4) subacromial bursitis. The procedures performed included (1) arthroscopic superior labral repair; (2) open biceps tenodesis; (3) limited debridement of the posterior labrum and superior labrum and intraarticular rotator cuff; (4) removal of loose os acromiale; (5) subacromial decompression and acromioplasty. (PX12).

The Arbitration Decision dated February 18, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 13. The Tri-Star Approval Letters were entered into evidence at the time of arbitration as Petitioner's Exhibit 14.

The Arbitration Decision dated February 18, 2015 was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The exhibit was duplicative of that as contained in Petitioner's Exhibit 13. (RX1; PX13).

CONCLUSIONS OF LAW

The parties stipulated that Petitioner sustained an accident on March 5, 2014 that arose out of and in the course of her employment with Respondent, and that Petitioner's condition of ill-being was causally connected to this injury. (AX1).

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

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

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that she continues to be employed by Respondent as an office associate and was placed under no permanent restrictions from either Dr. Mall or Dr. Gornet. The Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 48 years old on her date of accident. Given the younger age of Petitioner and the fact that her treating physicians, Drs. Mall and Gornet, have placed her under no restrictions, the Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that, following her work injury, Petitioner returned to her pre-accident employment with Respondent. As there was no direct

evidence of reduced earning capacity contained in the record, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that she lost range of motion in her neck and has at times significant pain in her left shoulder, and that she is unable to lift anything with her left hand over five pounds. She testified that she cannot golf anymore, that she can no longer shotgun or bow hunt, that it is very difficult for her to fish and that she can no longer ride a motorcycle or 4-wheeler. At the time of the May 23, 2016 visit with Dr. Gornet, it was noted that Petitioner continued to do exceedingly well with her neck and was very pleased. It was noted that overall Petitioner was very pleased and had no focal neurological complaints. Petitioner was placed at maximum medical improvement regarding the neck. (PX8). At the time of the June 8, 2016 visit with Dr. Mall, it was noted that the left shoulder was doing well and that she had minimal complaints. Petitioner was recommended a home exercise program for the left shoulder for maintenance, and she was placed at maximum medical improvement for the left shoulder. (PX5). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely her continued complaints and limitations, were minimally corroborated by her treating records at the conclusion of her treatment with Drs. Gornet and Mall. The Arbitrator accordingly places lesser weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of **20% loss of use of the person-as-a-whole** as provided in Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF 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

Julie Tettaton,

Petitioner,

vs. NO: 14 WC 17488

17IWCC0232

Village Of Caseyville,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue(s) of accident, medical care, prospective medical, causal connection, prior settlement 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 15, 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: APR 13 2017
o040617
DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

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

TETTATON, JULIE
Employee/Petitioner

Case# **14WC017488**

17IWCC0232

VILLAGE OF CASEYVILLE
Employer/Respondent

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:

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

0180 EVANS & DIXON LLC
DAVID REYNOLDS
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

17IWCC0232

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)/8(a)

JULIE TETTATON
Employee/Petitioner

v.

VILLAGE OF CASEYVILLE
Employer/Respondent

Case # **14** WC **17488**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Collinsville**, on **April 28, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **April 17, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$56,691.44**; the average weekly wage was **$1,090.22.**

On the date of accident, Petitioner was **42** 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 **$N/A** for TTD, **$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 for any applicable bills previously paid under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner has sustained her burden of proof that her bilateral hand/wrist injuries arose out of and in the course of her employment with the Respondent on April 17, 2014.

The Arbitrator further finds that the Petitioner's bilateral hand/wrist condition (carpal tunnel) is causally related to her April 17, 2014 accident

Respondent shall pay the reasonable and necessary medical expenses, pursuant to the medical fee schedule, contained in Petitioner's Exhibit 5, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for any of the awarded medical expenses 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 the bilateral carpal tunnel release surgeries recommended by Dr. Choi.

The Arbitrator finds that the Petitioner's claim is not barred by the approval of a settlement contract in a prior separate case.

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.

17IWCC0232

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 28, 2016
Date

ICArbDec19(b)

AUG 15 2016

STATEMENT OF FACTS

Petitioner, a 43 year old laborer for the Respondent, and an 18 year employee, complains of numbness, tingling and sharp pains in her hands and wrists. She is seeking bilateral carpal tunnel (CTS) releases.

Petitioner testified that she is the only female that works for Respondent's water department as a laborer. She performed manual labor, including reading water meters, turn offs/turn ons, installing and/or changing out water meters, locating water lines and manually digging for water meter lids. She uses pipe wrenches in addressing meters, which have been modified to be longer to provide more leverage, and when doing so she gets sharp pains and has to stop working until the symptoms subside.

Turn ons and turn offs also require the use of the pipe wrench. She also has to sometimes manually dig the ground level meter lids out with a shovel, and pry up a ring. While the lids are at ground level, they can be covered by grass or landscaping. Repetitively doing this increases her symptoms.

To locate a line, she has to call 811 to get the main located. She would have to locate a service, which involves putting a fitting on the copper line coming out of the ground. She then has to sweep a machine back and forth to locate exactly where the line is, which sounds similar to using a metal detector. She uses a paint stick in the other hand to mark a location, and notes that because the activity increases her wrist pain, she often has to stop and switch hands as far as the machine and the paint stick.

The Petitioner testified she has worked on thousands of water meters during her employment with Respondent. When she is required to perform other duties in her position, they sometimes also involve repetitive gripping. Her symptoms are increased while at work, and her symptoms are better and hurt less when away from work. She cited cooking and laundry as activities at home which increase her symptoms, and testified that she cannot paint. She has pain at work daily.

The Petitioner testified that when she submitted her workers compensation claim in this case, the Respondent changed her work duties to some degree, but that she continued to perform similar duties and that she continued to have symptoms at work that continued to worsen.

Petitioner initially saw chiropractor Dr. Eavenson on 4/10/14 on referral from her attorney, and on 4/17/14 underwent EMG/NCV testing with Dr. Phillips on referral from Dr. Eavenson. Dr. Eavenson noted complaints of bilateral hand numbness. The Petitioner reported that in 16 years of employment with the Respondent with frequent checking and changing of meters, turning the meters on and off with large pipe wrenches, and constant flushing of hydrants. The diagnosis was bilateral carpal tunnel and ulnar neuropathy, and she was given activity restrictions. (Rx3). Petitioner underwent therapy with Dr. Eavenson and others at Multicare Specialists between 4/21 and 5/1/14, but she reported ongoing symptoms. (Px2; Rx3). Petitioner reported to Dr. Phillips "a long history of gradually progressive sharp dull throbbing aching bilateral hand pain with intermittent global hand numbness and nighttime awakenings." She noted a history of multiple trigger fingers. Dr. Phillips reported the testing revealed rather severe sensory motor median neuropathy at the right carpal tunnel, moderate to severe on the left side. There was no active cervical radiculopathy. (Px1).

On referral from Dr. Eavenson, the Petitioner followed up with Dr. Choi on 5/1/14. (Px3). His satellite office is in Dr. Eavenson's office. On 5/1/14, the Petitioner reported the noted symptoms, right greater than left, and provided the doctor with a 10 page job description. Dr. Choi specifically noted the following: "Overall she has been working there for the past sixteen years primarily in manual labor type work. For instance, she states that she works on all aspects of caring for water meters. This job requires her to manipulate ¾" to 1" pipe servicing. She uses pipe wrenches to tighten the nuts; digging the ring and lids at meter pits which may consist of using an axe to chop a tree; the use of a variety of tools during repair of the meter pits. Overall she states that she has changed or put in new or repaired thousands of water meters over the years with the use of meter pipe wrenches, gaskets, and screwdrivers. She attributes her work environment and the repetitive work duties that she has performed to the development of her symptoms over the years." She reported having the symptoms at work while working on the meters, noting her symptoms had worsened over the prior couple of months, especially night waking with numbness. Bilateral CTS was diagnosed and surgery was recommended by Dr. Choi. He testified that he believed the Petitioner had multiple non-work related CTS risk factors, and that the condition was preexisting, but that her repetitive flexion and extension movements with multiple tools over the years contributed to the underlying condition and development of symptoms, and thus that the job was a causal contributor. At the same time, he noted that the Petitioner had multiple non-work related risk factors, including being a female of menopausal age, obesity, The Petitioner followed up with Dr. Choi on 6/25/15, and he reiterated his recommendation of bilateral CTS releases. The Petitioner testified that she reported her pre-April, 2014 job duties to Dr. Choi. (Px3; Rx2).

Petitioner testified that her symptoms have worsened and gotten more frequent since 5/1/14. Dr. Choi released the Petitioner to regular duty after seeing her, and she has been doing her regular job since 5/14. While she testified that her job duties were modified by the Respondent after submitting this workers compensation claim, the reality is that her duties have not significantly changed with regard to the impact on her hands and wrists. She has not seen any other doctors for her hands other than Respondent's Sectioon 12 examiner, Dr. Rotman.

Petitioner has been doing turn on/turn offs as a daily job since April of 2014. Before that, she did them once a month. It requires her to open the ground level lids, and then use a different wrench to turn the meters on and off. She performed water meter repairs both before and after 4/14. She performed shoveling and digging both before and after 4/14, almost every day. She would have to travel from location to location to do her jobs in the Respondent's truck. How many residences she would visit per day would vary – it depended on the job and what she had to do at each location. As to reading meters, she would record the numbers, which entailed writing it down. She did this both before and after 4/14.

On cross examination, the Petitioner agreed she'd had symptoms "for a little while" prior to April, 2014, but couldn't say exactly how long. She is 5'3", and weighs 200 pounds. She is a pack per day smoker. She has not

been diagnosed with diabetes, gout or arthritis. The Petitioner also testified that she was diagnosed with high blood pressure about 10 years prior, and takes Lisinopril for this. She also takes Ritalin for narcolepsy, Klonopin for anxiety and Wellbutrin for depression.

The Petitioner had prior surgery on the bilateral 3rd and 4th fingers in 2012 (right hand) and 2016 (left) with Dr. Mirly. She testified she is not claiming these trigger finger conditions as work related because she did not believe they were. Her testimony indicated that she did not address her trigger fingers with Dr. Choi. Dr. Choi indicated that she would need to be off work at least 6 weeks after CTS release surgeries, and, noting she would be fired if she missed 6 weeks of work, the Petitioner testified this impacted her decision to file a workers compensation claim in this matter.

Dr. Choi testified via deposition on 9/15/15. (Px4). Dr. Choi confirmed a diagnosis of carpal tunnel syndrome based on his physical exam, where he found positive findings of CTS, and that this was consistent with the EMG/NCV and Petitioner's job duties. Dr. Choi recommended bilateral carpal tunnel releases based on Petitioner's age and the severity of the condition. Dr. Choi specifically stated that he wanted to perform surgery sooner rather than later to lessen the chance of irreversible nerve damage for Petitioner. He indicated he planned to perform open procedures, with a two week gap between the procedures on each hand, noting he was not experienced in endoscopic/arthroscopic CTS releases. He testified that there was some additional risk with the open procedure, but that increased risk was not that great. (Px4).

Dr. Choi took note of Petitioner's job duties and reported Petitioner worked a manual job dealing with water meters, noting she had worked on thousands of meters throughout her 16 year carrier. When asked if Petitioner's CTS was aggravated by her work activities, Dr. Choi opined that the Petitioner had essentially an underlying preexisting CTS condition and that the work duties aggravated the condition to the point of creating symptoms. Dr. Choi noted that the Petitioner did have other risk factors, such as gender, obesity and an ongoing smoking history, but that within a reasonable degree of medical certainty the Petitioner's work duties were a contributing factor to the CTS condition. Dr. Choi testified that while the Petitioner's job duties were varied to some degree, such variable duties on a weekly basis in this case could still aggravate carpal tunnel syndrome if those activities are performed on a weekly basis over the span of 15 years. (Px4). He also noted the second visit was essentially an update, as he continued to recommend surgery through the 6/25/15 visit and the time of his testimony.

On cross examination, Dr. Choi agreed that only 10% of his practice involved CTS, that he did not hold a hand fellowship or expertise, and that he did not have significant enough experience to perform endoscopic/arthroscopic CTS procedures. He had, however, performed hundreds of CTS releases. He also agreed that he did not hold the Petitioner off work, noting he would not typically have done so given she had been continuing to work when she came to see him.

With regard to causation, he agreed that it was theoretically possible that the non-work risk factors alone could have resulted in the CTS condition, and that the work risk factors were not the prevailing factor, it still was more probable than not that the work factors over 16 years contributed to the condition, particularly given her relatively young age. Having non-work related risk factors does not mean someone will automatically get CTS. It was Dr. Choi's understanding that while the Petitioner did not perform activities that were repetitive in the way that an assembly line might be, the activities nevertheless would be considered repetitive if she did it weekly over many years, and it involved a lot of grasping and some level of force with wrist extension and flexion. He believed that the work she did in wrenching to work on water meters was the main contributor, and that she would do this activity for a good portion of her work week. The Petitioner also reported to him times where she had to access meters in awkward ways underground, which included digging activity..

At Respondent's request, Petitioner was evaluated by orthopedic surgeon Dr. Rotman pursuant to Section 12 of the Act, and he provided deposition testimony on 10/6/15. (Rx1). Dr. Rotman examined the Petitioner on 12/1/14. He has an added certification qualification in hand surgery, and he has been practicing since 1990. Dr. Rotman agreed with the diagnosis of bilateral carpal tunnel syndrome and the need for release surgeries. (Rx1). The fact that the Petitioner had prior trigger finger issues was significant to Dr. Rotman, as he testified that individuals with trigger fingers frequently have carpal tunnel syndrome because they are based on a similar idiopathic process which causes tendons and ligaments to thicken. Dr. Rotman testified that the Petitioner had non-work related CTS risk factors that included obesity and gender/age. He further noted that he reviewed medical records which indicated the Petitioner needed to decrease her sugar load, and that people who are prediabetic are more prone to develop thicker ligaments. (Rx1).

Dr. Rotman opined that the job duties are not a risk factor in the carpal tunnel syndrome. He noted there were breaks between hand activities and it is not assembly line work. Her job duties vary throughout the day and she may have to go from one house to another, so there are breaks between job locations. On certain days, she may be looking for pipes. Other days, she is tightening bolts. Like Dr. Choi, Dr. Rotman reviewed a job description provided to him by the Petitioner. He acknowledged that the Petitioner had to perform turn on and turn offs, which involved taking a wrench and turning a valve. The Petitioner also noted she had to use a shovel to find water meters, and would occasionally use a pick axe. Pipe wrenches would have to be used as well as cheater bars, post hole diggers, garden spade, hacksaw, and a variety of tools. Dr. Rotman did note that some of her activities may have been heavy, but those were done only occasionally. On cross examination, Dr. Rotman testified that he did not believe that the work duties aggravated the Petitioner's CTS condition, although he did agree that the job activities may have triggered CTS symptoms. (Rx1).

The Petitioner was shown a prior workers compensation lump sum settlement contract and agreed that there was language in the document indicating that it was resolving any and all accidents prior to settlement approval. She signed this on 4/8/14 and it was approved by the Arbitrator on 4/25/14. The Respondent sought to enter the prior settlement contract into evidence as Rx4, but the Arbitrator determined that the contract was not relevant to this case, and rejected the exhibit. It should remain part of the record as a rejected exhibit.

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 in this case finds that the Petitioner has sustained her burden of proving that she sustained accidental injuries arising out of and in the course of her employment with the Respondent. The key issue in a case like this involves the "arising out of" aspect of the issue of accident. In such case, it must be determined whether the job activities constituted an accident within the meaning of the Act, and whether the activities involved an increased risk of injury to the worker.

Here, it is acknowledged that the Petitioner's job activities were not "repetitive" within a definition that would be demonstrated by a job, for example, on an assembly line, where one does the exact same job activity and hand motions constantly throughout the day. However, the Arbitrator believes that in this case, based on the evidence, the activities were performed often enough to constitute a cumulative trauma within the meaning of

the Act, particularly given the force that appears to have been required in the Petitioner's job activities while gripping a variety of tools.

The evidence indicates that the Petitioner is the only female working in her position with the employer. The Arbitrator believes it is fair to make the inference that the work involved in the job could be quite heavy. The job involved having to use a pipe wrench with a cheater bar that the Petitioner indicated they would weld to the wrench to create more leverage. The need to do this indicates to the Arbitrator that the removal of bolts/nuts and the movement of valves could be extremely heavy work. While it is true that the Petitioner's job duties varied, it seems that almost every tool she used involved a need to strongly grip that tool and to exert fairly significant force to utilize it. This clearly oftentimes, particularly with bolts/nuts and valves, would require her to push/pull while utilizing a pipe wrench. Anyone who has used a wrench in this fashion can understand the need to hold the wrists stiffly to hang onto the tool while trying to turn the bolt/nut or valve with force. The Arbitrator finds that the Petitioner has proven an accidental injury to the hands/wrists in this case within the meaning of the Act.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner's bilateral CTS condition is causally related to the accident. In making this finding, the Arbitrator relies on the opinion of Dr. Choi. Additionally, while Dr. Rotman disputes the determination that the Petitioner's work duties aggravated her underlying CTS condition, he does acknowledge that the work activities may have triggered the Petitioner's symptoms. Thus, it does appear that he agrees that the type of work activities the Petitioner performed could, at a minimum, impact the symptoms. Under Illinois law, the accident need only be a cause of a condition of ill-being, and need not be the primary or prevailing factor. Taking the evidence on balance, the Arbitrator believes the greater weight of the evidence supports a causal connection in this case.

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 the medical expenses that were alleged to be causally related to the 4/17/14 accident as Petitioner's Exhibit 5. The submitted bills carry different balances, but the Arbitrator notes that all appear related to the treatment via Dr. Eavenson and Dr. Choi, including therapy and EMG/NCV testing. The Arbitrator awards the Petitioner the bills contained in Px5. The Arbitrator notes that the Respondent's liability for these expenses is limited by the Fee Schedule contained in Section 8.2 of the Act. Additionally, the parties have stipulated that the Respondent is entitled to Section 8(j) credit for any medical payments that were covered by the Petitioner's group health insurance through the Respondent policy, and the Respondent shall hold the Petitioner harmless from any and all collection efforts with regard to the awarded expenses for which such credit is granted.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the recommended bilateral CTS release procedures recommended by Dr. Choi are causally related to the 4/17/14 accident, and the Respondent shall authorize same. The Arbitrator notes that there is some evidence from Dr. Choi which suggests that the open procedures he is planning to perform involve some increased level of risk versus that associated with an endoscopic/arthroscopic procedure. While the

Arbitrator believes that, based on Dr. Choi's testimony, this increased risk is minimal, it also makes sense to the Arbitrator to allow the Petitioner to choose which procedure she would like to follow through with. Thus, the Arbitrator also believes it is reasonable to allow the Petitioner to obtain surgery through another orthopedic surgeon that the parties can agree on who would have the proper experience to perform an arthroscopic/endoscopic CTS release. It should be noted that this is not an open invitation to ongoing treatment. The evidence amply indicates that the Petitioner has fairly severe bilateral tunnel, and that the next step in this process is surgery. Thus, the only specific prospective medical awarded via this decision is CTS release surgery, either open or arthroscopic/endoscopic, and any reasonable and necessary causally related post-surgical treatment consistent with Section 8(a) of the Act. If the Petitioner so chooses, and the Petitioner and Respondent cannot agree on an endoscopic/arthroscopic surgeon, the award of open CTS release with Dr. Choi will stand. The important thing in this case is that the Petitioner obtains the procedure most likely to provide relief.

WITH RESPECT TO ISSUE (O), WHETHER A PRIOR LUMP SUM SETTLEMENT CONTRACT BARS THE CURRENT CLAIM, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator relies on Commission Rule 7020.20(b) in finding that the prior contract (case number 12 WC 33737) is not relevant to the issues in the case at bar. The cited rule states that: "An Application for Adjustment of Claim must be limited to one accident or claim."

In this case, the 12 WC 33737 contract indicates agreement that it resolved any and all incidents, aggravations or exacerbations arising out of the Petitioner's employment. The Arbitrator believes that 7020.20(b) limits an Arbitrator's jurisdiction in a single case to the accident or claim involved in that case. Thus, it is unclear how a settlement in that case for a single claim can impact a separate case that involves a separate claim. As such, the Arbitrator finds that the prior settlement does not bar this claim. It's hard to understand how a contract in one case with one claimed accident can then bar a claim in a separate accident given the language of the rule. Had the prior claim also involved bilateral CTS, particularly given that the cause of the accident involved activities over a period of time, the Arbitrator would have made a different finding with regard to the relevance of the prior settlement, as an argument could clearly be made in such case that the current claim involves the same accident or claim as the prior case and settlement..

In making this finding, the Arbitrator notes that it certainly appears that the limiting language at issue in the prior contract showed a meeting of the minds between the parties to bar all possible claims through the date of that contract's approval, and there may well have been consideration provided for such agreement. The Arbitrator simply believes that the Arbitrator's jurisdiction in 12 WC 33737 was limited to the accident date that was listed in the Application and settlement contracts per Rule 7020.20(b).

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

Linda Lauher,

Petitioner,

vs. NO. 14WC 18811

Sacred Heart Griffin,

17IWCC0244

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 accident, medical expenses, causal connection, prospective medical care, 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 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 $15,000.00. 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: APR 19 2017
SJM/sj
o-4/6/2017
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

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

LAUHER, LINDA
Employee/Petitioner

Case# **14WC018811**

SACRED HART GRIFFIN
Employer/Respondent

17IWCC0244

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:

1727 LAW OFFICES OF MARK N LEE LTD
1101 S SECOND ST
SPRINGFIELD, IL 62704

1680 CASSANO & ASSOCIATES
LAWRENCE CASSANO
1240 IROQUOIS AVE SUITE 210
NAPERVILLE, IL 60563

17IWCC0244

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)

Linda Lauher
Employee/Petitioner

v.

Sacred Heart Griffin
Employer/Respondent

Case # **14 WC 018811**

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 **McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **4/21/2016**. 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, **1/7/2013**, 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 **$16,251.47**; the average weekly wage was **$345.78**.

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 reasonable and necessary charges for all reasonable and necessary medical services.

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

ORDER

Respondent shall pay reasonable and necessary medical services, as provided in Sections 8(a) and 8.2 of the Act and per the stipulation of the parties, subject to any credit pursuant to Section 8(j).

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the proposed carpal tunnel release operation.

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.

6/8/2016

Signature of Arbitrator

Date

JUN 16 2016

ICArbDec19(b)

Findings of Fact

Petitioner is a 56 year old who is currently retired, prior to retirement she worked for the Respondent. (Trans. Pg. 9-10) Petitioner testified she was employed at Sacred Heart Griffin High School as a food service worker and worked for the Respondent for 15 years. Petitioner worked from 7:00-1:00, Monday through Friday. (Trans. Pg. 11, 37) Petitioner testified on January 7th 2013, that her hands were hurting and that she had pain in her wrists and thumbs. (Trans. Pg. 11-12) Petitioner testified that when she started her day at work her pain would be at a five but by the end of the day of the working day her hands would be a ten. (Trans. Pg. 27-28) However, on weekends Petitioner testified that her hands would remain at a 5 and not get worse. (Trans. Pg. 29)

Petitioner testified that the first thing she did was process 75-80 kids through breakfast and operated a cash register. (Trans. Pg. 13) Petitioner then testified she would do prep for whatever bar they were having that day from 8:00-10:30. (Trans. Pg. 17) Petitioner would feed approximately 750 students as they all ate in school. (Trans. pg. 16) During the lunch period Petitioner would operate a cash register and replace emptied items as the period went on. (Trans. Pg. 18)

After lunch she would then have to wash pans used for that day's bar and wash them manually, by hand. Petitioner testified that she used a steel-wool pad, and a dish cloth. Petitioner testified that that washing the pans would increase the symptoms in her hands (Trans. Pg. 19) Petitioner washed pans for an hour everyday regardless if the bar was prepared that day. (Trans. Pg. 24)

Petitioner testified that she would have to prepare a variety of bars per week, one week she would prepare a salad bar, then a taco bar, Asian bar, and sandwich bar. She later mentioned a potato bar as well. (Trans. Pg. 12) For the salad bar she would take different vegetables and would rinse them off, slice and dice them manually which would bring on the symptoms in her hands. (Trans. Pg. 14-15) For this activity, she primarily used her dominate right hand to chop while using the other to hold the vegetables. She would then use a five gallon bucket to fill up the bar with ice using the bar, and would empty off the ice at the end of the day using a dustpan. (Trans. Pg. 16)

Petitioner testified she prepared an Asian bar, that involved cooking vegetables, but Petitioner testified that she would have to use a deep fry pan and that the motion would increase the symptoms in her hands. (Trans. Pg. 20)

Petitioner then did a spaghetti bar where she would fill pots with water and cook 60 pounds of pasta and strain the pasta which required her to pick up the 60 pounds and dump into the warmers. She would also stir the noodles manually using a commercial kitchen spoon. When she stirred the spoon it made her hands worse. (Trans. Pg. 23)

Petitioner also described her work at a sandwich bar, where she would slice big chunks of turkey, ham and roast beef using a commercial slicer that was done all week. (Trans. Pg. 24)

The final bar Petitioner described was the potato bar. Petitioner testified she would have to wrap 100 potatoes, put them on a big sheet pan and bake them. She would also prepare a cheese sauce that required a wire whip that also impacted her hand pain. (Trans. Pg. 28)

Petitioner first treated with Dr. McClintock, her primary care physician on 1/17/2013. In the report, Dr. McClintock noted that the Petitioner had bilateral hand pain on both sides. It also documented that she did a lot of repetitive type work for Sacred Heart Griffin in their cafeteria.

Petitioner underwent an EMG on 1/22/2013, it again documents Petitioner's work for respondent and reported that the Petitioner had bilateral extensor tenosynovitis and carpal tunnel syndrome.

Petitioner followed up with Dr. Schopp on 2/18/2013. Dr. Schopp documented that Petitioner's work with Respondent and recommended the possibility of carpal tunnel release. On 3/18/2013 Dr. Schopp injected Petitioner's thumbs with cortisone.

A letter dated 4/24/2013 dictated by Dr. Schopp gave the opinion that Petitioner's work with Respondent exacerbated her basilar joint arthritis and carpal tunnel syndrome and that her symptoms are work related, as she notes her symptoms are worse during work activities.

Dr. Schopp again injected Petitioner's thumbs on 7/1/2013. Petitioner treated with Dr. Greatting on 1/16/2014. Petitioner testified that Dr. Schopp referred Petitioner to Dr. Greatting because Dr. Greatting concentrated upper extremities and Dr. Schopp concentrated in knees and hips.

Dr. Greatting 1/16/2014 notes do not dictate a work history but Petitioner testified she did tell Dr. Greatting about her job. Petitioner recalled that Dr. Greatting had children who attended school at Sacred Heart Griffith. Dr. Greatting noted that Petitioner would like to avoid surgery and ordered further conservative care.

Petitioner followed up with Dr. Greatting on 3/20/2014. It was at this point Dr. Greatting ordered Petitioner undergo surgical intervention.

Petitioner underwent right thump trapezial excision and carpometacarpal joint arthroplasty with flexor carpi radialis tendon, and right carpal tunnel release on 5/28/2014.

Petitioner then underwent hand therapy at Taylorville Memorial Occupational therapy after her surgery. On 9/10/2014 Petitioner was released to work light duty. Petitioner testified she did work light duty with Respondent. Petitioner testified her hand is doing much better after this surgery.

On 10/13/2014, Dr. Greatting ordered Petitioner undergo the same surgery on her left hand. Petitioner testified she has not undergone this surgery. Petitioner testified she would like to pursue this surgery as well.

Petitioner underwent a section 12 examination with a Dr. Michele D. Koo on 10/7/2015. Dr. Koo reviewed the history provided by Petitioner and did not see any factors from her work at Sacred Heart Griffin that would cause her bilateral carpal tunnel syndrome or bilateral CMC arthritis. Dr. Koos attributes Petitioner's condition to her being overweight, having hypertension, and her smoking. Dr. Koo did not believe that Petitioner's job was not continuous, hard, fast, repeated of an assembly type occupation that would lead to bilateral carpal tunnel syndrome or bilateral thumb CMC joint arthritis.

Dr. Greatting was deposed on August 10, 2015. In this deposition Dr. Greatting reiterated the treatment he performed on Petitioner. He was also presented with a hypothetical job description that was similar in manner to what was testified by Petitioner on the date of trial. (PX-2. Pg. 16-19) Dr. Greatting opined that based upon the job described was hand-intensive repetitive work, which required repetitive extension and flexion of the wrists. (PX-2. Pg. 19) Dr. Greatting opined that by the job information provided it sounded to be sufficiently forceful and repetitive in nature to contribute to the development of carpal tunnel syndrome. (PX-2. Pg. 20) Dr. Greatting opined that while Petitioner would likely have CMC joint arthritis anyway he did think the job described could aggravate the symptoms and accelerated the symptom's to make it require treatment. (PX-2. Pg. 20-21) After reviewing the risk factors for the development of carpal tunnel, Dr. Greatting it was his opinion that Petitioner's occupation contributed to the development of Petitioner's bilateral carpal tunnel condition and aggravated her bilateral CMC joint arthritis. (PX-2. Pg. 35-36)

Conclusions of Law

In regard to disputed issue (F), the Arbitrator makes the following conclusions of law:

The Arbitrator concludes that Petitioner sustained a repetitive trauma injury arising out of and in the course of her employment with Respondent that manifested itself on January 7, 2013.

In support of this conclusion the Arbitrator notes the following:

Petitioner saw Dr. McClintock on 1/17/2013 and reported that her hands were hurting due to her work with Respondent. She repeated this history to Dr. Schopp who wrote a letter on, 4/23/2014 that explained he opined that Petitioner's work activities aggravated her condition.

Petitioner's testimony regarding her work activities was unrebutted. She gave essentially the same history to Dr. Koo as part of her examination. Dr. Greatting was also given

a job description by way of a hypothetical question that was nearly identical to what was testified to at the date of trial and what was given the Section 12 examiner.

Of note, Petitioner has had to use a tool marked as Petitioner's Exhibit 4. It appeared to use a lot of force and a lot of Petitioner food prep activities required manual dexterity and repetition, including breaking up ground beef, chopping vegetables, and using a commercial meat slicer.

The Arbitrator finds the opinions of Dr. Greatting and Dr. Schopp to be more persuasive then that of Dr. Koo. While Petitioner does has some risk factors that predisposed her to development of carpal tunnel her job is of a high enough repetitive nature that would contribute and aggravate her bilateral carpal tunnel and bilateral CMC joint arthritis condition until surgical intervention was necessary. While Dr. Koo did not feel the Petitioner's job required a continuous, hard, fast assembly type operation in order for the claim to be compensable. The law places no such requirement on the Petitioner. She must only prove that her work activity was a causative factor in the development of her conditions.

Ultimately, Petitioner's testimony of her symptoms getting worse over the course of the day, and worse still at the end of a week, with the only relief being when she is away from the job, establishes that her work aggravated and made symptomatic her conditions to the point of necessitating treatment.

In regard to disputed issues (K), the Arbitrator makes the following conclusions of law:

Both Dr. Greatting and Dr. Koo agreed that surgery was appropriate to treat Petitioner's bilateral carpal tunnel and CMC joint arthritis. Having determined both conditions to be related to Petitioner's work activity for Respondent, the Arbitrator finds the proposed surgery necessary and orders Respondent to pay for same, subject to the fee schedule. In light of the Arbitrator's decision with respect to accident and causation, the Arbitrator orders the Respondent to pay the past medical bills offered into evidence, pursuant to Sections 8 (a) and 8.2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Craig Taylor,
Petitioner,

vs.

NO: 14 WC 19953

State of Illinois,
Department of Transportation,
Respondent,

17IWCC0229

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

While the Commission concurs with the Arbitrator's reasoning, the Commission strikes from the decision the specific reference to the case of *Independent Mechanical Industries, Inc. v Illinois Workers' Compensation Commission*, 2015 IL App (2d) 130696WC-U (2nd Dist 2015); as a Rule 23 order, it lacks precedential authority. The other findings and reasoning of the Arbitrator are adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that, other than as noted above, the Decision of the Arbitrator filed February 17, 2016 is hereby affirmed and adopted.

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

APR 13 2017

DATED:

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

o-04/05/17
jdl/jl
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TAYLOR, CRAIG
Employee/Petitioner

Case# **14WC019953**

SOI; IL DEPARTMENT OF TRANSPORTATION
Employer/Respondent

17IWCC0229

On 2/17/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.41% 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:

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

3291 ASSISTANT ATTORNEY GENERAL
DIANE 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' COMP MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

FEB 17 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

CRAIG TAYLOR
Employee/Petitioner

v.

SOI; ILLINOIS DEPARTMENT OF TRANSPORTATION
Employer/Respondent

Case # 14 WC 19953

Consolidated cases: ____

17IWCC0229

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **December 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 ____

17IWCC0229

FINDINGS

On **February 10, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did 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 **$71,475.00**; the average weekly wage was **$1,374.51**.

On the date of accident, Petitioner was **50** years of age, *married* with **0** dependent child(ren).

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

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

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

Respondent is entitled to a credit of **$any benefits paid through group ins** under Section 8(j) of the Act.

ORDER

The Arbitrator finds Petitioner did not suffer an accident that arose out of and occurred in the course of his employment on February 10, 2014.

As such, all other issues are moot.

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

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

Edward Lee
Signature of Arbitrator

2/9/16
Date

FEB 17 2016

Craig Taylor v. State of Illinois/Department of Transportation
DOA: 02/10/2014, 14-WC-19953

FINDINGS OF FACT AND CONCLUSIONS OF LAW

On June 11, 2014, Petitioner filed an Application for Adjustment of Claim with the Illinois Workers' Compensation Commission, listing the Illinois Department of Transportation as the Respondent and alleging an accident on February 10, 2014. Petitioner's Application alleges an accident when he was "trying to open hood during school bus inspection," affecting his "right shoulder."

The Arbitrator finds:

Preliminary Matter

The Arbitrator notes Petitioner testified at the hearing, held on December 20, 2015, that he was not alleging a "repetitive injury but a one-time incident while ... trying to open hood during school bus inspection."

However, the Arbitrator notes that (treating orthopedic surgeon) Dr. Chamberlain's explicit testimony on November 19, 2015 was that Petitioner did not have an "acute injury at a specific time and date while at work," but rather that Dr. Chamberlain's "causation opinion" was "solely based on a repetitive trauma theory."

As such, the Arbitrator notes that he will look at all theories of accident in this case in determining whether Petitioner suffered an accident that arose out of and occurred in the course of his employment on February 10, 2014.

Work History

Petitioner has been employed as a Vehicle Compliance Inspector at Respondent, Illinois Department of Transportation (IDOT), since April 1, 1997. Petitioner testified that his job duties require his to perform inspections of school buses, church vans, and charitable vehicles, as well as inspections for diesel admissions and training for truck inspections.

Medical Records

On December 29, 2009, Petitioner saw Dr. Beaty, who noted, "Pain to right upper arm the past three weeks without specific injury. Previous rotator cuff surgery on that side about ten years ago, but this pain is distal to shoulder itself."

On October 31, 2013, Petitioner saw his primary care physician, Dr. Marc McCleary, at Clinton County Rural Health Clinic & Sports Medicine, who noted, "He does have complaint of R shoulder pain. Patient had rotator cuff repair of R shoulder several years ago. He also has some burning on the inside of R elbow." Dr. McCleary prescribed Petitioner a trial of Medrol and told him to return as needed.

The Arbitrator notes Petitioner's Application alleges an accidental injury to his right shoulder on February 10, 2014 that occurred when he was "trying to open hood during school bus inspection."

On February 11, 2014, Petitioner saw Dr. McCleary. The Arbitrator notes there is no mention of any accident, injury or increase in symptoms the day before, on February 10, 2014. In fact, the Arbitrator notes there is no mention of Petitioner's job duties or work activities at all. Rather, Dr. McCleary noted:

> Patient is a 50 year old white male who presents to clinic with complaint of R shoulder pain. Patient had rotator cuff repair about 10 years ago. Over the past few months, he has noticed increased pain and decreased range of motion of R shoulder. He is L handed, but is having trouble using his R arm for much of anything due to the deficits.

For Assessment, Dr. McCleary stated, "Shoulder pain – patient with signs of shoulder pain. Some concern for issue with rotator cuff. Possible weakness or repeat tear. Will check MRI to see if new damage. If WNL, will send to physical therapy for further treatment."

Dr. McCleary did not prescribe Petitioner any medications or give Petitioner any restrictions.

It is clear from Petitioner's Exhibit #1 that Petitioner processed this bill through his group insurance, Healthlink, only.

On February 14, 2014, Petitioner underwent an MRI of his right shoulder at St. Joseph's Hospital, which found, "The supraspinatus tendon reveals diffuse signal abnormality and some thickening. However, within the distal aspect of the tendon along the posterior central portion, there is a focal subcentimeter region of fluid signal where there appears to be discontinuity. This is consistent with a tear. There is no frank muculotendinous retraction identified."

It is clear from Petitioner's Exhibit #1 that Petitioner processed this bill through his group insurance, Healthlink, only.

On February 17, 2014, Petitioner returned to Dr. McCleary, who noted, "Patient is L arm dominant, but had previous R shoulder MRI tear and repair. He was having increased pain and decreased ROM. MRI shows full thickness tear of supraspinatus." For Assessment, Dr. McCleary stated, "Rotator cuff tear – non dominant arm, but since it is a repeat tear, the picture is more complicated. Will send to Barnes to see shoulder specialist for further assessment and options."

Again, Dr. McCleary did not prescribe Petitioner any medications or give Petitioner any restrictions. Again, it is clear from Petitioner's Exhibit #1 that Petitioner processed this bill through his group insurance, Healthlink, only.

On February 27, 2014, Petitioner filled out a Comprehensive Health History for Washington University. That form asked:

Why are you seeing the doctor today? Right shoulder pain.
How long has the pain/problem been present? 9 months.
Has the pain/problem worsened recently? Yes. How recently? 1 month.
What started the pain/problem? Opening Hoods

Additionally, Petitioner filled out a Washington University Shoulder Evaluation Form. That form asked:

Do you have shoulder pain? Yes
How long have you had pain? 9 months
Did an injury cause the pain? BLANK
Did your injury occur on the job? BLANK
Do you have night pain? Yes
Do you take pain medication? No

On February 27, 2014, Petitioner saw Dr. Aaron Chamberlain at Washington University Physicians. Dr. Chamberlain stated:

> We had a long discussion today regarding the natural history of rotator cuff tears and rotator cuff disease. He has a likely recurrent rotator cuff tear after rotator cuff repair that was done over 10 years ago. He has no history of a discrete injury, but has noted he's been totally using his arms at his job for many years.

Dr. Chamberlain stated Petitioner's "symptoms are so mild" and recommended an ultra sound and physical therapy. Dr. Chamberlain told Petitioner to return in 6 months.

Incident Reports

Petitioner did not report the accident to anyone at Respondent IDOT until March 6, 2014, when Petitioner told his supervisor, Grant White, that he has "right shoulder pain" from "REPETITIVE USE OVER TIME – OPENING HOODS OF BUSES CAUSED SHOULDER PAIN." For "Date of Accident/Incident," Supervisor White stated, "REPETITIVE USE OVER TIME." For "Hour" of accident/incident, Supervisor White left that box BLANK. For "Exact Location," Supervisor White stated, "Various."

Petitioner first mentioned February 10, 2014 to Respondent IDOT on March 13, 2014 when he filled out his Employee's Notice of Injury. Petitioner stated that he had injured his "right arm/shoulder area" and he had been to see Dr. Aaron Chamberlain at 4921 Parkview, St. Louis, Mo.

Petitioner stated that his date of injury was February 10, 2014 at "approximately 10:00 am." The Employee's Notice of Injury asked, "What duty were you performing at time of injury?" Petitioner responded, "School bus inspections trying to open hoods that were stuck."

When asked, "If not reported on Date of Incident, explain," Petitioner stated, "Not a lot of pain until I went to sleep and pain went away in a couple of days."

However. Petitioner testified at trial:

Question: After this incident of 2/10/14, did your symptoms ever go away until your surgery?

Petitioner: No, they did not.

Deposition of Dr. Chamberlain

The Arbitrator notes Dr. Chamberlain testified by way of deposition on November 19, 2015 at Petitioner's request. Dr. Chamberlain testified that he was a board-certified orthopedic surgeon with a subspecialty in shoulder and elbow surgery. Dr. Chamberlain testified that 95% of his practice centers around treating shoulders and he sees 100 patients a week, performing 12 surgeries per week.

The Arbitrator notes Dr. Chamberlain testified that Petitioner worked as a school-bus mechanic, which required lifting and labor with his arms. However, the Arbitrator notes from Petitioner's testimony, as well as Supervisor White's Supervisor's Report of Injury or Illness, that Petitioner is actually a Vehicle Compliance Inspector, which only requires inspections of school buses, church vans, and charitable vehicles, as well as inspections for diesel admissions and training for truck inspections.

However, the Arbitrator notes Petitioner did testify that he went to school for auto mechanics and that he has five vehicles at home that he does the maintenance work on, including oil changes, rotating of tires and doing brake work. Petitioner testified that he lifts and carries the tire for those vehicles.

On direct exam, Dr. Chamberlain testified:

Question: Can you briefly just tell us what he told you that day about his symptoms?

Dr. Chamberlain: At the approximate ago of 50 years old he had the chief complaint of right shoulder pain. He had a history of a prior rotator cuff repair done in 2003. And then in the months prior to seeing me, approximately nine months prior to seeing me, he noticed recurrence of the pain in his shoulder that was then worsening over the month prior to seeing me.

Question: Did he tell you about the onset of that problem, how it began?

Dr. Chamberlain: The initial problem prior to 2003 he didn't discuss, but the more recent one, when I asked what his reason or what he felt the pain was due to, he states that, he told me that he was, his line of work involved a lot of heavy labor with his arms and felt that it might be related to that.

Question: Did he explain to you or demonstrate for you any type of mechanism of injury or what he was doing on a daily basis that he felt led to the development of these symptoms?

Dr. Chamberlain: Yes. So what I – and what I've noted here and – I remember the conversation clearly – was that he works as a mechanic for school buses, and part of the job, or part of his job is to obviously work under the hood of the school buses. And he

described some school buses that had difficult hoods to raise for whatever reason, and that his method for raising that was to stand on the bumper and then with both arms with some violent actions sometimes raise the hood so that he could access the mechanics under the hood.

Question: Okay. And was this more of a gradual onset or did he tell you that it was an acute injury?

Dr. Chamberlain: He stated that it was about nine months prior that he felt that it began. He didn't provide a particular date or incident, but he states it was nine months prior to seeing me, and that then gradually it worsened over that course of nine months.

Question: Very good. ...

(PX 9, pg 8-10)

Dr. Chamberlain: Let me review. Activity modification was suggested and physical therapy. We did discuss what I've described as the natural history of rotator cuff tears. Which we know to be over time tears can enlarge at younger ages in labor occupations. We feel it's a larger risk. Non operative management can present a larger risk for patients especially when it involves the anterior part of the supraspinatus. ...

(PX 9, pg 12)

Question: Basically, my question is within a reasonable degree of medical certainty would the job duties that he described to you, kind of this lifting mechanism with his right shoulder that he's performing on a repetitive basis at his job, would that in any way either cause, contribute to or aggravate the development of his right shoulder condition and symptoms?

Dr. Chamberlain: It can, yes.

Question: And is that your opinion in this case?

Dr. Chamberlain: Yes.

Question: What's the basis for that?

Dr. Chamberlain: Just the mechanism of what he describes is his action, as well as the nature of full-thickness tear in his young age group, and the location of the tear.

(PX 9, pg 13)

Then, on cross exam, Dr. Chamberlain testified:

Question: I know that you've given an opinion that Mr. Taylor suffered a work-related injury to his right shoulder. It doesn't appear that you are stating that he had any acute injury at a specific time and date while at work, is that correct?

Dr. Chamberlain: That's correct.

Question: So your causation opinion today then is solely based on a repetitive trauma theory?

Dr. Chamberlain: Yes. It's based on the mechanism of his job and the pain that he experienced while doing that job, I guess.

(PX 9, pg 19)

Question: So when we talk about the mechanism of injury, are you only talking about the job duties where he has to stand on a bumper and yank on a hood?

Dr. Chamberlain: Those are the particular job description – that's the particular job description I was aware of that in my opinion does lend itself to the mechanism of injury described.

Question: And so essentially you are saying that he stood on a bumper and yanked on a hood in a repetitive way that culminated in a shoulder injury, is that correct?

Dr. Chamberlain: More likely than not, yes.

Question: How often would he stand on a bumper and yank on a hood?

Dr. Chamberlain: I don't know.

Question: And do you know if he did this during all the same environmental conditions?

Dr. Chamberlain: I do not know that.

Question: And do you know the amount of force that he was using when he was yanking on the hood?

Dr. Chamberlain: I can't quantify that, no. He just described a, what I would describe as a lot of force. Or sometimes he'd describe and demonstrate kind of a violent type of force that he required.

Question: Okay. So essentially as we sit here today, you don't have any knowledge as to whether he yanked on a hood one time or two times versus 20 times versus 100 times, would that be correct?

Dr. Chamberlain: His description of it was it was numerous, that it was with some frequency, probably more than one or two times. But the exact number I don't know.

Question: And was he doing this daily?

Dr. Chamberlain: I don't know.

Question: And are you aware of any of his other job duties?

Dr. Chamberlain: No ma'am. Other than repairing school buses, no.

Question:	And are you aware of any of those job duties or do you believe that any of those job duties other than yanking on the hood contributed to the repetitive nature of his injury?
Dr. Chamberlain:	If I were to infer with working as a school bus mechanic that it involves lifting and labor with the arms, which I'm familiar with in some other settings, then, yes, I think that it could also have contributed perhaps.
Question:	And that's as a school bus mechanic?
Dr. Chamberlain:	As – yeah.
Question:	And do you know how often he would do the lifting with his arms and the labor with his arms?
Dr. Chamberlain:	As often as he was at work. I don't know how often he worked.

(PX 9, pg 20-22)

Question:	Given the condition of someone who has a prior right rotator cuff tear and repair, is it possible that the opening of these hoods, the yanking of these hoods, didn't affect his right shoulder at all?
Dr. Chamberlain:	It's possible.
Question:	And is it possible given Mr. Taylor's right shoulder condition and the fact that he had a prior right rotator cuff tear and repair, it is possible that the shoulder condition that you saw was just a natural progression of his physical condition since the time that he had the first repair?
Dr. Chamberlain:	It's possible.

(PX 9, pg 24)

Petitioner's Testimony

Petitioner testified at the hearing on December 20, 2015 that on February 10, 2014, he "was inspecting school buses at New Athens." Petitioner testified it had snowed and he "got to the end of the busses where I started doing the spare busses." Petitioner testified that he "tried to open the hood and it wouldn't open," so he "put both of his feet inside the bumper holes and jerked hard once." When the hood wouldn't open, he "tried it again and at that point I felt pain in my right arm."

Petitioner testified that when he saw Dr. McCleary on October 31, 2013 and complained of right shoulder pain, that he felt at that time that his job duties were causing his right shoulder pain.

Medical Records

On March 21, 2014, Petitioner underwent an ultrasound, which showed a "complicated full-thickness tear involving the supraspinatus and infraspinatus tendon. It is difficult to measure accurately. The tear begins near the lateral foot print of the supraspinatus tendon and has an oblique posterior and medial course through the rotator cuff towards the bursal surface. The anterior component the tear measures at least 14 mm in length, 20 mm in width, and is located 8 mm from the intra-articular portion of the biceps tendon."

On March 31, 2014, Dr. Chamberlain called Petitioner and recommended Petitioner proceed with arthroscopic rotator cuff repair.

On October 17, 2014, Petitioner underwent a right shoulder arthroscopic rotator cuff repair, performed by Dr. Chamberlain.

Petitioner returned to Dr. Chamberlain on October 27, 2014 for follow up. Dr. Chamberlain returned Petitioner to work with restrictions of no use of the right arm.

On December 1, 2014, Petitioner returned to Dr. Chamberlain, who took Petitioner out of his sling, prescribed physical therapy and returned Petitioner to work with restrictions of no lifting greater than 3 pounds, no overhead work, no outstretched motion and no repetitive motion.

On January 12, 2015, Petitioner returned to Dr. Chamberlain, who told Petitioner to continue his physical therapy and return to work with restrictions of no lifting greater than 10 pounds, no overhead work, no outstretched motion and no repetitive motion.

Petitioner returned to Dr. Chamberlain for the last time on February 23, 2015. Dr. Chamberlain noted Petitioner "noticed a significant improvement with his strength and range of motion" and had "great strength with manual motor testing the rotator cuff." Dr. Chamberlain returned Petitioner to work full duty and told Petitioner to return in the future if he had any "questions or concerns."

On June 4, 2015, Petitioner returned to Dr. McCleary. Petitioner did not have any right shoulder complaints and Dr. McCleary's physical exam of Petitioner's musculoskeletal system was "overall findings were normal." Petitioner did complain about mid back and low back pain, including some grinding and pain in his low back. Dr. McCleary's only Assessment was "Back pain – likely some core strength issues and some arthritis. Recommend that patient continue with HEP and will add Mobic to daily regimen."

Petitioner's Prior Right Should Injury

On August 5, 2002, Petitioner saw Dr. Lefebvre at Clinton County Rural Health Clinic & Sports Medicine, who noted. "Patient presents to the office complaining of pain in his right shoulder and right arm. It has been present intermittently for the last month. He injured it when he tried reaching behind him to pick up something in the back seat of his vehicle."

Petitioner testified on direct exam that in 2005, 2006, he had a surgery to his right shoulder. Petitioner stated that shoulder injury did not "have anything to do with work" and he did not "make any sort of a workers' compensation claim."

However, on cross-exam, Petitioner admitted that he told Tristar (State of Illinois' insurance carrier) that his original shoulder injury in 2002, 2003 occurred at work. Petitioner admitted that he told Tristar he was originally run over by a school bus at work.

Further, the Arbitrator takes judicial notice that Petitioner, Craig Taylor DOB 8/31/1963, filed a workers' compensation claim against "State of Illinois" on September 10, 2003. That case was given workers' compensation number 03-WC-43821 and alleged an injury on June 18, 2002 affecting Petitioner's "back up and lo ext right." The Arbitrator notes that case was dismissed on October 19, 2006.

Petitioner's Testimony

Petitioner testified that he is "back to normal, able to do most everything that [he'd] done before this surgery. Feels great." Petitioner testified that he "very rarely" has discomfort in the arm when he sleeps.

Petitioner also testified that he intends on using a cross bow when he deer hunts from now on; however, Petitioner admitted on cross-exam that he was given a permit for his cross-bow by Dr. Lehman after his first shoulder surgery. Petitioner admitted that he obtained his cross-bow well before 2014.

Issue (C) Did an accident occur on June 16, 2014 that arose out of and in the course of Petitioner's employment with Respondent?

The Arbitrator notes Petitioner testified at the hearing, held on December 20, 2015, that he was not alleging a "repetitive injury but a one-time incident while ... trying to open hood during school bus inspection." However, the Arbitrator notes that (treating orthopedic surgeon) Dr. Chamberlain's explicit testimony on November 19, 2015 was that Petitioner did not have an "acute injury at a specific time and date while at work," but rather that Dr. Chamberlain's "causation opinion" was "solely based on a repetitive trauma theory."

As such, the Arbitrator notes that he will look at all theories of accident in this case in determining whether Petitioner suffered an accident that arose out of and occurred in the course of his employment on February 10, 2014.

Petitioner's Credibility

The Arbitrator notes some concern about Petitioner's credibility, as the Arbitrator finds it highly unusual that Petitioner would now claim a specific incident on February 10, 2014, when he told his supervisor and his orthopedic surgeon, Dr. Chamberlain, that he had a gradual injury

due to his repetitive job duties, and he has never mentioned a specific incident to his primary care physician, Dr. McCleary

Additionally, Dr. Chamberlain testified that he specifically remembered Petitioner telling him that Petitioner was a school bus mechanic, when Petitioner is actually a vehicle inspector.

Further, Petitioner testified at trial that his right shoulder symptoms had never gone away after February 10, 2014, but on his Employee's Notice of Injury, for the question, "If not reported on Date of Incident, explain," Petitioner stated, "Not a lot of pain until I went to sleep and pain went away in a couple of days.

Finally, Petitioner testified on direct exam that in 2005, 2006, he had a surgery to his right shoulder. Petitioner stated that shoulder injury did not "have anything to do with work" and he did not "make any sort of a workers' compensation claim."

However, on cross-exam, Petitioner admitted that he told Tristar (State of Illinois' insurance carrier) that his original shoulder injury in 2002, 2003 occurred at work. Petitioner admitted that he told Tristar he was originally run over by a school bus at work.

Despite Petitioner's statements, his medical records show that on August 5, 2002, Petitioner saw his primary care physician, who noted he had injured his right shoulder when he "tried reaching behind him to pick up something in the back seat of his vehicle."

The Arbitrator notes Petitioner filed a workers' compensation claim against "State of Illinois" on September 10, 2003 that alleged an injury on June 18, 2002 affecting Petitioner's "back up and lo ext right." That case was dismissed on October 19, 2006.

Acute Injury on February 10, 2014

The Arbitrator notes this case is very similar to a recent decision by the First District Appellate Court of Illinois in *Hosteny v Illinois Workers' Compensation Comm'n and Anning Johnson Co.*, 397 Ill.App.3d 665 (2009). In *Hosteny*, the Appellate Court upheld the Commission's reversal of the arbitrator's decision, which awarded workers' compensation benefits to the petitioner.

In *Hosteny*, the Petitioner was a foreman at a job site that required him to carry 32-foot ladders "throughout the day" while painting window lintels. Petitioner alleged a series of neck injuries due to carrying the 32-foot ladder.

The *Hosteny* Court stated that purpose of the Act is to protect employees against risks and hazards which are peculiar to the nature of the work they are employed to do. *Illinois Bell*

Telephone Co. v. Industrial Comm'n, 131 Ill.2d 478, 483, 137 Ill.Dec. 658 (1989). An injury is compensable under the Act only if it "arises out of" and "in the course of" one's employment. 820 ILCS 305/2 (West 2004). Both elements must be present at the time of the employee's injury in order to justify compensation, and it is the employee's burden to establish these elements by a preponderance of the evidence. *Rodin v. Industrial Comm'n*, 316 Ill.App.3d 1224, 1226, 250 Ill.Dec. 486 (2000).

The *Hosteny* Court stated that "in the course of" element refers to the time, place, and circumstances under which the accident occurred. *Dodson v. Industrial Comm'n*, 308 Ill.App.3d 572, 575, 241 Ill.Dec. 820 (1999). An injury is said to "arise out of" one's employment when there is a causal connection between the employment and the injury; that is, the origin or cause of the injury must be some risk connected with the claimant's employment. *Brady v. Louis Ruffolo & Sons Construction Co.*, 143 Ill.2d 542, 548, 161 Ill.Dec. 275 (1991). Typically, an injury arises out of one's employment if, at the time of the occurrence, the claimant was performing acts the employer instructed the claimant to perform, acts incidental to the claimant's assigned duties, or acts which the claimant had a common law or statutory duty to perform. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 58, 133 Ill.Dec. 454 (1989).

In *Hosteny*, the Commission found Petitioner's testimony was not credible. On appeal, the petitioner argued that his testimony was "uncontradicted," and the Commission, as the trier of fact, was without discretion to discount his testimony unless it was impeached, contradicted by positive testimony or circumstances, or found to be inherently improbable. *Hosteny*, 397 Ill.App.3d at 667. The Appellate Court disagreed, stating that, although an employee's testimony about an alleged accident might be sufficient, standing alone, to justify an award of benefits under the Act, it is not enough where consideration of *all* facts and circumstances demonstrate that the manifest weight of the evidence is against it. *Hosteny*, 397 Ill.App.3d at 667; citing *Caterpillar*, 83 Ill.2d at 218.

Further, the *Hosteny* Court found that portions of petitioner's testimony were contradicted by the record. *Id.* The *Hosteny* Court found that petitioner's medical records during the accident period do not reference a work injury. *Id.* Specifically, the Hosteny Court noted that Petitioner had seen his primary care physician after the alleged accidents, but did not "mention a work-related injury, reference a specific incident involving his work activities, or relate being injured while performing work activities." *Id.*

Additionally, the *Hosteny* Court found that while petitioner insisted that he had reported a work-related injury to his physician, they found it "curious that, despite having had prior experience with the workers' compensation system," petitioner did not request his physician process his treatment as a workers' compensation claim. *Id.*

Further, the *Hosteny* Court was concerned about Petitioner's reporting of the alleged injuries. *Id.* While petitioner's last alleged injury was in August, he did not report any alleged injuries to his employer until September. *Id.* As such, the *Hosteny* Court found that, given petitioner's prior experience with the workers' compensation system, "the delay in reporting the alleged accidents to his employer and physicians belie the veracity of his testimony." *Id.*

Additionally, the *Hosteny* Court pointed out that when the petitioner did finally report his condition to his employer, he was "unable to link his condition to a specific incident at work," despite "expressly" testifying at his workers' compensation hearing to an acute incident where he "felt pain" at work on June 4, 2004 and on August 2, 2004. *Hosteny*, 397 Ill.App.3d at 668.

Consequently, the *Hosteny* Court stated:

> In short, while there was no witness testimony that an accident did not occur on either June 4, 2004, or August 2, 2004, there was other evidence in the record inconsistent with claimant's testimony that he sustained a work-related injury on either of those dates. In particular, that evidence indicates that: (1) claimant did not report a work-related accident to any of his medical providers until September 28, 2004; (2) despite his experience with the workers' compensation system, claimant processed his initial treatment using a group insurance card; (3) claimant did not report a work-related accident to respondent until September 22, 2004; and (4) when claimant informed respondent that his condition was work related, he was unable to link the condition to a specific date.
>
> *Hosteny*, 397 Ill.App.3d at 668-669.

As such, the *Hosteny* Court upheld the Commission's finding that petitioner did not sustain an acute accident that arose out of and occurred in the course of his employment. *Id.*

Here, like *Hosteny*, Petitioner first reported right shoulder symptoms to his physician, Dr. McCleary, on October 31, 2013, but did not mention that his symptoms were work-related. Petitioner then returned to Dr. McCleary on February 11, 2014, but did not mention any accident, injury or increase in symptoms the day before, February 10, 2014. In fact, Petitioner did not even mention his job duties or work activities on October 31, 2013 or February 11, 2014.

Rather, the Arbitrator notes Dr. McCleary, on February 11, 2014, stated Petitioner's symptoms had occurred "over the past few months." not the day before, and Dr. McCleary did not mention "yanking" or "opening bus hoods" at all.

Further, when Petitioner returned to Dr. McCleary on February 17, 2014, Petitioner again did not describe any work injury, mention his job duties or report any increase in symptoms.

Additionally, like *Hosteny*, the Arbitrator notes Petitioner process his February 11, 2014 and February 17, 2014 office visits with Dr. McCleary, as well as his February 14, 2014 MRI, through his group insurance, Healthlink.

The Arbitrator also finds it notable that Petitioner continued working full duty after February 10, 2014 and that he was not prescribed any medication after seeing Dr. McCleary on February 11, 2014. Instead, Petitioner continued living and working in the same manner that he was prior to February 10, 2014, despite alleging that he had a severe, permanent increase in right shoulder symptoms.

Petitioner then saw an orthopedic surgeon, Dr. Chamberlain, 17 days after the alleged February 10, 2014 "accident." The Arbitrator finds it highly significant that, like *Hosteny*, Petitioner did not mention the February 10, 2014 "accident" or increase in symptoms to Dr. Chamberlain, either. Rather, Dr. Chamberlain, in both his records and his deposition, stated that Petitioner did not report any specific accident, injury or instance at work.

In fact, Petitioner left "Did an injury cause the pain" question BLANK when filling out Dr. Chamberlain's paperwork. For "What started the pain/problem?" Petitioner wrote generally, "Opening Hoods," but did not describe any specific occurrence on February 10, 2014.

Most significantly, however, Dr. Chamberlain stated in his records, "He has no history of a discrete injury, but has noted he's been totally using his arms at his job for many years." Then, Dr. Chamberlain stated in his deposition, "He stated that it was about nine months prior [to February 27, 2014] that he felt that it began. He didn't provide a particular date or incident, but he states it was nine months prior to seeing me, and that then gradually it worsened over that course of nine months."

The Arbitrator finds it significant that Dr. Chamberlain, like Dr. McCleary, did not prescribe Petitioner any medications or give him any restrictions; rather, Petitioner again continued in his same activities after seeing Dr. Chamberlain, as well.

Finally, like *Hosteny*, the Arbitrator finds it highly significant that Petitioner did not report any accident, injury or increase in symptoms to Respondent IDOT on February 10, 2014. Instead, Petitioner continued working full duty as he had before February 10, 2014 and did not report his right shoulder condition to anyone at IDOT until March 6, 2014.

Even then, like *Hosteny*, on March 6, 2014, Petitioner did not mention February 10, 2014 to his Supervisor. Petitioner did not report any specific incident or increase in symptoms on

February 10, 2014, but rather told his supervisor that his right shoulder symptoms were a result of "repetitive use over time" and that "opening hoods of buses caused shoulder pain." In fact, Petitioner's supervisor specifically noted Petitioner's right shoulder symptoms occurred in "various" locations.

As such, like *Hosteny*, the Arbitrator concludes that Petitioner failed to prove he sustained an acute accident that arose out of and occurred in the course of his employment on February 10, 2014.

Repetitive Trauma Theory

"Gradual injury stemming from repeated trauma clearly is compensable under the Workers' Compensation Act as long as the employee proves the injury is work-related and not the result of normal degenerative processes." *Zion–Benton Township High School District 126 v. Industrial Comm'n*, 242 Ill.App.3d 109, 113, 609 N.E.2d 974, 978 (1993). The employee need not show external violence to the body to prove an accidental injury. *Id.* An employee who suffers a repetitive-trauma injury must meet the same standard of proof as an employee who suffers a sudden injury. *Durand v. Industrial Comm'n*, 224 Ill.2d 53, 64, 862 N.E.2d 918, 924 (2006).

To establish a repetitive-trauma injury, the claimant must show that the injury is work related and not the result of a normal degenerative aging process. *Peoria County Belwood Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 530, 505 N.E.2d 1026, 1028 (1987). A claimant must produce competent evidence of objective conditions or symptoms to show that her job duties caused her present disability. *Nunn v. Industrial Comm'n*, 15r7 Ill.App.3d 470, 477, 510 N.E.2d 502, 506 (1987).

While medical testimony as to causation is not necessarily required, where the question is one within the knowledge of experts only, expert testimony is necessary to show that the claimant's work activities caused the complained of condition. *Id.*, 510 N.E.2d at 506. Cases involving repetitive trauma primarily concern medical questions and the claimant generally relies on medical testimony to establish a causal connection between the work performed and her disability. *Id.*, 510 N.E.2d at 506–07. Where a claimant alleges accidental injuries caused by repetitive trauma, it is for the Commission to determine whether a claimant's disability is attributable solely to a degenerative condition or to an aggravation of a preexisting condition due to a repetitive trauma. *Cassens Transport Co., Inc. v. Industrial Comm'n*, 262 Ill.App.3d 324, 331, 633 N.E.2d 1344, 1349 (1994).

The Arbitrator finds it highly unusual that Petitioner specifically stated he did not have a "repetitive injury but a one-time incident while … trying to open hood during school bus inspection," while his treating orthopedic surgeon, Dr. Chamberlain, specifically stated Petitioner

did not have an acute injury, but only gave a causation opinion based on a repetitive trauma theory of injury.

Dr. Chamberlain testified that his causation opinion was "solely based on a repetitive trauma theory." When directly asked, "It doesn't appear that you are stating that he had any acute injury at a specific time and date while at work, is that correct?" Dr. Chamberlain stated, "That's correct."

As such, while Petitioner changed his theory of the accident at trial, the Arbitrator will look at the record as a whole to determine if Petitioner suffered a repetitive trauma accident on February 10, 2014.

Petitioner is seeking recovery for his right shoulder condition. As causation for Petitioner's right shoulder condition under a repetitive trauma theory is a question within the knowledge of experts only, expert medical testimony is required to establish Petitioner's work activities caused or aggravated his right shoulder condition.

In this case, after considering the record as a whole, the Arbitrator finds Petitioner has not set forth sufficient expert medical testimony to establish Petitioner's work activities caused or aggravated his right shoulder condition. Rather, it is clear that Dr. Chamberlain, Petitioner's treating orthopedic surgeon, did not have sufficient knowledge of Petitioner's specific job duties to be able to provide a meaningful expert medical opinion.

While Dr. Chamberlain testified that "more likely than not" Petitioner "stood on a bumper and yanked on a hood in a repetitive way that culminated in a shoulder injury," that was Dr. Chamberlain's only knowledge of Petitioner's actual job duties. The Arbitrator finds this is clearly shown by Dr. Chamberlain's deposition testimony;

Question:	How often would he stand on a bumper and yank on a hood?
Dr. Chamberlain:	I don't know.
Question:	And do you know if he did this during all the same environmental conditions?
Dr. Chamberlain:	I do not know that.
Question:	And do you know the amount of force that he was using when he was yanking on the hood?
Dr. Chamberlain:	I can't quantify that, no. He just described a, what I would describe as a lot of force. Or sometimes he'd describe and demonstrate kind of a violent type of force that he required.

Question:	Okay. So essentially as we sit here today, you don't have any knowledge as to whether he yanked on a hood one time or two times versus 20 times versus 100 times, would that be correct?
Dr. Chamberlain:	His description of it was it was numerous, that it was with some frequency, probably more than one or two times. But the exact number I don't know.
Question:	And was he doing this daily?
Dr. Chamberlain:	I don't know.
Question:	And are you aware of any of his other job duties?
Dr. Chamberlain:	No ma'am. Other than repairing school buses, no.
Question:	And are you aware of any of those job duties or do you believe that any of those job duties other than yanking on the hood contributed to the repetitive nature of his injury?
Dr. Chamberlain:	If I were to infer with working as a school bus mechanic that it involves lifting and labor with the arms, which I'm familiar with in some other settings, then, yes, I think that it could also have contributed perhaps.
Question:	And that's as a school bus mechanic?
Dr. Chamberlain:	As – yeah.
Question:	And do you know how often he would do the lifting with his arms and the labor with his arms?
Dr. Chamberlain:	As often as he was at work. I don't know how often he worked.

The Arbitrator further finds Dr. Chamberlain's causation opinion to be flawed, as he testified that Petitioner worked as a school-bus mechanic, which required lifting and labor with his arms. However, the Arbitrator notes from Petitioner's testimony that Petitioner is actually a Vehicle Compliance Inspector, which only requires inspections of school buses, church vans, and charitable vehicles, as well as inspections for diesel admissions and training for truck inspections. The Arbitrator notes Petitioner did not testify at any time that his job requires any heavy lifting or heavy labor with his arms.

The Arbitrator does find it significant that Petitioner testified that he went to school for auto mechanics and that he has five vehicles at home that he does the maintenance work on, including oil changes, rotating of tires and doing brake work. The Arbitrator finds it significant that Petitioner testified that he lifts and carries the tires for *those* vehicles.

As such, the Arbitrator finds Dr. Chamberlain's knowledge of Petitioner's job duties is vague, incomplete and, at times, false. The Arbitrator finds that there is no evidence in the record

that supports that Petitioner's job duties were "repetitive in nature," so as to constitute a "repetitive injury" under the Workers' Compensation Act. In fact, not even Petitioner testified as to when, where and how often he would "stand on a bumper" and "yank" on "bus hoods."

As such, the Arbitrator does not find Dr. Chamberlain's opinion to be credible and finds Dr. Chamberlain's opinion to be an insufficient expert medical opinion to establish causation in a repetitive trauma case. The Arbitrator takes note that this finding is in line with recent Commission and Appellate Court decisions regarding the sufficiency of expert medical opinions in repetitive trauma cases.

In *King v Pitney Bowles*, the Illinois Workers' Compensation Commission, on March 22, 2012, in a repetitive trauma case, affirmed the decision of the Arbitrator, who found that petitioner failed to establish that she suffered an accident that arose out of and in the course of her employment by respondent.

In that case, petitioner was seeking compensation for low back injuries caused by alleged repetitive job duties. *Susan M. King v Pitney Bowes Inc*, 08 IL.W.C. 2938, 12 I.W.C.C. 0312, 2012 WL 1385804 (Ill.Indus.Com'n). Petitioner relied on a causation opinion provided by Dr. Zindrick, who relied only on petitioner's statements as to her job duties. In finding Dr. Zindrick's opinion not credible, the Arbitrator stated:

> Petitioner relies on a causation opinion of Dr. Zindrick. Dr. Zindrick relied on Petitioner's statements as to her job duties. However, he had no clear idea of the frequency of the tasks she reported to him or of the frequency of the various stresses that she would encounter. She told him that she at times had to lift up to 50 pounds but not how often that occurred. He knew she delivered paper to various stations but not how often or how large of loads to which stations. His knowledge was only of general description not of how repetitive or how stressful. Based on the foregoing, the Arbitrator concludes that Dr. Zindrick did not have sufficient knowledge of Petitioner's job duties, repetitive activity and stresses regularly experienced to give a meaningful and sufficient opinion to establish repetitive trauma.

As such, the Arbitrator in *King* found that petitioner failed to establish that she suffered an accident that arose out of and in the course of her employment by respondent.

Likewise, the Second District Appellate Court of Illinois, on April 13, 2015, overturned the Illinois Workers' Compensation Commission's finding of causation in a repetitive trauma case, finding that the expert medical testimony relied upon by the Commission was "unreliable given [the physician's] lack of knowledge of claimant's specific job duties and the fact that the evidence presented regarding claimant's work duties for the employer was inconsistent with the

underlying basis [of the] causation opinion. *Independent Mechanical Industries, Inc. v. Illinois Workers' Compensation Comm'n*, 2015 IL App (2d) 130696WC-U, 2015 WL 1641432 (Ill.App. 2 Dist.).

In that case, petitioner was seeking compensation for carpal tunnel syndrome allegedly caused by her "repetitive" job duties. Petitioner relied on a causation opinion provided by Dr. Nagle, whose knowledge of petitioner's job duties was based on a printout from the online Dictionary of Occupational Titles and petitioner's work history. In finding Dr. Zindrick's opinion not credible, in an unpublished opinion, the Appellate Court stated:

> Although both the Commission's decision and claimant rely on Dr. Nagle's opinions, we find they do not support an award in claimant's favor. Dr. Nagle admitted several times during his deposition that he was not aware of claimant's actual job duties. He identified a printout from the online Dictionary of Occupational Titles, describing the duties of a plumber in the construction industry, and testified that the activities described therein could cause or aggravate carpal tunnel syndrome. However, as even claimant acknowledges, he did not work as a "construction plumber" for the employer. As discussed, claimant's testimony showed he spent the majority of his work day on the task of "check[ing] plumbing," which did not require heavy, repetitive grasping. Although some of claimant's tasks required the forceful use of his hands, he performed those tasks only occasionally. Thus, Dr. Nagle's assumption that claimant's work required heavy, repetitive grasping without time to relax and recover conflicts with the evidence presented at arbitration regarding claimant's actual job duties.
>
> ...
>
> Medical evidence establishing the existence of a causal connection is particularly important in both repetitive-trauma cases and cases involving a preexisting condition of ill-being. Here, Dr. Nagle's causation opinion was unreliable given his lack of knowledge of claimant's specific job duties and the fact that the evidence presented regarding claimant's work duties for the employer was inconsistent with the underlying basis for Dr. Nagle's causation opinion—that the performance of heavy, repetitive grasping without time to relax and recover could cause or aggravate carpal tunnel syndrome. We note Dr. Carroll offered the only other opinion as to causation in the case. He opined claimant's work for the employer as a "check plumber" neither caused nor aggravated claimant's carpal tunnel syndrome. Dr. Carroll's reports and deposition reflect he was aware of claimant's specific work activities for the employer and had the opportunity to review claimant's "daily activity sheets." Given these circumstances, we find the Commission's reliance on Dr. Nagle's causation opinion was not supported by the record and against the manifest weight of the evidence.

As such, the Appellate Court in *Independent Mechanical Industries* found that petitioner failed to establish that he suffered an accident that arose out of and in the course of her employment by respondent.

Consequently, the Arbitrator finds this case to be in line with prior recent cases and finds Dr. Chamberlain's opinion to be an insufficient expert medical opinion to establish causation in a repetitive trauma case.

The Arbitrator also finds it notable here that Dr. Chamberlain testified that it was possible Petitioner's "yanking of these hoods" did not affect his right shoulder at all. Dr. Chamberlain testified that "it's possible" that Petitioner's right shoulder condition "was just a natural progression of his physical condition since the time that he had the first repair."

Therefore, based on the foregoing, the Arbitrator concludes that Petitioner failed to prove he sustained a repetitive-trauma accident on February 10, 2014 that arose out of and in the course of his employment with Respondent, either.

Issue (E) Was timely notice of the accident given to Respondent?

Consistent with the determinations above, this issue is rendered moot.

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

Consistent with the determination as to accident above, this issue is rendered moot.

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

Consistent with the determinations above, this issue is rendered moot.

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

Consistent with the determinations above, this issue is rendered moot.

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

Consistent with the determinations above, this issue is rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rigoberto Garduno,

Petitioner,

vs.

NO: 14 WC 23353

First Class Moving & Storage,

Respondent.

17IWCC0199

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of the Arbitrator's Denial of the Petitioner's Petition to Reinstate and evidentiary issues, and being advised of the facts and law, reverses the Order of the Arbitrator and remands the matter to the Arbitrator for the reasons set forth below.

The Petitioner filed an Application for Adjustment of Claim on July 9, 2014. The Respondent filed a Motion to Set a Trial Date Certain or Dismissal for Want of Prosecution on February 23, 2015. Arbitrator Carlson Granted said Motion on June 10, 2015. The Petitioner subsequently filed a Motion for Reinstatement of the Case on August 19, 2015. Arbitrator Carlson Denied said Motion on September 11, 2015. The Petitioner then filed his Petition for Review on October 9, 2015. The Respondent filed their Petition for Review on October 22, 2015.

Section 7020.9(c) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission states the following:

> Petitions to Reinstate shall be docketed, and assigned to and heard by the same Arbitrator to whom the cause was originally assigned. Both parties must appear at the time and place set for hearing. Parties will be permitted to present evidence in support of, or in

17IWCC0199

opposition to, the petition. The Arbitrator shall apply standards of fairness and equity in ruling on the Petition to Reinstate.

The Commission notes that no reason was provided by the Arbitrator for the denial of the Petitioner's Motion for Reinstatement of the case on September 11, 2015. No hearing was held and no record was created on that date. Therefore, in the absence of a record, the Commission has insufficient information or evidence to make a proper determination.

Accordingly, based on all of the above, the Commission reverses the Order of the Arbitrator dated September 11, 2015, reinstates the Petitioner's case, and remands this case back to the Arbitrator for a hearing and the creation of a record.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Order of the Arbitrator dated September 11, 2015 is hereby reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that case number 14 WC 23352 is hereby reinstated.

IT IS FURTHER ORDERED BY THE COMMISSION that case number 14 WC 23352 is remanded to the Arbitrator for a hearing and the creation of a record.

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: APR 4 - 2017

TJT/gaf
O: 2/28/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Schenita Stewart,

Petitioner,

17IWCC0214

vs.

NO: 14 WC 25227

Village of Lincolnwood,

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, causal connection, permanent partial disability and penalties and fees, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below and finds that Petitioner failed to prove that her accidental injuries on June 27, 2014 arose out of and occurred in the course of her employment by Respondent.

Petitioner, a 40-year-old sergeant for the Lincolnwood Police Department claimed workers' compensation benefits for injuries to her right leg sustained on June 27, 2014. Surveillance video footage of the accident was admitted into evidence as Respondent's Exhibit 3 and was viewed during arbitration. Petitioner, while riding her personal motorcycle into Respondent's parking lot, collided with a stationary Bobcat pallet fork utility vehicle. At arbitration, Petitioner testified that she saw the Bobcat as she rode into the parking lot but accidentally rode too close to it. The front side of the motorcycle crashed into the Bobcat forks. The forks lodged in the motorcycle causing it to immediately turn over. The Lincolnwood Fire Department arrived on the scene and Petitioner was transported to Presence St. Francis Hospital where she underwent an open reduction and internal fixation of her right tibia, performed by Dr. Rajeev Garapati. Petitioner returned to full duty work in October of 2014. The parties agreed that Petitioner's medical expenses were paid by Respondent's group health insurance and Petitioner was paid her full salary.

Respondent disputes that Petitioner's accident arose out of or occurred in the course of her employment. Respondent argues that Petitioner's accident occurred while she was off-duty, as she was outside of a reasonable time prior to her start of her work shift. Respondent further argues that Petitioner's accident did not arise out of her employment, but out of a personal risk: her failure to exercise reasonable care driving her motorcycle. After considering all of the evidence, we agree.

Petitioner's Testimony

Petitioner testified that she has been working as a police officer for Respondent for 16 years. As of June 27, 2014, she was a sergeant for Respondent as a shift supervisor. On the date of accident, she was working the 3:00 p.m. to 11:00 p.m. shift. Petitioner testified that it is her longstanding practice to arrive at work early to talk to the previous shift supervisor and prepare herself for her shift. She commutes to work in either her personal pickup truck or her personal motorcycle. She testified that when she rides her motorcycle, she parks it in the garage that is designated for police cars. The garage is accessed via the gated lot that is also designated only for police vehicles. Petitioner testified that some other employees, in addition to herself, park their motorcycles or personal vehicles in the secured lot or the garage for their own convenience. She testified that she had a remote control for the automatic gate to the secured lot that was given to her by Lieutenant Dave Macaluso five or six years earlier.

Respondent's exhibit #1 is a map showing the Village of Lincolnwood complex and the parking areas. Petitioner identified the secured police vehicle parking lot as well as the other parking areas. Other than the secured lot and the garage, the rest of the parking areas are open to employees as well as the public. Petitioner testified that when she rode her motorcycle to work, she chose to park in the garage to prevent it from getting "dinged up." She agreed, however, that she was free to park in any of the general parking areas and that she was not assigned to any parking space or any parking lot.

On June 27, 2014, Petitioner testified that the automatic gate to the secured lot was already open as she approached on her motorcycle. She denied seeing any warning signs outside of the secured lot that construction work was under way. She testified, "As I approached the gate on my motorcycle, I could see the back of a public works truck, a yellow public works truck, which was on the left side of the parking lot, which would be the east side of the parking lot. Manuel [Mr. Vega], a public works employee, was leaning into the passenger side of that truck. He stopped leaning, got up, he was standing up. He waved his hands, and then he moved out of the way." (T. 22) She further testified, "I took that as I was free to continue to go into Garage 3 to park my bike. As once he moved, I got closer, is when I saw the Bobcat. I was not panicked when I saw the Bobcat because I had enough room to clear the Bobcat." (T. 23) Petitioner estimated there were more than 5 yards between the Bobcat and the yellow truck. She further testified, "As I proceeded through the area, I saw that the forks, the Bobcat's forks were off the ground and protruding into the open area. The forks hit the front of my highway bars on my motorcycle, which in turn jolted me off the bike. My right leg hit one of the forks. I'm not sure which fork it hit. I heard it snap. I fell to the ground. When I fell to the ground, I landed on my back." (T. 25)

Petitioner testified that she did not know at the time if the Bobcat's engine was on or off; she did not see it moving, and she denied seeing any lights. Petitioner estimated that she rode into the lot at a speed of 10 to15 miles per hour. It was not until she was on the ground after the collision that she looked over and saw another public works employee, Mr. Resendez, inside the Bobcat. At Petitioner's direction, Mr. Vega ran to the nearby Lincolnwood Fire Department to get help.

Petitioner testified that she was aware that work had been going on in the area for at least a week prior to the accident. She believed that public works employees were taking up an area of grass and replacing it with pavers. She could not recall if she rode her motorcycle to work earlier that week. Petitioner was shown Respondent Group Exhibit #6, which consists of 46 photos taken on the date of accident by Officer Knapp, who performed the investigation at the scene. Petitioner agreed that photo #6-1 shows the yellow truck and the Bobcat. Petitioner agreed that Respondent's Exhibit #3, the surveillance video, is an accurate representation of the accident she sustained. She agreed that the surveillance footage show an oscillating light on top of the Bobcat, although she did not recall seeing it prior to the accident.

Petitioner agreed that the accident occurred at 1:48 p.m. and her shift did not start until 3:00 p.m. She testified that she received compensation for "shift preparation." She denied knowing exactly how much time Respondent would compensate her for on the basis of shift preparation; she denied knowing whether it was limited to only 12 minutes ahead of her shift. She testified that she always goes in to work early but she does not receive overtime pay for the additional time she spends at work.

Testimony of Former Deputy Chief of Police Lewandowski

Petitioner offered the testimony of Chief Lewandowski who served as the Deputy Chief of Police for the Village of Lincolnwood from 2008 to 2013 and is currently employed as the Chief of Police for the Village of Glencoe. Chief Lewandowski testified that he has known Petitioner since she was hired in 1999. When he left Lincolnwood in 2013, Petitioner was employed as a detective and had not yet been promoted to Sergeant. He recalled that Petitioner came in to work early "quite often," sometimes up to an hour early, and would often stay late after her shift; he testified that this was behavior common to detectives. Chief Lewandowski agreed that he knew Petitioner rode a motorcycle in addition to her regular vehicle, and that she parked her motorcycle inside the garage. He agreed that it was routine and customary for officers to park their motorcycles inside the secured area for their own convenience, but he did not recall any explicit permission having been given for the practice.

Chief Lewandowski testified that he did not recall how much shift preparation time would be compensated but he estimated up to four hours per month. He testified that compensation for shift preparation is not overtime; overtime would have to be approved by the Chief.

Testimony of Lieutenant Martin

Petitioner offered the testimony of Lieutenant Martin, a police officer for the Village of Lincolnwood for 25 years. He testified that he has known Petitioner for 20 years and that they are very good friends. Lieutenant Martin was aware that Petitioner had an accident on June 27, 2014 on her motorcycle in the secured parking lot. He agreed that he had also parked his own personal vehicle within the secured area prior to June 27, 2014, and that other employees parked there as well. He testified that he understands that employees are no longer allowed to park any personal vehicles within the secured area, although he did not recall who made that decision.

Lieutenant Martin did not arrive on the scene until after the accident had occurred. He testified that he supervised Officer Knapp, who performed the investigation. Lieutenant Martin testified that when he arrived at the scene Petitioner was still on the ground. He identified Respondent's Exhibit #6-1 and agreed that it was an accurate representation of what he observed on June 27, 2014; he saw the position of the Bobcat, the truck, and Petitioner's motorcycle. He agreed that the gate to the secured lot is open in the photo. He testified that unless propped open the gate closes automatically. He agreed that Respondent's Exhibit #1 is an accurate representation of the Village complex, showing the location of the secured area and the general parking areas. He testified that there is also street parking, although people generally park in the lots. Officer Martin agreed that employees who rode motorcycles sometimes parked in the garage where there was less risk of damage, although he did not recall that any motorcycle had ever been damaged in the general parking areas.

Lieutenant Martin testified that Petitioner frequently came in to work early. He believed that compensation for up to four hours for "shift preparation" was allowed, as long as an employee also worked their full scheduled hours.

Testimony of Officer Knapp

Petitioner offered the testimony of Officer Knapp. He has worked for Respondent for sixteen years and is currently assigned to the patrol division. He was hired the same year as Petitioner and he testified that they are friends as well as coworkers. On June 27, 2014, Officer Knapp arrived at work at approximately 1:50 p.m., just after the accident occurred. Officer Knapp's shift on that day was from 2:00 p.m. to 10:00 p.m. He testified that he was notified by Lieutenant Martin that Petitioner had just been injured in a crash in the secured lot and asked him to conduct an investigation. Officer Knapp agreed that he completed Respondent's Exhibit #4 and #5, the Illinois Traffic Crash Report and the Lincolnwood Police Department Case Report.

When Officer Knapp arrived at the scene of the accident, Petitioner was no longer there. Officer Knapp took photographs, measurements, and spoke with Mr. Resendez and Mr. Vega. Mr. Resendez told Officer Knapp that he was sitting in the parked Bobcat and was in the process of calling his supervisor when Petitioner ran into the Bobcat. Mr. Vega told Officer Knapp that he saw Petitioner coming in and tried to wave at her to get her attention and when she did not slow down he jumped out of the way. Officer Knapp testified that when he completed the investigation he saved the photos onto to a CD and submitted his reports.

Officer Knapp did not recall exactly when the construction work started that spring. He did not know if Petitioner had previously driven into the secured lot while the work was going

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on. Officer Knapp agreed that employees could park in any of the general lots or public areas, which he identified on Respondent's Exhibit #1. He assumed that employees parked their personal motorcycles within the secured area for their own convenience; he was not aware of any motorcycles having been damaged in the public areas.

Officer Knapp was shown Respondent's Exhibit #6, the photos he took after the accident. He agreed that photo #6-1 accurately represents the scene as he saw it on June 27, 2014. He had no recollection of seeing any construction warnings outside of the automatic gate to the secured area. He agreed that he has watched the surveillance video and saw Mr. Vega step out of the way after waving at Petitioner from the space between the truck and the Bobcat. This comported with the witness statement he took from Mr. Vega that he tried to get Petitioner's attention and then stepped out of the way because Petitioner did not slow down coming toward him.

Testimony of Mr. Resendez

Respondent offered the testimony of Mr. Resendez, a 20 year employee for the Village of Lincolnwood. He started as a laborer and is now a foreman. Mr. Resendez testified that on June 27, 2014 he was unloading paver bricks in the police vehicle parking lot. A grass area that was removed was to be replaced with bricks. The work began two or three weeks earlier, and on June 27, 2014 they were just going to unload the paver bricks from the truck using the Bobcat. Mr. Resendez identified Respondent's Exhibit #6-1 as an accurate representation of the accident scene as he saw it that day. At the time of the collision, he was inside the Bobcat with the engine off. He testified that an orange light on the top of the Bobcat stays on even when the engine is off. Mr. Resendez testified that he was on a phone call when Petitioner's motorcycle collided with the Bobcat forks. He testified that he did not see her approach and he was very surprised when he felt something strike the Bobcat. He stayed in the Bobcat while the police investigated because it is impossible to exit the Bobcat while the forks are up. Mr. Resendez was shown Respondent's Exhibit #6-20; he agreed that the forks were measured at approximately two feet off of the ground.

Mr. Resendez testified that on June 27, 2014 he was working with Mr. Vega to unload the paver bricks. They blocked the automatic gate sensors with two cones so the gate would remain open. He agreed that the cones are visible in Respondent's Exhibit #6-3. Whenever the gate is open, a red light on top of the pillar remains illuminated. He agreed that they did not place construction signs or flags in the area. They kept the gates open so that there would be clear vision into and out of the secured lot. Mr. Resendez testified that Mr. Vega wore a green safety vest; he was supposed to warn anyone coming through. Mr. Resendez did not see any actions of Mr. Vega to warn Petitioner, as he was inside the Bobcat and was not looking.

Mr. Resendez testified that he was very shocked and upset by the accident, and that he and Mr. Vega visited Petitioner at the hospital later that day. He also recalled giving his witness statement to Officer Knapp.

Testimony of Manuel Vega

Respondent offered the testimony of Mr. Vega, an eight year employee for the Village of

17IWCC0214

Lincolnwood. On June 27, 2014 he and Mr. Resendez were unloading two pallets of pavers from a truck. Mr. Vega was wearing his green reflector vest with orange stripes and was guiding Mr. Resendez in the Bobcat. He testified that they kept the automatic gates open with cones because they wanted any incoming traffic to see the truck. At the time of the accident, the truck engine was running, although it was parked and nobody was inside of it. The Bobcat engine was shut off, and Mr. Resendez was inside the Bobcat on a phone call. The orange light on top of the Bobcat continued to oscillate even though the engine was off. Mr. Vega testified that he stood between the truck and the Bobcat, and he saw Petitioner coming into the lot through the open gate. He testified that he did not see Petitioner slow down as she approached. He testified that he waved both arms in front of his body "to prevent her from coming through," but then "jumped to the side" because "I didn't want to get hit." (T. 108-109)

Mr. Vega testified that after the accident he ran to the Fire Department to get help. After work, he and Mr. Resendez, and another employee, went to visit Petitioner in the hospital.

Mr. Vega did not recall having seen Petitioner in the secured parking lot during the two or three weeks before the accident, however on cross examination he agreed that he was not there every day during that time period. He agreed that June 27, 2014 was the first day that the pallets of brick pavers were being unloaded. Mr. Vega testified that he has not seen the video surveillance of the accident. He could not recall exactly how much space there was between the truck and the Bobcat. He did not recall if he was leaning into the truck before Petitioner rode into the area. He testified that he was standing between the Bobcat and the truck when he waved his arms in front of his body as Petitioner approached. He agreed that the Bobcat forks were positioned approximately two feet off of the ground at the time of the accident.

Testimony of Chief LaMantia

Petitioner called Chief LaMantia to testify at arbitration. Chief LaMantia has been Chief of Police for Lincolnwood since October of 2006. He was on vacation on June 27, 2014 and Deputy Chief Walsh was the acting Chief of Police on duty in his absence.

Chief LaMantia denied that it was his decision to not provide workers' compensation benefits to Petitioner with respect to the accident of June 27, 2014. He testified that his office provided factual information pertaining to the accident as requested by the insurance carrier, and it is the insurance carrier who has the authority to decide compensability. Chief LaMantia testified that he returned from vacation a few days after the accident, although he believed he was notified on June 27, 2014 by Deputy Chief Walsh. He did not recall giving any specific instructions for the accident investigation. Chief LaMantia testified that he saw the video a few days after he returned from vacation and briefly spoke with Petitioner on the phone.

Chief LaMantia testified that he has known Petitioner since he started working for the Village of Lincolnwood in 2006. He agreed that Petitioner has been promoted within the department during his tenure, and that she is an excellent employee. Chief LaMantia testified that he never told Petitioner to park her motorcycle in the garage, although he did not have any problem with her doing so for her own convenience. He agreed that some other employees parked their motorcycles within the secured parking area, including himself and his secretary

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Ms. Liss. He testified that the secured parking area's restriction to only police vehicles is now enforced, and that he and all other employees no longer park their personal vehicles within the secured area.

Chief LaMantia testified that from the report, he understood that the accident occurred at 1:47 p.m. He testified that supervisors are to report 12 minutes prior to their shift. He testified that his officers "come early, stay late, stop in when they're off duty. It's a recurring practice." (T. 61) Chief LaMantia denied any knowledge of what specific duties Petitioner would have performed during the hour prior to her shift on June 27, 2014. He testified that she could have chosen to do very many different things as she had many different responsibilities. He also agreed that Petitioner was a very sociable and popular person and an excellent employee.

Respondent later recalled Chief LaMantia to testify. Chief LaMantia agreed that he is familiar the work required for a supervisor to perform shift preparation and that 12 minutes is adequate. He testified that those 12 minutes are intended merely for preliminary duties prior to roll call, and it is not intended to encompass all of the other duties, responsibilities, and tasks of the shift supervisor during their shift. He testified that supervisors can continue shift preparation during roll call. He agreed that he heard Petitioner's testimony that she voluntarily goes in to work early. On cross-examination, he agreed that there was no policy against police officers voluntarily coming in to work early. He furthermore agreed that Petitioner is diligent and hard working, "She comes early. She stays late." (T. 167) However, he testified that in his opinion all of Petitioner's work could be done within her scheduled shift, and additional hours are not necessary to do the work that she is paid for.

Testimony of Mr. Metzger

Petitioner called Mr. Metzger, the supervisor of workers' compensation claims for the Intergovernmental Risk Management Agency ("IRMA"), a municipal risk pool. He agreed that IRMA also provides liability insurance for the Village of Lincolnwood. Mr. Metzger has been a supervisor with IRMA for nine years. Previously, he was a supervisor with AIG Insurance. He has given testimony before and is familiar with the Workers' Compensation Act. Mr. Metzger testified that he is the sole supervisor for workers compensation claims and he supervised Petitioner's claim of accidental injury on June 27, 2014. He testified that he consulted with legal counsel and made decisions on the compensability of the claim, ultimately finding it not compensable on the basis that it did not arise out of employment. Petitioner was not on duty at the time and was over an hour ahead of her scheduled time, was not directed to park in any specific area of Respondent's premises, and ignored signs of personal risk. He understood that there was a light on top of the Bobcat, and that someone present to warn Petitioner had to actually jump out of her way.

Mr. Metzger testified that he obtained accident investigation information from the Village of Lincolnwood. He testified that he saw the surveillance footage of the accident, but he had not seen it recently. Mr. Metzger did not perform his own on-site investigation but he agreed that he read all of the investigative reports. Mr. Metzger was shown the photos in Respondent's Exhibit #6 and agreed that he had seen them before. He agreed that the forklift forks were raised in the photographs. He was shown Respondent's exhibit #4 and #5, the Illinois Traffic Crash Report

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and the Lincolnwood Police Department Case Report and he testified that he believed he had seen them before. Mr. Metzger testified that his opinion remains that Petitioner's claim is non-compensable. "I still see someone hitting a stationary object. If she had run into a police car that was parked in the parking lot, in my eyes it would be the same thing. If a police car was parked and she ran into the back of it, it's still a stationary object." (T. 28)

Testimony of Ms. Heard

Petitioner called Ms. Heard to testify at arbitration. Ms. Heard is the senior workers' compensation claims adjustor at IRMA. She has been employed by IRMA for 9 years. She currently handles 194 cases. Ms. Heard testified that she was the only adjustor on Petitioner's claim, although her supervisor Mr. Metzger handled the claim for about a month before assigning it to her. When she received the claim, she believed it was still under investigation. She agreed that the Act provides that within 14 days of a request for benefits there must be a response if benefits are not to be paid. She testified that she received no request for medical payments or TTD benefits. Ms. Heard did not recall ever getting contacted by a medical provider requesting authorization. She agreed she did not write a denial letter to Petitioner.

Ms. Heard testified that she spoke with Mr. Metzger about the claim, and upon receiving the Application for Adjustment of Claim they attempted to get the full investigation file to Respondent's legal counsel. She did not believe that she knew the full extent of Petitioner's injuries until she consulted with Respondent's legal counsel. She agreed that an off-work note dated September 30, 2014 contained in her own file indicates a diagnosis of "status post ORIF right proximal tibia fracture." (Petitioner's Exhibit 6). She agreed that she did not personally request medical records or bills from any medical providers, as the case was being handled by defense counsel. Ms. Heard agreed that she was aware that Respondent's group insurance paid Petitioner's medical bills. Ms. Heard agreed that she also knew Petitioner was represented by an attorney, but that she did not send a denial letter to Petitioner's attorney or direct Respondent's legal counsel to do so.

Discussion

Respondent's Exhibit #3 is the video surveillance footage of Petitioner's accident. Petitioner did not challenge its fairness or accuracy in representing the events of June 27, 2014. Furthermore, there was no challenge to the photographs in evidence as Respondent's Exhibit #6. The Commission finds the surveillance video and photographs of the scene to be reliable and instructive. We note that the surveillance camera's vantage point is from within the secured parking lot, looking directly out across the lot and toward its automatic entrance gate, which stands open. The entire scene of the accident and all of the following events are clearly visible on surveillance video. The pickup truck and the Bobcat are clearly visible in the foreground, inside the gate. The front of the truck faces toward the camera and the Bobcat is positioned perpendicular to the truck, with its forks facing the truck's passenger side. Both vehicles are stationary, and an oscillating light is visible on top of the Bobcat. There appears to be several yards between the Bobcat and the side of the pickup truck.

A worker identified at arbitration as Mr. Vega, wearing a safety vest, stands next to the

passenger side of the truck. Petitioner and her motorcycle come into view outside of the open gate. As she is approaching from the side, she makes a right turn in order to rides straight ahead through the gate. We note that she passes through the open gate without appearing to slow down as Mr. Vega turns to face Petitioner. Mr. Vega quickly backs away from the side of the pickup truck and places his body in the path of Petitioner's approach. He spreads his legs and waves his arms, before jumping to the side behind the Bobcat and out of Petitioner's path. Petitioner rides close to the Bobcat forks, which catch on the front side of her motorcycle. The motorcycle immediately turns over with Petitioner on it.

We note that the space between the Bobcat and the truck is much wider than the width of Petitioner's motorcycle. However, she appears to veer close to the Bobcat rather than to pass through the middle of the space. We note that Petitioner herself testified that she observed the Bobcat, the Bobcat's forks, and the truck, and did not doubt that she had plenty of room to pass by. She further testified that she did not believe she needed to slow down. The surveillance video evidence supports Petitioner's testimony, as well as the testimony of the occurrence witnesses and the documentary evidence with respect to the events of June 27, 2014.

After considering all of the evidence, we reverse the Decision of the Arbitrator where we find that Petitioner's accident did not arise out of or occur in the course of her employment. We find that Petitioner was an off-duty officer at the time of her accident and was not in the course of her employment. An injury is said to be in the course of employment with it takes place within the period of employment, at a place where the employee reasonably may be, and while the employee is fulfilling her duties. It is generally true that employees who have fixed hours of work at a fixed location sustaining an injury going to or returning from the employment are not in the course of their employment. However, among the exceptions courts have found to this general rule, injuries that occur to an employee in an employer's parking lot have been found to occur in the course of employment even when they happen before or after the time an employee is actually working. This determination depends upon the particular facts and circumstances of each case. We find that Petitioner's voluntary arrival at work, over an hour prior to the start of her fixed start time, was not a reasonable period of time before work and her injury did not occur in the course of her employment. Petitioner failed to prove that Respondent controlled, directed, relied on, or benefitted from her voluntary additional time spent at work, although it was common and not impermissible behavior.

We furthermore find that Petitioner's accident did not arise out of her employment. Generally, injuries occurring on an employer's parking lot when hazardous conditions exist are compensable in Illinois as arising out of employment. However, we are not persuaded that Petitioner proved a causal relationship between her injuries and any hazardous condition of Respondent's premises. The evidence shows that there were many vehicles parked in the secured parking lot, through which Petitioner decided to drive her motorcycle to park inside the garage. The Bobcat and the truck were stationary vehicles when Petitioner encountered them, and they did not obstruct Petitioner's path. Considering all of the facts and circumstances in this case, we find that Petitioner's injury resulted from her personal actions. She testified that prior to the accident, she had an unobstructed view of the truck and the Bobcat and that she observed Mr. Vega in front of her. Furthermore, she testified that she was not surprised to see public works employees in the secured lot, as she was aware that work was being performed in that area prior

to the date of accident. Petitioner testified that she believed that she did not need to slow down and could easily ride through the space between the truck and the Bobcat. Unfortunately, she ultimately veered into and collided with the forks of the parked Bobcat. However, we do not find that any employment-related risk caused Petitioner's accidental injuries.

We further find that penalties and fees are not appropriate in this case. Petitioner was paid her full salary for her lost time and her medical bills were paid by Respondent's group coverage. No delay in medical treatment has been alleged. Petitioner stipulated at arbitration that Respondent was entitled to credit for all medical bills paid by group insurance. The Act provides that the Commission shall give consideration as to whether the employer has made payments under Section 8(j) in determining whether penalties under Section 19(k) are appropriate. Furthermore, we find no evidence of a written demand for payment of worker's compensation benefits, such as a demand for medical authorization or TTD, and we do not find any evidence of bad faith on the part of Respondent. Respondent offered ample evidence and testimony to support its basis for denial of the claim. In this case no requested benefits were delayed or withheld from Petitioner.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision filed February 10, 2016 is hereby reversed and no benefits are awarded.

The party commencing 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: APR 6 - 2017
KWL/plv
o-3/8/17
42

Kevin W. Lamborn

Joshua D. Luskin

DISSENT

I must respectfully dissent from the majority's decision that the Petitioner failed to prove accident. I would instead affirm the findings of Arbitrator Fruth and find that Petitioner did prove she sustained injuries to her right leg as a result of her work related activities, and is entitled to reasonable medical expenses, temporary total disability, and permanency benefits. However, I agree with the majority regarding their reversal as to penalties and fees.

The Petitioner was employed as a sergeant by Respondent, and has worked as a police officer for Respondent for 16 years. As part of her routine in her supervisory role, she would arrive at work approximately an hour early and talk to the shift supervisor of the previous shift, as well as perform other work duties. For 12 minutes of the time in

which she was at work early, she could have received compensation from the Village of Lincolnwood per her contract, but she opted not to receive it. On June 27, 2014, as was her routine when the weather permitted, Petitioner arrived to work on her motorcycle and entered the gated "secure parking area" to park her motorcycle in the secure lot, Garage 3 where all officers park their personal motorcycles. As Petitioner entered the lot that day, there was no indication that there was construction going on in the parking lot such as signs, flashing lights or cones. As Petitioner passed through the entry gate, she saw the back of a public works truck and a public works employee leaning into the passenger side of the truck. She saw him wave as she came towards him, indicating it was OK to come through. He moved to the side and allowed her to pass and saw a Bobcat with its forks extended off the ground. Petitioner thought she had enough room to pass through, but as she proceeded through the area, her right leg hit one of the Bobcat's forks, which caused her to fall off her bike and her right leg to snap.

The public works employees testified that the gates to the secure area had remained open, and that they used cones on the inside of the gate to block the sensors from working. There were no visible cones to those entering the lot, no traffic barriers set up, no "reduced speed", caution or danger signs, nor were there cones set up in or before the entryway to the secured parking area. Further, the public works employees did not issue any verbal warnings to Petitioner when they saw her drive through.

The Chief of Police testified it was a common practice for police officers to park their personal motorcycles in garage 3 which was part of the secure parking lot. The former Deputy Chief of Police for Lincolnwood testified that he was aware Petitioner traveled by motorcycle and parked in the secure lot as this was common and accepted practice for Lincolnwood police officers. He was also aware that Petitioner often came in early and stayed late due to her responsibilities as shift supervisor.

Accidental injuries sustained on an employer's premises within a reasonable time before and after work are generally deemed to be in the course of the employment. However, the fact that an injury is in the course of the employment is not sufficient to impose liability; to be compensable, the injury must also "arise out of" the employment. 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. Sisbro, Inc. v. Industrial Comm'n, 207 Ill.2d 193, 203 (2003), Caterpillar Tractor Co. v. Industrial Comm'n, 129 Ill.2d 52, 62 (1989).

Although Petitioner's accident occurred approximately an hour before her scheduled shift, there was sufficient, credible testimony to support that Petitioner routinely arrived early and stayed late to complete work functions that were of benefit to Respondent. Additionally, Petitioner was exposed to a greater risk than the general public because she regularly drove her motorcycle to work and parked in garage 3 in the secure parking area. This lot was not open and/or available to the general public. When an injury

to an employee takes place in an area which is the usual route to the employer's premises, and the route is attendant with a special risk or hazard, the hazard becomes part of the employment. Special hazards or risks encountered as a result of using a usual access route satisfy the "arising out of" requirement of the Act. See Bomarito v. Industrial Comm'n, 82 Ill.2d 191, 195 (1980); see also Mores-Harvey v. Industrial Comm'n, 345 Ill. App.3d 1034, 1040 (2004).

Based on the above, I would find that Petitioner sustained a compensable accident that arose out of and in the course of her employment and that she is entitled to medical expenses, temporary total disability, and permanency benefits.

Charles J. DeVriendt

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

April Hileman,
Petitioner,
vs. NO: 14 WC 25260

State Of Illinois/Choate Mental Health Center,
Respondent,

17IWCC0233

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

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

DATED: APR 13 2017
o040617
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HILEMAN, APRIL Case# **14WC025260**
Employee/Petitioner

ST OF IL/CHOATE MENTAL HEALTH CENTER
Employer/Respondent

17IWCC0233

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:

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
KYLEE J JORDAN
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 20 2016

RORALEE A. HASBIA, Acting Secretary
Illinois Workers' Compensation Commission

17IWCC0233

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

APRIL HILEMAN
Employee/Petitioner

v.

STATE OF ILLINOIS/CHOATE MENTAL HEALTH CENTER
Employer/Respondent

Case # 14 WC 25260

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

FINDINGS

On **March 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 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 **$52,324.47**; the average weekly wage was **$1,006.24**.

On the date of accident, Petitioner was **50** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$0** 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 she sustained a compensable non-traumatically-induced mental disability which arose out of and in the course of her employment. 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

June 15, 2016
Date

JUN 20 2016

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

17IWCC0233

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

APRIL HILEMAN
Employee/Petitioner

v. Case #: 14 WC 25260

STATE OF ILLINOIS/CHOATE MENTAL HEALTH CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On her date of accident, Petitioner was 50 years old, single, with no dependent children. She was employed by Choate Mental Health as a Storekeeper 1, and had been employed by Choate for 31 years. When items come into the facility, the storekeeper must check the items, make sure they are all there, and sign the receipt. One copy of the receipt is kept, and the other copy is given back to the person who made the delivery. This was corroborated by Petitioner's supervisor, Mr. Chris Wells, who was present at the request of Respondent without subpoena but was called as Petitioner's first witness.

Mr. Wells is the Business Administrator for Respondent's Choate Mental Health facility, and was in that position as far back as 2011. He has known Petitioner since first grade, and also has known her in her capacity as storekeeper at Choate, which has been about nine years. He was also Petitioner's supervisor. Mr. Wells testified he was generally familiar with Petitioner's Exhibit 5, titled "Summary from the Food Store", but did not agree that the items stated in the document were entirely true. The summary mentioned someone named Greg, and Mr. Wells testified that referred to Greg Randalls, the storekeeper assigned to the food store prior to Petitioner. In the summary, Petitioner alleged when she started in her position there was six months or more of deliveries still on pallets and that you could not walk through an aisle without tripping over something. Mr. Wells testified he did not recall there being six months of deliveries on pallets, and disputed that the supplies were blocking aisles. He acknowledged that some of the stock, such as cereals and canned goods, were past their expiration date and conceded this did create a problem. He denied asking Petitioner to use the expired products, and testified he would have asked her to destroy them.

Mr. Wells testified that beginning in November 2011, after Mr. Randalls retired, Petitioner was the sole storekeeper in the food store. The position has been both a one-person and a two-person job. Petitioner was the sole storekeeper for about two years, but during that

time there were quite a few out of town staff members who would come to assist in the store. In continuing to read through the summary, Mr. Wells testified he did not recall Petitioner having acted as the purchasing agent, but agreed she did work with some contracts. He did not recall her becoming ill in 2012, but did recall her complaining about her kidney issues, and recalled asking her to return to work when she felt she could. He disagreed with Petitioner's statement that pleas for assistance were ignored. He agreed she did get behind in her job duties, but did not agree it "would have taken a miracle" to get caught up, but rather diligence. He agreed more help would have assisted as well. He agreed that Dale (Brooks) did visit the store and spent time with Petitioner to assist her in streamlining processes.

Mr. Wells acknowledged that Petitioner's description of the work environment contained in the summary was generally accurate, and conceded it was a very busy place. He agreed that Petitioner told him it was a stressful work place.

Mr. Wells was questioned by Respondent's counsel regarding Petitioner's work product, with which he had issues. He testified that he, his account supervisor, and his facility director at the time, had a big concern regarding receiving reports. He explained that receiving reports are reports generated after food stuffs are delivered. In order to pay a vendor, the storekeeper is required to receive in the goods, verify them, and create a report that indicates the item was received properly and the price was correct per the contract. The receiving report then goes to a commodity control clerk or a vouchering clerk, who makes sure all the numbers are correct, and then payment is allowed to be generated through the comptroller's office.

Mr. Wells testified the law requires receiving reports be completed within just a few days of receipt of the goods, and that a problem had arisen with Petitioner, as they were not getting her receiving reports in a timely fashion. He talked with Petitioner two to three times a week to ask her to provide receiving reports so that payments could be processed.

Mr. Wells testified there was a specific incident in December 2013 regarding a receiving report for a delivery of pies received from the Illinois Department of Corrections. The accountant clerk indicated she had not received a receiving report from the food store for the goods, and Mr. Wells showed Petitioner the document saying the pies had been received in, with someone's initials on the document. Petitioner disputed receipt of the pies, and when asked to complete the receiving report for the pies, she declined to do so because she did not recall physically receiving them. Mr. Wells disputed Petitioner's statement to Dr. Felthous, Respondent's Section 12 examiner, that she was asked to do something unethical or illegal by completing the receiving report. He disputed this because there was proof that the items had been received in, and thus the report needed to be completed.

Mr. Wells reviewed Respondent's Exhibit 7, a Memorandum and Disciplinary Action Form. He testified he was approached by the facility director and assistant facility director and a decision was made to transfer Petitioner to a different department. They felt that Petitioner would be best suited to be moved into property control, based upon delays that were occurring in her receiving reports and a problem with inventories not having sufficient accuracies. The position in property control was still a storekeeper position, which carried the same title and pay, with less work. Mr. Wells testified Petitioner ultimately ended up being a storekeeper for the

general store. The dry goods store and food store are separate stores but both part of Store 1 at the facility. He testified it was explained to him by the facility and assistant facility directors that the move was in response to Petitioner being unable to keep up with the amount of work she had as a storekeeper in the food store.

Mr. Wells reviewed page two of Respondent's Exhibit 7, Disciplinary Action Form, which listed the charge as insubordination on March 5, 2014, and disrespectful conduct on March 6, 2014. The conduct referenced occurred the day of and the day after a meeting with Petitioner, which Mr. Wells was a part of. He had Petitioner go to his office initially to advise her that he had been directed to move her to property control, to which Petitioner responded she "can just take a leave of absence". Following the meeting with Petitioner, Mr. Wells spoke with the facility director and assistant director. In that Petitioner had stated she was going to leave, Mr. Wells was instructed to collect her keys from her. He asked Petitioner to submit the keys, and she declined. He contacted the chief of security and asked him to obtain the keys from Petitioner. Mr. Wells testified Petitioner never returned her keys to him. His understanding was that Petitioner was suspended over this.

The Memorandum on page one of Respondent's Exhibit 7, mentioned a pre-disciplinary meeting which took place on October 22, 2014, as well as problematic behavior and cursing by Petitioner. Mr. Wells was not part of that meeting, but was part of the conversation which involved Petitioner's cursing. He testified that when he learned that Petitioner had returned to work, he went to the general store to greet her and see how she was doing. He spoke with her and the other storekeeper, and after a few minutes Petitioner approached him. She stated she wanted to know why she was being treated like a "fuc____ terrorist". Mr. Wells testified he did not have an answer for her, as he did not know she was being mistreated by anyone, so he excused himself from the situation. He made a report about it, as he did not believe it was an appropriate way to engage in conversation, and he did not want a conflict with Petitioner.

Mr. Wells testified that the decision to transfer Petitioner to a different area was not his decision, but that it was a way to eliminate problems with bad inventories and to get paperwork more current. There had been a long period of time of trying to coax and urge Petitioner to get her receiving reports done, and it was not a simple instance of one receiving report.

On re-direct examination, Mr. Wells testified he gave Petitioner evidence that the pies in dispute had been received. He gave that to her either in person or by email, and most likely in person. He did not have a copy of the documentation at trial. He acknowledged that if Petitioner did not have proof of receipt, it would be an improper act and against the administrative code to fill out a report stating she had received the goods. Mr. Wells testified he had never seen anyone get fired over something like that. He denied threatening Petitioner with termination if she did not sign the report and had no knowledge of anyone else threatening her in that way. He further denied threatening Petitioner with discipline or sanctions if she refused to sign the receiving report in question and had no knowledge of anyone else threatening her in that way. He testified Petitioner did not tell him about anyone else so threatening her.

Mr. Wells acknowledged Petitioner was off work for six or seven months, that he had read her medical report, and that she said there was stress emanating from her work environment

and that she was asked to commit illegal or improper acts by him. He testified there are currently two employees in the receiving area where Petitioner used to work.

Mr. Wells testified there was no doubt in his mind that he showed Petitioner proof that the goods in question were received, and that it was therefore appropriate to ask her to draft a receiving report. The report in question was well beyond the time limit required for it to be completed. He reiterated he had never threatened Petitioner in any way, and that the only time they discussed receiving reports and the potential for discipline was in order to get the reports moving, since Petitioner was behind on them.

Petitioner testified she had been employed at Choate for 31 years and was familiar with their procedures. She confirmed that she had prepared the document titled "Summary from the Food Store", Petitioner's Exhibit 5, and that the facts contained therein were accurate.

With regard to the delivery of pies in question, Petitioner testified that when she was given the receipt for the delivery it did not have a signature on it and she therefore refused to complete the receiving report. She testified she did not receive them, and had she completed the receiving report she would have violated policy and procedure. Her understanding was that if she filled out a receiving report where someone got paid for something not received, it would be a misappropriation of funds.

Petitioner testified that a similar incident occurred after this that she was involved in. It involved an unsigned receipt for dried turkey that had not been received. She spoke with the vendor and it was discovered the items had not, in fact, been received.

Petitioner testified that when she first became a storekeeper there were three others in the position as well, and that at some point she became the only remaining storekeeper. She was the sole person in the position for about two years, though she did have temporary assigned helpers during that time. Petitioner testified that during that two year period her health started going downhill. She started having anxiety attacks and losing her ability to focus and concentrate. Prior to the claim at issue, Petitioner had one other claim for about six weeks when she hurt her neck. She denied ever treating with a psychiatrist, psychologist, or counselor prior to the events in question.

Petitioner testified that after the events occurred, she sought treatment with her family practitioner, Dr. Karen Strack, and was also examined by Dr. Alan Felthous at Respondent's request. Dr. Felthous suggested she might consider counseling if the problems continued. Dr. Strack thought it was best for Petitioner to be off work, due to the affect work was having on her physically. Petitioner missed time from work, for which she was not paid.

Prior to the events in question, Petitioner testified she had never been disciplined or written up. In her current position she still has to sign for goods, but has not seen receipts or orders without a signature since she returned to work. She explained that when documents come in and have signatures on them, indicating the items have been received, the documents are then stored at the facility as part of the normal course of business for record keeping, and that she maintained them.

Petitioner testified that the treatment she received by Dr. Strack helped her and that she was back to work. She continued to have some symptoms of anxiety, including trouble sleeping, trouble concentrating, and a lack of motivation.

On cross-examination, Petitioner confirmed she maintained the records of deliveries and that anyone in the business office for the stores had access to them. She testified she did not bring a copy of the record at issue, as it was state property and she was not allowed to take it off the state property. She did not ask anyone if she could bring it to trial, for proof in her case.

Petitioner acknowledged she had outside stressors besides her job, including family issues and issues with her health. She agreed for the most part with what Dr. Felthous had in his report with regard to those outside stressors, but testified that at the time of his report her anxiety attacks were caused by the stresses at work. Her mother's health issues were not as big of a factor at that time, and they did not go downhill until later.

Petitioner testified her current position was storekeeper in Store 1. She admitted that on the day she was told she was being transferred, she told Mr. Wells that she was not going to accept the transfer and was going to go on medical leave. She conceded that she took the transfer as a personal affront to her character and that she was angry. Petitioner was asked by Respondent's counsel why she was upset about being transferred to a department that was less stressful, when her position in the food store was so stressful and so understaffed. She responded, "Because that was my job." She testified she had received the help she had requested and was allowed to finish training the help. She believed she could have gotten everything caught up and done her job just fine. She was again asked why she would not be happy to take a transfer when she was so stressed and overwhelmed, experiencing anxiety attacks, and felt she was being insulted. She responded, "Because I like my job."

Petitioner acknowledged that her current position carries the same title as her previous job and the same amount of pay. She testified she talked with someone in the union about the situation and had asked for grievance paperwork, but had not seen it yet. She also had not filed a complaint with the EEOC. She had applied for non-occupational disability benefits when she was off work but the claim was denied, based on the pending worker's comp claim.

Petitioner testified that she believed any person in the same circumstances she had been in would have felt overly stressed. She did not believe Mr. Wells was intentionally unethical, but she no longer trusted him to direct her as an employee because he asked her to receive goods that she had not received. Petitioner conceded that Mr. Wells had asked her many times to complete receiving reports.

Respondent called Ms. Gina Millis as a witness. Ms. Millis has been at Choate since 1993 and is currently the Interim Labor and Relations Administrator. In her position she deals with all of the contracts, grievances, discipline, and any issues that arise with employee conduct. She hears grievances, attends third level and arbitration hearings, and works with human resources. Ms. Millis reviewed Respondent's Exhibit 7, confirmed she prepared the document, and confirmed it was kept in the normal course of her business. She testified she served the

document upon Petitioner and that she was a party to the proceedings involved in the document. She confirmed that the Exhibit was a true and accurate copy of the documents served on Petitioner, except that the signatures were not on the copy.

On cross-examination, Ms. Millis acknowledged that Petitioner's two-day suspension was taken down to one day, through the grievance process which went to the third level. The suspension was for failure to return her keys, rather than for swearing.

The Arbitrator notes that Petitioner's Exhibit 5, titled "Summary from the Food Store" was a typed page, undated and unsigned, wherein Petitioner described the condition of the food store when she was first assigned as storekeeper, the process of ordering and receiving food, her requests for help, and her statement that she was "following my better judgment and taking a leave as I should have back in 2012". PX5.

On March 10, 2014, Petitioner presented to Karen Strack, D.O., with Rural Health/Anna Medical Clinic. Dr. Strack reported, "Patient is here for a note for work." Petitioner related she had been under considerable stress at work, was feeling very anxious and restless, and felt there was a fair amount of injustice being done at work. She noted she had been at the facility for 29 years and had only taken two leaves of absence, for kidney problems and for childbirth. She reported her employer was moving her job from store room 1 to store room 2, which she took as an affront to her character, and she felt they were treating her like a criminal. Petitioner related she had started having panic attacks and chest pain, and her blood pressure was elevated. She had spoken to her union representative just prior to going to the doctor's office. PX3, RX6.

Dr. Strack noted Petitioner had medullary sponge kidney with nephrocalcinosis and recurrent kidney stones and was on enalapril for her renal disease. Dr. Strack talked with Petitioner about the other stressors in her life. Specifically, Petitioner had a teenage son and was also her mother's caretaker, in that her mother had cognitive impairment secondary to a posttraumatic brain injury. On examination, Petitioner's blood pressure was 150/108, which was noted to be above her normal of about 134/88. Petitioner appeared tense, anxious, and slightly frustrated, but there was no tearfulness or depression. Dr. Strack's assessment was (1) "Workman's Comp"; (2) stress; (3) hypertension; (4) medullary sponge kidney; and (5) status post history of bilateral lower extremity neuropathy. With regard to treatment, Dr. Strack noted, "She will consider this opportunity of being off work for the next 3 months to use for physical therapy for her neuropathy and further workup of her leg pain." The Arbitrator notes that there is no mention in this office note of leg pain or bilateral lower extremity neuropathy. PX3, RX6.

On April 10, 2014, Petitioner completed an Employee's Notice of Injury form. She indicated she had recurring anxiety attacks for at least three months prior to leaving work on March 5, 2014, which had caused an increase in her blood pressure. With regard to how the injury occurred, Petitioner wrote it was continued unrelenting stress from her job, without adequate or any response from management to correct problems. She stated when problems were brought to management she was either ignored or "they retaliated". She marked yes as to whether a negligent third party caused or contributed to the accident, and wrote that there was a repeated failure on the part of management to address problems, and that there was retaliation by

management when problems were brought to them. She described her injuries as "mental and physical". RX1.

Petitioner returned to Dr. Strack on April 14, 2014, "for follow up on leave from work". It was noted she was receiving what she perceived to be aggravation from her supervisor when she voiced her opinion that things were not being done properly. She reported the stressors at work became so bad she began to have panic attacks when she would approach work, and her blood pressure would go up and she would become very hot, flushed, and anxious. It was noted she had hoped to retire in another two or three years. She related since she had been off work she had been doing much better and that her blood pressure had been better. Her physical examination was normal. Dr. Strack's assessment was (1) anxiety disorder with panic attacks; (2) hypertension; (3) proteinuria; and (4) "Workmen's Comp". Treatment plan included completion of forms and return in one month. It was noted, "She is not requesting nor requiring any medication for anxiety at this time." PX3, RX6.

On April 23, 2014, an Employer's First Report of Injury was completed. It was noted Petitioner had stated she had panic attacks once a week due to the work environment (management) and being overworked. She stated it started four months prior but she was diagnosed on March 10, 2014, with anxiety, panic disorder, and hypertension. The nature of the injury was listed as "stress". RX2.

On May 14, 2014, Petitioner returned to Dr. Strack and reported that as long as she stayed at home, away from work and away from old co-workers, she was fine. She related she had a minor panic attack when she started visiting with a friend who was a co-worker, and that it was very unpleasant. She experienced chest pressure, anxiety, and palpitations. Dr. Strack noted Petitioner "has had acute-on-chronic work stress". Petitioner related she had been there many years, had rarely taken time off, felt her boss was overbearing and picking on her, and felt she had been targeted. She did not know whether it was in response to other issues going on at Choate, "sort of a house cleaning", but she felt the pressure and anxiety made working there difficult. She related it raised her blood pressure, and that if she remained away from work her pressure was fairly good. There had only been three days in the past month where she had to take extra medication to get it under control. It was again noted Petitioner had medullary sponge kidney and other renal issues, and that her blood pressure was being vigilantly monitored. Assessment was "acute-on-chronic work stress" and it was noted that a worker's comp form was completed. Petitioner was to remain off work until further notice. PX3, RX6.

Dr. Strack completed a Physician's Statement for authorization for disability leave on May 14, 2014. Her diagnosis was acute and chronic work stress, as well as medullary sponge kidney and nephrocalcinosis. Subjective symptoms listed were anxiety, panic, and accelerated hypertension when talking to or about work. Objective findings were listed as, "BP meds required adjustment upward". It was noted Petitioner had improved. With regard to limitations, Dr. Strack marked "psychological" and noted her issue was psychological and not physical. She noted Petitioner was temporarily totally disabled and it was unknown when she would be able to return to work. She did not believe it was a permanent disability. PX3.

On June 16, 2014, Petitioner followed up with Dr. Strack. It was noted the appointment was for the purpose of medication refills and paperwork for leave from work. Petitioner related she had no money coming in for worker's comp and had no air conditioning at home most of the time. It was also noted there was no air conditioning at work. Dr. Strack noted that Petitioner had kidney stones with dehydration and with no air conditioning at work, it was "not in her best interest". It was noted there was work stress because they were going to give her two duties. She related that the last person to work that job was behind, which would put her at a disadvantage and high stress. She reported she felt like she was going to have a heart attack each morning. During the office visit, she reported no chest or arm pain, and no shortness of breath. It was noted she had chronic back pain and severe disc disease, and that she had to lift 75 to 100 pounds multiple times a day. She reported less pain radiating down her legs than before, and no falling like when her legs went numb at work. She reported no depression. Her physical and psychological examinations were normal. Assessment was medullary sponge kidney with nephrocalcinosis, hypertension, panic disorder, and chronic back pain. PX3, RX6.

Petitioner returned to Dr. Strack on July 14, 2014, for what was noted to be follow up for hypertensive disorder, chronic back pain, medullary sponge kidney with nephrocalcinosis, and panic disorder. Past medical history included domestic violence or abuse, as well as degenerative disc disease in the spine and compression fracture of L4-5. Petitioner reported no chest pain, no arm pain on exertion, no shortness of breath, and no palpitations. It was noted her hypertension was still unstable, especially when discussing work. It was also noted that her leg was still weak but better than when she left work. Petitioner reported no depression or sleep disturbance, but she also reported insomnia. Her physical and psychiatric examinations were normal. Assessment included hypertension, chronic back pain, medullary sponge kidney with nephrocalcinosis, panic disorder, and work stress. PX3, PX6.

Petitioner returned to Dr. Strack on August 14, 2014, at which time she reported no chest or arm pain and no shortness of breath. It was noted her blood pressure had been stable, and that even discussing work no longer triggered a major pain attack. She reported she was still smoking and felt that with the work stress she was not able to quit. It was noted that despite being on her feet as much or more than when at work, there had been no swelling in her legs. Petitioner reported no depression and no sleep disturbances. She related she "was considering going back to work next month and would like to have valium for occasional stressful days". Her physical and psychiatric examinations were normal. Assessment was hypertension and medullary sponge kidney with nephrocalcinosis. She was to return in one month. PX3, PX6.

On September 15, 2014, Petitioner followed up with Dr. Strack, at which time she reported her hypertension increased thinking about work. She reported she had been on leave from work and was ready to try to go back, but she felt anxious that some of the same issues may be there. It was noted she would be prescribed Ativan, in anticipation of going back to work. Her physical and psychiatric exams were normal. Assessment was chronic back pain, anxiety, and work stress. Forms were completed to return to work. PX3, PX6.

Petitioner followed up with Dr. Strack on October 21, 2014, and reported daily stress at work and elevated blood pressure. She denied chest pain, arm pain, and shortness of breath. Due to work related stress, she needed a refill of Ativan. Physical examination was normal, with

the exception of tenderness in the cervical area due to enlarged lymph nodes as a result of a spider bite on her cheek and a cat scratch on her neck. Psychiatric exam was normal. PX3.

Petitioner returned to Dr. Strack on January 12, 2015, as her left eye was swollen, red, and painful. She had been doing house repairs and blow-in insulation got in her eye. She followed up for this condition on January 13, 2015. PX3, PX8.

There were several medical records submitted for dates of service prior to Petitioner's date of accident. They included the following diagnostic studies, which were unrelated to Petitioner's alleged stress:

1. February 21, 2014, abdomen and pelvis CT
2. August 1, 2013, lumbar x-rays
3. July 10, 2013, abdomen x-ray
4. July 10, 2013, kidney scan/renal flow and function study
5. May 13, 2013, abdomen and pelvis CT
6. April 23, 2013, retroperitoneal ultrasound

Prior medical records also included the following office visit notes from Dr. Strack:

1. January 7, 2014, follow up for back pain, hypertension, and medullary sponge kidney. It was noted she had slightly elevated blood pressure and that she continued to deal with a lot of family and home stress. Blood pressure was 154/80.
2. November 13, 2013, for refill of Norco and to discuss her mother. Also present during the visit was Petitioner's son and sister, all of whom were concerned about grandma (Petitioner's mother). Dr. Strack noted, "Fifteen minutes was spent in discussing family stressors (mom)." Assessment included chronic pain, "acute and chronic family stress", and renal listhiasis. Blood pressure was 158/90.
3. October 10, 2013, for back pain and leg pain. It was noted she had multilevel degenerative disc disease and facet arthropathy. Blood pressure was 140/83.
4. July 11, 2013, for leg weakness bilaterally and nephrocalcinosis with medullary sponge kidney. Blood pressure was 111/75.
5. April 11, 2013, for hematuria and significant pain in her left back/flank area. Blood pressure was 154/82.
6. February 11, 2013, for medullary sponge kidney with nephrocalcinosis. It was noted her blood pressure was up, likely due to pain. Blood pressure was 175/96. RX6.

On September 29, 2014 a pre-disciplinary meeting occurred with Petitioner and a Disciplinary Action Form was completed. This was regarding an incident of insubordination on March 5, 2014, and insubordination and disrespectful conduct on March 6, 2014. It was noted Petitioner was suspended for the insubordination for two days, October 8 and 9, 2014. On October 29, 2014, a Memorandum was written by Gina Millis in Labor Relations to Petitioner regarding the inappropriate interaction (disrespectful conduct) which was .the subject of a pre-disciplinary meeting on October 22, 2014. It noted that the employer had reviewed the matter and determined there would be no disciplinary action taken. It further noted that the case presented "significant evidence of problematic behavior" by Petitioner. The evidence indicated that Petitioner was cursing, which was unacceptable, and it was expected she would interact in a

more civil way in the future. Copy of the Memorandum was noted to Petitioner's supervisor, Chris Wells. RX7.

On November 5, 2014, and November 12, 2014, Petitioner was evaluated by Respondent's Section 12 examiner, Dr. Alan Felthous, who issued a report on December 19, 2014. She gave a history of working for Respondent for 29 years, and of a work injury on March 5, 2014, which resulted in her filing for worker's compensation and taking leave until September 16, 2014. Dr. Felthous interviewed Petitioner for two and one-quarter hours on November 5, and for one and one-half hours on November 12. He reviewed medical records from Dr. Strack, as well as a retroperitoneal ultrasound of April 23, 2013, an abdominal and pelvic CT of May 13, 2013, and a diagnostic imaging report, renal flow and function study, and abdominal x-ray of July 10, 2013. He also reviewed job descriptions of Petitioner's positions with Respondent. PX4, RX4.

When interviewed on November 5, 2014, Petitioner reported she had worked in the food store of Choate in a Store 1 position. The position involved receiving food, sending out supplies, and paying for items received. She reported that in December 2013 she was instructed to pay for items that were not received and she did not comply, as she believed this to be unethical, illegal, and against policy. She related that nothing came of the matter. She reported she began having panic attacks, which she related to being instructed to pay for items not received, followed by insistence that she comply. She subsequently received two preliminary disciplinary actions, the first for declining to turn in keys, and the second for asking her supervisor why everyone was acting like she were a "fuc____ terrorist". Her union representative put forth a rebuttal to each charge. The first incident was considered insubordination, for which she received a two-day suspension. The second incident resulted in an admonishment to "watch her language". She related she was told she would be removed from her present position and reassigned elsewhere because she could not think straight. PX4, RX4.

Petitioner related the work conflicts led to "panic attacks", which she experienced every day when she went to work. She stated she had no mental problems except when she was at the store. She experienced stress, distress, and anxiety attacks, and felt like she was having a heart attack because she had chest pain, difficulty thinking, difficulty breathing, and pain down her arm. The episodes lasted five to thirty minutes and were brought on or made worse if she went to work and was then told to take actions that violated the law. Petitioner reported that when she was told she would be reassigned to "property control" she had anxiety for about an hour. She considered the job to be a "paperwork job", and she was given no explanation for the reassignment other. She reported that "later others denied having said anything about the reassignment". PX4, RX4.

Petitioner reported that prior to December 2013 she had never experienced such anxiety episodes. In the week prior to the first evaluation with Dr. Felthous, Petitioner reported she had had two episodes. She advised when she had episodic anxiety she would take one Ativan, and if the anxiety lasted for an hour or so she would take another. She had been taking Ativan two to four times a week. She denied taking any other medication for her nerves, although she had tried Xanax and did not like it because it made her feel drugged.

Petitioner was interviewed a second time on November 12, 2014. She reported that in November 2013 she had been instructed to document payments to vendors differently than she had been doing. She felt she was matching figures according to the contract, and that she was not in error. She reported that by December her supervisor, Mr. Chris Wells, began to push her to handle documentation differently and she began to experience episodes of anxiety. As time went on, she was increasingly pressed to comply with the alternative payment documentation and by February 2014 she was experiencing anxiety nearly every day at work. She explained to her supervisor that she could not do paperwork for an item that had not been received, as it would be misappropriation of state funds. She stated he would assent at the time, but then two days later again instruct her verbally and through email to comply. PX4, RX4.

Petitioner related that on March 5, 2014, she was instructed to go to Mr. Wells' office. He was her supervisor, but also the business administrator for both the mental hospital and the developmentally disabled section of Choate. She had been experiencing panic attacks every morning, and was anxious going into the meeting. Mr. Wells informed her she was being transferred to Property Control, and asked her to turn in her keys to the grocery store. Petitioner asked why she was being transferred, and related she felt she was going into a panic attack. She was told the move was not a disciplinary measure. Petitioner related she was unable to think straight at that time, obtained a union representative, signed out of the facility, and began a leave from work. She was on leave without pay for six and a half months and returned to work on September 16, 2014. PX4, RX4.

When interviewed on November 5, 2014, Petitioner reported having two anxiety episodes over the week prior, for which Ativan was helpful. She had been taking Ativan two to four times a week. When interviewed on November 12, 2014, she reported her last anxiety episode was the week prior and that it was short in duration. She attributed her improvement to being in a position where no one bothered her and she was able to do her work. She related the pace was slower and she could order items on an as-needed basis, without having to project nine months in advance. She reported she still lifted, carried loads, unloaded trucks, and used a pallet jack, all of which she enjoyed. She explained that her position was still in Store 1, but that she was working in the area for paper goods and chemicals, rather than groceries, and the demands were different. She stated she had not been assigned any task recently that she considered to be unethical or illegal. PX4, RX4.

Prior to her position as store clerk, Petitioner worked as a mental health technician for more than 19 years, which she enjoyed. She worked with disturbed patients who were sometimes violent, and assisted in their care. She advanced to mental health technician four, the highest level for that position. She and her husband divorced after more than 18 years of marriage when her son was 13, necessitating a change in her hours and job assignment. At that time she was reassigned to work in the store, the center for receiving and distributing goods that were delivered to the hospital. She related she enjoyed that work, especially the lifting and moving, because she enjoyed being busy and physically active. PX4, RX4.

With regard to Petitioner's past personal history, she reported her grades in school were average to low average. Although she was never assessed, she believed she may have had a learning disability, as she had trouble reading. She reflected that school was an unpleasant

experience for her, that she was a loner, that she was "odd man out", and that others treated her differently. She recalled a specific unpleasant memory of her first grade teacher calling her a communist. She left high school at the age of 15 and later received her GED through a local junior college. She earned an Associates Degree in Machinery, Tools, and Die. She then went to work for Choate Mental Health Center. PX4, RX4.

Petitioner reported her parents divorced when she was four and she had no contact with her father. She had some contact with her siblings, none of whom had any significant medical or mental problems. Her mother had also been employed at Choate, and 25 years ago was attacked by a patient and beaten. She sustained a traumatic brain injury with dementia and recurrent vertigo, as well as cervical injury which required surgery. Her mother was deemed to be totally disabled, but was capable of living alone and taking care of herself with minimal assistance. Petitioner reported her mother's level of function fluctuated between being confused and being fine. She checked on her twice a week and assisted with her personal finances. PX4, RX4.

Petitioner's own marriage involved physical abuse toward the end of the marriage, and in one episode she was struck in the face, which fractured the lower part of her left eye orbit and required surgical implantation of a non-metallic plate. She has no current involvement with her ex-husband. Petitioner reported her current interests were playing interactive internet games, reading articles on the internet, building things, doing home repairs, and taking care of her dog, cat, and chickens. PX4, RX4.

Dr. Felthous reviewed Petitioner's medical records from Dr. Strack, which included treatment for medullary sponge kidney with nephrocalcinosis. Of note, on April 11, 2013, Petitioner reported she was having stress and worsening anxiety. On July 11, 2013, she reported a history of multiple traumas from having been in an abusive relationship with an alcoholic husband. She was seen that date for kidney follow up, as well as complaint of episodic numbness radiating down both legs. She was diagnosed with multi-level degenerative disc disease, facet arthropathy and extensive kidney stones. On October 10, 2013, her main complaint was leg weakness and tenderness at L5-S1. It was noted she had a history of compression fracture at L4-5 in 1993. On January 7, 2014, Petitioner reported much family and home stress. Her blood pressure had increased from 111/75 to 154/80. Dr. Felthous further reviewed Petitioner's records from March 10, 2014, through September 15, 2014, as summarized by the Arbitrator above, in conjunction with Petitioner's treatment by Dr. Strack. PX4, RX4.

Dr. Felthous noted during the mental status examination that Petitioner's hair appeared somewhat disheveled. She expressed annoyance and distress over the process of the exam, relating her mother had been so evaluated after a work injury, and Petitioner did not believe the evaluator addressed her mother's needs. She expressed concern that the present evaluation would similarly not address her own needs. The examination itself was normal. PX4, RX4.

Dr. Felthous diagnosed Petitioner with Adjusting Disorder with Anxiety, and noted it was substantially improved. The condition manifested, by her report, with anxiety following a stressful conflict with her job requirement. The anxiety related to a particular work related conflict that began in December 2013, increased over the following months, and peaked on March 5, 2014. It had subsided substantially since then, but not completely. He noted

Petitioner's distress was out of proportion to the severity of intensity of the stressor, which made it difficult for her to return to work in March 2014. Her medical records did not indicate she was distressed over her significant health issues regarding her kidney, but did indicate she was concerned about her blood pressure increasing due to stress. Dr. Felthous noted that Dr. Strack's record of January 7, 2014, explicitly stated Petitioner was experiencing much family and home stress, though she did not relate that to Dr. Felthous during either interview. Dr. Felthous concluded that not all of the stress Petitioner experienced in early 2014 was necessarily due to the work conflict. PX4, RX4.

Dr. Felthous opined that, although Petitioner's episodes of stress and anxiety might have peaked on March 5, 2014, her anxiety did not begin suddenly on that date. He noted her medical records show evidence of stress and anxiety experienced earlier in the year that were fueled by family stressors in her life, not related to work. Specifically, Petitioner had stresses related to raising her adolescent son and caring for her cognitively impaired mother. PX4, RX4.

Dr. Felthous noted that Petitioner's medical records included a diagnosis of "panic disorder", which Dr. Strack later changed to "anxiety state, unspecified, and work stress". He opined that some of Petitioner's self-reported symptoms were consistent with panic attacks; however, she described them as triggered by work-related events. As such, they were not "recurrent, unexpected panic attacks" and did not constitute a panic disorder. PX4, RX4.

Dr. Felthous also diagnosed Petitioner with Paranoid Traits, manifested as distress and suspiciousness that others had malevolent motives and were deceiving her. He noted she was preoccupied with doubts about the trustworthiness of others and read personally adverse meanings into remarks by others. She showed resentment, perceived attacks on her character or reputation, and was quick to react angrily. Dr. Felthous pointed out, however, that he could not rule out the possibility that Petitioner's supervisor was, in reality, demanding she commit unethical and illegal acts. If this actually happened, he opined it would diminish the support for the diagnosis of Paranoid Traits. PX4, RX4.

In summary, Dr. Felthous opined that Petitioner experienced emotional stress, anxiety, and resentment that resulted in sleep disturbance, and that Petitioner associated the anxiety episodes with her work environment. Her anxiety and stress peaked on or about March 5, 2014, but she began experiencing stress in December 2013 and it gradually worsened in the following months. He opined that some of her distress in early 2014 may have been related to family issues, according to her treating records. His diagnosis was Adjustment Disorder with Anxiety. Dr. Felthous noted Petitioner experienced anxiety and stress regarding specific tasks she was instructed to carry out several months prior to March 5, 2014, and that the event on March 5 was apparently more stressful than the others for her. He opined that any employee could be expected to experience distress if required to do something they believed to be unethical or illegal, and if disciplinary-like actions flowed from this. He opined that Petitioner's reaction, however, was an overreaction, manifested by an adjustment disorder, whereby relief came from avoidance of the work place. PX4, RX4.

Dr. Felthous noted Petitioner reported she continued to experience anxiety episodically, although much less frequently than before. She was back at work in a different position, where

the pace was slower and the previous conflict was less likely to occur. He opined that Petitioner's Adjustment Disorder had substantially improved and she was fit to work in her current position. He noted, however, that it had not completely resolved. PX4, RX4.

Dr. Felthous opined that the anxiety and distress Petitioner experienced on March 5, 2014, and after were related to the event of March 5, but also related to the recurrent conflict she experienced beginning months before, when asked to carry out tasks she considered unethical and illegal. He also opined that there was evidence of family related stresses apart from those at work. Appropriate treatment consisted of environmental adjustment, as had occurred with her change in job, and/or counseling to assist her in adjusting to work-related stresses. PX4, RX4.

With regard to treatment, Dr. Felthous opined that with while Petitioner's adjustment disorder may have been worsened by the event of March 5, 2014, she was already experiencing anxiety and distress, as well as conflict regarding work assignments, months before then. Her disorder was improving with the job change and Dr. Felthous opined she may continue to improve and completely resolve without any change in treatment. He further opined that counseling would offer a faster and more complete possibility of recovery. While an anti-depressant is typically used with good effect for episodic anxiety, Dr. Felthous noted Petitioner's case was complicated by her kidney disease. If she received medical clearance and her kidney condition was stable, it would be an option if carefully monitored. However, he opined that unless Petitioner's condition worsened, use of an anti-depressant was not compelling at this time. He stressed, however, that Petitioner would benefit from counseling. PX4, RX4.

Dr. Felthous did not find any reason to place restrictions or limitations on Petitioner's physical activities or employment from a psychiatric standpoint. Petitioner reported she enjoyed being physically active at work. Dr. Felthous also did not find any reason for restrictions or limitations of Petitioner's normal activities of daily living. He noted Petitioner had demonstrated she was capable of working full duty in her current job assignment, which she reported as being less stressful. He opined that Petitioner demonstrated on her mental status exam that she had the cognitive capacity to handle virtually any job, including the position she held prior to the incident of March 5, 2014. He noted her risk was her tendency to let her strong opinions affect her judgment, and then to overreact if her opinion was not accepted. He noted, however, that if Petitioner was in fact asked to do something unethical or illegal, then her response may not have been unreasonable. He opined Petitioner was fit for duty for both her current position and her pre-injury position, but noted if she was assigned to her pre-injury position she may experience a resurgence of anxiety, for which counseling should be helpful. PX4, RX4.

Dr. Felthous opined that Petitioner's Adjustment Disorder with Anxiety had substantially, but not completely, recovered. Given her improving course, it was expected she would continue to improve with anxiety episodes becoming less and less frequent and intense. He again opined that counseling to assist her in adjusting to stressors should be useful. PX4, RX4.

Dr. Felthous testified by way of deposition on March 30, 2015. He is a Board Certified Psychiatrist, Forensic Psychiatrist, and Medical Examiner, and has been practicing psychiatry since 1975. He is licensed in Missouri, Illinois, Texas, Kansas, and Kentucky. He has a forensic practice and consults on issues in both civil and criminal law. He also rotates on inpatient

service at St. Louis University Hospital, provides clinical services for the Juvenile Detention Center in St. Louis, and fills in for other psychiatrists in capacities such as providing treatment at the St. Louis County Jail. He also has substantial teaching responsibilities, especially in the area of forensic psychiatry, and writes and publishes on the topic of psychiatry. Dr. Felthous was previously the medical director of Chester Mental Health Center in Chester, Illinois, and had some familiarity with Choate Mental Health Center. PX6, RX5.

Dr. Felthous testified consistent with his report of December 19, 2014, and confirmed his diagnosis of adjustment disorder manifested primarily by anxiety. In his report he noted Petitioner's distress was out of proportion to the severity of intensity of the stressor, and he was asked to explain what stressor was being referred to. He testified the stressor that Petitioner described was the conflict she experienced in her supervisor telling her to do something that she understood to be illegal, unethical, and against policy. When asked to explain what he meant by her stress was out of proportion, he testified anyone might feel anxious if they were called upon to do something they thought was illegal, unethical, or against policy. However, Petitioner described what appeared to be anxiety attacks, episodes where she felt extreme anxiety. She had heart palpitations, felt short of breath, had pain, felt numbness going down one of her arms, and she had trouble thinking. Dr. Felthous testified this description of an anxiety attack would be beyond what most people would experience. PX6, RX5.

Dr. Felthous testified that even if Petitioner's account was untrue, and she was not required to do something unethical or illegal by her supervisor, his opinion would not change because he assumed Petitioner's perception was true, even if the facts were not. He believed that Petitioner believed what she was telling him, and her symptoms were what they were, whether her account is accurate or not. His diagnosis would not change either, as her perception might have been affected by her personality and her way of perceiving things in general. If what Petitioner reported to him was untrue, however, it would make him question her credibility. Dr. Felthous testified his diagnosis was based on Petitioner's subjective complaints, her recounting of the events, how she felt, and the symptoms she experienced after the event. PX6, RX5.

Dr. Felthous testified Petitioner mentioned two preliminary disciplinary episodes, wherein she had representation and responded to those. With one of those episodes, she was suspended for a few days, and for the other she was cautioned to watch her language. The information provided by Petitioner was included in his report. He testified that if Petitioner experienced stressors with her supervisor, where she was not required to do anything illegal or unethical, and she was disciplined appropriately according to agency policy, that would be a stressor that would affect a normal employee. He testified it is common for an employee to experience anxiety when disciplined. PX6, RX5.

Dr. Felthous testified that in the medical records of Dr. Strack it was mentioned several times that Petitioner expressed distress and stress over dealing with her adolescent son and caring for her mother who was demented and had suffered a traumatic brain injury. He testified Petitioner may have also mentioned this in passing during his evaluations. PX6, RX5.

Dr. Felthous testified Petitioner still had ongoing adjustment disorder with anxiety, but that it was much improved compared with before. At the time he saw Petitioner, she was working full duty at Choate. PX6, RX5.

On cross-examination, Dr. Felthous agreed that Petitioner's diagnosis was work-related, but did not know the legalities of her bills being paid. With regard to treatment, he testified Petitioner had medical conditions for which she needed continued treatment. As to her adjustment disorder, he testified it would be very useful for Petitioner to be in ongoing counseling. He opined that seeing a counselor once a week for an hour would be supportive, and that cognitive therapy might be especially useful. PX6, RX5.

When asked what evidence he had that Petitioner was disciplined for anything, Dr. Felthous testified Petitioner herself shared the information. He understood the first instance of discipline was because she refused to turn in her keys when she was transferred to a different position. The second instance was for use of an expletive, asking why everybody was treating her like an expletive terrorist. He testified Petitioner kind of tied all of this together as the issue with her supervisor. He understood from her that the reason she was told to turn in her keys was because she was being transferred from the grocery part of the store to the paper and chemical part of the store. Dr. Felthous testified he understood from Petitioner that this was in response to her having difficulty being told she had to indicate they were paying for something they weren't receiving. She gave the impression that this was in response to her complaints. Dr. Felthous testified his understanding of the second instance of discipline was because Petitioner asked why everyone was treating her like a fuc____ terrorist. PX6, RX5.

Dr. Felthous testified cognitive therapy and counseling would have to be re-evaluated after a certain period of time. Her condition appeared to be improving as it was, though he did not know if Petitioner would remain in the position she was in at the time of the two evaluations. He testified she experienced a lower stress in that position than where she was before, and if she were reassigned to the prior position, then the counseling may be especially useful. He noted Petitioner was still somewhat symptomatic for anxiety, though it was improving, when he saw her. He would like to see her continue in counseling for several months, and would expect her condition would continue to improve. Dr. Felthous opined that Petitioner's job change may have been a material factor in her improvement. PX6, RX5.

On June 8, 2015, Petitioner returned to Dr. Strack for review of her medication refills. She reported no chest or arm pain, no shortness of breath, and no palpitations. Her blood pressure had been under good control. She reported chronic back pain with lifting and carrying at work, and it was noted she had known degenerative disc disease and facet arthropathy which periodically required pain medication. She reported no depression and stated "work stress is better". Her physical and psychiatric examinations were normal. Dr. Strack continued to list "occupation-related stress disorder" as one of five diagnoses for Petitioner. RX8.

On June 19, 2015, Petitioner underwent a bone densitometry of her lumbar spine and left hip, both of which revealed normal bone marrow density. She underwent various lab tests on September 28, 2015, unrelated to her work. She underwent a parathyroid scan on October 9, 2015, also unrelated to her work. PX8.

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 and in the course of her employment, 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). In order to satisfy the "arising out of" portion of the Act the Petitioner must show that the injury was derived from 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. v. Industrial Comm'n*, 207 Ill.2d 193, 203 (2003).

Psychological injuries are compensable under one of two theories. The first is "physical-mental", when the injuries are related to and caused by a physical trauma or injury. *Matlock v. Industrial Comm'n*, 321 Ill.App.3d 167, 171 (1st Dist. 2001). The second is "mental-mental", when the claimant suffers a "sudden, severe emotional shock traceable to a definite time, place and cause which causes psychological injury or harm...though no physical trauma or injury was sustained. *Pathfinder Co. v. Industrial Comm'n*, 62 Ill.2d 556, 563 (1976); *Matlock*, 321 Ill.App.3d at 171.

On-the-job stress, of itself, is not a disease. Events and conditions capable of producing stress exist in every employment environment. Mental disorders not resulting from trauma must arise from a situation of greater dimensions than the day-to-day emotional strain and tension which all employees must experience. The worker must prove that employment conditions, when compared with nonemployment conditions, were the major contributing cause of the mental disorder. *Chicago Board of Education v. Industrial Comm'n*, 169 Ill.App.3d 459, 466-468 (1st Dist. 1988).

Recovery for non-traumatically-induced mental disability is limited to those employees who can establish that: (1) the mental disorder arose in a situation of greater dimensions than the day-to-day emotional strain and tension which all employees must experience; (2) the conditions exist in reality, from an objective standpoint; and (3) the employment conditions, when compared with the nonemployment conditions, were the major contributing cause of mental disorder. *Matlock*, 321 Ill.App.3d at 171, citing *Northwest Suburban Special Education Organization v. Industrial Comm'n*, 312 Ill.App.3d 783, 787 (1st Dist. 2000).

In this case, Petitioner alleges she suffered from a mental disability incurred from mental stressors related to a "hostile work environment" that came to a peak on March 5, 2014. On that day she was informed she would be transferred to a different department because she could not keep up with her work load. She further alleges a mental disability incurred as a result of several stressful work incidents. Her claim is a "mental-mental" claim, since she did not experience or witness a trauma.

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that she sustained an accident that arose out of and in the course of her employment. In so concluding, the Arbitrator addresses five significant areas.

Instruction to falsify a report—Petitioner asserts she was required by her supervisor to do something unethical and/or illegal, and that she was subsequently disciplined for not doing it. In making this assertion, Petitioner attempted to establish the first of the three requirements set out in *Matlock*, that being that "the mental disorder arose in a situation of greater dimensions than the day-to-day emotional strain and tension which all employees must experience". Petitioner, however, failed in this endeavor. Her supervisor, Mr. Wells, agreed that a specific incident occurred in December 2013, when he asked Petitioner to complete a receiving report that was past due, and he agreed that Petitioner refused because she did not recall the shipment being received in. Mr. Wells credibly testified that he provided documentation to Petitioner showing receipt of the shipment, and that at no time did he ask or instruct Petitioner to falsify a report, thereby doing something unethical and/or illegal.

The Arbitrator finds it significant that Petitioner never mentioned this incident to her treating physician, Dr. Strack, despite the fact that she reported a multitude of other purportedly stressful incidents. In addition, Petitioner did not reference this incident when she completed the "Employee's Notice of Injury" form on April 10, 2014, nor when she typed out her page of complaints and issues titled "Summary from the Food Store". There was no evidence or indication that Petitioner reported this incident to her union representative, and no indication it was discussed during her disciplinary meetings. In fact, the first mention of this incident in any record is in Dr. Felthous's report of December 19, 2014. Petitioner reported to Dr. Felthous that she was instructed to pay for items not received, which she believed to be unethical, illegal, and against policy. She further reported that she did not comply "and nothing came of the matter". She went on to report, however, that she began having panic attacks which she related to being instructed to pay for items not received.

The Arbitrator finds Petitioner's assertion that she was instructed to falsify a report to not be supported by the record and to not be credible.

Outside stressors—The record clearly documents that Petitioner had two to three significant stressors outside of work: her health, her mother, and possibly her teenage son. The record established Petitioner suffers from severe renal issues, for which she takes medications and must constantly be monitored by several doctors. She has undergone multiple procedures related to the renal disease. The record also established Petitioner is the primary caretaker for her mother, who suffered a traumatic brain injury as a result of being beaten while working at Respondent's facility, and that being her caretaker brings much stress. On November 13, 2013,

Petitioner presented to Dr. Strack accompanied by her son and her sister, all of whom were concerned about her mother. There was discussion regarding her mother's head, neck, and shoulder pain, her poor balance, her medications, her confusion and disorientation, her depression, and the like. Dr. Strack noted that 15 minutes was spent in discussing family stressors. The Arbitrator notes this was prior to the above-mentioned incident, when Petitioner was asked to complete a past due report. Again on January 7, 2014, Dr. Strack noted Petitioner "reports she continues to deal with a lot of family and home stress". The Arbitrator notes this was after the above-mentioned incident had occurred at work, and that the incident was not mentioned, nor was any other work stress mentioned. With regard to Petitioner's teenage son being a stressor, the Arbitrator notes this is mentioned in the record in several places, but there are no details as to how her son was a stressor.

The Arbitrator finds Petitioner's outside stressors to be significant.

Work Stressors—The record contains several instances of Petitioner noting work stressors to various people. On March 10, 2014, she reported to Dr. Strack that she was under considerable stress at work, that she was feeling anxious and restless, and that there was a fair amount of injustice being done at work. On April 10, 2014, Petitioner completed the Employee's Notice of Injury form and stated she was injured from continued unrelenting stress from her job, without adequate or any response from management to correct problems. She also stated when problems were brought to management she was either ignored or "they retaliated". She told Dr. Strack on April 14, 2014, that she was receiving what she perceived to be aggravation from her supervisor when she voiced her opinion that things were not being done properly. On May 14 she reported her boss was overbearing and was picking on her, and that she was being targeted. On June 16 she reported there was work stress because "they were going to give her two duties". When Petitioner was evaluated by Dr. Felthous, she reported that in November 2013 she had been instructed to document payments to vendors differently than she had been doing, and that she did not feel she had been doing them wrong. She reported that in December 2013 her supervisor began to push her to handle documentation differently, and that as time went on she was increasingly pressed to comply with the new method.

The Arbitrator finds that the work stressors reported by Petitioner were not out of the ordinary, and in fact were typical work stressors commonly encountered in the workplace. In a similar case, the Appellate Court noted that, "A heavy workload, personal disputes between employees and supervisors, (and) unfulfilled expectations...are endemic to claimant's occupation." The court went on to find that "the events to which claimant testified were not out of the ordinary or of greater dimension than one might reasonably find in the normal workplace environment". *City of Springfield v. Industrial Comm'n*, 214 Ill.App.3d 301, 309 (4th Dist. 1991). The Arbitrator finds this case to be factually similar, and further finds Petitioner did not establish that the conditions she reported were uncommon.

Petitioner's perception and personal history—Dr. Felthous diagnosed Petitioner with Paranoid Traits, manifested as distress and suspiciousness that others had malevolent motives and were deceiving her. He noted she was preoccupied with doubts about the trustworthiness of others and read personally adverse meanings into remarks by others. She showed resentment, perceived attacks on her character or reputation, and was quick to react angrily. His report

included Petitioner's personal history of having been abused, and of her self-characterization as being a loner, "odd man out", and being treated differently. Dr. Felthous pointed out, however, that if Petitioner was in fact instructed to commit an unethical and/or illegal act, it would diminish his support for the diagnosis. If that assertion were found not to be true, it would not change the diagnosis, as Petitioner's perception was that it was true. However, Dr. Felthous testified it would make him question Petitioner's credibility.

The Arbitrator finds Dr. Felthous to be persuasive in his opinions and reasoning. While Petitioner may have perceived her situation to be dire and her work stressors to be out of the norm, the Arbitrator is not persuaded. Petitioner's response to her situation and work stressors, however, did appear to be out of the norm. Her appearance and demeanor at trial were somewhat defiant, and her testimony regarding the facts of the case appeared to be out of proportion to the actual record.

Credibility—The Arbitrator recognizes that Petitioner's perception of the events that transpired are, to some degree, her reality. However, the Arbitrator also notes there are several inconsistencies in her testimony and the record. First, she testified that her mother's health issues were not a big factor at the time that she was reporting she was disabled due to work stress. Yet Dr. Strack's medical records clearly document Petitioner was concerned about her mother's health in November 2013 and January 2014, the same time period she is also claiming work stress. Second, on cross-examination, Petitioner was asked why she was so upset in being transferred from such a stressful and overwhelming job to a less stressful one. She responded, "Because I like my job." Given her claim for mental stress, this response defies logic Third, in her interviews with Dr. Felthous and during her testimony, Petitioner put a great deal of emphasis on the incident with her supervisor regarding the late report and an alleged unethical act. Yet she did not mention the incident to her treating doctor, she did not mention it in her Employee's Notice of Injury, and she did not mention it in her "Summary from the Food Store". Fourth, Petitioner claimed that her elevated blood pressure was due to workplace stress. Her medical records, however, document that she had struggled to control her blood pressure for years. In addition, her blood pressure at some medical appointments prior to her claim were higher than after she sought treatment for her alleged workplace stress.

Taken as a whole, the Arbitrator finds Petitioner to be lacking in veracity.

Based on the foregoing, and the record in its entirety, the Arbitrator concludes that Petitioner has failed to prove by a preponderance of the evidence that she sustained a compensable non-traumatically-induced mental disability. The stress from her work environment was not "extraordinary" from an objective standpoint and, when compared to her nonemployment stress, was not the major contributing cause of her mental disorder.

All other issues are moot, and the Arbitrator makes no finding with regard to those issues.

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

David Posadas,

Petitioner,

vs. NO: 14WC 29909

Central Transport,

17IWCC0211

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 15, 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: APR 6 - 2017
o033017
SM/jrc
044

Stephen Mathis

David L. Gore

Deborah Simpson

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

POSADAS, DAVID
Employee/Petitioner

Case# **14WC029909**

CENTRAL TRANSPORT
Employer/Respondent

17IWCC0211

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:

0293 KATZ FRIEDMAN EAGLEET AL
DAVID M BARISH
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602-2983

4407 HINSHAW & CULBERTSON
PETER H CARLSON
222 N LASALLE ST SUITE 300
CHICAGO, IL 60601

D. Posadas v. Central Transport , 14 WC 029909

17IWCC0211

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)

David Posadas
Employee/Petitioner

Case # 14 WC 029909

Central Transport
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 **3-10-16 and 5-13-16**. 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 _____

17IWCC0211

FINDINGS

On the date of accident, **4/1/2014**, 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 **$50,464.96**; the average weekly wage was **$970.48**.

On the date of accident, Petitioner was **37** 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 **$5,954.65** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$5,954.65**.

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

ORDER

Petitioner's claim for medical expenses and TTD is denied, because the Arbitrator finds that there is no causal connection between Petitioner's current condition of ill-being regarding his low back and the accidental injuries sustained on April 1, 2014, as is further explained below.

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 15, 2016

Date

ICArbDec19(b)

AUG 15 2016

FINDINGS OF FACT

Petitioner, David Posadas, was employed by Respondent, Central Transport, as a truck driver/unloader. He was employed by Respondent for four to five months before April 1, 2014. He had been working for a predecessor company, Vitran, with the same people and at the same terminal for over a year. He had worked in the trucking industry for 19 years. Petitioner's job duties included driving a truck, hooking trailers, making deliveries, making pick-ups and unloading freight. He would use a forklift on occasion.

Petitioner testified that he felt "great" when he began working on April 1, 2014. He had a prior back injury in 2009 and missed a week from work. He saw a chiropractor due to a motor vehicle accident. He was having no problems with his back on April 1, 2014.

Petitioner testified that he was injured on April 1, 2014, when the forklift that he was driving was hit by a co-worker driving another forklift. Petitioner felt that he was hit on purpose because he was hit more than one time. He had been hit before by co-workers in the recent past. He continued to work for a while, but he began hurting and he left work early. He spoke to his supervisor and said he was not feeling well. He did not mention anything about forklifts hitting him. On the following day, Petitioner called off of work, as he could not get out of bed. He spoke with Tim and told him about the incident with the forklift. He came to work the next day and was sent to Concentra by Respondent. Petitioner later testified that he was unsure whether the last time he was hit by another forklift was April 1st or April 2nd. He could not identify the co-workers who ran into his forklift. He said that he never saw them again, even when he was doing yard duties.

The records from Concentra document a visit on April 3, 2014 with a claimed date of accident of April 2, 2014. The record indicates "Shock impact on forklift injured lower back." The record describes that Petitioner was driving a forklift and was hit by another forklift. He was diagnosed with a low back strain and given restrictions. The record notes a history of a MVA 5 years before and it is unclear whether the record states that Petitioner was in pain for 5 years or that the incident occurred 5 years prior. Petitioner began a course of physical therapy. He was excused off of work and paid compensation.

Petitioner testified that he was in pain during therapy, but he was released to go back to work when he was seen at Concentra on April 18, 2014. Petitioner was unable to perform full duty work when he returned and was given light duty. He worked light duty from April 22, 2014 through January 27, 2015. He worked partial hours and was paid temporary partial disability benefits. The Parties stipulated that all lost time benefits were paid to Petitioner until Respondent stopped TTD benefits based on Dr. Kornblatt's report.

Petitioner continued to see doctors at Concentra. Petitioner underwent an MRI. The Concentra record for May 7, 2014 states the MRI showed a bulge at L4/5 and a far lateral protrusion at L5/S1 with left lateral canal narrowing and foraminal narrowing. He continued to participate in physical therapy. Concentra referred Petitioner to Dr. Mercier for treatment. Dr. Mercier ordered injections, which did not help much. Concentra next referred Petitioner to Dr. Salehi, for a surgical consultation. Dr. Salehi diagnosed annular tears at L4/5 and L5/S1. Dr. Salehi felt that, based on the MRI, surgery was not needed.

Petitioner followed up with a doctor of his own choosing, Dr. Gerard Cicero, DC, at Chicago Neck & Back Institute. The initial history to Dr. Cicero is not documented. Dr. Cicero ordered additional therapy for Petitioner. He also recommended that Petitioner use a TLSO brace. Dr. Cicero referred Petitioner to Dr. Wilson for an EMG. The history given to Dr. Wilson was that Petitioner had off and on back pain over the years which Petitioner attributed to hitting bumps on a forklift. There was said to be no specific precipitating event to the patient's recent back pain. Dr. Cicero interpreted the EMG result as showing a right L5

radiculopathy. On December 1, 2014, Dr. Cicero charts the history that Dr. Wilson recorded on 11/5/2014 (This is probably sloppy charting by Dr. Cicero {he is reading a large amount of the Dr. Wilson 11/5/2014 chart and later says that Dr. Wilson fails to address whether the condition is work related} but it could also be that Dr. Cicero supports the history given to Wilson). Petitioner received conservative care, was off of work and was paid temporary total disability compensation. On January 20, 2015 Petitioner underwent an epidural steroid injection at L5/S1. (Px. 3)

Petitioner at first admitted giving Dr. Wilson the history of on and off back pain for a long period of time and no specific event and then denied giving that history.

In March of 2015, Respondent set up a §12 evaluation with Dr. Michael Kornblatt. Petitioner gave Dr. Kornblatt a history of his forklift being struck two times (once head on and once on the side). Dr. Kornblatt's diagnosis was that Petitioner at most suffered a self-limiting lumbosacral strain and possible contusion. Dr. Kornblatt felt Petitioner should have been at maximum medical improvement four weeks post injury but stated he would like to review the MRI. Dr. Kornblatt wrote an addendum on October 12, 2015, after reviewing 2 MRI studies and additional records, stating that his opinion did not change. Petitioner was at MMI as of March 2, 2015 and was capable of full duty work. No further treatment was needed. He did not have a surgical lesion. It is noted that Petitioner denied prior back problems when he saw Dr. Kornblatt. (Rx. 7, 8)

Petitioner continued to treat with Dr. Cicero. Petitioner testified that at the time he was seeing Dr. Cicero after the visit to Dr. Kornblatt, he was still in excruciating pain and any movement would bring on pain and that bending forward brought a dramatic increase in his pain. Petitioner had difficulty sleeping and he would have to take more medication. He had a difficult time finding a comfortable position in bed.

Dr. Cicero referred Petitioner to Dr. Slack. Petitioner was first seen by Dr. Slack on April 9, 2015. Petitioner denied any history of prior back problems when he saw Dr. Slack. The history given to Dr. Slack was of a work related injury on April 2, 2014. Petitioner was driving a forklift and the floor was uneven, so he was bounced around in the seat, then he was struck by another fork lift on the side. He was jostled around and felt increased back pain. Dr. Slack felt there had been an aggravation of degenerative disc disease and suggested work conditioning. He also noted the L5 radiculopathy, per the EMG. On July 22, 2015, Dr. Slack charted that there was a symptomatic aggravation of degenerative disc disease and facet disease. He suggested facet blocks to determine the extent of the disease. Perhaps work conditioning would allow Petitioner to return to work. He felt Petitioner remained temporarily totally disabled. (Px. 4, 5)

Dr. Cicero was no longer being paid and released Petitioner from his care, to full duty work, as of May 18, 2015. At trial, Petitioner denied knowing abvout the full duty release, but then admitted that he had applied to various employers as a truck driver. When Petitioner was seen by Dr. Cicero on July 13, 2015, Petitioner reported that he had been exercising and looking for employment because Respondent would not take him back despite the full duty release. (Px. 3, Rx. 3)

Temporary total disability compensation was terminated after Dr. Kornblatt's examination.

Petitioner next went to his primary care doctor, Dr. Ramirez, after he obtained health insurance in September of 2015. Dr. Ramirez referred Petitioner to Dr. Laich, a neurosurgeon. Dr. Laich's initial chart is not contained in his records. A follow-up visit note of December 3, 2015 indicates that Petitioner is being seen post diagnostic studies and a psych evaluation. PTSD was said to be not related. Petitioner related his back symptoms to poor equipment at work and the last straw was "impact on dock." A recent CT study, compared with an MRI, showed mild degenerative changes and stenosis, worse at L3-L4 and secondary at L4-L5. Petitioner underwent

a discogram on February 18, 2016. Petitioner had concordant pain at L3/4. An annular tear was said to have previously been seen at that level. Dr. Laich prescribed surgery and Petitioner testified that he was scheduled for surgery on April 4, 2016. Drs. Ramirez and Laich have authorized Petitioner off of work. Petitioner apparently underwent low back surgery on April 4, 2016. (Px. 7, Px. 10)

Petitioner received psychiatric care from Dr. Ofelia Ionescu, MD. Dr. Ionescu cleared Petitioner for fusion surgery from a psychiatric standpoint. Dr. Ionescu's records show that Petitioner was delusional, hallucinatory and said that his neighborhood had listening devices. Petitioner testified that he had not been treated for PTSD. He did receive psychiatric treatment when he was a kid. Petitioner testified that he is currently receiving psychiatric treatment for "sleep disorder." It is noted that the diagnosis posited by Dr. Ionescu was: Schizophrenia, paranoid type versus Opiate analgesics dependency-abuse producing psychosis. (Rx. 5)

Petitioner testified that he has lived off money saved from his tax refund and that he lives in his brother's home. He has pain with forward bending and what he described as "any normal activities." He testified that cooking, wiping down a counter, or any movement, would bring on a dull pain in his lower back. Petitioner testified that he would love to get back to work.

Dr. Kornblatt and Dr. Slack testified via evidence deposition. Both Dr. Slack and Dr. Kornblatt felt that Petitioner was not a surgical candidate. (Px. 5, Rx. 7)

Respondent submitted video surveillance evidence showing Petitioner walking, walking around Respondent's truck yard, getting in his car, driving and bending forward to move something in his car trunk. Four video discs were entered in evidence, but three discs are duplicative. The surveillance films document activities of 38 minutes (1/12/15-1/17/2015) and 14 minutes (2/6/2015 - 2/8/2015). (Rx. 6)

Petitioner's Bills Exhibit was Px. 9. Petitioner claimed TTD from 1/28/2015 to 5/13/2016.

The matter proceeded as a §19(b)/8(a) proceeding. It was agreed that Petitioner could submit claimed bills from the fusion surgery at a later hearing.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below. The Arbitrator finds that Petitioner's testimony was not entirely credible, as is set forth below.

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between his employment and his injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989) Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

In support of the Arbitrator's decision regarding Issues C, D and E (Accident/Arising Out Of and In the Course Of, Date of Accident and Notice), the Arbitrator finds:

Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on April 1, 2014. The forklift that Petitioner was driving was struck by a forklift driven by a co-worker, causing

Petitioner back pain such that he left work early on 4/1/2014, called off on 4/2/2014 and was referred by Respondent to Concentra for treatment on 4/3/2014. The Arbitrator is persuaded that an accident occurred on 4/1/2014 at work and that Petitioner suffered a back strain/contusion as a result.

Petitioner's testimony and the records of Concentra establish that proper notice, as required by §6 of the Act, was given to Respondent.

In support of the Arbitrator's decision regarding Issue F (Causation), the Arbitrator finds:

Petitioner's current condition of ill-being regarding his low back is not causally related to the injury of April 1, 2014. The Arbitrator finds Dr. Kornblatt's opinion that Petitioner suffered a resolved lumbosacral strain and contusion as a result of the accident to be persuasive and most consistent with the evidence adduced. Dr. Slack's opinion is not persuasive, especially because Petitioner denied prior back problems to Dr. Slack and the history of onset was related to forklift driving on bumpy surfaces and a collision that was the last straw.

Given Petitioner's inconsistent testimony regarding the accident, the date of the accident, the inconsistent histories given to the various providers and the records of Dr. Ionescu, the Arbitrator cannot find in Petitioner's favor on the issue of causal connection beyond the condition diagnosed by Dr. Kornblatt.

In support of the Arbitrator's decision regarding Issues J (Medical Expenses) and L (TTD) the Arbitrator finds:

Based upon the Arbitrator's finding regarding Issue F (Causation) above, Petitioner's claim for medical expenses incurred after March 2, 2015 is denied.

Petitioner's Bills Exhibit was Px. 9.

Dr. Cicero's bill for services rendered after 3/2/2015 is denied.

Dr. Ramirez's bill is denied because the claimed bills are for 11/23/13 ($200.00), 3/2/2014 ($121.57) (incurred before the date of accident) and 6/26/2014 ($106.00) (cough for 1 month, asthma and chronic persistent cough, obviously not related to a back injury).

The bills from Dr. Slack, Dr. Laich and MRI Lincoln are denied based upon the Arbitrator's finding on causation and the opinion of Dr. Kornblatt that Petitioner was at MMI as of 3/2/2015.

As to the issue of TTD, the Arbitrator finds that Petitioner is entitled to TTD benefits through the time that Respondent terminated benefits based upon Dr. Kornblat's report. The Arbitrator's understanding is that all owed TTD and TPD benefits through the date that Respondent stopped paying have been paid. Petitioner sought TTD from the date of termination of benefits through the date of trail. The claim for further TTD is denied based upon the Arbitrator's finding regarding causation above and the persuasive opinions of Dr. Kornblatt.

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

Stephen Chestnut,

Petitioner,

vs.

NO. 14WC 31223

17IWCC0242

Watco Companies, LLC,

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 accident, medical expenses, causal connection, prospective medical care, 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.

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: APR 19 2017
SJM/sj
o-4/6/2017
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

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

CHESTNUT, STEPHEN
Employee/Petitioner

Case# 14WC031223

17IWCC0242

WATCO COMPANIES LLC
Employer/Respondent

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:

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

2904 HENNESSY & ROACH PC
MICHAEL J HOLT
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

17IWCC0242

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)

Stephen Chestnut
Employee/Petitioner

v.

Watco Companies, LLC
Employer/Respondent

Case # **14 WC 31223**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Collinsville** on **August 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. ☒ 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 _____

17IWCC0242

FINDINGS

On the date of accident, **6/10/2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$44,721.21**; the average weekly wage was **$972.20**.

On the date of accident, Petitioner was **56** years of age, *married* with **0** dependent children.

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

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

Respondent is entitled to a credit of **$1,364.90** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $1,905.00, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $1,364.90 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.
Respondent shall pay reasonable and necessary medical services of $1,905.00, as set forth in Petitioner's exhibit 6, as provided under Sections 8(a) and 8.2 of the Act. Respondent is due an 8(j) credit of $1,364.90.

Respondent shall authorize and pay for the treatment recommended by Dr. Rogalsky, including but not limited to surgery.

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

5/10/16
Date

ICArbDec19(b)

MAY 13 2016

FINDINGS OF FACT

On June 10, 2014 Petitioner was employed by respondent as a maintenance mechanic. The parties agree that an incident occurred on that date, the dispute concerns whether Petitioner sustained accidental injuries as a result of the incident and whether the current condition of ill-being is related to the accident.

On June 10, 2014, Petitioner was called to repair a welding lead for an air arc welder. A welding lead is a long cable with a diameter approximately the size of a quarter. Petitioner testified he stripped the cable lead and was utilizing an Allen wrench to try to tighten the "ball-points" onto the cable. With his right hand he used a ½ inch Allen wrench which was about six to seven inches long to tighten the set screw into the cable. With his left hand he was holding the cable to keep it from spinning around when he was applying the significant pressure necessary with the Allen wrench. Petitioner testified that his left arm was sitting on the side seal of the railcar. As he was trying to tighten the set screw, a co-worker threw a large piece of metal tie down track from the third deck of the rail car into a metal scrap box situated near Petitioner. When the metal hit the scrap box it made a sound like an explosion and bounced out of the scrap box towards Petitioner. Petitioner testified that he was startled and his left arm slid off of the side seal and hit the deck of the car, about ten inches below the side seal. Petitioner indicated the metal did not strike him directly on the shoulder. Petitioner stated he did not feel any sudden pain but knew something was not right with his left arm. He felt some tingling in the arm and figured it would become better. He filled out a "precautionary" reportof the accident. On the report, he responded to the question "why did the incident occur" by writing "reaction." He described the injury/illness as "left shoulder and neck." (PX 5)

Two of Petitioner's co-workers, Shane Tinnon and Dane Ruyle testified at the hearing. Both witnesses confirmed that a piece of metal approximately 5 feet long was thrown from the third deck of the railcar on which Petitioner was leaning. The third deck was approximately 15 – 20 feet above the floor.

Mr. Tinnon indicated that when the piece of tie-down track was thrown, it landed in the box but jumped out and hit the ground. It startled Petitioner. He walked over to Petitioner and asked if he was O.K. Mr. Tinnon testified that the railcar depicted in the photographs which were admitted into evidence is similar to the one involved on the accident date. (RX 2) The photographs show a similar depiction, but not the exact scene as it looked on the accident date.

Dane Ruyle confirmed that Petitioner was leaning into the railcar fixing the air arc lead at the time the metal was thrown into the scrap box. He testified that at the time of the incident he was on his hands and knees leaning over the side of the railcar watching Petitioner do the repair. Mr. Ruyle stated it was not his air arc lead that was being repaired and he was not doing any work at that point, just watching. When asked whether his work on the car was done at that time, Mr. Ruyle said "[y]es, all the track was cut up off the car." He later testified that he had more steel to throw off the car, but he hadn't done that yet. He also indicated it was not his break time and that he wasn't doing his job at the time. Mr. Ruyle indicated he did not see Petitioner jump or anything. When asked why he did not see Petitioner jump, He responded "maybe I was looking away because apparently there was an argument and I missed that too". He did not talk to Petitioner or have occasion to observe him for the rest of the day.

Petitioner was treated by Dr. Rogalsky, a Board Certified Orthopedic Surgeon. Petitioner presented with tingling and stiffness in left shoulder. Dr. Rogalsky noted a history of injuring his left shoulder when "[p]atient was leaning on his left elbow on a machine and cranking hard with his right hand on a cable and something slipped off and a piece of metal fell from above onto the ground behind the patient and then as it tilted over, struck the posterior aspect of his **right** shoulder. At impact, the patient's left elbow slipped off the object he was leaning on and struck a solid surface causing pain in the elbow and radiating up and into the shoulder at impact." (PX 1 at 1). Petitioner had no prior problems with the left shoulder. An MRI of the left shoulder revealed a supraspinatus advanced tendinosis with full-thickness tearing of the anterior and mid fibers measuring 1.8 x 1.5 cm with tendon retraction to the mid humeral head. (PX 3 at 1). Dr. Rogalsky indicated the MRI findings were consistent with the clinical picture and a diagnosis of left post traumatic rotator cuff tear. (PX 1 at 3). Petitioner was scheduled for left shoulder decompression and rotator cuff repair. (PX 4 at 7). On August 29, 2014, Dr. Rogalsky noted Petitioner was still awaiting surgical approval through Workers' Compensation, and in the interim was placed on Tramadol for pain. (PX 1 at 5). Petitioner was returned to work on September 12, 2014 with no restrictions pending surgery. Dr. Rogalsky recommended surgery to the left shoulder and Petitioner desires to have that surgery. Dr. Rogalsky testified the rotator cuff tear was caused by the incident Petitioner cited in the history. (PX 4 at 9). Dr. Rogalsky further testified that the lesion depicted on the MRI appears to be acute and it is not a thin degenerative rotator cuff that is torn but rather full-thickness normal appearing rotator cuff that has been traumatized and pulled apart. (PX 4 at 17).

Dr. Li performed a records review at Respondent's request. Dr. Li indicated that it was his understanding that Petitioner was working at ground level and had his left arm on something; there was a piece of metal thrown off and bounced off making a sound. It was not clear whether the object struck Petitioner in the shoulder or not. Petitioner jerked his left arm and then hit his elbow against something. He was not seen hitting his elbow but was seen jerking his arm. Dr. Li testified the left shoulder MRI showed a small to moderate size full thickness rotator cuff tear. It was his opinion that it was a chronic tear which predated the accident. Dr. Li agreed that Petitioner was a candidate for arthroscopic surgery to the shoulder.

CONCLUSIONS

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

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

Petitioner was repairing a welding lead when a loud piece of metal crashed behind him causing him to jam his left arm into the railcar. Petitioner's testimony was corroborated by the testimony of Respondent's witness, Shane Tinnon, with regard to the location of Petitioner and the positioning of his left arm on the side seal of the railcar. The Arbitrator found Petitioner to be a credible witness.

Dr. Rogalsky testified the rotator cuff tear was caused by the incident Petitioner cited in the history. Dr. Rogalsky further testified that the lesion depicted on the MRI was an acute full-thickness tear. Dr. Li testified the left shoulder MRI showed a small to moderate size full thickness rotator cuff tear. It was his opinion that it was a chronic tear which predated the accident. Dr. Li testified Petitioner could not tear anything just by jerking his arm. However, the Arbitrator finds that Petitioner did, indeed, strike his left arm on the railcar and not

simply jerk his arm. Further, the Arbitrator finds the testimony and opinions of Dr. Rogalsky more persuasive than those of Dr. Li in this case.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that sustained an accidental injury which arose out of and in the course of his employment with Respondent and that his current condition of ill-being is 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?

Issue (K): Is Petitioner entitled to any prospective medical care?

Dr. Li took no issue with the medical treatment provided to Petitioner thus far, and further agreed Petitioner was a candidate for arthroscopic surgery to the shoulder. Based upon the foregoing and the record taken as a whole, as well as the Arbitrator's findings with regard to issues C & F, Respondent shall pay reasonable and necessary medical services of $1,905.00, as set forth in Petitioner's exhibit 6, as provided under Sections 8(a) and 8.2 of the Act. Respondent is due an 8(j) credit of $1,364.90. Further, Respondent shall authorize and pay for the treatment recommended by Dr. Rogalsky to repair Petitioner's left shoulder condition.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Timothy Tomaszewski,
Petitioner,

vs.

NO: 14 WC 33043

17IWCC0257

Chicago Office Technologies,
Respondent.

DECISION AND OPINION ON REVIEW

Respondent appeals the decision of Arbitrator Flores finding that Petitioner sustained an accidental injury arising out of and in the course of his employment on June 27, 2014. As a result, Petitioner was temporarily totally disabled from June 27, 2014 through February 17, 2016 for 85-6/7 weeks and Respondent is to authorize and pay for the second post-operative epidural steroid injection to the low back prescribed by Dr. Salehi. The Issues on Review are whether Petitioner sustained an accidental injury arising out of and in the course of his employment on June 27, 2014, whether a causal relationship exists between the alleged June 27, 2014 work accident and Petitioner's current condition of ill-being, and if so, the extent of temporary total disability and whether Petitioner is entitled to future medical treatment. The Commission, after reviewing the record, reverses the Arbitrator and finds Petitioner failed to prove he sustained an accidental injury arising out of and in the course of his employment on June 27, 2014 for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner, a 52 year old outside sales representative, testified that he is an outside sales representative for a company that sells technology, copiers and computer software solutions. His job was to make cold calls. He had a quota to fill. Cold calling was done in one of two ways. First, it is done by sitting in an office and telephoning prospective clients all day, and second, it is performed by knocking on doors and meeting people. He was assigned to a geographic sales territory. He was relatively new to the job and as of June 27, 2014, he had been there only a couple of months. He was initially placed in a training program for a period of six weeks. Petitioner testified that the amount of time he spent in the office working versus being out in the field working varied. He would estimate that he spent approximately 2-3 days in the office making calls and the rest of the time he was out in the field. On the days he was in the field, he would not have a reason to go into the office. He would plot out his day, and he would leave directly from his house on the northwest side of Chicago to perform the sales call. His assigned territory was in the cities of Wheaton, Lombard, Oak Brook Terrace and part of Villa Park. The office he worked out was in a huge office complex that was located in Itasca.

2. Petitioner testified that on June 27, 2014 he was leaving his house and was going to meet a customer at Schweppee on North Avenue when he realized he did not have any business cards. On the way to the scheduled appointment, he decided to stop at the office in Itasca, run in and pick up some business cards and then go to his territory. He had not planned on going to the office in Itasca that day. He was going to canvas his territory after his appointment with Schweppee. He had parked his car and was walking toward the office when he tripped over a curb that he did not see. He felt that the curb was not really well marked. Half of the curb was in the shade and the curb was not painted yellow. He fell over the curb. After he fell, he landed on his right side. He hit his head. His main injures were to his right shoulder and low back along with experiencing some symptoms which were radiating down his legs.

3. Richard Rosalia testified he was a sales director for Respondent at the time of the alleged accident and he is now a sales executive for Respondent. As a sales director, he managed a team of approximately seven sales associates. He testified Petitioner was one of those seven sales associates. Petitioner had been assigned to his team for two months at the time of the alleged accident. Mr. Rosalia testified a sales associate is responsible for managing existing accounts and for attempting to find new accounts. The sales associates attempt to find new account by both making telephone calls and/or emailing potential clients and by going door to door to potential clients. The sales associates are assigned specific territories. On a typical day, the sales associate would come into the office in the morning and work on whatever (s)he had planned for the day. They would make cold calls and send emails to prospective clients, organize their work and keeping on top of the list of existing accounts. Then they would have two to three appointments scheduled throughout the day where they visited current accounts or met someone for the first time. Following that, the sales associates would typically finished the day in the office wrapping up the day's activities. The expectation was that they would come into the

office in Itasca at the beginning of the day before they would go out to their face to face calls. There would be some days that the sales associates would be in the office all day. Occasionally, but not often, the sales associates would not come into the office at all and they would be in the field all day. This activity is more of the exception than the rule.

4. Mr. Rosalia testified that while he does not have a specific recollection of the date, the team calendar indicated that on June 27, 2014 there was a mandatory telephone prospective blitz scheduled from 9 a.m. to 11 a.m. Since it was mandatory, it was up to the manager of the team to excuse someone from this event. Mr. Rosalia testified he does not recall excusing Petitioner on June 27, 2014 from the telephone blitz. He testified Petitioner would not have been restricted from going to Schweppes so long as they did not have anything scheduled. Two years after the fact, he does not have a specific recollection if Petitioner had a conversation with him about not coming into the office because he was following up with Schweppe and also performing other sales calls. He also does not recall if he had to discipline Petitioner for missing any tele-prospecting phone blitzes. Mr. Rosalia testified the telephone blitzes were typically once a week, and it would be unusual for someone to miss a blitz. The blitzes were standing appointments on the calendar and they would typically be placed on the calendar at least a week in advance. Mr. Rosalia testified it would especially be unusual for someone new and right out of training to miss a blitz. He agreed normal sales procedure would to be to go out in the field with one's business cards.

5. Ellen David testified she is the vice president of the human rights program for the Respondent. She testified Petitioner was one of thirty five sales people in the Itasca office. Petitioner would have been working as a sales representative for about a month after his sales training ended. At that time the training period was six weeks long. She said when they recruit potential sales employees, they are very specific about the fact that the sales role requires the sales associated to be at the office on a daily basis from 8 a.m. to 5 p.m.

6. Ellen David testified Respondent does not own the building or the parking garage. There are other companies in the 14 story building. Respondent's office is located on two floors. Ms. David testified it is not part of their agreement to maintain the parking garage. A few of the employees have a specifically assigned parking space, but in general it is a big, multi-level parking garage. Ms. David said the vice president of the office and the sales directors schedule the day-to-day workings of the sales people. She agreed the "drive-bys" conducted by the sales staff would require them to be away from the office. She is not aware of Petitioner being disciplined for missing any mandatory meetings.

7. Petitioner was called as rebuttal witness. He stated he felt that the tele prospecting blitzes were not mandatory. He testified if a sales associate did not have anything going on in the field or they were not out cold calling or going out to meet with clients, then they would come into the office to do the telephone blitz. Petitioner testified prior to June 27, 2014

he had missed a telephone blitz. He did not ask permission to miss telephone blitzes, and he had not been reprimanded for or been told they were mandatory. From general office talk, he was aware of other members of his team missing telephone blitzes. Petitioner said it was a common occurrence. Petitioner said in the month of June 2014 there were four to five telephone blitzes, and he only attended the first one. He testified they would find out about the blitz from Rich or through the calendar. Petitioner said he was never told the telephone blitzes were mandatory.

8. The June 27, 2014 Addison Fire Protection Medic Report was placed into evidence. It indicated Petitioner, a 52 year old male, fell. Specifically, Petitioner stated he was running late to work so he was in a hurry while walking in the parking garage from his car. He further stated he tripped over a curb and fell onto his right side. It was noted Petitioner was complaining of pain in his right shoulder, elbow, hip and leg. He denied neck or back pain.

9. Petitioner was taken to Alexian Brothers Medical Center via the Addison Fire Department. At Alexian, Petitioner provided a history of tripping and falling over curb while walking into work. A lumbar CT was performed evidencing no acute fracture or subluxation and degenerative changes in lower lumbar spine. The cervical CT evidenced no fracture or subluxation. The head CT evidenced no intracranial hemorrhage and the right shoulder x-rays was normal with no evidence of a fracture or dislocation. Petitioner was diagnosed with a contusion of right shoulder and lumbar radiculopathy.

10. On July 21, 2014, Petitioner was seen by Dr. Callangan at the Occupational Health Services. At that time, Petitioner provided a history while walking in the parking lot at work at about 0800, he tripped on a curb and fell on his right side and on his right shoulder, and he also hit his head. Petitioner reported he had a lot of right shoulder pain with limited motions and also had a lot of pain in his low back with radiculopathy on the right leg down the big toe. Dr. Callangan diagnosed Petitioner with low back pain/lumbago, thoracic/lumbar radiculitis, neuritis, shoulder pain, multiple contusions of the head, right shoulder, right side of his back, a rotator cuff syndrome, a strain of the lower and upper back and a neck strain. Petitioner was instructed to see an orthopedic doctor for a further evaluation and management of his right shoulder. Petitioner indicated he wanted to see Dr. Koh, a spine specialist, for a further evaluation and management of his condition. Petitioner also wanted to see Dr. Salehi.

11. The July 9, 2014 Lumbar MRI showed a prior left hemilaminectomy at L5, significant right lateral recess stenosis at L5-S1. There was also a far lateral herniated disc at L5-S1 causing significant foraminal stenosis. The radiologist opined that lateral recess stenosis at L5-S1 is due to facet and ligamentous hypertrophy.

12. On July 17, 2014, Petitioner followed up with Dr. Callangan who noted that Petitioner's primary complaint is severe low back pain. Petitioner reported he had seen Dr. Salehi, a

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neurosurgeon, for his low back and other problems, and he was following up with Dr. Jason, an orthopedic surgeon, for his right shoulder. Lastly, he was receiving physical therapy for his shoulder from Dr. Koh. Dr. Callangan told Petitioner there was no reason to follow up with him. He was instructed to continue to use the over-the-counter medication; he was to remain off work until July 21, 2014, and he was discharged from their care with instructed to return as-needed.

13. On September 3, 2014, the physical therapist indicated Petitioner presented with a right shoulder sprain and possible internal derangement. Petitioner reported a decrease in pain after some scapular repositioning and GH joint mobilization. The therapist opined Petitioner has progressed very well with his shoulder and he was no longer in need of physical therapy for his shoulder.

14. On October 22, 2014, Petitioner was evaluated by Dr. Ross. Dr. Ross opined based on Petitioner's history and his medical records, Petitioner's work accident caused his asymptomatic pre-existing condition to become symptomatic. He further agreed with Dr. Salehi that Petitioner is a candidate for right L4-5 and L5-S1 lumbar hemilaminotomies, foraminotomies and possible diskectomies.

15. On November 22, 2014, Dr. Salehi performed lumbar surgery consisting of a right inferior L4 to superior S1 hemilaminectomy and decompression of lateral recess, foraminotmy of right L5-S1 from a medial approach and a far lateral discectomy and decompression of the foramen at L5-S1.

16. On February 5, 2015, Petitioner underwent a second lumbar MRI which evidenced moderate to significant foraminal stenosis on the right side of L5-S. There was no recurrent herniation and only moderate central stenosis at L3-4 and L4-5.

17. On March 10, 2015, Petitioner followed up with Dr. Salehi who noted Petitioner reported he continues to have constant pain in the right side of his lower back that radiates down his right leg. Dr. Salehi indicated Petitioner would like to proceed with the lumbar fusion surgery.

18. On August 19, 2015, Petitioner received a termination letter from Respondent.

19. On April 7, 2016, Petitioner followed up with Dr. Salehi who stated Petitioner has noted some recent improvement in his radicular symptoms, and given the improvement he states he is no longer interested in pursuing lumbar decompression and fusion surgery. Hence, our office will continue to give it more time as well. We would recommend that Petitioner undergo an epidural injection and check back in four weeks.

20. On May 14, 2016, Dr. Salehi noted Petitioner underwent an injection and states it helped with about 50% of his right leg pain. He recommended Petitioner follow up in four weeks

for a re-evaluation. If symptoms worsen, they would again discuss a spinal cord stimulator. Lastly, Dr. Salehi indicated that for now Petitioner can work light duty.

21. On June 18, 2016, Petitioner followed up with Dr. Salehi who indicated Petitioner has had good, but temporary relief following his epidural injection. He was advised to proceed with a second injection and to recheck in four weeks. Dr. Salehi said if Petitioner continues to remain symptomatic, he will again discuss a spinal cord stimulator, but for now Petitioner can work light duty so long as he is driven to and from work.

After reviewing the entire record, the Commission reverses the Arbitrator and finds Petitioner failed to prove he sustained an accident that arose out of and in the course of his employment on June 27, 2014. More specifically, the Commission finds Petitioner was not a traveling employee at time of accident. The Commission further finds Petitioner was not exposed to a risk of injury to a greater degree than a member of the general public.

The Commission notes the Petitioner put forth alternative theories: 1) Petitioner was a traveling employee at the time of the alleged accident and 2) Petitioner sustained an injury while in a parking lot on his way into work. The Commission further notes while the Arbitrator acknowledged both theories of the case and the Arbitrator found the facts support the theory Petitioner sustained an injury while in a parking lot on his way to work, the Arbitrator presented the Commission with mixed language contained in both a traveling employee analysis and a parking lot analysis. Specifically, the Arbitrator used both the foreseeable language contained in a traveling employee theory along with the use of the word defective which is often seen in parking lot cases. As such, the Commission believes each theory must be addressed independently of the other theory.

In reviewing the traveling employee analysis in relationship to the evidence, the Commission finds that Petitioner was not a traveling employee at the time of the alleged June 27, 2014 work accident. In so holding, the Commission notes the similarities to the recent case of *Allenbaugh v. IWCC and City of Peoria Police Department*, 58 N.E.3d 872 (2016) where the claimant was not found to be traveling employee at the time he stopped to get equipment for a scheduled mandatory training class outside of his usual hours of duty. While there are some factually distinctions between the two cases, there are significantly greater factual parities between *Allenbaugh* and the case at bar. In the *Allenbaugh*, Id., the Appellate Court held the traveling employee doctrine did not apply when claimant was simply driving his personal vehicle to his normal workplace. With the exception of Petitioner's profession differing from that of Mr. Allenbaugh and the fact that he was driving to work inside his usual hours of employment as opposed to abnormal hours, the two factual scenarios appear to be consistent with one another in that both employees were commuting to their office in their own vehicles and from their personal residences in order to obtain the required tools of their trade at the time of the event. They were also on the way to attending their mandatory work activities. Arguably, even if

Petitioner were collecting his business cards, he had detoured from his ultimate route and had not yet taken on the mantel of a traveling employee. The Commission believes only after Petitioner had completed the detour of collecting his business cards and had gotten back on the road toward his scheduled appointment and/or cold calls would he be deemed a traveling employee. However, this is not the case here. The incident in question occurred prior to that point in time.

The Commission notes the event occurred in a parking garage. The evidence shows the parking garage is attached to a fourteen story office building in Itasca. Additionally, Respondent's company rents out two of the floors as a tenant in the building. Ms. David testified Respondent does not own the building or the parking garage. Nor is there anything in Respondent's lease that requires it to maintain the parking garage. While a few of the officers of Respondent's company have assigned parking spaces, it is otherwise a large, multilevel parking garage with no assigned parking. As such, the Commission finds that the parking garage was not controlled by the Respondent. While the Arbitrator indicated that Respondent's employees parked in that parking lot only, there is no evidence the employees were instructed to limit their parking to that lot. Given the totality of the evidence, the Commission finds the parking lot exception does not apply in the case.

The Commission has also reviewed whether or not Petitioner was injured at a place where he was required to be in the performance of his duties and whether Petitioner was exposed to a risk common to the general public to a greater degree than the general public. Arguably, whether Petitioner was in the parking lot because he was going into work to participate in a telephone blitz or was going into the office to retrieve business cards, the Commission could say Petitioner was in a place where he was required to be in the performance of his job. He also was exposed to a risk that was common to the general public in that there are often curbs located in parking garages. Thus, the question is whether Petitioner was subjected to a risk common to the general public to a greater degree than the general public. To answer that query, the Commission turns to Petitioner's own words. Petitioner, an employee of only a couple of months, told the EMT that he was "running late to work so he was in a hurry while walking in the parking garage from his car". The Commission finds Petitioner's own words appear to show his behavior was of a more personal nature stemming from the fact that as a new hire he did not want to be disciplined or fired for being late to work rather than advancing one of his work duties on behalf of his employer.

Based on the above, the Commission reverses the Arbitrator and finds Petitioner failed to prove his injuries arose out of and in the course of his employment on June 27, 2014.

17IWCC0257

IT IS THEREFORE ORDERED BY THE COMMISSION since Petitioner failed to prove he sustained an accidental injury arising out of and in the course of his employment on June 27, 2014, his claim for compensation is hereby denied.

LEC/jm

APR 24 2017

O: 2/23/17

Stephen J. Mathis
Stephen Mathis

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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
L. Elizabeth Coppoletti

DISSENT

I respectfully dissent from the majority decision and would affirm the Arbitrator's well-reasoned decision in its entirety.

David L. Gore
David L. Gore

17IWCC0215

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

Audra Shaw,

Petitioner,

vs. NO: 14WC 35468

Mitchellsville Country Store,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 16, 2015 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.

17IWCC0215

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: APR 7 - 2017
o040417
CJD/rlc
049

Charles J. DeVriendt

Elizabeth Coppoletti

Joshua D. Luskin

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

SHAW, AUDRA
Employee/Petitioner

Case# **14WC035468**

MITCHELLSVILLE COUNTRY STORE
Employer/Respondent

17IWCC0215

On 11/16/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.34% 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:

5236 CULLEY FEIST KUPPART ET AL
KREIG B TAYLOR
3 S MAIN ST SUITE 2
HARRISBURG, IL 62946

1962 BLEYER & BLEYER
JOSEPH BELYER
PO BOX 487
MARION, IL 62959-0487

17IWCC0215

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)

Audra Shaw
Employee/Petitioner

v.

Mitchellsville Country Store
Employer/Respondent

Case # 14 WC 35468

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 **September 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 ___

17IWCC0215

FINDINGS

On the date of accident, **July 18, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did 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 $--; the average weekly wage was $**233.16**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **2** dependent children.

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

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

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

ORDER

Petitioner failed to prove she sustained an accident on July 18, 2014 that arose out of and in the course of her employment with Respondent or that her current condition of ill-being in her low back is causally connected to her accident. Petitioner's claim for compensation is denied and no benefits or penalties and attorney's fees are awarded.

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

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

Signature of Arbitrator

November 6, 2015
Date

ICArbDec19(b)

NOV 16 2015

Audra Shaw v Mitchellsville Country Store, 14-WC-035468 (19(b))

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

The medical records of Community Health and Emergency Services indicate that on July 18, 2014, Petitioner appeared for a previously scheduled medical appointment. Her medical records indicate that she was there for a recheck of her weight. Petitioner was also asking to have her pain medications refilled and asking for some kind of pain shot as she had fallen at work and injured her right hip. On exam Petitioner had tenderness in her lumbar spine and moderate pain with range of motion. Petitioner's diagnoses included hypertension, obesity, lumbago, and tobacco abuse. With regard to her lumbago Petitioner was encouraged to lose weight for health reasons and schedule a follow up visit. Petitioner was prescribed Norco for pain. She had also been prescribed Norco on June 13, 2014. (PX 1)

On August 21, 2014, Petitioner returned to Community Health and Emergency Services regarding a knot on her left hand. Petitioner reported that she had injured her hand at work approximately four weeks earlier when an object fell on her hand and the knot had since developed. In the Section marked "Review of Systems" a notation of back pain was made. On exam, Petitioner was noted to have muscle spasms and moderate pain with motion of her lumbar spine. An x-ray of the left hand was taken which was negative. Petitioner was advised to rotate heat and ice to her low back and to schedule a follow-up visit with PA-C Bebout if she noticed no improvement in four weeks. Petitioner was again given a prescription for Norco with no more refills to be given without an appointment. (PX 1; PX 2)

Petitioner next presented to Katie Jackson (PA-C) at Ferrell Hospital Family Practice on September 5, 2014. Petitioner presented to establish herself as a new patient with Dr. Oldham. She gave a history of "having a flare-up of her back pain issues" and she had been off of her Norco for a while because Dr. Peterson had passed away and she was seeing a new provider at Community Health and Emergency Services; the new doctor would not give her the prescription for Norco. Petitioner complained of pain in her right sciatic area going all the way from her right hip down to her ankle. She mentioned her previous back surgery. Petitioner also indicated she had been doing a lot of lifting at work where she was a cook and it had been flared-up for about five weeks. On exam Petitioner displayed a slow gait "because of pain" and she preferred to stand because of increased pain associated with sitting. Petitioner was very fidgety and couldn't get comfortable as she favored her left side. Petitioner had positive straight leg raising on the right side. Her strength could not be assessed due to pain. PA-C Jackson indicated that Petitioner had right sciatica and she was given a prescription for Norco and also asked to

return to the Clinic to see Dr. Oldham. Petitioner was also given a shot of Decadron, Nubain, and Phenergan along with a five day course of Prednisone. Physical therapy and further imaging were discussed but not ordered. (PX 3)

Petitioner returned to PA-C Jackson on September 11, 2014 with complaints of low back pain that still bothered her. Petitioner reported improvement in her pain with the Decadron shot for about three days and that she was able to go back to work but she suffered a flare-up when her boss made her lift sixty pound items. Ms. Jackson noted new complaints of right lower extremity weakness and radiation. On exam Petitioner had positive straight leg raising on the right and tenderness to palpation. Petitioner also reported memory-related problems noting she couldn't remember her children's names at time. Petitioner's history included a couple of brain aneurysms and two CVAs and surgery in 2011 for an aneurysm. Petitioner was diagnosed with "chronic low back pain." She was given a note restricting her from lifting over ten pounds. PA-C Jackson realized that the restriction might cause Petitioner to lose her job but felt Petitioner probably qualified for disability. PA-C Jackson noted, "She states she has tried to apply for this before and I told her that she could be a [W]almart greeter so she went ahead and went back to work but with her aneurysm and her inability to perform the job that she has because of her back, I don't think that she needs to be this lifting and I think she would qualify for disability" A new MRI was ordered. (PX 3)

Petitioner underwent a CT of her lumbar spine on September 25, 2014. It revealed her prior fusion at L5-S1 with intervertebral cages and total laminectomy with osteophyte formation on the left resulting in L5 nerve root compression, a widely patent right foramen, a left lateral disc herniation at L4-5 with left L4 nerve root compression and left L5 compression within the lateral recess, and a mild annular disc bulge at L2-3 resulting in bilateral foraminal encroachment. (PX 4)

Petitioner next returned to PA Jackson on September 27, 2014, for the PA to review with her the CT scan of her lumbar spine. Petitioner complained of increased back pain when lifting. The CT of the lumbar spine showed the prior fusion at L5-S1 with intervertebral cages and total laminectomy with osteophyte formation resulting in L5 nerve root compression. There was also a left lateral disc herniation at L4-5 resulting in significant L4 and L5 nerve root compression and a mild annular disc bulge at L2-3 resulting in bilateral foraminal encroachment. Petitioner was diagnosed with a left L4-5 herniated disc and referred to Dr. Fleming or Jones (neurosurgeons) as soon as possible. (PX 3)

Petitioner signed her Application for Adjustment of Claim herein on October 2, 2014 alleging a back injury when she fell in a cooler on July 18, 2014. (AX 2)

Petitioner returned to see PA-C Jackson on October 21, 2014. At that visit she requested a refill on her weight loss medication. She also needed a refill on her Norco for her back pain and reported she was seeing a neurosurgeon that day. (PX 5)

On October 21, 2014, Petitioner was seen by Michael Bryant, PAC of Brain & Spine Institute. Petitioner gave a history to a doctor of an incident at work when she was going to a cooler to get frozen chicken and she tripped over soda bottles. She reported immediate right leg pain with the fall and a feeling of giving away in her knee. PA-C Bryant's assessment was lumbar radiculopathy, a herniated disc, and lumbar spondylosis. He recommended further imaging studies. (PX 6)

A lumbar myelogram was performed on November 7, 2014. It revealed a large L4-5 right paracentral disc protrusion causing moderate to severe right and mild left neural foraminal narrowing. The prior surgery was also noted with no evidence of surgical complications. (PX 6)

On November 18, 2014 Petitioner met with PA-C Jackson regarding a recent hospital visit she had had for cardio issues. She also requested, and received, a Norco refill. (PX 5)

The myelogram was reviewed by Dr. Fleming and PA-C Bryant on November 18, 2014 and they agreed an appointment should be set up with Petitioner to discuss surgical options. (PX 6)

After being seen by PAC Michael Bryant, Petitioner was seen by Dr. Mark Fleming on December 1, 2014, with back pain complaints. Petitioner provided Dr. Fleming with a history of tripping and falling at work in mid-July. She also noted to Dr. Fleming that she had undergone the prior L5-S1 interbody fusion with Ray cages in 1999. Dr. Fleming was of the opinion the CT findings of a disc rupture at L4-5 would be "appropriate" for her injury and symptoms as she "clearly" has a large disc rupture consistent with her complaints and an acutre disc rupture would be a pathology most consistent with the type of precipitating event/injury she described. He recommended a fusion noting "I feel her described injury at work in July 2014 is very consistent with and most likely to be the direct cause of this disc rupture." (PX 6)

Petitioner continued to treat with PA-C Jackson and on December 19, 2014, she saw PA-C Jackson for a medication refill of her Norco for chronic back pain. Petitioner reported her right leg was hurting and her leg was giving out and that a neurosurgeon was planning on performing a fusion procedure but she needed cardio clearance first and that appointment was pending for January 6, 2015. Petitioner's Norco was refilled. (PX 5) I

Petitioner returned to PA-C Jackson on January 17, 2015, again for a refill of Norco for her chronic back pain. Petitioner reported that the Norco wasn't controlling her pain anymore and she wanted to add an additional tramadol. She also desired some Nitro for angina episodes and didn't want to go to the ER. Petitioner's Norco was refilled and she appeared stable on her current dose. She was further advised that she can take up to two Tramadol at a time. (PX 5)

Petitioner returned to PA-C Jackson on March 17, 2015 for a flare-up of her chronic back pain. Petitioner gave a history of it going back two weeks. Petitioner reported that she was using a chair to get around Walmart and she hurt from her lumbar area down her right leg to her ankle. According to Petitioner a neurosurgeon was planning on performing a lumbar fusion but Petitioner needed workers' compensation to approve it. Petitioner again reported difficulty exercising due to her back. Petitioner was given an injection and prednisone prescription. She was also given a refill for Norco. (PX 5)

Petitioner returned to PA-C Jackson on April 18, 2015, and the purpose of the visit was for her weight management and also for a shot for her back pain. The shot was declined because she didn't have a driver. (PX 5)

Petitioner returned to PA-C Jackson on April 20, 2015 requesting a shot for her back pain. She expressed having wanted one on Saturday when seen but she didn't have a driver with her. The shot was given and she was told to continue with her home pain medications. (PX 5)

Petitioner again saw PA-C Jackson on April 22, 2015 regarding her ears, insomnia, and weight management. Petitioner's request for a pain shot for her back was again declined because she didn't have a driver. (PX 3)

PA-C Jackson re-examined Petitioner on May 5, 2015 regarding medication refills and the need for a mammogram order. Petitioner's prescription for Norco due to lumbar pain was refilled. (PX 5)

Petitioner returned to PA-C Jackson on May 7, 2015, for a follow-up regarding insomnia with no mention of back pain or back difficulties. (PX 5)

Petitioner returned to PA-C Jackson on May 12, 2015, for a visit for a skin infection in the left groin area. (PX 5)

Petitioner returned to see PA Andrew Hosman on June 12, 2015, for a tick bite.

Musculoskeletally, Petitioner displayed full range of motion and her strength was 5/5 throughout. (PX 5)

Petitioner returned to see PA Casey L. Carlile, NP on June 29, 2015, for bilateral ear pain. Petitioner's gait was unremarkable. No focal neurologic deficits were observed. (PX 5)

On/about August 13, 2015 Petitioner filed a Petition for Penalties. (See AX 1)

Petitioner's case proceeded to arbitration on September 10, 2015. The disputed issues included accident, causal connection, notice, medical bills, penalties and attorney's fees, and prospective care. Respondent's representative at the hearing was Mike Duncan. Witnesses testifying at the hearing were Petitioner and Mike Duncan. At the time of arbitration Respondent requested leave to file responses to the 19(b) Petition and Petition for Penalties and Attorney's Fees. Permission was granted without objection. Those pleadings were received by the Arbitrator subsequent to the hearing, printed and marked as RX 2 and 3 respectively and included as part of the record.

Petitioner testified that she was employed by Respondent as a cashier and cook and that she normally worked the 8:00 a.m. to 1:00 p.m. or 9:00 a.m. to 1:00 p.m. shift. Petitioner further testified that on Friday, July 18, 2014 she was preparing for the lunch crowd when she tripped over a stack of soda in the cooler while going to get fish and fell backwards onto her back. The event was not witnessed and she didn't know if the supervisor was there.

Petitioner testified that she continued working and that when her supervisor showed up she told him that she had fallen in the cooler while getting fish and had a doctor's appointment. Petitioner also testified that she told her daughter who worked there as a cashier.

Petitioner acknowledged that she knew what to do in the event of an accident as she herself had written the employee manual. (RX 1)

Petitioner testified that she went to Dr. Peterson that day and told him or his office about the accident. He ordered x-rays and gave her a script. Petitioner testified that she didn't work until the next week (the following Monday) and when she returned to work she felt pain while working.

Petitioner acknowledged prior back surgery in 1999 but denied any "significant" problems since the surgery and denied any other back injuries or "significant" complaints

between then and July 18, 2014.

Petitioner testified that Dr. Peterson died so she established care at Ferrell Hospital where she saw a PA-C and told her about the accident. She ultimately underwent a CT scan and told her employer about the results of it thereafter. Petitioner testified to speaking with "Mike" on September 30, 2014 and telling him that Katie (the PA-C) wanted her to be seen quickly because she needed therapy or surgery and a neurosurgeon. According to Petitioner, "Mike" didn't have the workers' compensation papers and told her that the next day would be her last. Petitioner also recalled asking "Mike" for the workers' compensation papers earlier but he didn't have them then either.

Petitioner testified that she was terminated on September 30, 2014 and that no reason for the termination was given. She has been looking for work.

Petitioner testified that Dr. Fleming has recommended surgery and she will proceed with it if it is authorized. She denied the ability to sit, stand, or lay down for very long. She cannot drive because it hurts her back. Petitioner continues to get pain medication from her primary care physicians. She testified that her back "is not good."

On cross-examination Petitioner testified that her daughter brought her to the hearing that day. She also acknowledged that if she could find work she would be working. Petitioner identified her supervisor as Mike Duncan.

Petitioner also testified that she told Mike Duncan "sometime" between July 18, 2014 and September 30, 2014 that she was going to seek medical care. She did not put anything in writing but further explained that Mr. Duncan provided her with no forms.

On further cross-examination Petitioner denied any back problems until July 18, 2014. While she acknowledged being prescribed pain medication one month earlier, she testified that it was for headaches. She further denied that the appointment for July 18, 2014 had been previously scheduled or that she was there for her weight.

With regard to the accident Petitioner testified that she fell onto her back and hit the concrete floor with her back and the sodas with her head. Mike Duncan wasn't there when it occurred but she told him about it in the afternoon. Petitioner also told her sister. Petitioner testified that before she was terminated by Mr. Duncan she asked to be on workers' compensation.

On redirect examination Petitioner acknowledged undergoing brain surgery and having really bad headaches requiring the use of Norco. She testified that they increased the

Norco after her back injury. She also acknowledged that if the July 18th, 2014 office note says she was there for a follow up visit and fell on her right hip, "it's possible." Petitioner explained that she felt she needed surgery as of September 27, 2014 and that she needed to be taken off work around the time she and the PA-C reviewed the CT scan.

Mike Duncan also testified. Mr. Duncan is retired and has owned the store for the last four years. He described it as a convenience store, diner, and gas station. Petitioner was one of his employees and she worked primarily as a cook but also as a cashier. The store had a big lunch crowd and Petitioner handled it. He further testified that the back wall of the building has federal and state employment information.

Mr. Duncan testified to a big walk-in cooler of soda. He denied that Petitioner ever mentioned an accident or that her daughter ever mentioned anything to him. He received no documentation about an accident before July 30, 2014.

Mr. Duncan testified that Petitioner was terminated for repeated health code violations (such as not wearing the proper gloves) as she wouldn't comply with health code regulations for work. Mr. Duncan testified that he told Petitioner she was being terminated and that the next day would be her last. According to him she looked "overwhelmed" and asked to be placed on workers' compensation. She didn't mention an injury. Mr. Duncan gave her his agent's name and number. According to Mr. Duncan, Petitioner worked the next day and never gave him any documentation regarding a work injury. Mr. Duncan denied any knowledge of the accident until he received the Application for Adjustment of Claim.

On cross-examination Mr. Duncan denied ever having any workers' compensation claims filed against him or ever receiving any work restrictions form Petitioner. He felt Petitioner performed her job. He testified that the health department comes every quarter and that Petitioner was never written up for not wearing gloves. He explained that he didn't ask Petitioner what happened when they talked. He simply gave her his agent's name and number. He denied knowing about any CT scan. .

The Arbitrator concludes:

Issue (C) Whether Petitioner sustained an accident on July 18, 2014 that arose out of and in the course of her employment with Respondent.

Petitioner failed to prove she suffered an accident on July 18, 2014 that arose out of and in the course of her employment with Respondent.

The Arbitrator notes that there are no records from Community Health and Emergency Services pre-dating July 18, 2014. However, it is apparent from the July 18, 2014 office record that Petitioner had previously been seen at Community Health as she was there on the 18th for a "recheck" of her weight. The notes from that visit further show dates upon which medications had been previously prescribed to Petitioner. Included in these prior medications was a prescription for Norco to be taken for pain. That prescription was renewed on July 18, 2014 at the same dosage and rate.

The Arbitrator further notes that the first mention of any specific history of falling at work in any medical documentation was on October 21, 2014, after the Application for Adjustment of Claim was filed by Petitioner indicating a date of loss of July 18, 2014. (AX 2) While the office record of July 18, 2014 does state that Petitioner mentioned falling at work and injuring her right hip there are no details as to when and how the fall occurred. More importantly, the second visit to the family physician (PA) following the purported date of accident does not make any indication of an injury to her back or reference to the alleged fall. She then returned to the facility on August 21, 2014 for hand complaints, rather than back complaints. Thereafter, at her next visit on September 5, 2014 (where she was establishing care at Ferrell Hospital) she made no reference to an alleged injury on July 18, 2014; rather, she spoke of a "flare-up of back pain issues" with no further details. Petitioner then returned to PA Jackson six days later reporting a "flare-up" of back pain when her boss made her lift sixty pound items. Again, there was no mention of any accident in a cooler at work. On September 27, 2014 Petitioner again associated her low back complaints with lifting at work and said nothing about a cooler incident. As noted above, it was not until after she filed her Application for Adjustment of Claim and then initiated treatment with yet another new provider that the exact details of a fall in a cooler at work emerged. Due to the lack of consistent corroboration of a specific and detailed accident within the medical records pre-dating the filing of her claim herein the Arbitrator concludes that Petitioner failed to prove she sustained an accident at work on July 18, 2014 that arose out of and in the course of her employment with Respondent.

The Arbitrator further notes that Petitioner testified that she mentioned the accident to her daughter that day as her daughter also worked for Respondent. Petitioner also testified that her daughter drove her to the hearing. Petitioner could have had her daughter testify in support of her claim; however, she did not. Petitioner further testified that she told PA-C Jackson about the accident. The office note doesn't corroborate the details of her accident and Ms. Jackson did not testify.

The Arbitrator was also troubled by Petitioner's testimony finding that she was not as candid about some matters as she could have been. For example, she initially denied

having had a previously scheduled appointment with the doctor for July 18, 2014 and denied that any such appointment would have been for a recheck of her weight. However, the office notes of that date clearly suggest otherwise and it was only when faced with the contents of that visit during redirect examination that Petitioner testified, somewhat reluctantly, that it was "possible" the visit was pre-scheduled and for her weight. Petitioner also testified that while she had been taking Norco prior to her alleged accident for headaches stemming from a previous brain condition and, furthermore, she claimed her Norco dosage increased after her alleged accident. No medical records were submitted by Petitioner to corroborate that testimony and the July 18, 2014 office note shows no change in her Norco prescription from the month before.

In *Nee vs. Illinois Workers Compensation Commission,* 2015 Ill.App. (1st) 132609 WC, the court held that a claimant in a workers' compensation proceeding has the burden of proving by a preponderance of the evidence all of the elements of the claim including proof that he or she suffered an accident that arose out of and in the course of the employment. Petitioner has failed to prove with a preponderance of the evidence based upon the inconsistent histories provided to the medical providers.

Issue (F) Causal Connection.

Even assuming, arguendo, that Petitioner did sustained an accident on July 18, 2014 that arose out of and in the course of her employment with Respondent, Petitioner failed to prove that her current condition of ill-being in her low back is causally related to that accident. In support thereof, the Arbitrator notes that, at most, Petitioner presented to Community Health Services on July 18, 2014 mentioning she had fallen at work. Thereafter, she continued to treat at Community Health and with PA Jackson but failed to mention an accident at work when she fell in a cooler. Instead, she referenced lifting duties or "flare-up" with no details. None of these providers provided a causation opinion. While Dr. Fleming addressed causation in his medical records and felt Petitioner's fall in the cooler was "consistent with and most likely the direct cause" of Petitioner's herniated disc and need for surgery, he was solely relying upon Petitioner's representation as such. He did not review any prior records and, as such, was unaware of inconsistencies in Petitioner's histories to earlier providers. That his opinion was unrebutted does not render it persuasive as it was not based upon complete and accurate information.

It is also troubling that, despite ongoing complaints to Dr. Fleming, various physicians assistants who have seen Petitioner since May of 2015 have failed to make mention or notation of any ongoing back complaints or signs of back problems. Furthermore, Petitioner only denied "significant" back pain complaints before her accident, thereby

allowing one to reasonably infer that Petitioner may have been experiencing some type or episodes of back pain prior to the alleged accident. That testimony combined with Petitioner's failure to submit treatment records pre-dating her alleged accident further undermines causation.

Petitioner's claim for compensation is denied. No benefits are awarded as all remaining issues are moot.

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17IWCC0196

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHARLES STROBEL,

Petitioner,

vs.

NO: 14 WC 42649

SOI/IDOT,

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 generally agrees with the Arbitrator's analysis of the five factors in Section 8.1b(b) of the Act but finds that factor (v), "evidence of disability corroborated by the treating medical records," was given too much weight. Petitioner has no permanent medical restrictions for his right arm. Although most of Petitioner's testimony regarding his current condition is corroborated by the medical records, he also testified that he has continuous numbness that runs down into his ring and little fingers and they are "as cold as ice." (T.12, 25). The Arbitrator found that, "Petitioner's description of his ongoing symptoms suggests a nerve impingement." (Dec. at 5). However, the Commission finds that the medical records do not reflect complaints of numbness or coldness in the fingers. In particular, at Petitioner's last visit with Dr. Sasso, on May 15, 2015, there is no record of any such complaints and Dr. Sasso wrote:

> Examination shows that he still has some point tenderness over the lateral epicondyle of the right elbow. He has no significant tenderness over the radial tunnel. It is an improvement from last time. He has full range of motion with elbow extension and flexion. He has normal sensation with brisk capillary refill

distally. 17IWCC0196

(Px3). A Lidocaine injection was performed and Petitioner was told to continue with Motrin and return as needed. There are no records in evidence to indicate that Petitioner had returned to Dr. Sasso prior to the hearing on December 3, 2015.

The Commission finds that the most recent examination showing that Petitioner had normal sensation and brisk capillary refill does not corroborate his testimony that he has continuous numbness in his fingers and that they are "cold as ice." We also note that, although Petitioner testified that he discussed with Dr. Sasso "intensively and more than once" about the possibility of surgery being necessary in the future, this is not corroborated by the medical records. Based on these findings, we modify the permanency award to 17.5% loss of use of the right arm.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $721.66 per week for a period of 44.275 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 17.5% loss of use of the right arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $10,726.19 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 is entitled to a credit under §8(j) of the Act for payments made by its group insurance carrier; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

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

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

DATED: APR 3 - 2017

Charles J. DeVriendt

Kevin W. Lamborn

Joshua D. Luskin

SE/
O: 3/8/17
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STROBEL, CHARLES
Employee/Petitioner

Case# **14WC042649**

17IWCC0196

SOI/IDOT
Employer/Respondent

On 9/21/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.50% 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:

0099 GLASS & KOREIN LLC
MICHAEL KOREIN
7012 W MAI ST
BELLEVILLE, IL 62226

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

0558 ASSISTANTATTORNEY GENERAL
KENTON OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1430 CMS BUREAU OF RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

SEP 21 2016

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

17IWCC0196

17IWCC0196

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

- [ ] 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

Charles Strobel
Employee/Petitioner

v.

SOI/IDOT
Employer/Respondent

Case # **14** WC **42649**

Consolidated cases: **N/A**

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **12/3/15**. By stipulation, the parties agree:

On the date of accident, **3/2/14**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**74,640.00**, and the average weekly wage was $**1,435.38**.

At the time of injury, Petitioner was **56** years of age, ***married*** with **no** dependent children.

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

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

17IWCC0196

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

ORDER

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, Respondent shall pay Petitioner the sum of **$721.66**/week for a further period of **63.25** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **25% loss of use of the right arm**.

Respondent shall pay Petitioner compensation that has accrued from **11/21/14** through **12/3/15**, and shall pay the remainder of the award, if any, in weekly payments.

Per stipulation of the parties, all TTD has been paid and none is owed.

Respondent shall pay reasonable and necessary medical services of $10,726.19, as set forth in PX 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.

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

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

Signature of Arbitrator

9/8/16
Date

ICArbDecN&E p.2

SEP 21 2016

FINDINGS OF FACT

At trial on December 3, 2015, Respondent stipulated to accident, notice, and causal connection. The only issues in dispute are nature and extent and unpaid medical bills (ARBX1).

Petitioner, Charles Strobel, has been employed with Respondent, Illinois Department of Transportation (hereinafter "IDOT" or "Respondent") since October, 1989. As of March 2, 2014, he was employed as a road crew supervisor. He is 58 years of age. His job duties involved unloading signs, putting up road signs, running a jack hammer, handling motor vehicle accidents, lane closures, shoveling broken concrete into the backhoe, and other heavy lifting, pushing and pulling.

On March 2, 2014, Petitioner slipped on ice in his truck bed and fell to the ground, striking his non-dominant right arm and elbow. He had no previous problems with his right arm, elbow, or hand; no evidence of pre-existing upper extremity problems was presented. Upon giving notice of his injury, Petitioner went to Fayette County Hospital emergency room for treatment and testing. X-rays at the time revealed large joint effusion, anterior and posterior fat pad displacement and were suspicious for radiographically occult fracture, especially the radial head (PX1-010). He was taken off work from that date and later kept off work under the care of Dr. Sasso (PX3-046 to 047) who diagnosed a radial head fracture possibly old lateral collateral ligament injury (PX3-023). Dr. Sasso ordered a CT scan of the right wrist on April 1, 2014, showing progressive healing of the distal radial comminuted and impacted fracture (PX3-007). An MRI arthrogram of the right elbow joint the same day showed mild osteoarthritis, multi focal bone contusions, diffuse posterior elbow subcutaneous edema, intact tendons and ligaments and no fracture or dislocation (PX3-003). Again, the doctor saw the patient on April 8, 2014 and diagnosed right elbow injury, radial head and neck fracture (PX3-021). On May 2, 2014, due to continued symptoms in the right elbow and clinical findings of a lack of 5 degrees of full extension, with tenderness over the lateral epicondyle, and pain with wrist and elbow extension, Dr. Sasso added right lateral epicondylitis to his diagnosis (PX3-020). He was allowed to start restricted duty on May 12, 2014 (PX 3-044). Petitioner was later fitted for and provided a counterforce forearm strap at Working Hands (PX3-035).

Petitioner underwent an injection into the ERCB tendon origin on July 8, 2014 (PX3-018), but persisting symptoms included pain with any type of lifting, restricted motion, point tenderness over origin of ERCB tendon, and cracking sounds in the elbow. In August, 2014, Petitioner was given flexor patches and Voltarean gel. He was told to switch from Motrin to Meloxicam (PX3-017). When rest and other conservative measures failed, Petitioner was referred to APEX Physical Therapy (PX5). After a course of physical therapy, Dr. Sasso noted ongoing right lateral epicondylitis and recommended immobilizing the wrist and wearing a fitted strap when doing any activity (PX3-015). Physical therapy continued through APEX. Petitioner was noted to have decrease in mass of his right proximal forearm compared to his left. Petitioner also had decreased grip strength on the right averaging 86 lbs compared to his left grip strength averaging 139 lbs. (PX5-003). Petitioner wanted to try resuming full duty and, on November 21, 2014, Dr. Sasso released him for that attempt (PX3-038). By December 8, 2014, Petitioner was back at the Wellness Clinic complaining about popping in the right elbow while testing his capacity for full duty activities (PX2-005). By March 11, 2015, Petitioner returned to Wellness Clinic and noted that he was unable to use the right arm for certain tasks. He could not use a shovel or open a jar. The pain in the elbow is lateral and radiates into the hand (PX2-003). Petitioner retired from work in December, 2014 due to his own perceived inability to perform the full functions of his job. On March 11, 2015, he was again given work restrictions of no lifting, pushing or pulling greater than 5 lbs with the right upper

extremity and referred back to Dr. Sasso (PX2-002). Dr. Sasso saw Petitioner on March 26, 2015, and diagnosed right lateral epicondylitis and right radial tunnel syndrome (PX3-014). By May 15, 2015, Dr. Sasso noted slight improvement with continued lingering symptoms, noted Petitioner continues to take Motrin when needed and does not engage in heavy lifting. That physical examination showed point tenderness over the lateral epicondyle of the right elbow, improved tenderness over the radial tunnel. He diagnosed right lateral epicondylitis improved but still symptomatic and improved right radial tunnel syndrome. Dr. Sasso administered another injection into the CRB tendon on the right side, which was tolerated. Petitioner was released from care PRN (PX3-013). Petitioner did not return to Dr. Sasso because he was informed this was as good as he would get. Petitioner and Dr. Sasso discussed surgery, but believed the likely degree of relief to be achieved did not justify the risks of the procedure.

Petitioner testified that the treatment he received from each facility and provider was beneficial. He still has swelling and stiffness of the right elbow with usage and daily numbness radiating to the ring and small finger of that right. He notices weakness with a constant cracking and popping noise whenever he flexes or extends the elbow, and still has diminished grip strength.

Petitioner testified that he left his job because he did not feel competent to perform the heavy labor that was required. Because of his ongoing symptoms, which never existed before this accident, he decided not to proceed with the landscaping business that he had planned to open upon retirement. He now buttons his shirt with his left hand and opens the car door with his left hand. Additionally, he was an avid weight lifter, able to do 40 pushups 3-4 times per week, and able to press 200 lbs. over his head with either arm. He no longer lifts weights or does pushups. He used to hit the heavy bag and engage in boxing; he ceased these activities due to the lasting effects of these injuries including the inability to completely straighten out the right arm. He also enjoyed cutting wood, as he lives in a rural area, but can't operate his chainsaw or chop wood. He can only lift his 4-year old grandson one-handed, avoiding use of the right arm. He used to play full court basketball, but no longer engages in that or other sports. Petitioner also no longer handles the landscaping around his house that he'd always done before this accident. He no longer shovels or lifts heavy items such as moving furniture. He will not even attempt to climb a ladder. Lastly, he no longer sleeps on his right side, since that causes his entire arm to go numb.

Duc to his understanding that he was as good as he was going to get, he has not sought additional treatment since May 15, 2015. Instead, he manages his symptoms through the use of ibuprofen or Motrin which he takes with every meal. He uses his orthotic brace when engaged in any activity. Petitioner also ices his elbow at least two times per week.

CONCLUSIONS

Were 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, as a matter of law, that the services rendered at the facilities identified in Pet. Ex. 6 were reasonable, necessary, and causally related to Petitioner's work injuries.

Therefore, Respondent shall pay reasonable and necessary medical services of $10,726.19, as set forth in PX 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.

What is the nature and extent of the injury?

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party submitted an impairment rating. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner's job was heavy labor which involved unloading heavy signs, shoveling broken concrete into the backhoe, putting up signs, running a jack hammer, fixing bent or broken guard rails, or any other maintenance that needed to be done on the highways in the State of Illinois.. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 56 years old at the time of his injury **(ARBX1)**. The Arbitrator considers Petitioner to be a middle aged individual and concludes that Petitioner's permanent partial disability (PPD) will be moderately greater than that of an older individual because Petitioner will have to live and work with the consequences of the injury for a longer period of time. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner no longer works because of the injury to his arm. He wanted to work for two more years but felt that, with the inability to perform his job, he was doing a disservice to his co-workers. The Arbitrator therefore gives *lesser* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes evidence of disability in Petitioner's treating medical records indicates that Petitioner has residual lateral epicondylitis, radial tunnel syndrome, and a healed fractured radial head. The Arbitrator finds that Petitioner was a credible and forthright witness at trial. Petitioner's description of his ongoing symptoms suggests a nerve impingement. As a result, he no longer engages in the activities, chores, hobbies, etc. described herein. He treats these ongoing problems with use of a brace; daily use of Motrin or ibuprofen; ice; rest; and activity modification, limitation and avoidance. The Arbitrator finds that Petitioner's testimony regarding his current condition of disability is reasonably corroborated by the medical records given that Petitioner suffered a radial head fracture, lateral epicondylitis, and radial tunnel syndrome. This suggests that Petitioner suffers more than a mild disability. 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 25% loss of use of the right arm pursuant to §8(e) of the Act.

17IWCC0196

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLAMSON

☒ 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

Sonya Colson,

Petitioner,

17IWCC0206

vs. NO: 14 WC 43375

Casey's General store,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 21, 2016 is hereby affirmed and adopted.

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

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

17IWCC0206

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: APR 5 - 2017
KWL/vf
O-2/6/14
42

Thomas J. Tyrrell

Michael J. Brennan

DISSENT

I respectfully dissent from the Majority's opinion affirming the Arbitrator's decision. I find that I am persuaded by the testimony of the Petitioner who at arbitration testified that while at work on the date of the claimed accident she was bending at the waist and picking up an amount of pizza dough that was the equivalent of two handfuls when she felt a pop sensation in her low back. After a thorough review of all the evidence contained within the record I am persuaded and would hold that the Petitioner has failed to prove this event of taking two handfuls of pizza dough out of a mixer placed her at a risk that is greater than the general population is exposed to, or that this was even a peculiar risk in her employment. I would find Petitioner failed to demonstrate that she sustained a compensable injury which arose out of her employment duties.

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0206

COLSON, SONYA
Employee/Petitioner

Case# **14WC043375**

CASEY'S GENERAL STORE
Employer/Respondent

On 7/21/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

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 17IWCC0206

SONYA COLSON
Employee/Petitioner

v.

CASEY'S GENERAL STORE
Employer/Respondent

Case # **14** WC **43375**

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 14, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 12, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$16,596.32**; the average weekly wage was **$319.16**.

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

Respondent shall be given a credit of **$506.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$506.00**.

Respondent is entitled to a credit of **$11,115.61** under Section 8(j) of the Act.

ORDER

As explained in the Arbitration Decision, Respondent shall pay reasonable and necessary medical services as reflected in Petitioner's Exhibit 1 that remain unpaid, not to exceed **$225,919.36**, except for those itemized in Arbitrator's Decision, pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for amounts paid, including those paid through its group medical plan, for which credit is allowed under Section 8(j) of the Act. Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit under Section 8(j).

Respondent shall pay Petitioner the sum of **$253.00/week** for **100** weeks, as provided in **Section 8(d)2** because the injuries sustained caused a **20%** 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.

Signature of Arbitrator

July 19, 2016
Date

JUL 21 2016

STATE OF ILLINOIS)
) ss
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

SONYA COLSON
Employee/Petitioner

17IWCC0206

v.

Case #: **14 WC 43375**

CASEY'S GENERAL STORE
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On September 12, 2014, Petitioner was 50 years old, married, with no dependent children. She was employed by Casey's General Store as a Kitchen Manager and was making pizza dough. She testified the pizza dough mixer was bigger than a three foot by two foot chair and it rested on legs in which the mixing bowl sits and has switches that operate paddles which are two feet high. The dough maker mixes up the pizza dough, then the dough is taken out by handfuls and divided into four containers evenly. Petitioner testified that on the date of accident she was pulling the dough from the bottom of the mixer to put it into the appropriate container. She was bent over about three-quarters of the way to her toes to get to the bottom of the bowl, pulling up two handfuls of sticky pizza dough to put into the container, and felt a pop and immediate pain as she was lifting the dough on the way back up. She testified she felt instant pain in her low back, around the waistline and down into her buttocks. Petitioner testified that prior to this incident she had never injured her low back, had never had an MRI of her low back, and had never had a worker's compensation claim for her low back. She acknowledged she had previously gotten a non-medical massage on occasion, but had not had one for two to two and a half years prior to this accident.

Following the accident Petitioner presented to her family physician, who prescribed muscle relaxers and physical therapy, neither of which helped a lot. She also underwent three injections, one of which helped. She eventually underwent surgery by Dr. Raskas and she testified she got a good result and it helped. She testified her current back and leg pain is very minimal, the numbness and tingling are gone, and she only occasionally gets a twitch. She takes Aleve when needed, which is very rarely. Her range of motion is good and she is able to lift, bend, stoop, and pull the way she did before the accident,

Petitioner testified she returned to full duty work two weeks after her surgery. Her job at the time, and her current job, was not with Respondent. In January 2015 she began working as a

lead dispatcher for Shawnee Mass Transit, which is a desk job. She testified it was a better job, better opportunity, and better location.

On cross-examination, Petitioner testified she had seen a chiropractor on very rare occasions in the past but had never had an MRI of her low back. She acknowledged she had previously had cervical problems around 2002, for which she had an MRI and underwent physical therapy but not surgery. Petitioner testified she was honest with the physicians she had seen for this accident, including Dr. Randolph, Respondent's physician, and Dr. McElheny, her family physician. She confirmed she had not seen any physician for her lumbar condition since her appointment with Dr. Raskas in June 2015. She has never been under any activity restrictions, is currently working full duty, and is earning more than when she was working for Respondent. Petitioner testified she was involved in a motor vehicle accident in October 2014 when a semi truck tire blew and went up underneath her car. She did not have to pull off the road or swerve, as the tire blew out the back. It caused damage to the underside of her car but she was not injured.

Following her accident, Petitioner sought treatment with Dr. Brian McElheny on September 15, 2014. She complained of low back pain primarily in the mid and lower right areas, which did not radiate. She characterized it as intermittent, mild in severity, moderate in intensity, and sharp. She related it was an acute episode which started two days prior. Dr. McElheny's note states, "She does not recall any precipitating event or injury. This occurred at work." Examination revealed a slowed gait, decreased range of motion and pain with flexion, and tenderness to palpation in the lumbar spine and right paraspinal muscles. Assessment was low back pain and Dr. McElheny recommended avoidance of heavy exertion, cigarette smoke, and fatty foods. He prescribed physical therapy, ice and heat to the affected area, and Flexeril and Voltaren. PX3, RX3.

On September 16, 2014, Petitioner presented to Real Rehabilitation for an initial physical therapy evaluation. She reported she had an onset of back pain on September 12, 2014, when pulling pizza dough out of the mixer and putting it in the tub. She reported severe pain in the lower and mid back, primarily on the right, and it was noted she could not move to the chair, sit, or stand without severe pain. On palpation she had severe muscle tenderness and spasm in the lumbar region bilaterally. Range of motion was decreased and she had pain with all motion. Petitioner attended physical therapy sessions from September 18 through October 6, 2014, with consistent complaints of pain and inability to sit or stand without pain. It was noted she was working part time but the pain flared up after about four hours of work. PX4.

Petitioner returned to Dr. McElheny on October 7, 2014, and reported low back pain, most prominent in the mid lumbar spine, which did not radiate. She characterized the pain as intermittent, moderate in intensity, sharp, and achy. Dr. McElheny noted it was a chronic but intermittent problem with an acute exacerbation which began one month prior when she was pulling a load. Petitioner complained of paravertebral muscle spasm but denied radicular leg pain. Examination revealed a slowed gait, decreased range of motion, and pain with flexion. Assessment was low back pain which had not improved with three weeks of treatment. Dr. McElheny prescribed Prednisone, and continued Flexeril, heat to the affected area and avoidance of heavy exertion. Petitioner was to follow up as needed. PX3, RX3.

Petitioner attended physical therapy from October 8, 2014, through October 15, 2014, and reported consistent complaints of pain, especially after working for four hours. PX4.

On October 18, 2014, Petitioner presented to Memorial Hospital of Carbondale, upon advice of her attorney, for elevated blood sugar and lightheadedness. She reported she had been taking Prednisone for eight days for work related back problems and had stopped taking it. She was administered insulin and fluids and was discharged. PX5.

On October 20, 2014, Petitioner returned to Dr. McElheny following care in the emergency department. She had elevated blood sugar in the ER which went down with fluid. She continued to complain of low back pain which had been progressively worsening. She reported she could not work longer than four hours without being miserable with pain and that lifting made it worse. The Arbitrator notes that Dr. McElheny did not perform an examination of the low back, despite Petitioner's noted complaints to that area, but did list "low back pain" as one of the diagnoses. He further limited Petitioner's work to four hours at a time and no lifting more than ten pounds for a month. PX3, RX3.

Petitioner attended physical therapy from October 22, 2014, through January 16, 2015, and reported consistent complaints of pain and worsening of symptoms with activity. It was noted she remained antalgic in her gait and guarded in her movements. She continued with a limited work schedule and was concerned about returning to full duty. She reported increased symptoms when she had to make dough or with any type of pulling motion. Examinations continued to reveal point tenderness and spasms with palpation. PX4.

On December 2, 2014, Petitioner presented to Dr. David Raskas and reported she was injured at work on Friday September 12, 2015, when she bent over and lifted pizza dough out of the bowl and felt a significant pull in her low back. She thought it would go away, but by Sunday she was not better and called into work to report the incident. Dr. Raskas noted Petitioner had insulin dependent diabetes and also noted she had recently been given a tapered dose of steroid which left her hospitalized with elevated blood sugar. Petitioner reported she was continuing to work. On examination, hip range of motion was full and non-tender, straight leg was negative, and strength was equal bilaterally. Dr. Raskas noted no neurologic deficits to indicate nerve involvement. He recommended increasing her physical therapy to include active core strengthening and lower extremity strengthening. Petitioner was allowed to work with restrictions of no heavy lifting, bending, or twisting. PX6.

On January 19, 2015, Petitioner underwent a lumbar MRI upon referral by Dr. Raskas. It revealed multilevel degenerative disc disease and facet arthropathy, with broad-based changes greater at L4-5 and mild encroachment. Petitioner returned to Dr. Raskas following the MRI, with continued complaint of low back pain, down left buttock and left leg. She reported she had changed jobs to a desk job, which was easier on her. Dr. Raskas reviewed the MRI scan, which he reported showed spondylosis with facet hypertrophy and stenosis at L4-5. He recommended epidural injections and facet blocks at L4-5. Petitioner was allowed to continue working at her regular duty job. PX6.

Petitioner underwent a facet medial branch block at L4-5 on January 29, 2015, and an epidural steroid injection at L4-5 on February 5, 2015. Both injections were administered by Dr. Patricia Hurford. PX6, PX8.

On March 2, 2015, Petitioner returned to Dr. Raskas. She reported the facet block did not help much but the epidural injection helped for about a week. On examination, her strength was normal and SI joint provocative maneuvers were negative. She reported she could not stand or walk very far because her left leg would go numb. Dr. Raskas' impression was spinal stenosis and neurogenic claudication. He recommended a CT myelogram to evaluate for nerve root compression, and noted she may be a candidate for a limited decompression at L4-5. He opined that the need for the treatment was directly attributable to her work injury. PX6.

On March 10, 2015, Petitioner underwent a CT myelogram, which showed: (1) L2-3 minimal disc bulging with no canal or foraminal narrowing; (2) L3-4 mild to moderate disc protrusion with moderate facet arthropathy; (3) L4-5 disc protrusion with mild to moderate facet arthropathy, thecal sac narrowing, and mild foraminal narrowing; (4) L5-S1 disc protrusion with no canal or foraminal narrowing. PX7.

Following the CT myelogram, Petitioner was seen by Dr. Raskas on March 10, 2015. He reviewed the CT and the previous MRI with Petitioner and reported she had a herniated disc at L3-4 lateralizing to the left, stenosis at L4-5 and L3-4. Dr. Raskas noted Petitioner had undergone conservative treatment of activity modification, physical therapy, injections, and anti-inflammatory medication, none of which relieved her symptoms. He recommended surgery and opined the findings and need for surgery were related to her work accident. PX6.

On April 17, 2015, Petitioner underwent bilateral laminotomies and foraminotomies at L3-4 and L4-5, removal of herniated disc at L3-4, and insertion of instrumentation at L3-4 and L4-5. Postoperative diagnoses were herniated disc and spinal stenosis at L3-4, stenosis at L4-5, and neurogenic claudication. PX6, PX 9.

Petitioner returned to Dr. Raskas on May 1, 2015, and reported relief of her pre-operative left leg pain, but a little pain in the right groin. The incision was healing but did have some drainage. Petitioner was given antibiotics as a precaution, especially in light of her diabetes. She was allowed to return to work four hours a day, with no lifting, pushing, or pulling over ten pounds and no repetitive bending, twisting, or squatting. PX6.

On June 1, 2015, Petitioner returned to Dr. Raskas. She reported she was doing very well and that her pain was only 1/10. She still got pain in her right buttock and occasional tingling in her leg, but reported she felt much better overall. Her incision was healing without problems and her neurovascular examination was normal. She was referred to physical therapy and was to return in five weeks. PX6.

Petitioner participated in physical therapy at Real Rehabilitation from June 2, 2015, through June 15, 2015. It was noted she had improvements in strength and overall conditioning. Petitioner cancelled her final appointment and was determined to be discharged. PX4.

On June 4, 2015, Petitioner was evaluated by Respondent's Section 12 examiner, Dr. Bernard Randolph. She reported on her date of accident she was pulling a batch of dough out of a mixer when she experienced a pulling sensation and pain in the low back. She reported that she was not doing anything unusual that day, that she typically prepared pizza dough about once daily, and that her back symptoms gradually worsened. Dr. Randolph reviewed records from Dr. McElheny and noted that the history recorded by him was that Petitioner denied a precipitating event or injury but that the symptoms started while working. Dr. Randolph also reviewed records from Dr. Raskas and Dr. Hurford, along with the MRI and CT myelogram. RX2.

Petitioner reported that postoperatively the fairly continual buttock symptoms had diminished and she had a significant reduction in low back pain. Her pain was 1-2/10. She reported she had mildly increased symptoms with walking uphill and prolonged sitting, and had mild discomfort with bending. Dr. Randolph noted Petitioner no longer worked for Respondent and was currently in a primarily sedentary job. She was not taking any pain medications on a routine basis. Petitioner reported the incident involving the blown semi tire and indicated she was not injured and did not have any change in lumbar symptoms following this. She acknowledged limited treatment for her back in the past for which she had received chiropractic treatment, but stated the last adjustment was about two years prior to the work accident. RX2.

Examination revealed active flexion was functional with slight pain on the extreme of the range. Lumbar extension was minimally reduced with mild to moderate pain complaints, and motion was minimally reduced bilaterally on lateral flexion. The remainder of the examination was normal, and Waddell's tests were negative. RX2.

Dr. Randolph opined that Petitioner sustained a muscular strain to the lumbar area on September 12, 2015. He noted the initial medical record did not indicate symptoms started as a result of a specific incident, and that it was only later that Petitioner provided the story that symptoms developed when pulling pizza dough. Dr. Randolph noted Petitioner had a pre-existing history of multilevel degenerative disc disease, facet arthrosis, mild degenerative spondylolisthesis, and degenerative spinal stenosis, especially at L3-4 and L4-5. Dr. Randolph opined that the work accident did not aggravate or fundamentally change the natural history of the pre-existing degenerative condition. He did not believe the incident involving the blown semi tire aggravated Petitioner's lumbar condition. Dr. Randolph opined that Petitioner reached maximum medical improvement from the work accident by January 20, 2015. He further opined that the surgery performed on April 17, 2015, was related to Petitioner's pre-existing lumbar degenerative condition. He did not believe she was at maximum medical improvement as respects the surgery, but estimated she would be so by early August 2015. RX2.

Dr. Raskas testified by way of deposition on January 18, 2016. He is a Board Certified Orthopedic Surgeon and limits his practice to the treatment of patients with spinal disorders. He performs 250 to 300 surgeries a year. PX11.

Dr. Raskas testified consistent with his treating records and opined that Petitioner's work accident caused her injury and need for treatment. He further opined that the incident involving the blown semi tire did not affect her condition, and noted she was already in physical therapy

when the incident occurred. He agreed with Respondent's examining physician, Dr. Randolph, that the incident did not aggravate her lumbar condition. PX11.

Dr. Raskas testified that intraoperatively he found a herniated disc and spinal stenosis, which he correlated with Petitioner's symptoms when she first sought treatment with him. He testified that postoperatively Petitioner did very well. The last time he had seen her was June 2015, at which time her pain was a one. She was to return after physical therapy, but was doing so well she did not go back. PX11.

Dr. Raskas testified that Petitioner's spinal stenosis was a cause of her symptoms and that it was aggravated by the work incident. In addition, her herniated disc was a cause of her symptoms and it was caused by the work incident. He testified the inciting event that caused the spinal stenosis to become symptomatic and to progress was Petitioner's work accident. Dr. Raskas disagreed with Dr. Randolph's opinion that Petitioner had reached maximum medical improvement before her surgery, as Petitioner was not better and was not back to her preinjury state. He further disagreed with Dr. Randolph's assertion that because Petitioner did not initially have leg pain it was not related. He testified that Petitioner developed leg pain over time, and that back injuries evolve over time. PX11.

On cross-examination, Dr. Raskas acknowledged he did not review any medical records for treatment prior to his examination, nor did he review any accident reports. His opinion of the accident was based upon Petitioner's recitation of the event. Dr. Raskas testified his understanding of the accident was that Petitioner bent over and was lifting pizza dough out of a bowl when she felt a significant pull in her low back. He conceded he did not know how much the pizza dough weighed, how big it was, the height it had to be lifted, whether it was free or restrained or stuck, or whether it was close to her body or further away. When asked if the activity was different than what Petitioner may have been doing in the activity of making food in her home, Dr. Raskas testified he did not ask her how she made food at home. However, she described being bent over and feeling a pop in her back, which is a common mechanism for a disc injury. He conceded people have disc injuries like that while at home, and he conceded he did not have specific details on the mechanics of her incident other than she was bent over, lifting pizza dough. PX11.

Dr. Raskas testified that in commenting on causation it is sometimes important to know facts such as body positioning. In this particular case, however, where a person is bent forward and pulling pizza dough and feels something in their back, that movement is consistent enough to produce a disc herniation and aggravate spinal stenosis. PX11.

Dr. Raskas agreed that when he first saw Petitioner she did not report any buttock or radiating leg pain, and that when he saw her again in January 2015 she was reporting both. He acknowledged Petitioner had a different job with a different employer at that time, and that it was a desk job that was easier on her. She had an increase in pain but had been having back pain the entire time, and her condition had not resolved. PX11.

Dr. Raskas confirmed Petitioner was allowed to return to work on May 1, 2015, and that he saw her for the final time on June 1, 2015. At the final visit she reported she was recovering

and she did not return after that. Dr. Raskas opined Petitioner was at full duty with no restrictions. PX11.

Dr. Raskas did not believe Petitioner's smoking impacted the overall condition of her spine. He testified tobacco use was associated with degenerative disc problems because it can weaken a disc and allow it to herniate. He did not believe there was an association between smoking and spinal stenosis, nor between diabetes and either of Petitioner's spine conditions. He testified spondylolisthesis is more commonly found in females, but that Petitioner's height and weight would not dramatically affect the diagnosis. PX11.

On February 26, 2016, Dr. Randolph issued a report after reviewing the deposition transcript of Dr. Raskas. He opined that the surgical procedure performed addressed the effects of degenerative spinal stenosis and that Petitioner's work activities on September 12, 2014, were not the cause of the eventual lumbar surgery that was performed. RX2.

Dr. Randolph testified by way of deposition on April 6, 2016. He is Board Certified in physical medicine and rehabilitation. Dr. Randolph testified consistent with his reports. Prior to examining Petitioner he reviewed medical records from Dr. McElheny, Southern Illinois Hospital of Carbondale, Real Rehabilitation, Dr. Raskas, Dr. Hurford, and Frontenac Surgery and Spine Care Center. He also took a history from Petitioner, who stated she had pulled a batch of dough out of a mixer and developed a pulling sensation in her low back. RX1.

Petitioner indicated the surgery she underwent reduced her low back pain but she continued to have some discomfort in the buttocks. She rated her pain at 1-2/10. She reported discomfort with movement, prolonged sitting, and bending. She was not taking any pain medications. Dr. Randolph testified Petitioner's past medical history was significant, in that she had indicated she had had back pain in the past, to the extent that her function would be affected. She described it as her back going out from time to time, and she acknowledged she had gone to a chiropractor from time to time prior to the work accident. She also reported a history of smoking and Dr. Randolph opined that smoking was a risk factor for low back pain and early degenerative disc disease. RX1.

Dr. Randolph testified that his review of the physical therapy records from Real Rehabilitation indicated Petitioner had improved with respect to strength and mobility during the course of treatment and that she was functioning significantly better with reduced pain by January 2015. RX1.

Dr. Randolph reviewed a job demands analysis and job description of Petitioner's work. The documents revealed that the work Petitioner did was classified as medium work demand, based on her position as a cashier and general worker at the store. Dr. Randolph testified that based on the history Petitioner provided, and the records, she developed a muscular strain in the low back on September 12, 2015. It was not evident in the records that the strain developed as a result of any specific incident; however, she reported she developed symptoms when pulling pizza dough. Dr. Randolph noted this history was not present in Dr. McElheny's records. RX1.

Dr. Randolph testified Petitioner had a history of multilevel degenerative disc disease, including facet arthrosis and degenerative spondylolisthesis, and varying degrees of spinal stenosis at L3-4 and L4-5. Petitioner also had a history of low back pain prior to the work accident. Dr. Randolph testified that the work accident did not aggravate or fundamentally change the natural history of the preexisting degenerative condition of Petitioner's spine. The history Petitioner provided of occasional back pain prior to the work accident was consistent with progressive degenerative disc disease. RX1.

Dr. Randolph testified that degenerative disc disease is a condition that is progressive in nature, by definition. As we age, the structures of the spine tend to wear and the discs themselves lose water content, which is called desiccation. The discs then bow outward as a result of loss of water content. The outer fibers of the disc wear out which can cause things like annular or disc wall injury. In addition, the joints on the back side of the lumbar segment tend to wear, and develop a condition called facet arthrosis. These things tend to develop as we age. They can develop as early as the second decade, but in most people by the third decade of life. Factors such as smoking and genetics will influence the rate at which an individual will develop degenerative change, but it occurs in everyone to some degree. Dr. Randolph testified that is what happened to Petitioner. RX1.

Dr. Randolph testified that the incident involving a blown semi tire did not appear to cause any significant trauma to her spine and did not effect on her low back condition. RX1.

Dr. Randolph testified that based on the clinical findings, when he saw Petitioner she did not require additional treatment to her back. He testified the surgery performed by Dr. Raskas was done primarily to treat the effects of lumbar spinal stenosis. He performed a decompression to decrease pressure on the nerves at two levels and placed instrumentation to improve stability. He also did discectomies at the affected levels. Dr. Randolph testified the surgery was not to treat any complaints Petitioner developed at her place of employment, but rather it was to treat her degenerative spinal stenotic condition. At the time of his examination Petitioner had not yet reached maximum medical improvement, but he anticipated her doing so by August 2015. RX1.

Dr. Randolph testified he reviewed the deposition transcript of Dr. Raskas. Based on that review, he opined that the surgery performed was done so primarily to treat spinal stenosis. He did not believe the surgery had anything to do with work activities, but was related solely to the effects of the degenerative condition of Petitioner's spine. RX1.

On cross-examination, Dr. Randolph testified that as a specialist in physical medicine and rehabilitation, he treats patients nonoperatively, does not perform surgery, and is not an orthopedic surgeon. If one of his patients needed consultation from an orthopedic surgeon, he would refer them to such a physician. He was familiar with Dr. Raskas but did not recall every referring a patient to him. Dr. Randolph agreed that Petitioner had a good outcome from the surgery performed by Dr. Raskas. RX1.

Dr. Randolph agreed that Petitioner reported to him that she had injured her low back at work while pulling a batch of dough out of a mixer. He noted, however, that in her primary care doctor's record there was no mention of the specific incident, but rather only that she reported

that the injury occurred at work. He testified that even though there was no specific mechanism documented, he did not disbelieve that her symptoms began at work. He conceded there was nothing in Petitioner's medical records that caused him to believe that no injury occurred. He further conceded that he did not review any medical records or diagnostic studies documenting symptoms, complaints of low back pain or treatment for low back pain prior to September 12, 2014. Petitioner indicated in her history that she had been treated for back pain prior to that date, but also indicated that it was approximately two years prior. Dr. Randolph testified that even though he did not have prior medical records by which to compare Petitioner's recent treatment, he still characterized her findings as degenerative, given the imaging which was consistent with degenerative disease. RX1.

Dr. Randolph agreed that Dr. Raskas found a herniated disc during surgery, and he agreed that disc herniations can occur acutely. He disagreed, however, that the incident in question caused Petitioner's degenerative stenosis in her low back to become symptomatic. His basis for that opinion was that, even though he had no records showing documented treatment prior to the accident, it did not mean Petitioner was not symptomatic prior to that time. He testified Petitioner indicated she had seen a chiropractor from time to time, but conceded she told him that her last treatment was two years prior to the accident. RX1.

Dr. Randolph's understanding was that Petitioner was capable of working full duty prior to the accident of September 12, 2014. He aware she had changed jobs after the accident but was not aware whether or not she was physically able to return to work after the accident. RX1.

Dr. Randolph acknowledged that he was the only physician that opined Petitioner was at maximum medical improvement on January 20, 2015. He was aware that Dr. Raskas saw Petitioner on January 18, 2015, and that he noted she continued to have low back pain which went down her left buttock and left leg. He testified, however, that for the work accident of September 12, 2014, Petitioner was at MMI. Her continued symptoms were related to her degenerative condition and the spinal stenosis. Dr. Randolph relied upon therapy notes from January 2015, which indicated Petitioner had progressed well in her strength and mobility and that she was performing daily activities more normally. He conceded she may not have been completely asymptomatic, but she had made very good progress symptomatically, and with respect to strength and function, by January 2015. He conceded Petitioner did not actually have physical therapy on January 20, 2015, the date he set as her having reached MMI, and conceded her last therapy session before surgery was January 15, 2015. His MMI date of January 20, 2015 was an estimate. Dr. Randolph conceded Petitioner was not at any point symptom free prior to undergoing surgery. RX1.

Dr. Randolph acknowledged that Dr. Raskas recommended epidural steroid injections and facet blocks and that those are treatments he also recommends and performs in his practice. He agreed that as a treating physician in his own practice he treats a patient's symptoms and based on the history provided, and not only what he sees on an MRI or x-rays. He would not recommend treatment for a patient who had degenerative findings if they were not symptomatic. With regard to a lumbar strain, he testified the condition could be symptomatic anywhere from a few days to a few months. RX1.

Dr. Randolph agreed that a disc injury could be caused by the mechanism of bending over to lift or pick something up, or by something even less significant, although that would not typically happen. He conceded that he was unaware of any other traumatic event that could have caused Petitioner's symptoms, but testified he did not know everything she did in her daily activities, such as doing laundry, cleaning her house, or going to the grocery store. He testified any of those things could potentially cause some discomfort in the low back. RX1.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After review of the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows.

In support of the Arbitrator's decision relating to issue (C), whether Petitioner sustained an accidental injury that arose out of and in the course of his 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. 805 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App.3d 1010, 1013 (1st Dist. 2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 57 (1989). An "accident" encompasses anything that happens without design or any event that is unforeseen by the victim. *E. Baggot Co. v. Industrial Comm'n*, 125 N.E. 254, 255 (1919). An injury is also accidental within the meaning of the Act if a worker's existing physical structure, whatever it may be, gives way under the stress of his usual labor. *Laclede Steel Co. v. Industrial Comm'n*, 128 N.E.2d 718, 720 (1955). If the injury coincides with these definitions and is traceable to a definite time, place, and cause, then said injury is accidental within the meaning of the Act.

The Arbitrator finds that Petitioner has met her burden of proof in establishing that an accident occurred which arose out of and in the course of her employment. In so concluding, the Arbitrator finds significant that Petitioner gave a consistent history of the accident to her treating and examining medical providers, as well as at trial. The Arbitrator found Petitioner to be credible in her testimony. In addition, the Arbitrator finds that Petitioner's accident was a result of a risk incidental to her employment and not a neutral risk.

Respondent disputes the accident in part because Petitioner's first treatment record with Dr. McElheny indicates that she could not recall any precipitating event, but did report that it occurred at work. However, the initial physical therapy exam the very next day contains a clear history of Petitioner's back popping as she was bending over and pulling pizza dough out of a mixing bowl. Given such a detailed and consistent account of how the accident occurred, the Arbitrator is persuaded, and believes Dr. McElheny's history-taking is simply lacking in details. Petitioner's account of how the accident occurred is consistent throughout all of her medical records, with the exception of the one note by Dr. McElheny. The Arbitrator is persuaded by the totality of the records, and in particular by the initial physical therapy note one day after Dr. McElheny's note. Understanding that medical providers vary in their ability to accurately record

a history, the Petitioner should not be penalized by Dr. McElheny's single note, when the therapy note the very next day recorded a detailed history of the accident.

Respondent also disputes the accident based on the assertion that Petitioner's injury resulted from a neutral risk of reaching into the mixing bowl to pull out pizza dough, and that such activity was not a risk greater than that faced by the general public. However, one cannot dismiss an injury that occurs during a routine and uneventful motion such as reaching simply because the motion itself is not peculiar if, at the time of the occurrence, the claimant was engaged in an activity she might reasonably be expected to perform incident to her assigned duties. *Accolade v. Illinois Workers' Compensation Comm'n*, 2013 IL App (3d) 120588WC, 990 N.E.2d 901, 908 (3rd Dist. 2013). In addition, in the case of *Don Young v. Illinois Workers' Compensation Comm'n*, the Appellate Court awarded recovery for a shoulder injury the claimant sustained as a result of reaching into a box of parts while performing his job duties. The Court held in that case that even if the act of reaching was one performed by the general public on a daily basis, the risk to which claimant was exposed was necessary to the performance of his job duties at the time of the injury. The Court stated, "When a claimant is injured due to an employment-related risk—a risk distinctly associated with his or her employment—it is unnecessary to perform a neutral risk analysis to determine whether the claimant was exposed to a risk of injury to a greater degree than the general public." *Don Young v. Illinois Workers' Compensation Comm'n*, 2014 IL App (4th) 130392WC, 13 N.E.3d 1252, 1258-1259 (4th Dist. 2014).

In this case, the Arbitrator finds that Petitioner's activities were distinctly related to her employment rather than a neutral risk. While the Arbitrator recognizes that the act of reaching and pulling are common to the general public, the Arbitrator notes that the mixer in question was not an ordinary mixer, nor was the amount of dough being handled a normal amount. The mixer was estimated to be at least three feet by two feet and the paddles themselves were two feet. The bowl was obviously deep, as Petitioner had to bend three-quarters of the way down to her toes to reach its bottom. In addition, while bent over and reaching, Petitioner had to grab a large chunk of heavy, sticky dough. She testified she filled both hands with the large chunk of dough, an amount not normally handled by the general public in the course of daily activities. Although neither she nor Dr. Raskas knew the weight of the dough, the Arbitrator finds this to not be dispositive. The Arbitrator finds that the size of the dough, the fact that Petitioner reached to the bottom of the bowl and leaned three-quarters of the way to the floor, and the fact that the mixer and bowl were of an industrial size and nature, all combined to create a risk incidental to Petitioner's employment. The risk was not a neutral risk and was not a risk faced by the general public.

In support of the Arbitrator's decision relating to issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

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

The Arbitrator finds that Petitioner's current condition of ill-being is related to her work accident of September 12, 2014. In so concluding, and in light of the Arbitrator's finding with respect to issue (C), the Arbitrator finds significant that the record reveals no other cause for Petitioner's complaints, no complaints or treatment temporally close to the accident, and no intervening accident or other cause of Petitioner's complaints. The Arbitrator also finds it significant that the record is consistent with regard to Petitioner's ongoing complaints, the history of the accident, and the lack of meaningful improvement with conservative treatment. Petitioner credibly testified that she reached to the bottom of an industrial mixer bowl and pulled out a chunk of pizza dough with both hands and felt a pop in her back when coming back up. She further credibly testified, and the record corroborated, that she had low back pain immediately after the accident, which continued throughout her treatment.

It has long been recognized that, in preexisting condition cases, recovery will depend on the employee's ability to show that the work-related accidental injury aggravated or accelerated the preexisting disease, such that the employee's current condition of ill-being can be said to have been causally connected to the work injury and not simply the result of a normal degenerative process of the preexisting condition. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 204-206 (2003). The existence of health problems of an employee prior to a work-related injury nether deprives the employee of a right to benefits nor relieves the employee of the burden of proving a causal connection between the employment and the subsequent health problems. *Neal v. Industrial Comm'n*, 141 Ill.App.3d 289, 296 (1st Dist. 1986).

In this case, Petitioner credibly testified that she had not experienced any back problems nor received any medical treatment for back symptoms for at least two years prior to the accident. The Arbitrator finds it significant that the record is void of any medical records prior to Petitioner's accident, including any records temporally close to her date of accident.

The Arbitrator is mindful of Dr. Randolph's opinion that Petitioner's symptoms are related to the natural progression of her underlying degenerative disc disease, but is not persuaded by same. Dr. Randolph had several bases for his opinion. His first basis was the lack of history in Dr. McElheny's initial note regarding Petitioner pulling pizza dough from the bottom of the mixer bowl. The Arbitrator addressed this issue above and declines to follow this basis for Dr. Randolph's opinion. His second basis was that, although he agreed the activity described could have caused a disc injury, he believed daily activities such as doing laundry, cleaning house, or grocery shopping also could have caused it. The Arbitrator finds significant the lack of any record of Petitioner injuring her back by such activities or by any means other than the reported accident at work. The Arbitrator declines to follow this basis for Dr. Randolph's opinion. His third basis was Petitioner's statement that she had treated for occasional back pain prior to the accident. Although Dr. Randolph acknowledged and conceded that Petitioner had not treated for at least two years prior to the accident, he nonetheless opined that the lack of treatment did not mean she was not symptomatic. The Arbitrator finds this opinion to be without logic and without a credible basis, and declines to follow same.

The Arbitrator is persuaded by the record as a whole and by the opinions of Dr. Raskas with respect to Petitioner's current condition of ill-being being related to her work accident of

September 12, 2014. The Arbitrator therefore finds that Petitioner has met her burden of proof on the issue of causal connection.

In support of the Arbitrator's decision relating to issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

Under Section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury. *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill.App.3d 463, 470 (4th Dist. 2011) (citing *University of Illinois v. Industrial Comm'n*, 232 Ill.App.3d 156, 164 (1st Dist. 1992).

The Arbitrator finds the opinion of Dr. Raskas to be credible and more persuasive than that of Dr. Randolph. The Arbitrator notes there is no evidentiary basis for Dr. Randolph's opinion that Petitioner had reached maximum medical improvement on January 20, 2015. Petitioner did not see a physician on that date that could have released her, and in fact had seen Dr. Raskas the day before, who recommended injections. The record clearly demonstrates that Petitioner was still symptomatic from her work injury on that date.

In light of the Arbitrator's findings with respect to issues (C) and (F), the Arbitrator finds that medical services rendered to date, including surgery, were reasonable and necessary in Petitioner's care and treatment relative to her accident of September 12, 2014. The Arbitrator finds that Respondent is liable for outstanding medical bills as set forth in Petitioner's Exhibit 1, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act, with the following exceptions.

The Arbitrator declines to award any interest charges, to the extent that they are being claimed, in Petitioner's Exhibit 1. The record does not substantiate and Petitioner did not proffer evidence that interest was properly charged pursuant to Section 8.2(d)(3).

The Arbitrator declines to award charges billed by Dr. Raskas/Orthopedic & Sports Medicine for CPT code 99080, Special Report. A provider may not charge a fee for writing a standard report that is generated in the normal course of treatment. Although a provider may charge an additional fee for a special report that is unusual or outside the standard reporting form, the Arbitrator finds that none of the medical reports submitted into evidence meet this standard. As such, charges for such reports are not reasonable and the Arbitrator finds that Respondent is not liable for them.

In awarding the bill submitted by Gailcrest Neurological Services, LLC, the Arbitrator does so with a caveat. The provider must submit all necessary records, data elements, and applicable invoices required by Respondent to properly evaluate and process the charges submitted. The Arbitrator is mindful that the charges are substantial and finds that they must

comply with all aspects of the medical fee schedule, including the National Correct Coding Initiative, in order to be payable.

The parties stipulated and the Arbitrator finds that Respondent is entitled to a credit of $11,115.61 for amounts previously paid, including those paid through its group medical plan, for which credit is allowed under Section 8(j) of the Act.

In support of the Arbitrator's decision relating to issue (K), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

In order to be eligible for temporary total disability benefits, a claimant must prove not only that he did not work, but also that he was unable to work. *City of Granite City v. Industrial Comm'n*, 279 Ill.App.3d 1087, 1090 (1996).

As explained more fully above, Petitioner's medical treatment, including her surgery of April 17, 2015, is causally related to her injury at work on September 12, 2014. Due to her surgery, Petitioner was taken off work completely and thus temporarily and totally disabled from April 17, 2015, through May 1, 2015, a period of two weeks.

The parties stipulated that Petitioner's average weekly wage was $319.16. The Arbitrator finds Petitioner's temporary total disability rate to be $253.00 per week, the statutory minimum in effect at the time of her injury. Petitioner is entitled to two weeks of disability, for a total of $506.00. The parties stipulated Respondent has paid Petitioner for her time off work for this period of time and shall receive credit for same.

In support of the Arbitrator's decision relating to issue (L), the nature and extent of Petitioner's injury, the Arbitrator finds the following:

With regard to the nature and extent of disability, for accidents occurring after September 1, 2011, pursuant to Section 8.1b of the Act, in determining the level of permanent partial disability the Arbitrator must look at the following five factors.

In regard to factor **(i) the reported level of impairment pursuant to Subsection (a)**, although this accident was after the effective date of Section 8.1b of the Act, neither party offered into evidence a reported level of impairment pursuant to subjection (a). As such, the Arbitrator gives no weight to this factor.

In regard to factor **(ii) the occupation of the injured employee**, the record reveals that Petitioner was employed as a Kitchen Manager at the time of the accident and that she voluntary made a job change to a more sedentary position. The Arbitrator notes that Dr. Raskas testified Petitioner was able to return to work with no restrictions or limitations. The Arbitrator gives some weight to this factor.

In regard to factor **(iii) the age of the employee at the time of the injury**, Petitioner was 50 years old at the time of her accident. She has been able to return to work without restrictions,

albeit in another position for a different employer. Given her age, she will have to work with the ill effects of her injury for another 12 to 15 years. The Arbitrator notes Petitioner has degenerative disc disease, which is progressive and which pre-existed and is unrelated to her accident. With regard to her work related injury, the Arbitrator finds that over time Petitioner's condition could improve, stay the same, or get worse. However, there was no evidence offered to indicate with any degree of likelihood how her age would impact her disability, and the Arbitrator does not speculate as to same. The Arbitrator does note and find significant that Petitioner returned to work a mere two weeks following her back surgery, indicating an ability to heal quickly and a desire to be a productive employee. The Arbitrator places some weight on this factor.

In regard to factor **(iv) the employee's future earning capacity**, Petitioner voluntarily made a job change, earning more money than in her previous position with Respondent. There was no evidence presented to show that Petitioner's future earning capacity has been impacted, and the Arbitrator has no basis to expect she will have any decreased earning capacity in the future. The Arbitrator place little weight on this factor.

In regard to factor **(v) evidence of disability corroborated by the treating medical records**, the Arbitrator notes Petitioner sustained a herniated disc at L3-4 with symptomatic stenosis, for which she underwent bilateral laminotomies and foraminotomies at L3-4 and L4-5, removal of herniated disc at L3-4, and a two-level disc replacement. The medical records document Petitioner's complaints of pain throughout her treatment. However, at her final examination by Dr. Raskas on June 1, 2015, she reported she was doing very well and that her pain was nearly gone. She still got occasional pain in her right buttock and tingling in her leg, but felt much better overall. The Arbitrator notes Petitioner testified that she continues to have a twitch and takes over-the-counter medication as needed for her symptoms. She has switched to a less labor-intensive job, which helped. The Arbitrator places significant weight on this factor.

The Arbitrator notes that consideration of the factors enumerated in Section 8.1b does not simply require a calculation, but rather a measured evaluation of all five factors, of which no single factor is the sole determinant on the issue of permanency. Taking the above five factors into consideration, and based on the record in its entirety, the Arbitrator finds that Petitioner has sustained a 20% loss of use of the person as a whole (100 weeks) pursuant to Section 8(d)2 of the Act. The parties stipulated that Petitioner's average weekly wage is $319.16. The Arbitrator finds that her permanent partial disability rate is $253.00 per week, the statutory minimum in effect at the time of her injury.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tara R. Maschhoff,

Petitioner,

vs.

NO: 14 WC 43732

17IWCC0254

State of Illinois/Lawrence Correctional Center,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, 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 January 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.

DATED: APR 24 2017
TJT:yl
o 4/11/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MASCHHOFF, TARA S
Employee/Petitioner

Case# **14WC043732**

ST OF IL LAWRENCE CORRECTIONAL CENTER
Employer/Respondent

17IWCC0254

On 1/13/2016, 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 0.47% 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:

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

JAN 13 2016

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

17IWCC0254

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

TARA R. MASCHHOFF
Employee/Petitioner

v.

STATE OF ILLINOIS
LAWRENCE CORRECTIONAL CENTER
Employer/Respondent

Case # 14 WC 43732

Consolidated cases: none

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Edward Lee, Arbitrator of the Commission, in the city of Mt. Vernon, on October 7, 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 _____

17IWCC0254

FINDINGS

On **September 25, 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 **$95,268.16**; the average weekly wage was **$1,832.08**.

On the date of accident, Petitioner was **62** 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 **$2,093.97** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of **$2,093.97**.

Respondent is entitled to a credit of **any amount of medical bills awarded** under Section 8(j) of the Act.

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of **$1,221.38**/week for **7 weeks**, commencing November 5, 2014 through December 23, 2014, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$2,093.97** for temporary total disability benefits that have been paid.

Medical benefits

Respondent shall pay reasonable and necessary medical services of **$39,881.45**, as provided in Sections 8(a) and 8.2 of the Act.

Permanency

The Arbitrator finds that Petitioner sustained permanent partial disability to the extent of **10% loss of use of person as a whole** pursuant to §8d2 of the Act. This represents **50** weeks of disability at a PPD rate of **$735.37**.

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

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

Edward Lee
Signature of Arbitrator

12/18/15
Date

ICArbDec p. 2

JAN 13 2016

STATEMENT OF FACTS

On September 25, 2014, Petitioner was employed as a Teacher at the Respondent's facility. She had been a teacher there since 1998. Her usual shift is from 7:00 am to 5:00 pm. She teaches three classes a day for Adult Basic Education to inmates in the Academic Building. Her job duties also included performing audits. (T. pp. 7-9) Petitioner testified that an audit is a method in which she is to investigate inmates' grievances. Audits are usually due on the 20th of each month. Petitioner was allowed to go on vacation in the month of September and was told her audit would be taken care of by someone else. (T. pp. 10-11) When Petitioner returned from vacation on September 23, 2015, she was given the same audit to complete and that it was due immediately. Petitioner worked on the Audit over the next two days.

On September 25, 2014, Petitioner was performing her classroom duties for the two morning classes. She then skipped lunch period and walked to the Administration building in order to obtain a flu shot (provided by the employer) and to speak to two counselors concerning the audit. (T. p. 13) She returned to the Academic building to teach her third class of the day which ends around 3:30 pm. Usually after this class, Petitioner testified, that she would clean up the room. But on this day, Petitioner just locked the classroom door and went back to the Administration building to speak to the counselors again about the audit. She knew that they would leave their jobs at 4:00 pm. (T. p. 15) While she was interviewing the counselors, Petitioner realized that it was the end of the month and that there was a mandatory staff meeting she needed to attend that started at 4:00 pm. So at 3:45 pm Petitioner was rushing from the Administration building to the Academic building to attend the meeting. She testified that she used the sidewalks connecting the two buildings at ground level. She rushed to the Academic building and had to use a key to enter the Academic building. The locked doors were at the bottom of the stairwell and at the top of the stairwell leading to the 2nd floor where the meeting took place. (T. pp. 16-17) As Petitioner ascended the staircase she fell forward onto her right shoulder hitting the concrete steps. She was sprawled out on the steps for a matter of minutes. (T.pp.24-25) She testified that besides rushing to the meeting, she was carrying a cup of tea in her right hand and the audit papers in her left hand. The steps were made of concrete with a metal strip on the edge of each step. (T. p. 19) (R.X. 5) Petitioner also testified that the steps were usually littered with debris from the inmates' gum wrappers and eraser tops.(T.p. 23) Petitioner finally completed her ascent to the exit for the 2nd floor. She had to use her left hand to turn the key on the door. Petitioner gave notice immediately to Warden Treadway.

Warden Treadway called health care in the facility. A nurse came with a wheelchair and Petitioner was taken to health care. While in health care, Petitioner also completed the paperwork used by the facility to document work related accidents. Petitioner was assisted in completing these forms by another teacher, Donna McCormick. (T. pp. 29-30)

Petitioner sought medical treatment the very next day at Miller Chiropractic. She was treated six times and then was referred to Dr. Anand Prashanth. (PX 1) She was treated by Dr. Prashanth starting October 6, 2014. The MRI performed at Richland Memorial Hospital on October 20, 2014 showed a partial to full thickness supraspinatus tendon tear, post-traumatic, and adhesive capsulitis of the right shoulder. She was given a pain management injection on October 27, 2014. On November 5, 2014, she underwent surgery including a subacromial decompression and acromioplasty. She completed her physical therapy at Richland Memorial Hospital. (PX 2) She was kept off work from November 5, 2014 through December 23, 2014. Temporary Total Disability (TTD) was paid to Petitioner from November 5 to November 17, 2014. Petitioner was not paid any TTD from November 18 to December 23, 2014. (T. p. 35) The Petitioner testified that she wasn't sure who paid who medical bills.

Petitioner credibly testified that she is right hand dominant and now has a constant ache in her right arm. She has lost strength in her arm, and feels a "catch" when she raises her arm. As a teacher, she needs to write on the white board but noticed pain in her arm at the end of the work day. The facility was able to lower the white board to accommodate her. (T. pp. 35-36) At home, her arm tires more quickly when gardening or baking.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner sustained an injury arising out of and in the course of her employment with the Respondent. The Petitioner credibly testified that she fell on the steps of the facility because she was rushing from one work activity to another. She had been given an audit that was to be completed ASAP and she was required to attend a staff meeting at the end of each month. On September 25, 2014, the Petitioner was investigating the audit at around 3:30pm in the Administration office. She realized she was running late for the mandatory staff meeting in the Academic Building. She rushed from one building to the other, swiftly ascended the locked staircase, while carrying a cup of tea in one hand and the audit papers in the other. This perfect storm of events caused her to fall onto the steps and injure her right shoulder. The fact that the phrase, "rushing", was not in any incident reports does not refute the validity of her testimony. It is apparent in the incident reports filed that there is limited space to explain all the events that occurred at the accident site. (RX 1 &2) Respondent's witness stated that the photos of the stairs do not show a defect. Yet, Respondent's exhibit 5B shows that the metal strip on the edge of the steps was worn and the Respondent's witness testified that the painted metal strip was worn. (T. p. 62) The Petitioner credibly testified that any use of the elevator near the stairs was primarily for the ADA, disability offenders. (T. p. 65) Use of the elevator by employees is restricted to those who had a doctor's permit.

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

Having found in favor of the Petitioner for accident, the Arbitrator finds that Petitioner's right shoulder injury was caused by the accident of September 25, 2014. The medical records consistently refer to the accident as the reason Petitioner was treating for the right 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?

Having found in favor of the Petitioner for accident and causation, the Arbitrator finds the resulting medical care by Miller Chiropractic, Dr. Prashanth, and Richland Memorial Hospital is reasonable and necessary. The medical bills listed in the Stipulation sheet are Respondent's responsibility: Miller Chiropractic $890.00; RMH Professional Services $38,707.94; Clinical Radiologists $677.00; out-of-pocket reimbursement to Petitioner of $416.51.

"K" What temporary benefits are in dispute?

Having found in favor of the Petitioner for accident, causation, and medical bills, the Arbitrator finds that Petitioner was off work and entitled to TTD from November 5, 2014 through December 23, 2014. The Petitioner's physician, Dr. Prashanth, ordered Petitioner's lost time after the surgery until her return to work. (PX 2) Respondent is due a credit of $2,093.97 for partial payment of the time off.

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

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a Teacher at the time of the accident and that she *is* able to return to work in her prior capacity as a result of said injury. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 62 years old at the time of the accident. Because of her advanced age, Petitioner's injury will not heal as well as a younger person. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner returned to her regular job. 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 testified that the injured right shoulder is her dominant arm. She has a constant ache and the arm is now weaker than before. She still has a catching/pulling sensation in the arm. She cannot perform her teaching job without the pain and the employer lowered the white board to accommodate her arm injury. At home, her arm tires more quickly doing gardening and baking. Because of Petitioner's credible testimony, 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 10% loss of use of person as a whole pursuant to §8d2 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

Derrick Redmond,
Petitioner,

vs. NO: 15 WC 00848

Jewel Food Stores/New Albertson's Inc.,
Respondent,

17IWCC0221

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, 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 August 26, 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: APR 13 2017
o033017
DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

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

REDMOND, DERRICK
Employee/Petitioner

Case# **15WC000848**

JEWEL FOOD STORES/NEW ALBERTSON'S INC
Employer/Respondent

17IWCC0221

On 8/26/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2333 WOODRUFF JOHNSON & PALERMO
JAY JOHNSON
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

5074 QUINTAIROS PRIETO WOOD & BOYER
CAROL CESARETTI
233 S WACKER DR 70TH FL
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Derrick Redmond
Employee/Petitioner

v.

Jewel Food Stores/New Albertson's Inc.
Employer/Respondent

Case # 15 WC 00848

Consolidated cases: _____

17IWCC0221

An *Application for Adjustment 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 **7/12/16**. 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, **12/10/14**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$$10,240.00 (over 16 weeks)**; the average weekly wage was **$640.00**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **0** dependent child.

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

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$8,503.59** for other benefits, for a total credit of **$8,503.59**.

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

ORDER

Because Petitioner failed to meet his burden of proof as to accident and causal connection, all 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

8-26-16
Date

ICArbDec19(b)

AUG 26 2016

FINDINGS OF FACT

17IWCC0221

The Petitioner, Derrick Bernard Redmond, stated that he was an employee of Jewel on December 10, 2014. (T.9) He had begun working for Jewel on July 28, 2014. (T.9) Prior to that time, he had been doing similar work in a warehouse for Thermo Fisher for 14 years. (T.42)

His job at Jewel was as an assembler which entailed picking produce. (T.9) This included picking cases of product such as bananas, meats, and sacks of potatoes. (T.10) The assembler fills orders for various stores by building product to roughly six feet high. (T.10) The assembler must meet a production quota of 93-95%. (T.10) However, Petitioner did not testify as to how much volume of produce that percentage equates to.

Petitioner has had a number of previous reported work accidents and other non-work injuries. In 2004, he sustained an injury to his hand while working for Fisher Scientific. (T.34) Petitioner did not recall a 2005 injury to his chest while working for the same company. (T.35) Petitioner did not recall any workers compensation cases that would have been filed for accidents occurring in 2005. (T.36) He only remembered the carpal tunnel case involving his hand. (T.36) He recalled settling a case for $1,600.00. (T.36) He also recalls settling a case for 17.5% loss of a hand, which totaled around $11,100.00. (T.37) The IWCC database indicates that the Petitioner filed two workers compensation cases in 2006. One stemmed from a date of accident of November 1, 2005 and the other stemmed from a date of accident of January 6, 2006.

Petitioner also testified that he was in a motor vehicle accident, which he thought occurred sometime before 2011. (T.37) Petitioner testified that he injured his lower back as part of that accident, but reported no other injuries. (T.37)

Petitioner also testified that he alleged an injury to his back in October 2014 while working for Jewel, and that case is still pending. (T.37-38) The alleged December 10, 2014 accident is the second reported work injury in the five month span that he worked for Jewel. (T.38)

Petitioner claims he suffered a work related accident on December 10, 2014 while working in the warehouse for Jewel. (T.11) On that particular day, he was picking product that included meats, bananas, and potatoes because it was close to the holidays of Thanksgiving and Christmas. (T.11) When asked by his attorney, Petitioner indicted that he picked cases including turkeys on that date. (T.12) Petitioner generally described a constant flow of work around the holidays, and he specifically gave a general hypothetical example of possibly having to go pick around 18 cases of turkeys at one time. (T.11) However, the Petitioner did not specify the number of cases of turkey that he specifically picked on December 10, 2014.

Petitioner testified the cases may weigh from 50 to 70 pounds, though it varies. (T.12) He testified that he did not know the exact weights of what he was lifting at the time of the

alleged accident. (T.41) Petitioner testified that he was doing turkeys that day as well. (T.12) He said that the stores seem to order a lot more produce around holiday time. (T.12)

Petitioner testified that he would have to stack the cases such that the top case reaches a maximum height of about six feet. (T.81) He testified the cases all have different dimensions and sizes, but all have a certain depth to them. (T.84) Petitioner testified that he is 5'10" tall, so the top portion of the highest case would be slightly above his head. (T.21)

He testified that as he was doing his orders that day, he began to feel a pain in his left arm. (T.12) Petitioner testified that he is right hand dominant. (T.46) He testified that he was also feeling pain in his back, left shoulder, and a shooting pain in his neck coming down to his left arm. (T.13) He noticed this as he was working, but he didn't think anything of it because he thought it would go away. (T.13) He testified that he finished working on December 10 without seeking treatment. (T.14) Petitioner did not identify any witnesses to the alleged accident. (T.38)

He testified that the next day he came in and was putting on his shirt because they have to put on a certain amount of clothes when they are working in the cold. He noticed when he was putting the shirt over his head that his shoulder was hurting really bad. (T.14) He testified that the nurse gave him a strap to put around his arm for the pain, and she also put some heat on his shoulder to relax the muscle. (T.14)

He testified that he worked for close to a week, but the pain was extremely bad. (T.15) After a week, he decided to seek some medical care and tell the supervisor. (T.15) He testified that the first medical attention he received was at Fit to Work, which is an on site medical facility. (T.15)

Petitioner testified that it was when he went to Fit to Work that they gave him a strap to put around his arm because of the pain that was coming down. (T.16) The strap goes around his forearm and pulls tight to stop the pain. (T.16) They then put heat on it, massaged it, and he went right back to work again. (T.16) Petitioner testified that he went to Fit to Work almost every day until he first went to Concentra. (T.16) Petitioner testified that the nurse told him if the pain gets any worse, then he should go see the doctor. (T.16)

Petitioner testified on cross exam that he saw the nurse at the Fit to Work clinic on December 10th. (T.40) He said it is not accurate that the first time he went there was on December 17th. (T.40) Petitioner then revised his testimony and stated that he recalls working through the day on the 10th, and then when he came in the next day and put his shirt over his head he noticed the pain in his shoulder and he went to Fit to Work. (T.43)

The records submitted at trial reflect that Petitioner first reported to Fit to Work on December 17, 2014. (PX2) Petitioner's reported chief complaints at that time were muscle weakness, discomfort, and soreness in the left shoulder and elbow. (PX2) There was no specific mechanism of injury listed, other than Petitioner's thought that the overhead repetitions were

more than he was used to. (PX2) The record notes some irritation of the left bicep tendon and wrist extensors. (PX2) It also notes that Petitioner has been able to complete his work completely. (PX2) He testified that he was physically able to still do everything he needed for his job. (T.47)

The records indicate that Petitioner returned to Fit to Work on December 19, 2014 and was given a gentle massage of the wrist extensors and biceps tendon. (PX2) No other treatment visits to Fit to Work are noted in the records submitted at trial. Petitioner did not recall going back to Fit to Work on December 19, as he thought he had gone to Concentra around that time. (T.48)

The records indicate Petitioner first went to Concentra on December 29, 2014, which was 19 days after the alleged accident and 10 days after his last documented treatment at Fit to Work. (T.16/RX4) At that visit, Petitioner presented with a chief complaint of shoulder and hand pain. (RX4) The history notes that this is the result of repeated lifting, doing regular work, and increased pain last night. (RX4) There is no explanation as to what caused Petitioner's increased pain the night prior to this visit. Petitioner claimed the pain occurred gradually, and he localized his pain to the left anterior shoulder. (RX4) The note indicates that the symptoms occur intermittently, and there is no radiation. (RX4)

A physical examination of various body parts was conducted at this visit. Examination of the neck revealed the neck was supple and symmetric with midline trachea and no masses. (RX4) Examination of the cervical spine revealed normal posture, no tenderness, and full range of motion. (RX4) In the section listing associated symptoms, the record specifically states "no neck pain." (RX4) He was given a diagnosis of forearm pain, forearm sprain, and shoulder pain. (RX4) He was placed on modified duty, which Jewel was able to accommodate. (RX4/T.18)

The records contain an additional note from Fit to Work dated December 31, 2014 that describes a verbal interaction. (PX2) The note states that Fit to Work did not specifically refer the Petitioner to an MD, but rather he went to the clinic on his own. (PX2)

Petitioner followed up with Concentra on January 2, 2015, and at that time Petitioner was given an additional diagnosis of neck pain for the first time. (RX4) He continued to treat with Concentra throughout January and into February, and they continued to give him work restrictions, which Jewel accommodated. (RX4) Petitioner testified that he was still working for Jewel in a light duty capacity, and he was physically capable of doing that at the time. (T.53) He testified that he was getting his regular pay at that time. (T.53)

Petitioner first saw Dr. Kevin Koutsky on February 19, 2015. (PX3) Petitioner testified that he was feeling the same at that time. (T.20) Dr. Koutsky reviewed the January 22, 2015 MRI and diagnosed Petitioner with cervical radiculopathy. (PX3) He prescribed Petitioner pain meds and recommended physical therapy and evaluation at the pain clinic. (PX3) He also

ordered Petitioner to be completely off work. (PX3) Petitioner testified that he was able to work at Jewel until the day before Dr. Koutsky took him off. (T.54)

Petitioner underwent an EMG on March 19, 2015 with Dr. Oleh Paly. (PX8) The test was suggestive of mild left C5-C6 nerve root irritation. (PX8) It was noted that possible irritation to smaller sensory nerve branches in areas which may have been subject to trauma may be present, but due to size cannot be measured by standard methods. (PX8)

Petitioner followed up with Dr. Koutsky's office on March 26, 2015. (PX3) Dr. Koutsky reviewed the EMG study and opined that the test confirmed C6-C7 radiculopathy. (PX3) In his deposition, Dr. Koutsky confirmed this was a mistake, and he meant to say C5-C6. (PX1)

On April 1, 2015, Petitioner saw Dr. Jay Levin for an Independent Medical Exam. (RX2) Petitioner told Dr. Levin that he had been doing a lot of overhead work and developed pain in the left shoulder and neck. (RX2) Petitioner told Dr. Levin that he has a previous carpal tunnel surgery due to his previous job, but he could not remember if it was the right or left hand. (RX2) Petitioner also denied any previous motor vehicle accidents. (RX2) He reported to Dr. Levin that his left shoulder was 70% improved. (RX2)

Petitioner localized his pain to the left shoulder and left forearm. (RX2) Dr. Levin was able to look at the MRI films and previous medical records. (RX2) He opined that no relationship exists between Petitioner's cervical spine complaints and the alleged accident. (RX2) He stated that Petitioner may have suffered at most a mild left shoulder strain. (RX2) He opined that the Petitioner does not require any further treatment and he should have reached MMI four weeks post injury. (RX2)

Dr. Levin testified that lifting requires shoulder joint motion, so depending on the force application with the hand or wrist, the application of force of the shoulder is from lifting. (RX1.33) The cervical spine is not exposed to such force, and in order for that to be involved there would have to be flexion, rotation, or other force applications. (RX1.33) If he was purely lifting, then he wouldn't move his neck and that shouldn't cause problems with the cervical spine. (RX1.34)

On April 7, 2015, Dr. Levin issued an AMA rating, and he opined that Petitioner had a 2% impairment of the left arm, which converts to a 1% man as a whole impairment.

Petitioner next saw Dr. Koutsky on May 1, 2015 and complained of continued neck and shoulder pain. (PX3) He was given a trigger point injection in the back. (PX3) Petitioner testified that at first the trigger points would ease his pain, but the pain would come right back. (T.25)

Petitioner testified that he continued to follow up with Dr. Koutsky or his physician's assistant through the summer of 2015 with very little changes. (T.26) The injections would

relieve his pain for maybe a week and a half, but then the pain would come right back. (T.26) By the fall 2015, Dr. Koutsky still had the Petitioner doing trigger point injections and continued to keep the Petitioner off of work. (T.27) He was still recommending the same pain meds, but the Petitioner was taking them sparingly. (T.27) He followed up with Dr. Koutsky into the winter of 2016 and continued to have the same issues and same recommendations. (T.27)

Petitioner saw Dr. Patel at the request of Dr. Koutsky on December 22, 2014. (PX7) Petitioner testified that he saw Dr. Patel at Dr. Koutsky's office, and he recommended a cervical steroid injection. (PX7/T.28)

Petitioner continues to see Dr. Koutsky to this date, with his last visit coming on June 16, 2016. (PX) Dr. Koutsky is still recommending that Petitioner remain off work completely and continue therapy. (PX) Petitioner testified that in the 16 months that Dr. Koutsky has had him completely off work, Dr. Koutsky has never mentioned anything about the possibility of returning to work with restrictions. (T.57) Petitioner testified that he has never asked Dr. Koutsky to give him restrictions. (T.58) Further, Petitioner could not remember ever discussing with Dr. Koutsky the possibility that he could be capable of a lighter duty job. (T.59)

Petitioner testified that he no longer wants the trigger point injections because they make him nauseated and want to throw up. (T.25) He stated that Dr. Koutsky is aware of those side effects, but he continues to make the injections available to the Petitioner as an option. (T.61)

Petitioner testified that the medications prescribed by Dr. Koutsky give him side effects as well, but Dr. Koutsky continues to prescribe them. (T.62) Petitioner was taking the pain meds, but they were addictive uppers. (T.24) When he would come down, the pain was still there. (T.24) He testified that the meds were giving him bowel movements and making him high, which he didn't like. (T.24) Petitioner testified that he is no longer taking the pain meds by his choice. (T.24)

Petitioner testified that there are certain visits where Dr. Koutsky does not perform the examination. (T.63) Some exams are performed by Dr. Koutsky's physician's assistant, Russell Wudel, or his advanced practitioner, Christine Koutsky. (T.63) Petitioner testified that there are some visits where he does not even see Dr. Koutsky at all. (T.63)

Petitioner testified that he did his physical therapy at Athletico, and there were no other facilities where he did physical therapy. (T.64) The first visit to Athletico was on February 23, 2015, which was right after he saw Dr. Koutsky the first time. (T.64) Petitioner testified that at some point he stopped having improvements with the physical therapy. (T.64) He stated that the physical therapy is not helping his neck, but he still gets prescribed the physical therapy by Dr. Koutsky. (T.65) He testified that he continues to do physical therapy to keep his strength so he doesn't decondition, but he is not also working out to maintain his strength and help himself. (T.81)

Petitioner testified that Dr. Koutsky has not discussed with him that there might be any increased risks of treatment with smoking. (T.67) To date, Dr. Koutsky has not given the Petitioner a prescription for surgery. (T.68)

Petitioner testified that he currently still gets the pain in his neck coming down to his arm, and he still gets tingling and cramps in all of his fingers and toes. (T.23) He testified that as he sits here today, he is still feeling the same. (T.31) He is not currently working anywhere, and has not worked since Dr. Koutsky took him completely off work at his first visit there on February 19, 2014. (T.32)

CONCLUSIONS OF LAW

In support of the Arbitrator's Decision as to C. WHETHER PETITIONER SUFFERED ACCIDENTAL INJURIES WHICH AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH RESPONDENT, the Arbitrator finds the following:

Petitioner is alleging that he suffered a repetitive trauma injury to his left shoulder and neck on December 10, 2014. Although Petitioner is alleging a repetitive trauma injury and not an acute injury, he still has the burden of providing the Arbitrator with sufficient evidence as to the alleged repetitive employment activities which he claims contributed to his condition. Petitioner testified that prior to December 10, 2014 he had never injured his neck or shoulder, and he is alleging that his repetitive trauma injury developed entirely on that specific day.

At trial, Petitioner testified in general that as an assembler he would pick orders and that during the holiday season around Thanksgiving and Christmas those orders increased. The Arbitrator notes that Thanksgiving had passed by the time of the alleged accident on December 10. Further, Petitioner had only been with the company for 5 months.

Petitioner testified that he would pick cases of produce and items such as bananas, meats, potatoes, and turkeys, which cumulatively weighed 50 to 70 lbs. He told Dr. Levin at the IME that the cases ranged in weight from 10 to 80 lbs. He testified that he was required to meet a productivity quota of 93 to 95 percent, but he did not give any testimony as to the rate he would pick or stack cases. He testified that the cases would be stacked to a maximum height of 6 feet or slightly above his head at 5'10". However, he did not specify where the bottom of the top layer of boxes would fall or the frequency of any reaching that he would do above his head. In fact, he did not clearly illustrate that he was actually required to lift any cases over his head.

Petitioner also testified that every case is a different size, and they must be organized as they are being stacked such that the pallet will not fall. However, Petitioner did not sufficiently describe the specific weights, dimensions, and frequency of lifting that may have contributed to a repetitive trauma accident over the course of the specific date of December 10, 2014.

Petitioner testified at hearing that he felt pain in his left arm, back, and shoulder area and down from his neck on December 10, 2014. However, Petitioner gave no testimony as to what he was actually doing on this particular date other than performing his job. He did not give any testimony at hearing that he was specifically injured stacking turkeys on this particular date and there is no indication in the medical records that he ever told any of the providers that his pain was due to stacking turkeys on this specific date.

At hearing, he testified that he would have been picking meats and produce. Interestingly, Dr. Koutsky is provided a detailed hypothetical alleging that Petitioner was stacking turkeys on the date he was injured, yet Petitioner never testified to that history and did not clearly mention turkeys as part of his job duties on December 10, 2014 until he was asked specifically by his attorney if the picking included turkeys. Petitioner gave no specific testimony as to whether the weights of the boxes he was handling on that specific date were closer to the 10lbs or 80lbs he alleged to Dr. Levin, whether they were a variety, and no specification as to what he was doing at the time he felt pain – i.e. picking cases of a specific type of produce or halfway through a pallet. Moreover, Petitioner gave no specific testimony to describe the manner in which he lifted product, the location he lifted the product from, or the distance or time in which any given product would have to be lifted.

Petitioner further testified that he was able to continue working throughout the day on December 10, 2014. He did not report the accident on that date. He testified that he did not think anything of the pain at that time because he thought it would go away. He further testified that it was the next day as he was putting on his shirt when he noticed the pain. (T.14)

Petitioner's testimony is that none of the lifting events described on December 10, 2014 motivated him to seek medical attention, yet the action of putting on his shirt at work the following day is what provoked him to finally seek treatment. The Arbitrator finds it significant that the precipitating factor for Petitioner to report the pain was putting on his shirt the morning of December 11, 2014 and not any of his employment activities of December 10, 2014.

The Arbitrator finds that Petitioner testified inconsistently with regard to his treatment following the accident, and his recollection of the treatment does not match the records found in the exhibits submitted at trial.

Petitioner first testified on direct examination that he went down to see the nurse at Fit to Work on December 11, 2014 after he felt pain putting his shirt on. He later testified that he continued to work and waited a week before he decided to seek some medical care and tell the supervisor. Petitioner also testified that he was seeing the nurse at Fit to Work "almost every day until [he] went to Concentra."

Petitioner then testified on cross exam that he first saw Fit to Work on December 10, 2014. He later revised this testimony and recalled working through the day on December 10 and seeing the nurse the next day after the shirt incident. He later admitted that he is not certain of

the dates, but "they should have the dates there," presumably referring to the Fit to Work records.

The earliest Fit to Work record submitted at trial is dated December 17, 2014. The only other record submitted at trial of Petitioner seeking treatment from Fit to Work is dated December 19, 2014. Based on the records, the Arbitrator concludes that Petitioner first sought treatment at Fit to Work on December 17, 2014, one week after the alleged accident, as this account was corroborated by at least one of Petitioner's versions at trial. The Arbitrator also concludes that Petitioner did not see Fit to Work on the consistent basis he testified to, as such consistency is not reflected in the records presented.

The Arbitrator cannot determine that the Petitioner's version of events as to when and how often he treated at Fit to Work is credible. The Arbitrator must rely on the records presented at trial which show that Petitioner did not seek treatment for one week following the alleged accident.

The Arbitrator finds it significant that the Petitioner did not report any injury on the alleged date of accident, December 10, 2014, and was able to complete his entire shift on that date. The Arbitrator notes that Petitioner has filed multiple prior workers' compensation claims, including one less than two months prior while working for Jewel. Petitioner should be familiar with the process for reporting an injury, yet he did not do so right away.

Based upon a preponderance of the evidence, the Arbitrator finds that Petitioner did not meet the burden of proving that he suffered accidental injuries arising out of and in the course of his employment on December 10, 2014.

In support of the Arbitrator's Decision as to F. WHETHER PETITIONER'S CURRENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY, the Arbitrator finds the following:

Assuming that the Arbitrator were to find that Petitioner met the burden of proof for accident, Petitioner failed to meet the burden of proof necessary to prove causation. The records submitted at trial indicate that Petitioner did not first seek treatment at Fit to Work until December 17, 2014, a full week after the alleged accident. Petitioner testified that he did not seek treatment at the time he was lifting crates during his employment, but rather he first went to seek treatment when he noticed pain while putting on his shirt prior to work the next morning.

The records submitted to trial indicate that Petitioner only treated at Fit to Work one other time on December 19, 2014. He then first treated with Concentra on December 29, 2014, a full 19 days after the alleged accident and 10 days after the records indicate he last saw Fit to Work. The Fit to Work records indicate that Petitioner's complaints at that time were of

irritation to the left bicep tendon and wrist extensors. The December 19 note describes discomfort in his forearm and biceps. The assessments and descriptions in the Fit to Work records do not appear to mention any shoulder or neck complaints. Further, the December 29 Concentra records indicate that Petitioner's pain was not radiating and found normal findings with full range of motion related to the cervical spine.

Petitioner testified that the nurse at Fit to Work told him to go see a doctor if the pain got worse. However, a December 31, 2014 note from Fit to Work indicates a verbal interaction with the Petitioner at that time and directly contradicts the Petitioner's testimony. The note states that Fit to Work did not specifically refer the Petitioner to an MD and he went to the clinic on his own.

When Petitioner finally reported to Concentra on December 29, 2014, the listed assessment was for (1) forearm pain, (2) forearm sprain, and (3) shoulder pain. This was the first time Petitioner was assessed with shoulder pain. It was not until he returned to Concentra on January 2, 2015 that an additional assessment of neck pain was included. Concentra gave Petitioner light duty work restrictions, which Jewel was able to accommodate. Petitioner testified that he was physically able to perform the light duty work that was provided.

Petitioner first saw Dr. Koutsky on February 19, 2015. At that time, Dr. Koutksy diagnosed Petitioner with cervical radiculopathy and removed him completely from work. Dr. Koutsky admitted in his testimony that he did not review any prior medical history notes before seeing Petitioner. (PX1.25) The records indicate that Dr. Koutsky believed the March 2015 EMG confirmed the diagnosis of radiculopathy. However, Dr. Koutsky testified that he is not an EMG expert and does not know how to read them, but rather he relies on the examiner's summary. (PX1.29) It should be noted that the examiner found the test was merely suggestive of mild left C5-C6 nerve root irritation, but further noted that due to size the irritation cannot be measured by standard methods.

Petitioner continues to see Dr. Koutsky to this day, and his findings and recommendations have not changed during that time. He continues to diagnose Petitioner with cervical radiculopathy and keep him completely off work for over 72 weeks and counting. Dr. Koutsky continues to recommend conservative treatment in the form of injections, physical therapy, and medications despite little to no improvement. To date, Dr. Koutsky has not recommended surgery for the Petitioner.

In his deposition, Dr. Koutsky testified to his causal opinion based on a hypothetical scenario provided by the Petitioner's attorney. The hypothetical proposed that Dr. Koutsky assume an individual identical to Petitioner that was placing cases of frozen turkeys that weighed up to 50 lbs onto pallets and building them up to 6 feet high. (PX1.23) Based on this specific hypothetical, Dr. Koutsky opined that performing these activities likely caused a condition of cervical radiculopathy with pain, numbness, tingling, and pain in the left upper extremity and

aggravated a pre-existing condition of stenosis, causing the acute cervical radiculopathy. (PX1.24)

Petitioner's testimony did not mirror the facts assumed in the hypothetical presented to Dr. Koutsky. Petitioner testified that he was lifting cases that included meats, bananas, and potatoes on December 10, 2014. He stated that all cases were of different weights and dimensions due to the fact that they contained varying products. As such, Petitioner did not testify to the hypothetical facts as presented to Dr. Koutsky at the time he issued his causal opinion, as Petitioner was not strictly lifting cases of frozen turkey on December 10, 2014. Further, none of the records indicate that Petitioner's work was as described in the hypothetical. Moreover, neither the hypothetical nor Petitioner's testimony refer to the duration, frequency, distance, or consistency of the lifting that Petitioner was required to do on December 10, 2014.

Dr. Levin, a board certified orthopedic and spinal surgeon, examined the Petitioner on April 1, 2014. At the exam, Petitioner denied any prior motor vehicle accidents. At trial, Petitioner testified that he injured his lower back in a motor vehicle accident sometime around 2011. Petitioner also told Dr. Levin that a lot of his work is overhead. However, it was established at trial that Petitioner has a height of 5'10" and is required to stack crates of a certain depth up to a maximum height of six feet. Petitioner told Dr. Levin that his cervical spine was 70% improved as of the date of the exam. He also reported that his left shoulder was 70% improved as well.

Dr. Levin reviewed the January 22, 2015 MRI of the left shoulder, other prior medical records and diagnostic imaging, and performed a physical examination on the Petitioner. Dr. Levin opined that Petitioner may have sustained a mild left shoulder strain as a result of the alleged December 10, 2014 accident, but there was no relationship between that occurrence and the Petitioner's cervical spine complaints. He further opined that Petitioner would have reached MMI referable to December 10, 2014 as of four weeks post-injury.

Petitioner testified that he feels pain in the neck shooting down the left arm and shoulder. He also describes pain, numbness, and tingling in all of his fingers and toes on both hands and both feet. Petitioner testified that he has a history of carpal tunnel syndrome, and the Arbitrator finds that the records lack any evidence of linking Petitioner's foot issues to his alleged cervical or shoulder condition.

Petitioner further testified that he had initial complaints of pain in his back, left shoulder, and a shooting pain in his neck coming down his left arm, though the initial Fit to Work records are not reflective of those complaints. Petitioner testified that he felt the same when he reported to Concentra on December 29, 2014. Petitioner further testified that he felt the same when he reported to Dr. Koutsky on February 19, 2014 and at subsequent visits thereafter. Petitioner further testified that as he sits here today, he is still feeling the same.

The Arbitrator finds the opinions of Dr. Levin to be more detailed, compelling, and credible that those of Dr. Koutsky. The Arbitrator also finds the records indicate that Petitioner did not vocalize any cervical radicular complaints until nearly three weeks after the alleged accident. In fact, the December 29, 2014 Concentra records specifically noted that Petitioner did not have any radiating pain and also had normal posture, no tenderness, and full range of motion in the cervical spine. Petitioner has a history of back issues, including an injury stemming from a motor vehicle accident of which he failed to tell Dr. Levin about. He also claimed a similar low back injury as part of an alleged October 2014 work accident occurring while employed at Jewel.

For the foregoing reasons, the Arbitrator finds that Petitioner has not met his burden of proving that his current condition is causally related to the injury.

In support of the Arbitrator's Decision as to J. WHAT AMOUNT OF REASONABLE AND NECESSARY MEDICAL EXPENSES SHOULD AWARDED, the Arbitrator finds the following:

Because Petitioner failed to meet his burden of proof as to accident and causal connection, the Arbitrator finds that all medical benefits are denied. In addition, Respondent shall be entitled to a credit in the amount of $8,503.59 reflective of all medical payments made by the Respondent to date.

Even if the Arbitrator were to believe that Petitioner's condition as of February 19, 2015 when he first saw Koutsky was related to the alleged work accident, Petitioner testified at hearing that he received multiple trigger point injections and medications that were ineffective and made him sick, but Dr. Koutsky kept prescribing them. Petitioner has provided no convincing evidence at hearing to substantiate an award of medical expenses for over 72 weeks of injections and medications that are ineffective for improving Petitioner's condition. The Arbitrator concludes that regardless of compensability, these medical expenses would have not been awarded as the Petitioner has not met his burden of proving that this treatment was reasonable and necessary, particularly for the length of time it was rendered.

In support of the Arbitrator's Decision as to K. WHETHER ANY PROSPECTIVE MEDICAL SHOULD BE AWARDED, the Arbitrator finds the following:

Because Petitioner failed to meet his burden of proof as to accident and causal connection, the Arbitrator finds that no prospective medical should be awarded. The Arbitrator finds the opinions of Dr. Levin to be more credible than that of Dr. Koutsky with reference to the

need for future treatment. Dr. Levin opined that Petitioner has reached MMI for a left shoulder strain as of 4 weeks post-accident.

Dr. Koutsky continues to prescribe conservative treatment measures. Petitioner has testified that he has not received any benefits from physical therapy, injections, or medications prescribed by Dr. Koutsky for some time. Nonetheless, Dr. Koutsky continues to keep the Petitioner completely off work with no possibility of restrictions and has not made any surgical recommendation in over 72 weeks of treatment. Interestingly, none of the notes from Dr. Koutsky seem to reflect Petitioner's complaints or side effects, and rather seem to suggest at least some improvement.

Based upon the failure of the Arbitrator to adopt the opinions of Dr. Koutsky and the obvious failure of Petitioner to have any improvement by this ongoing treatment plan, the Arb denies any prospective medical.

In support of the Arbitrator's Decision as to L. WHAT AMOUNT OF TEMPORARY TOTAL DISABILITY EXPENSES SHOULD BE AWARDED, the Arbitrator finds the following:

Because Petitioner failed to meet his burden of proof as to accident and causal connection, the Arbitrator finds that all temporary total disability benefits are denied.

Even if this Arbitrator were to consider entitlement to temporary total disability benefits, Petitioner has testified and shown that he was physically capable of working light duty and earning his full hourly wage at Jewel up until the day before he saw Dr. Koutsky. At that time, Dr. Koutsky took him completely off of work and has continued to keep him completely off ever since. He has never discussed or considered the possibility of restrictions with the Petitioner during that time or whether the Petitioner might be capable of returning to a light duty position.

Dr. Koutsky testified that he removed Petitioner from work due to pain, weakness, and numbness in the left upper extremity, and he reasoned that he could not carry on his duties as an assembler. (PX1.10) Dr. Koutsky testified that he does not know what type of work the Petitioner would be capable of doing, and he did not know whether Petitioner would have been capable of returning to another job. (PX1.32)

Moreover, Dr. Koutsky testified that one of the main reasons Petitioner should not be working is because he is taking painkiller medications. (PX1.58) However, Petitioner testified that he has not been taking the medications any longer because they were making him nauseated. In fact, Petitioner testified that he was already taking the medications sparingly by the fall of 2015, but Dr. Koutsky still testified on February 11, 2016 that the pain meds were a barrier to return. Furthermore, Dr. Koutsky testified that he did not even know what specific painkillers he had prescribed to the Petitioner. (PX1.61)

The Arbitrator finds it unreasonable that Dr. Koutsky took Petitioner completely off work, specifically citing the idea that Petitioner could not continue on as an assembler, when just a day prior to this visit Petitioner was physically able to perform accommodated light duty work at Jewel. For the foregoing reasons, even if the Arbitrator were to have found this case compensable, the Arbitrator is not persuaded by Dr. Koutsky's opinion regarding Petitioner's work status. Therefore, the Arbitrator finds that temporary total disability benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

VERNICE TERRELL,

Petitioner,

vs. NO: 15 WC 1749

PACE,

17IWCC0262

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical, prospective medical, temporary total disability (TTD), and evidentiary objections raised in the record, 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. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission notes the Arbitrator ordered Respondent to "pay Petitioner temporary partial disability benefits of $667.06/week for 18 weeks, commencing 9/16/15 through 1/19/16, as provided in Section 8(a) of the Act." This was an obvious scrivener's error on the part of the Arbitrator as the record establishes that TTD was at issue not temporary partial disability benefits. Further, in her conclusions of law, the Arbitrator found Petitioner was entitled to TTD benefits from September 16, 2015 through January 19, 2016. Therefore, the Commission corrects the Order section and page 12 of the Decision of the Arbitrator to reflect that temporary total disability benefits, not temporary partial disability, are awarded. All else is affirmed and adopted.

17IWCC0262

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 17, 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 $62,100.00. 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: APR 25 2017

MJB/tdm
O: 2-28-17
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

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

TERRELL, VERNICE
Employee/Petitioner

Case# **15WC001749**

PACE SUBURBAN BUS
Employer/Respondent

17IWCC0262

On 3/17/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.51% 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:

5094 SKLARE LAW GROUP
MICHAEL TRYBALSKI
20 N CLARK ST SUITE 1450
CHICAGO, IL 60602

1505 SLAVIN & SLAVIN
PATRICK SHIFLEY
100 N LASALLE ST SUITE 2500
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Vernice Terrell
Employee/Petitioner

v.

Pace Suburban Bus
Employer/Respondent

Case # 15 WC 01749

Consolidated cases: _____

17IWCC0262

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **January 19, 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

17IWCC0262

On the date of accident, **January 5, 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 **$52,031.20**; the average weekly wage was **$1,000.60**.

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

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

ORDER

Respondent shall pay for the reasonable and necessary medical services provided to the Petitioner, pursuant to the medical fee schedule or by previous agreement, to

1.) Bud's Ambulance Service,
2.) Ingalls Memorial Hospital,
3.) Ingalls Occupational Health,
4.) Evergreen Family Medicine,
5.) Accelerated Physical Therapy,
6.) Vertical Plus MRI of Hazel Crest,
7.) Illinois Back Institute,
8.) APAC Center for Pain Management ,
9.) Ingalls Same Day Surgery,
10.) Northwestern Medicine, and
11.) Riverside Medical Center,

as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for any payments made on the medical bills prior to hearing.

Respondent shall authorize and pay for further reasonable and necessary medical services, as recommended/prescribed by Dr. Koski, pursuant to the medical fee schedule provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of $667.06/week for 18 weeks, commencing 9/16/15 through 1/19/16, as provided in Section 8(a) of the Act.

Petitioner's request for penalties 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.

17IWCC0262

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

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

Deborah L. Simpson
Signature of Arbitrator

March 17, 2016
Date

ICArbDec19(b)

MAR 17 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Vernice Terrell,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 15 WC 1749**
	)	
Pace Suburban Bus,	)	
	)	**17IWCC0262**
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on January 5, 2015, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that Petitioner gave notice of the accident which is the subject matter of the dispute within the time limits stated in the Act. They agree that in the year preceding the injuries, the Petitioner earned $52,031.20, and that his average weekly wage was $1,000.60.

At issue in this hearing is as follows: (1) Did an accident occur that arose out of and in the course of the Petitioner's employment with Respondent; (2) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (3) Is the Respondent liable for the unpaid medical bills to Bud's Ambulance Service, Ingalls Memorial Hospital, Ingalls Occupational Health, Evergreen Family Medicine, Accelerated Physical Therapy Center, Vertical Plus MRI of Hazelcrest, Illinois Back Institute, APAC Center for Pain Management, Ingalls Same Day Surgery, Northwestern Medicine and Riverside Medical Center, totaling $50,006.13; (4) Is Petitioner entitled to TTD from September 16, 2015 through January 19, 2016; (5) Is Petitioner entitled to penalties and attorney's fees; and (6) Is Petitioner entitled to prospective medical care.

STATEMENT OF FACTS

Petitioner testified that she has been employed by Respondent as a bus driver since 1991. Petitioner has worked out of Respondent's dispatch hub located at 16320 Dixie Highway in Markham, Illinois for the entirety of her tenure. At trial Petitioner sketched a diagram indicating the general layout and directional orientation of the property (Arbitrator Exhibit #2). That diagram, along with Petitioner's testimony describes a centrally-located building with parking lots on the East, North, and West sides. Petitioner further indicated that vehicles entering the property would do so via 163rd place which ran east-to-west along the North end of the property.

At trial Petitioner testified that the parking lot located on the west side of the building provided parking for the personal vehicles of employee bus drivers such as herself. Petitioner labeled this area the "Driver Parking Lot" in red ink. Petitioner labeled the parking lot to the east of the building as the "maintenance lot," in green ink, and indicated that it was designated for those workers who perform vehicle maintenance. Petitioner testified that the parking lot at the north end of the building was open to members of the general public and contained handicap-accessible parking. The handicapped parking area is designated in purple ink. Petitioner also designated the path to the driver's parking lot in a broken red line and to the mechanics lot in a green line. Employees and the general public enter the lot at the same place; they just go to designated areas to park.

Petitioner stated that Respondent's policy prohibited employee bus drivers from parking their personal vehicles in the parking lot on the north side of the building. Petitioner stated that Respondent had instructed her to park in the "Driver Parking Lot" and that she had always used that lot. Petitioner testified that all bus drivers used the "Driver Parking Lot" and that she had never seen a member of the general public park in that lot.

According to Petitioner, the entrance located on the west side of the building closest to the "Driver Parking Lot" was not open to the general public. Petitioner stated that the general public would enter the building on the north side.

Petitioner testified that at approximately 4:30 a.m. on January 5, 2015 she parked her vehicle in a space within the "Driver Parking Lot." Petitioner's vehicle was parked such that it was facing south with the building being behind her, to the north. Petitioner estimated that her vehicle was parked eighty (80) feet from the entrance of the building based on her approximation that the distance roughly equaled four (4), 20-foot-long buses. Petitioner stated that it was still dark outside at the time she had parked, but that she was able to see and that there was lighting in the parking lot.

Petitioner stated that she exited her vehicle and began walking towards the building, slipping near the rear of her vehicle. According to Petitioner, a male co-worker by the name of Roosevelt came to her assistance.

Petitioner states that she fell two more times while making her way to the building. Petitioner testified that she believed that Roosevelt witnessed all three falls and that her third fall was also witnessed by Pace dispatcher C.J. Johnson. According to the Petitioner the first time she fell she hurt her lower back. The second time she fell she hurt her left side. On the third fall she fell on her face and breast area.

According to Petitioner, on the morning of January 5, 2015 the entire surface of the "Driver Parking Lot" was covered with a sheet of ice approximately one (1) inch thick. Petitioner testified that the parking lot had been cleared of snow, which was shoveled into piles. Petitioner stated that the ground remained icy. According to the Petitioner the Respondent did not use salt on the ice in the parking lot. Petitioner was unable to see the asphalt parking lot surface through the ice. Petitioner believed the other parking lots to be in the same general condition.

Petitioner testified that once inside the building she was assisted to a seating area, and emergency personnel were called to the scene. Petitioner testified that a written incident report was completed at that time.

Petitioner testified that she was taken by ambulance to the Ingalls Memorial Hospital emergency room. According to the Petitioner one of the paramedics fell in the parking lot when they were trying to put her in the ambulance.

A review of the medical records indicates that Bud's Ambulance Service reported to the scene at approximately 5:22 a.m. Records indicate that Petitioner had fallen on her left side and complained of left arm and left leg pain. Petitioner denied experiencing a loss of consciousness (Petitioner's Exhibit #1).

Petitioner was transported to the Ingalls Memorial Hospital emergency room via ambulance. Petitioner reported having fallen three times with complaints of pain in the left arm, back, and leg. Petitioner denied having hit her head, but did note some head pain. CT imaging of Petitioner's head and cervical spine were taken as well as X-ray imaging of Petitioner's lumbar spine. Petitioner was diagnosed with low back pain, left hip pain, headache, and neck ache. Records reflected the cause to be related to work activities." Petitioner was recommended to remain off of work for the day and advised to return the following day for re-evaluation. Upon release, Petitioner received 1000mg of Tylenol and was advised against driving (Petitioner's Exhibit #3).

At approximately 8:07 a.m. on January 5, 2015 a registered nurse with Ingalls by the name of Ernest Ogbeide is noted to have spoken with Pace Bus and been advised that Petitioner did not need to be drug tested and that upon Petitioner's release from the ER someone from the Pace office would come to pick her up. Mr. Ogbeide also notes having been advised that Petitioner did not need to be drug tested by Robert Burnett of Pace at 8:01 a.m. (Petitioner's Exhibit #3).

On January 6, 2015 Petitioner returned to Ingalls Occupational Health as directed. Restricted duty was recommended and Petitioner was advised to return for further evaluation in four days (Petitioner's Exhibit #5).

On January 7, 2015 Petitioner presented to Evergreen Family Medicine for examination complaining of low back pain. Petitioner was diagnosed with a lumbar sprain and taken off of work for a period of three days.

Petitioner returned to Evergreen Family Medicine on January 10, 2016 again with complaints of low back pain which were attributed to the January 5, 2015 fall. Petitioner was kept off of work until January 16, 2015 (Petitioner's Exhibit #7).

Petitioner returned to Ingalls on January 12, 2015 at which time x-ray imaging of the hip, sacrum and coccyx were obtained. A recommendation for physical therapy and for restricted work duty was recommended (Petitioner's Exhibit #5).

On January 19, 2015 Petitioner began a course of therapy at Accelerated Physical Therapy at the referral of Dr. Daniel Bakston of Ingalls Occupational Health. Petitioner reported low back, left hip/leg, and left side neck pain after having fallen three times on ice while at work

on January 5, 2015. Petitioner completed a total of eight sessions between January 19, 2015 and February 4, 2015 (Petitioner's Exhibit #9).

On January 22, 2015, Ingalls Occupational Health ordered an MRI of the lumbar sacral spine as well as an EMG of the lower left extremity. Petitioner was prescribed Prednisone, Acetaminophen, and Tramadol. Restricted work duty was again recommended (Petitioner's Exhibit #5).

On January 28, 2015 MRI imaging of Petitioner's lumbar spine was performed at Vertical Plus MRI of Hazel Crest (Petitioner's Exhibit #11).

Dr. Daniel Bakston of Ingalls Occupational Health met with Petitioner on February 5, 2015 to review the findings of the lumbar spine MRI. Dr. Bakston noted "some finding[s] on MRI that would cause radicular symptoms." Dr. Bakston diagnosed a sprain/strain of the lumbar sacral region and referred Petitioner for pain management (Petitioner's Exhibit #5).

Petitioner began treating with Dr. Amy Harmening of the Illinois Back Institute on February 12, 2015, continuing through June 23, 2015. During the initial consult on February 12, 2015, Petitioner reported having a 10 year history of back pain which had been worse since falling on ice in January (Petitioner's Exhibit #13).

Petitioner was examined by Dr. Suleiman B. Salman of Advanced Pain & Anesthesia PC on February 16, 2015. Petitioner complained of lower back pain and leg pain following a slip and fall on ice at work on January 5, 2015. Petitioner also stated that she had subsequently developed some shoulder pain, which had largely resolved through her completion of physical therapy. Petitioner was diagnosed with lower back pain and radiculopathy. A transforaminal epidural steroid injection at L4-5 and L5-S1 was ordered. Petitioner was taken off work (Petitioner's Exhibit #15).

On March 10, 2015 Petitioner underwent a transforaminal epidural steroid injection at L4-5 and L5-S1. Pre-operative and post-operative diagnoses included: low back pain, left lumbar radiculopathy, lumbar stenosis, lumbar degenerative disc disease with L4-5 disc protrusion, and L4-5 spondylolisthesis (Petitioner's Exhibit #15).

Petitioner returned to see Dr. Salman on March 23, 2015 at which time the recommendation was made for physical therapy evaluation and treatment, as well as a second ESI (Petitioner's Exhibit #15).

On April 21, 2015 Petitioner underwent a second transforaminal ESI at L4-5 and L5-S1. Petitioner followed up on May 4, 2015. A left medial branch block was discussed (Petitioner's Exhibit #15).

At the request of Respondent, Petitioner was seen by Dr. Avi Bernstein of the Spine Center on May 18, 2015 for purposes of a medical examination pursuant to Section 12 of the Act (Petitioner's Exhibit #23). Dr. Bernstein's report concluded that Petitioner's had a preexisting condition of the lumbar spine that was aggravated as a result of a work related incident. He stated that her treatment to date has been reasonable, necessary and appropriate for her clinical condition. He further concluded that she had a clinical condition, and her options consisted of living with her condition or considering surgery to decompress and stabilize her

spondylolisthesis and spinal stenosis (Petitioner's Exhibit #23). Dr. Bernstein opined that the Petitioner was "capable of performing work as a bus driver, however she should not be involved in any passenger assistance requiring any physical activity, in other words, no exertion more than 15-20 pounds of lifting" (Petitioner's Exhibit #23).

On July 14, 2015 Petitioner received a third round of transforaminal epidural steroid injections at L4-5 and L5-S1. Petitioner subsequently returned for follow up visits with Dr. Salman on July 27, 2015 and August 3, 2015 (Petitioner's Exhibit #15).

On September 29, 2015 Petitioner was examined by Dr. Tyler Koski at the Northwestern neurosurgical clinic regarding complaints of ongoing back and leg pain. Dr. Koski reviewed Petitioner's MRI imaging, noting L4-5 stenosis, and bilateral lateral recess stenosis. Dr. Koski also noted that x-ray imaging showed a mobile spondylolisthesis at L4-5 which in his opinion "explain[ed] the majority of her symptoms." Dr. Koski stated that there were other multilevel degenerative disc disease findings, but concluded that, "the overall symptom driver is likely [the] L4-5 segment." Dr. Koski diagnosed Petitioner with lumbar stenosis and spondylolthesis (Petitioner's Exhibit #19).

Dr. Koski discussed surgical versus nonsurgical management, noting that Petitioner's obesity significantly impacted her surgical candidacy. Dr. Koski determined that surgical intervention was likely necessary, in the form of "a minimally invasive transforaminal lumbar interbody fusion." Dr. Koski concluded that "trying to optimize [Petitioner] from a general health perspective" made the most sense going forward and recommended aquatic therapy exercises at Riverside Medical Center. Petitioner was placed on light duty (Petitioner's Exhibit #19).

Petitioner presented for evaluation at the Riverside Medical Center on October 8, 2015. A course of aquatic therapy was initiated on October 13, 2015 which continued through December 2, 2015 (Petitioner's Exhibit #21).

A DEXA bone density scan was performed at Little Company of Mary Hospital on October 12, 2015. Normal bilateral femoral neck density was noted (Petitioner's Exhibit #21).

On November 6, 2015 Dr. Koski documented that Petitioner had been "participating in aquatic therapy to assist with weight loss as well as symptom control in preparation for a potential spinal surgery" (Petitioner's Exhibit #19).

Dr. Koski examined Petitioner again on December 22, 2015 and advised Petitioner to remain off of work due to her lumbar stenosis. A follow up examination was scheduled for three months out (Petitioner's Exhibit #19).

At trial Petitioner testified that she continues to have pain and wishes to proceed with surgery as recommended by Dr. Koski of Northwestern Medicine.

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987).

Longstanding Illinois law mandates a claimant must show that the injury is due to a cause connected to the employment to establish it arose out of employment. *Elliot v. Industrial Commission*, 153 Ill. App. 3d 238, 242 (1987).

The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 Ill. 2d 214 (1969).

The burden of proving disablement and the right to temporary total disability benefits lies with the Petitioner who must show this entitlement by a preponderance of the evidence. *J.M. Jones Co. v. Industrial Commission,* 71 Ill.2d 368, 375 N.E.2d 1306 (1978)

A workers' compensation claimant has the burden of proving by a preponderance of the evidence that her injury arose out of and in the course of her employment. 820 ILCS 305/2 (West 2010). Both elements must be present in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483, 546 N.E.2d 603, 605 (1989).

In support of the Arbitrator's decision with regard to whether Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

"The phrase 'in the course of' refers to the time, place, and circumstances under which the accident occurred." *Orsini v. Industrial Comm'n,* 117 Ill. 2d 38, 44, 509 N.E.2d 1005, 1008 (1987). "Injuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work, or within a reasonable time before and after work, are generally deemed to have been received in the course of the employment." *Johnson v. Illinois Workers' Compensation Comm'n*, 2011 IL App (2d) 100418WC, ¶ 21, 956 N.E.2d 543.

"When an employee slips and falls, or is otherwise injured, at a point off of the employer's premises while traveling to or from work, her injuries are ordinarily not compensable under the Act." *Vill v. Industrial Comm'n*, 351 Ill. App. 3d 798, 803, 814 N.E.2d 917, 921 (2004). Under such circumstances, the accident occurs outside "the course of" the employment. *Northwestern University v. Industrial Comm'n,* 409 Ill. 216, 221, 99 N.E.2d 18, 21 (1951).

However, under what is commonly referred to as the "parking lot exception" courts have allowed recovery when an employee is injured in a parking lot provided by and under the control of the employer. *Vill v. Industrial Comm'n*, 351 Ill. App. 3d at 803, 814 N.E.2d at 922. This exception applies in circumstances where the employee's injury is caused by some hazardous condition in the parking lot. *Id.* In applying the parking lot exception, Illinois courts have held that so long as the employer has provided a parking lot for use by its employees, the fact that the

employer does not own the lot is immaterial. *C. Iber & Sons, Inc. v. Industrial Comm'n*, 81 Ill. 2d 130, 135, 407 N.E.2d 39, 42 (1980).

Once the parking lot is considered part of the employer's premises, any injury on the parking lot is compensable if it would be compensable on the employer's main premises. *Mores-Harvey*, 345 Ill. App. 3d at 1038, 804 N.E.2d at 1090-91.

Here, the Petitioner testified that she was injured in a parking lot which she states the Respondent had designated for use by employee bus drivers. Petitioner testified that Respondent had a policy requiring employee bus drivers to use this lot for the purpose of parking their personal vehicles while working. This testimony was unrebutted. Petitioner states she fell shortly before she was scheduled to begin her work shift, and while she was in the process of walking from her vehicle to the employee-only entrance located on the west side of the building. (designated in green ink on the drawing made during her testimony Arbitrator's Exhibit #2) Petitioner testified that since 1991 she had always parked in this same lot, she had always known other employee bus drivers to use this same lot, and that she had never seen members of the general public using this lot. This testimony was also unrebutted by the Respondent.

While the record is not conclusive as to whether or not Respondent owned the parking lot in which Petitioner fell, that fact is immaterial as to the determination at hand. In *De Hoyos v. The Industrial Comm'n.*, the Illinois Supreme Court stated, "this court has consistently held that where an employee is injured on company property while going to or leaving work such injuries are compensable, (*Wabash Railway Co. v. Industrial Com.* 294 Ill. 119; *Cunningham v. Metzger*, 258 Ill. App. 150.), adding that "we have previously pointed out that whether the employer owns or does not own the parking lot is immaterial so long as the employer has provided the parking lot for its employees." *De Hoyos v. The Industrial Comm'n.*, 185 NE 2d 885 (1962).

Here, the record is unchallenged; Respondent not only provided the "Driver Parking Lot" for use by employee bus drivers such as Petitioner, but had further exercised control by instructing employee bus drivers to use only that lot for parking their personal vehicles while working.

The Petitioner's injuries occurred while in the course of her employment for Respondent as that phrase is understood under the Illinois Workers' Compensation Act.

"Arising out of" the employment refers to the origin or cause of a claimant's injury. *Baldwin v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 472, 478, 949 N.E.2d 1151, 1156 (2011). For an injury caused by a fall to arise out of the employment, a claimant must present evidence which supports a reasonable inference that the fall stemmed from a risk associated with her employment. *Builders Square, Inc. v. Industrial Comm'n*, 339 Ill. App. 3d 1006, 1010, 791 N.E.2d 1308, 1311 (2003).

In *De Hoyos* the Illinois Supreme Court concluded that "when an employer provides a parking lot for employees and an employee falls on the parking lot, this fact being uncontroverted on the record, the employee is entitled to recover as a matter of law" adding also that "an employee who falls on a parking lot provided by his employer while proceeding to work

is subjected to hazards to which the general public is not exposed." *De Hoyos v. The Industrial Comm'n.* 185 NE 2d 885 (1962), at 887.

In *Suter v. Illinois Workers' Compensation Comm'n*, where the evidence showed that Petitioner "slipped on ice in the employer-furnished parking lot as she closed her car door shortly after arriving at work" the court reasoned that under the Supreme Court's holding in *De Hoyos* Petitioner was entitled to benefits under the Act as a matter of law. *Suter v. Illinois Workers' Compensation Comm'n* 2013 IL App (4th) 130049WC.

In *Chmelik v. Vana*, the court held that an injury "accidentally received on the premises of the employer by an employee going to or from his actual employment by a customary or permitted route, within a reasonable time before or after work, is received in the course of and arises out of the employment." *Chmelik v. Vana*, 31 Ill. 2d 272, 279, 201 N.E.2d 434, 439 (1964).

Similarly, numerous courts have addressed injuries occurring in areas not specifically designated for employee-only parking. For example, in *Metsa v. CDW LLC* the court refused to award benefits on the basis that the Petitioner had elected not to park in the employee-designated lot, instead using the public portion of the lot. The court reasoned that because the employee had parked in an area open to the public, she was exposed to no greater risk than was the public when crossing the lot. *Metsa v. CDW LLC,* 20 ILWCLB 90 (ILL. W.C. Comm. 2012).

Likewise, in *Patton v. Dixon Springs IIP* the claimant was denied benefits after falling in a parking lot accessible to both the general public and employees alike. The court ruled that because the employer did not mandate where in that shared parking lot employees were to park, they were at no greater risk of slipping and falling on ice than was the general public. *Patton v. Dixon Springs IIP*, 21 ILWCLB 25 (Ill. W.C. Comm. 2012).

In the present case, the Petitioner testified that the "Driver Parking Lot" in which she had fallen was open only to employee bus drivers. Petitioner further testified that she had been instructed by Respondent to use this parking lot, that she had always used this lot since beginning employment for Respondent in 1991, that other employee bus drivers similarly used this lot, and that she had never seen members of the general public parking their vehicles there. According to the Petitioner, the day before the accident it had rained followed by freezing temperatures and then snow. When she arrived at work that morning between 4:45 and 5:00 am, she observed that the Respondent had cleared the snow. It was in visible piles in the parking lot. There was a layer of ice on the asphalt parking lot. The Respondent had not salted or sanded the parking lot to help with the presence and the effects of the ice. Petitioner slipped on that ice three times before she traveled the approximately eighty feet from her parked car to the building's west entrance which was the designated entrance of the building for the bus drivers. According to the Petitioner, the general public did not have access to or use this entrance. There was an entrance on the north side of the building, where the general public parked, for the general public to enter or leave the facility.

Because Petitioner's employment required that she park her personal vehicle in an area not accessible to the general public, and because accessing her place of employment from that area required traversing approximately eighty feet of icy asphalt, the alleged incident of January

5, 2015 clearly occurred in the course of, and arising out of Petitioner's employment for Respondent.

In support of the Arbitrator's decision with regard to whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Arbitrator finds that Petitioner's current condition of ill-being is causally related to the injury. In holding so, the Arbitrator relies on the various medical records and opinions entered by Petitioner at trial. Those records reflect a course of treatment which began immediately after the incident in question, including ambulatory care at the scene. Petitioner's medical records document a consistent history with regard to affected body parts and mechanism of injury.

To the extent that it bears on the issue of causation, the Arbitrator further notes that Dr. Avi Bernstein concluded in his report after his examination of the Petitioner and the treating records at the request of the Respondent pursuant to Section 12 of the Act, Petitioner " appears to have a quiescent preexisting condition of the lumbar spine that was aggravated as a result of a work-related incident."

Similarly, Dr. Tyler Koski of Northwestern's neurosurgical clinic noted that while there was some "multilevel degenerative disc disease findings" evidenced by Petitioner's imaging, in his opinion "the overall symptom driver" was likely to be the L4-5 segment of Petitioner's lumbar spine.

Proof of an employee's state of good health prior to the time of injury, and the change immediately following the injury, is competent as tending to establish that the impaired condition was due to the injury. *Westinghouse Electric Co. v. Industrial Commission*, 64 Ill. 2d 244,356 N.E. 2d 28 (1976). Petitioner testified that she did not have any previous injury or pain that prevented her from performing her duties until she fell on the ice in the parking lot on January 5, 2015. Although Petitioner reported to at least one medical provider that she had had back pain in the past, she never missed work because of it and did not have any working restrictions due to the back pain. The being taken off of work, and the work restrictions, occurred during her treatment for the injuries after the fall in the parking lot on January 5, 2015.

In support of the Arbitrator's decision with regard to whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

According to Arbitrator's Exhibit #1, the Respondent disputes medical charges only to the extent that Petitioner's claim did not arise out of and in the course of employment. Because the Arbitrator has found that Petitioner met its burden with regard to the issue of Accident, Respondent's dispute is deemed moot.

Additionally, Dr. Bernstein, Respondent's Section 12 Examiner, opined that her treatment to date has been reasonable, necessary and appropriate for her clinical condition. He further concluded that she had a clinical condition, and her options consisted of living with her condition or considering surgery to decompress and stabilize her spondylolisthesis and spinal stenosis.

Respondent is therefore responsible for payment of all reasonable and necessary medical services rendered in the treatment of Petitioner's injuries of January 5, 2015.

In support of the Arbitrator's decision with regard to whether, Petitioner is entitled to any prospective medical care, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Arbitrator finds that Petitioner is entitled to prospective medical care, including, but not limited to, that treatment recommended by Dr. Tyler Koski of Northwestern and Riverside Medical Center as outlined in Petitioner's exhibits: 19, 20, 21, and 22. This finding is supported by the recommendations and findings of both Dr. Bernstein and Dr. Koski.

In support of the Arbitrator's decision with regard to whether, Petitioner is entitled to TTD benefits, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Petitioner testified that she received benefits through September 19, 2015. The Parties stipulated that the only benefits at issue were those from September 16, 2015 through January 19, 2016.

The Arbitrator finds that Petitioner is entitled to disputed TTD benefits for the period of September 16, 2015 through January 19, 2016, or a total of eighteen (18) weeks based on an average weekly wage amount of $1,000.60. In reaching this determination the arbitrator relies on the medical records of Dr. Tyler Koski and Riverside Medical Center indicating that during the period in question Petitioner was actively engaged in a course of treatment and unable to work due to injuries sustained on January 5, 2015.

In support of the Arbitrator's decision with regard to whether, penalties or fees be imposed upon Respondent, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

A Petitioner may be entitled to Penalties and Fees when the conduct of the Respondent demonstrates an unreasonable or vexatious delay in the payment of benefits for a covered claim under the Act.

The record shows that the Respondent made payment of benefits under the Act before denying benefits on the grounds that the accident was not compensable. Records indicate that the Respondent communicated with the Petitioner that it intended to deny the Petitioner's claim on the grounds that it was not a compensable accident. (Respondent's Exhibit #1) The Respondent cannot be said to have failed to communicate with the Petitioner.

The Petitioner claimed injury resulting from a slip and fall in a parking lot owned by the Respondent. The Petitioner admitted during her testimony that the parking lot had been plowed sometime after the snow the previous evening and before she arrived for work at 4:45 am, before her fall. The Petitioner testified that the lot was well lit and that there were no defects in the asphalt that contributed to her fall. The entrance to the parking lot was shared by the bus drivers, the mechanics and the general public. The Petitioner referred to the condition of the lot as a product of the weather across the entire city of Chicago.

Slip and fall claims are fact specific. Despite the fact that the Arbitrator finds the case compensable, the facts known to the Respondent prior to testimony (that the lot had been plowed, was in good condition, was open to the public, and was lit) all support a theory of non-compensability. The Respondent therefore had a reasonable justification to deny the claim pending an Arbitrator's decision.

The Respondents conduct was not unreasonable or vexatious in denying the payment of benefits under the circumstances of this case. The Petitioner's claim for Penalties is therefore denied.

ORDER OF THE ARBITRATOR

Respondent shall pay for the reasonable and necessary medical services provided to the Petitioner, pursuant to the medical fee schedule or by previous agreement, to

1.) Bud's Ambulance Service,
2.) Ingalls Memorial Hospital,
3.) Ingalls Occupational Health,
4.) Evergreen Family Medicine,
5.) Accelerated Physical Therapy,
6.) Vertical Plus MRI of Hazel Crest,
7.) Illinois Back Institute,
8.) APAC Center for Pain Management ,
9.) Ingalls Same Day Surgery,

10.) Northwestern Medicine, and
11.) Riverside Medical Center,

17IWCC0262

as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for any payments made on the medical bills prior to hearing.

Respondent shall authorize and pay for further reasonable and necessary medical services, as recommended/prescribed by Dr. Koski, pursuant to the medical fee schedule provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of $667.06/week for 18 weeks, commencing 9/16/15 through 1/19/16, as provided in Section 8(a) of the Act.

Petitioner's request for penalties is denied.

Deborah L. Simpson
Signature of Arbitrator

March 17, 2016
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nelson Perez,

Petitioner,

vs. NO: 15 WC 01939

The Mainati Organization,

Respondent,

17IWCC0222

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, 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. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 26, 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.

17IWCC0222

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $65,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 13 2017
o033017
DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

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

PEREZ, NELSON
Employee/Petitioner

Case# **15WC001939**

THE MALNATI ORGANIZATION
Employer/Respondent

17IWCC0222

On 7/26/2016, 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 0.42% 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:

2194 STROM & ASSOCIATES LTD
LINDSEY STROM
180 N LASALLE ST SUITE 2510
CHICAGO, IL 60601

1596 MEACHUM STARCK
NATASA TIMOTIJEVIC
225 W WASHINGTON ST SUITE 500
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION §19(b) DECISION

Nelson Perez
Employee/Petitioner
v.
The Malnati Organization
Employer/Respondent

Case # **15** WC **1939**

17IWCC0222

An *Application for Adjustment 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 **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. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment 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 any prospective medical care?

FINDINGS

On the date of accident, **October 12, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$13,642.20**; the average weekly wage was **$262.35**.

On the date of accident, Petitioner was **48** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of **$0** 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 claim for incurred medical treatment and prospective medical treatment is approved. Respondent shall pay reasonable and necessary charges for medical services, excepting for the specific findings under paragraph ***J*** of the attached Conclusions of Law, pursuant to §8(a) and the medical fee schedule as provided in §8.2 of the Act.

Respondent shall authorize and pay for the treatment recommended by Dr. Singh and Dr. Cheng, as well as all reasonable and necessary medical in follow up of the recommended procedure.

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

July 19, 2016
Date

JUL 26 2016

NELSON PEREZ v. THE MALNATI ORGANIZATION, INC.
15 WC 1939

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** What temporary benefits are in dispute? *TTD*; ***M:*** Should penalties be imposed upon Respondent?; ***O:*** Is Petitioner entitled to prospective medical care and services?

Eugene Jao, D.C., and Petitioner testified at trial. The evidence depositions of Dr. Kern Singh, Dr. Tom Stanley, and Dr. Lawrence Koss were admitted in evidence.

FINDINGS OF FACT

Dr. Jao testified that he is a licensed chiropractor. Dr. Jao explained that he is not permitted to give medication or administer injections or perform surgery. Dr. Jao treats his patients with manual therapy, chiropractic adjustments, and physical therapy modalities. He will refer a patient to a medical doctor for prescription medication and co-manage care if needed.

Dr. Jao testified that he evaluated Petitioner on March 10, 2015 (PX #7). Dr. Jao testified that on that date, Petitioner had reduced cervical extension and flexion, as well as mild spasm and tenderness on palpation of the cervical spine paraspinals. Dr. Jao felt that Petitioner had reached "maximum therapeutic improvement", which he distinguished from maximum medical improvement. He explained that "maximum therapeutic improvement" meant that it was his opinion that Petitioner would not benefit from more chiropractic care, but that he could benefit from other interventions, such as pain management. Dr. Jao explained that he felt Petitioner had reached maximum therapeutic improvement because he was not improving with chiropractic therapy. Dr. Jao opined that Petitioner could benefit for epidural injections in his cervical spine.

Dr. Jao did not testify regarding the lumbar spine.

Dr. Jao discharged Petitioner from care at La Clinica because he felt that Petitioner would no longer benefit from therapy at his office. Dr. Jao clarified that was not discharging Petitioner from care completely; in fact, he felt that Petitioner would benefit from other treatments, which is why he referred him to pain management.

On cross-examination, Dr. Jao testified that Petitioner had plateaued with the type of therapy that was being provided at his office. He also testified that Petitioner said he did not want to continue treatement with Dr. Jain. Dr. Jao found 5/5 upper extremity strength on exam on March 10, 2015. He also noted negative cervical

compression. Work status was not addressed because Petitioner was seeing other physicians. Dr. Jao did not refer Petitioner to Dr. Singh.

It was unclear whether Dr. Jao referred Petitioner to other physicians.

On re-direct examination, Dr. Jao further explained that just because a patient improves significantly, this does not mean that the patient does not require additional treatment. He again opined that Petitioner could benefit injections.

Petitioner testified that on October 12, 2014 he was working as a delivery driver for Respondent, Lou Malnati's. His job duties included delivering food from the restaurant to customers' homes, breaking down and disposing of boxes, and loading a soda machine. He testified that he would have to carry a pizza bag containing multiple pizzas, weighing approximately 30 pounds. His shifts lasted 6 to 8 hours, 4 or 5 days a week. On Saturdays he worked longer hours because he worked double shifts. Petitioner was working without restrictions at the time of the accident and was not under any medical care for neck or back issues.

On October 12, 2014, Petitioner was making a delivery on Sacramento Avenue when another car ran a stop sign, T-boning his car. Immediately after the collision, Petitioner had pain and numbness in his neck and back. Petitioner got out of his car and called the police. Petitioner's co-worker saw the accident and called his boss to report it.

After the accident, Petitioner was taken via ambulance to the Emergency Department at Norwegian American Hospital (PX #3). The Chicago Fire Department EMS Report was incorporated with PX #3. The EMS Report notes Petitioner's complaints of 8/10 neck and 10/10 lower back pain. Petitioner denied loss of consciousness and was noted to be walking about at the scene of the accident.

Petitioner presented to Norwegian American Hospital Emergency Department with complaints of neck and upper back pain. The neurological exam was normal. There was tenderness in the lower cervical spine and in the lumbar spine. CT scans of the cervical and lumbar spines were negative for fracture except for the spinous process of T1. There were degenerative changes from C3 through C7, causing spinal stenosis and foraminal compromise. There were degenerative changes and disc bulges from L2 through S1, causing stenosis and dural sac compression. Petitioner was discharged with Norco for pain and a direction to follow up with Dr. Snitovsky at the orthopedics clinic. Petitioner advised that he would consult his own orthopedist.

Petitioner sought additional medical treatment at La Clinica with Dr. Eugene Jao, DC, where he received physical therapy and chiropractor care. Petitioner testified that this treatment was helpful, but it did not alleviate his pain. Because of his continued pain, Petitioner sought a second opinion from Dr. Kern Singh at Midwest Orthopedics at RUSH. Petitioner testified that Dr. Singh referred Petitioner to his colleague, Dr. Cheng, for pain management. Dr. Cheng prescribed an epidural steroid injection. However, Petitioner has been unable to get the epidural steroid injection due to the denial of authorization. Petitioner wants this procedure because he continues to have neck pain and trouble sleeping.

Petitioner testified that he now drives on a limited basis. Petitioner is the only one in his family that drives because his wife does not have a driver's license. He takes his son to school in the morning which is about 3 blocks from his home. Petitioner also drives to the market, which is approximately five to ten minutes from his home, for the limited purpose of getting groceries. He only drives for brief periods of time and for specific purposes. Petitioner goes to the market two to three times per week. Petitioner testified that he continues to experience neck pain even with the limited amount of driving that he does.

Petitioner testified that his pain feels like a weight on his neck and experiences cracking with movement. Before the accident Petitioner had never felt this kind of pain, had not seen a doctor for neck or back pain, nor taken medication for neck or back pain.

Norwegian American Hospital (PX #3)

The Chicago Fire Department EMS report was incorporated in PX #3. It noted that Petitioner was complaining of neck and lower back pain at the scene. Petitioner reported a mild front passenger side collision. He denied loss of consciousness. Petitioner was observed walking at the scene

Petitioner reported to emergency department staff that he had T-boned the other vehicle and was complaining of neck and upper back pain. No obvious signs of injuries were observed. A CT of the cervical spine noted degenerative disc changes and uncovertebral hypertrophy at C3-4 with a large spur at C3-4 compressing the dural sac, causing spinal stenosis. There is uncovertebral hypertrophy at C4-5 causing right neural foraminal compromise and spinal stenosis. There was also central spinal stenosis at C5-6 and C6-7. A spinous process fracture at T1 was thought to be old. The general assessment was degenerative discs with ossification causing multilevel stenosis. A CT of the lumbar spine revealed bulging discs at L2-3 and L3-4 with compression of the right L4 nerve root. A diffuse bulge at L4-5 compressed the dural sac, with degenerative facet and ligamentum flavum hypertrophy.

La Clinica (PX #1 & PX #2)

The first clinical notes are dated March 16, 2014. The first billing entry for $125.00 is for a detailed examination on March 15, 2014, with another billing entry for $125.00 for another detailed examination on March 16 (PX #2).

On March 16 Petitioner's history of neck and low back complaints for a motor vehicle accident on March 12 were noted. He reported his emergency care at Norwegian American Hospital also. Therapy began on March 16, 2014 and continued through February 20, 2015. Therapy included hot packs, therapeutic exercises, and electrical stimulation. There was billing for a TENS unit on November 25, 2014, for there was no documentation of medical necessity. There were also billings on November 25, 29014

for a moist heat pad ((\$600.00) and a home exercise kit (\$890.00) for which there was no documentation of medical necessity.

An MRI of the cervical spine was performed November 18, 2014, on referral from Dr. Aleksandr Goldvekht. A 2.5 mm broad-based protrusion, most prominent to the left, was noted at C2-3; a broad-based 5 mm protrusion was noted at C3-4, most prominent to the; a .5 mm broad-based protrusion at C4-5 was noted; a broad-based protrusion 2.5 mm protrusion, most prominent to the left, was noted at C5-6; and a broad-based 3.5 mm protrusion, most prominent to the right, it was noted at C6-7. There is no clinical note documenting that Dr. Goldvekht had examined Petitioner before the MRI or that any other healthcare provider had ordered the MRI or documented the medical necessity for the MRI.

La Clinica billed for minimal re-examination on most, but not all, clinical visits. In addition there was billing for "expanded", "detailed", and "comprehensive" examinations on November 5 and December 8, 2014; February 18, February 25 and, March 10, 2015. The clinical records for the expanded, comprehensive, and detailed examinations do not document detail sufficiently to distinguish those exams from the minimal re-examinations. In addition La Clinica billed for detailed examinations on October 15 and October 16, 2014. There is only one clinical note that would support a billing for a clinical examination on either October 15 or October 15, that being October 16 only. There are two separate billing entries on December 8: for an expanded exam for \$75. Again the clinical records for December 8 show no discernible difference between those notes and notes for minimal exams on other dates. The March 10, 2015 expanded exam billing of \$85.00 relates to Dr. Jao's discharge of Petitioner.

The records contain two clinical notes by Dr. Neeraj Jain, a pain specialist, on December 8, 2014 and February 18, 2015. The record is unclear whether charges of \$170.00 for "comprehensive' examinations relate to Dr. Jain. Dr. Jain diagnosed cervical facet syndrome, cervical discogenic pain, cervical radiculopathy, lumbar facet syndrome, lumbar discogenic pain, lumbosacral radiculopathy, and thoracic strain/sprain. He recommended bilateral facet joint injections at C3-4, C4-5, and C5-6.

Respondent offered its Exhibit #1, a response to an appeal of a Utilization Review. Authorization for additional physical/chiropractic therapy had been requested for 3 times a week for 4 weeks, 12 sessions. Karen Powell, D.C., addressed a response to Dulce Vasquez, D.C., on January 2, 2015. Dr. Powell substantiated the denial of authorization due to lack of significant objective clinical findings and adequate documentation treatment goals and any progress toward those goals. Dr. Powell relied on 2013 ODG guidelines which stated 10 therapy visits over 8 weeks was indicated for a clinical presentation such as Petitioner's. After noting that Petitioner had completed 10 therapy sessions Dr. Powell confirmed the previous denial of certification for an additional 12 therapy sessions.

Dr. Kern Singh (PX #4 & PX #6)

Dr. Singh, a board certified orthopedic surgeon, saw Petitioner February 9, 2015. His narrative report addressed to Petitioner's counsel (PX #4) on that examination was admitted without objection. He examined Petitioner and reviewed the March 18, 2014 MRI. Dr. Singh diagnosed C3-4 and C6-7 spinal stenosis. Dr. Singh recommended one epidural steroid injection, without specifying at which level, and that Petitioner be off work.

Dr. Singh testified by evidence deposition on March 24, 2015 (PX #6). He testified that he reviewed Petitioner's medical records, MRI films, and performed a physical examination. Dr. Singh testified that Petitioner reported an accident history consistent with the medical records reviewed. Petitioner complained of neck pain with spasms with tingling into the left hand. Dr. Singh testified that Petitioner had not told him about any prior condition in his back or that he had received prior medical treatment for back pain.

Dr. Singh found that Petitioner had diffuse cervical spondylosis, which is diffuse disc degeneration, at multiple levels, with moderate to severe stenosis of at C3-4 and C6-7. Petitioner's subjective complaints corresponded to the objective clinical findings. In light of this, Dr. Singh recommended a cervical epidural steroid injection for diagnostic purposes. The injection would confirm the source of Petitioner's symptoms.

Dr. Singh noted that Petitioner had occasional symptomatic lumbar arthritis, but this has no bearing on his cervical spondylosis and stenosis. Dr. Singh further testified that he does not believe DISH syndrome can be confirmed without a CT scan confirming ligamentous calcification. Dr. Singh agreed with Dr. Stanley that DISH is a pre-existing syndrome. Dr. Singh stated that DISH can cause stenosis but noted that Petitioner was not symptomatic prior to the work-related injury. Dr. Singh felt that the presence of DISH syndrome cannot be confirmed with the diagnostic studies available.

Dr. Singh testified that Dr. Stanley dismisses the fact that Petitioner has severe stenosis at C3-4. He agrees that a cervical strain is consistent with the mechanism of injury. However, Petitioner's spinal cord and nerve root compression are plausible pathologies to explain Petitioner's interscapular pain, hand numbness and tingling. Dr. Singh disagreed that Petitioner's condition is only made up of pre-existing arthritis and DISH.

Dr. Singh opined that Petitioner's accident aggravated the underlying spondylosis causing him to be symptomatic. In support of this conclusion, Dr. Singh discussed how Petitioner had no symptoms of cervical spinal stenosis before the October 12, 2014 accident and that there is radiographic evidence on MRI. Dr. Singh testified that Petitioner's interscapular pain, as well as hand numbness, correlate exactly with the C3-4 spinal cord compression and a C6-7 nerve root compression. Dr. Singh testified that to a reasonable degree of medical and surgical certainty, there is a causal relationship between Petitioner's current condition of ill-being and the work-related accident.

Dr. Tom Stanley evidence deposition (RX #2)

Dr. Stanley performed a §12 IME of Petitioner at Respondent's request on January 8, 2015. Dr. Stanley is a board certified orthopedic surgeon. Dr. Stanley testified by evidence deposition on July 21, 2105.

Dr. Stanley testified that he did not review medical records from Norwegian American Hospital or the first note from La Clinica, dated October 12, 2014. He reviewed an Illinois Motorist Report and photographs of front bumper damage to a motor vehicle. He did review a La Clinica a note by Dr. Goldvekht dated October 16, 2014. He reviewed two medical notes from Dr. Goldvekht, dated October 15, 2014 and November 5, 2014. He reviewed an MRI report dated November, 2014, but did not review the actual MRI film. Dr. Stanley did not review any medical records from before the date of the work-injury. He did not review any medical records or MRI films prior to Petitioner's work injury diagnosing him with DISH syndrome. Dr. Stanley did not review medical notes from Dr. Singh, who was once Dr. Stanley's mentor, and whose opinion he respects.

Dr. Stanley testified that he took a history of the accident from Petitioner. On cross-examination, Dr. Stanley admitted that he only knew that Petitioner was involved in a motor-vehicle accident. Specifically, Dr. Stanley was unaware of the fact that Petitioner was T-boned. Dr. Stanley testified on direct examination that he reviewed photographs of the vehicle showing some damage to the front bumper. On cross-examination, Dr. Stanley acknowledged that he did not know if the photographs were of Petitioner's vehicle.

Dr. Stanley testified that the physical exam lasted approximately 15 to 20 minutes. Petitioner was 6'2" and 315 pounds. Petitioner had a history of hypertension and diabetes. Petitioner had a normal gait. Dr. Stanley found no positive Waddell signs. He found no evidence of nerve root compression. X-ray of cervical spine showed a pre-existing condition called diffuse idiopathic skeletal hyperostosis (DISH), a bony fusion of the cervical spine. Based on the x-rays, Petitioner had evidence of fusion from C3-7. Dr. Stanley did not believe that the motor vehicle accident aggravated Petitioner's pre-existing condition based on the fact that he found no evidence of nerve root compression. Dr. Stanley testified that the DISH would have been years, even decades, in the making. He further testified that DISH would cause neck stiffness and reduced range of motion due to the ossifications fusing the vertebra. Dr. Stanley opined that Petitioner's work-related accidental injury did not aggravate or accelerate the DISH syndrome. On cross-examination, he testified that he did not review any medical records or MRI films prior to Petitioner's work injury diagnosing him with DISH syndrome.

Dr. Stanley's diagnoses included cervical strain injury, resolved lumbar strain, and diffuse DISH syndrome. DISH syndrome is a degenerative condition that results in

the auto-fusion of the spine and limits the range of motion in the spine. Based on the X-rays, Petitioner had evidence of fusion from C3-7. Dr. Stanley did not believe that the motor vehicle accident aggravated Petitioner's pre-existing condition based on the fact that he found no evidence of spinal cord or nerve root compression. He further opined that the MRI findings were not caused by the accident. Dr. Stanley further testified that he believed Petitioner had exhausted physical therapy and that no further treatment would likely resolve his symptoms.

Dr. Stanley found that there was mild central canal stenosis at the C2-3 level, severe central canal stenosis with mass effect on the spinal cord at C3-4 as well as moderate neural foraminal stenosis, and mild central canal stenosis at C5-6. He also found moderate canal stenosis at C6-7 level. However, Dr. Stanley opined that only the cervical strain is related to the work injury. He concluded that Petitioner's cervical strain has resolved and that Petitioner had already reached MMI by the time of his examination.

Dr. Stanley testified that he does not know how many hours per day Petitioner bends, stoops, lifts, reaches, stands, or climbs as part of his job. Additionally, Dr. Stanley said that he does not know how long Petitioner's shifts typically lasted or how many days per week Petitioner worked. He further testified that Petitioner drives to and from the market, but admitted that he did not know how far the market is from Petitioner's home or how long it would take to drive there and back.

Dr. Lawrence Koss (RX #3)

Dr. Koss testified by telephonic evidence deposition on June 11, 2015. Dr. Koss is board certified in Family Medicine. He authored a Utilization Review for Respondent on April 16, 2015, which was Exhibit #2 for his deposition. He stopped seeing clinical patients in June 2014 when he took the position of Associate medical Director of Concentra Medical Review Stream.

Dr. Koss is familiar with the process of utilization review. I n performing utilization reviews he uses Official Disability Guidelines (ODG). He acknowledged on cross-examination that he did not know who publishes ODGs but understands that ODGs were created by Work Loss Data Institute. He reviewed medical records that were provided, consisting of 87 pages of medical and administrative records He was specifically requested to determine the necessity of proposed cervical epidural steroid injections for Petitioner. He relied on the diagnoses of cervical spinal stenosis and chronic neck pain. On April 16, 2015 Dr. Koss conducted a peer to peer telephone call with Christopher McGee, PA.

Dr. Koss reviewed the diagnostic criteria to determine radicular pain. He concluded that Petitioner did not have radicular pain which was confirmed by the requesting provider as well as multiple consultants on the case as noted in the records. Dr. Koss disagreed with opinions that diagnostic imaging was ambiguous, he found the

imaging clearly defined. There was spinal stenosis at C3-4 and C6-7, without evidence of myelopathy or radiculopathy. Due to lack of unequivocal evidence of radiculopathy Dr. Koss determined that guidelines and criterion for the injection were not satisfied.

On cross-examination Dr. Koss acknowledged that he did not have training in either orthopedic surgery or neurosurgery. He would normally refer patients requiring orthopedic or neurosurgical care to those specialists. He went on to testify that he would not normally defer to an orthopedic or neurosurgical specialist on a referral to them. He described his relationship with those specialists as cooperative, noting that he may on occasion treat together with the referred specialists.

On further cross examination Dr. Koss acknowledged that he had no independent recall all of the Utilization Review. His testimony was based entirely on his April 16, 2015 report. In addition, he testified that he was not paid for the utilization review. Dr. Carson acknowledged that he reviewed the MRI report only, never seeing the actual images. He normally defers to a radiologist's interpretation of MRI but does not generally defer to the opinions of orthopedic surgeons.

Respondent's objection to Petitioner's Exhibit #5 was sustained and the exhibit was not admitted in evidence.

CONCLUSIONS OF LAW

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

The Arbitrator must weigh the evidence which includes conflicted opinions of whether Petitioner's current claimed condition of ill-being is causally related to his work accident. Based on all the evidence the Arbitrator concludes that Petitioner proved that his current condition of ill-being is causally related to the accident.

It is undisputed that Petitioner had pre-existing DISH. The issue is whether the work related accident aggravated an asymptomatic pre-existing condition.

Petitioner presented the testimony of Drs. Jao and Singh, who opined that Petitioner's complaints were causally related to the work accident. They principally relied on Petitioner's history that he had no complaints with his neck before his accident. There is no medical evidence that Petitioner had such complaints. His testimony at trail that he did not have such complaints was credible. Therefore, the Arbitrator finds that causation opinions of Petitioner's treating physicians, particularly Dr. Singh, were persuasive.

Respondent presented the evidence deposition testimony of Dr. Stanley to rebut Petitioner's theory of causation. The Arbitrator did not find Dr. Stanley's opinions persuasive. Dr. Stanley opined that Petitioner merely suffered a cervical strain as a result of the work-related injury, and that Petitioner's current condition of ill-being is

the result of DISH syndrome. Dr. Stanley did not review any diagnostic films other than an X-ray, which, as Dr. Singh testified, is not a reliable tool for diagnosing DISH.

In addition, there was credible evidence that Petitioner was asymptomatic with his pre-existing DISH. Dr. Stanley does not explain how Petitioner became symptomatic but for the work related accident. The Arbitrator finds that Dr. Stanley's causation opinion is not credible.

Dr. Stanley further opined that Petitioner was at MMI. Whether a person is at MMI is determined by whether the condition caused by the injury has stabilized. Here, Petitioner's ability to perform an action, albeit on a limited basis, is not evidence that his condition has stabilized. Petitioner's ability to drive for brief errands does not establish that he has reached MMI.

There are quantitative and qualitative differences between Petitioner's professional and personal errands driving. While at work, Petitioner drove 6 to 8 hours delivering pizzas and other food packages to various locations. When delivering food he had to enter and exit his car cautiously so that the food order is not damaged or spilled. When making a delivery he had to traverse varying physical layouts while carrying the pizzas or other food. Alternatively, when driving his son to school or to market, he is in the car for brief periods of time. When shopping he can arrange and mange parcels in a manner less stressful than when he is making deliveries for Respondent.

The Arbitrator finds Dr. Stanley's MMI opinion was not persuasive.

Dr. Jao testified that Petitioner had reached maximum therapeutic improvement. In testimony Dr. Jao was careful to distinguish maximum therapeutic improvement from maximum medical improvement. It is clear that Dr. Jao determined that he had reached the limit of what care he could provide to Petitioner within the limits of his chiropractic license. This does not equate to maximum medical improvement under the Act.

The Arbitrator found Dr. Jao's explanation that maximum therapeutic improvement was different and distinct from maximum medical improvement. Dr. Jao persuasively explained that Petitioner had reached the limits of chiropractic care but still required additional medical care.

Here Petitioner proved a chain of events which established a previous condition of good health, an accident, and a subsequent injury resulting in disability that was sufficient circumstantial evidence to prove a causal nexus between the accident and his injury. Petitioner was able to prove his work-related incident, combined with his pre-existing DISH was responsible for his inability to work and is a factor in his present disabled condition.

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

Based on review of all the evidence the Arbitrator finds that Petitioner's medical services, in general, were reasonable and necessary.

With the following exceptions the Arbitrator further finds that the charges for Petitioner's medical services were reasonable and necessary:

1. March 15, 2014 $125.00 charge from La Clinica for which there is no clinical record.
2. $600.00 charge for moist heat pad for which there is no documentation of medical necessity.
3. $890.00 charge for home exercise kit for which there is no detailed description.
4. La Clinica charges after November 3, 2014. The Arbitrator takes note that Petitioner received extensive chiropractic care from La Clinica without significant relief. A request for an additional 12 sessions of therapy, after completion of 10 sessions, was denied on Utilization Review. Chiropractor Dr. Karen Powell authored a response to an appeal of the denial by practitioners at La Clinica. Dr. Powell documented her confirmation of the authorization denial in detail. She raised some of the same issues regarding documentation as did the Arbitrator in assessing the reasonableness of La Clinica charges. Nonetheless, the Arbitrator takes note that Dr. Powell assessed Petitioner's care from afar. She did not examine Petitioner at any time, but, rather, only evaluated the written page. Under these circumstances the Arbitrator gives deference to the judgment of medical providers on the scene. The Arbitrator concludes that the additional 12 sessions of therapy, through November 3, 2014, were reasonable and necessary. The Arbitrator further finds that Petitioner failed to prove that chiropractic care at La Clinica after November 3, 2014 was reasonable or necessary.

Also, the Arbitrator also finds that clinical notes from La Clinica do not support the varying charges for medical exams on the dates billed. The clinical notes do not document medical services of "expanded" or "detailed" or "comprehensive" exam services which warranted any more that the $40.00 charges for routine exams. Therefore, the Arbitrator finds that, except for the $125.00 charge for the initial evaluation on March 16, 2014, the reasonable charge for all subsequent examinations is $40.00, the charge for a minimal exam.

The Arbitrator further finds that the charges for chiropractic therapy modalities were reasonable and necessary.

K: What temporary benefits are in dispute? *TTD*

Based on findings set for the above the Arbitrator finds that Petitioner proved he is entitled to Temporary Total Disability (TTD) from January 12, 2015 to September 29, 2015 and ongoing, representing 37 & 2/7 weeks of TTD benefits.

M: Should penalties be imposed upon Respondent?

Petitioner has petitioned for §16 attorney's fees, and penalties pursuant to §19(k) and §19(l) due to vexatious and frivolous termination of Petitioner's benefits.

There is no evidence of bad faith or improper purpose here. Respondent reasonably relied on the IME report of Dr. Stanley, which opined that Petitioner had reached MMI and that he was capable of returning to work in a full duty capacity. Benefits were terminated only after receipt of this report. Furthermore, Respondent reasonably relied on the utilization reviews reports of Dr. Koss and Dr. Powell, who found the recommended treatments as not medically necessary.

There is no evidence that Respondent denied benefits to unduly burden Petitioner, or to cause a delay, or to harass the Petitioner. Respondent relied on evidence enumerated in the Act in denying and terminating payment of benefits. Notwithstanding the Arbitrator's findings that the proposed prospective medical care is reasonable and necessary, Respondent did not act in bad faith or with an improper purpose.

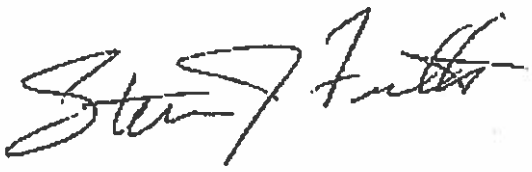
For the foregoing reasons, the Arbitrator denies award penalties pursuant to §19(k) and §19(l). Accordingly, the Arbitrator also denies an award attorney's fees pursuant to §16 based on penalties.

O: Is Petitioner entitled to prospective medical care and services?

The Arbitrator must weigh the opinions of Drs. Singh and Cheng and the opposing opinion of Dr. Lawrence Koss regarding the necessity of a diagnostic cervical epidural injection. An additional opinion was provided by Dr. Eugene Jao, a chiropractor, who agrees with the recommended cervical epidural steroid injection. Dr. Jao is not a physician licensed to practice medicine in all its branches. 225 ILCS 60, *et seq*. Dr. Jao testified that he is not a medical doctor and cannot recommend or administer injections. Therefore, the Arbitrator disregards Dr. Jao's opinions regarding the medical necessity of epidural steroid spinal injections.

The Arbitrator also disregards the opinions of Dr. Koss. Dr. Koss no longer practices clinical medicine. He is board certified in Family Practice. He did not examine Petitioner. Petitioner presents with an orthopedic problem. The Arbitrator can find no credibility in the opinions of Dr. Koss. On the other hand, Dr. Singh, board certified in orthopedic surgery, gave a reasoned opinion of the medical necessity for a diagnostic cervical epidural steroid injection.

Accordingly, the Arbitrator finds Dr. Singh's recommendation for prospective medical care persuasive and orders Respondent to authorize and pay for the diagnostic cervical epidural steroid injection and all reasonable and necessary follow up for assessment of the efficacy of the injection.



Steven J. Fruth, Arbitrator

July 19, 2016

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

Gregory Kasinger,

Petitioner,

vs. NO. 15WC002964

State of Illinois/Vienna Correctional Center,

17IWCC0243

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 accident, causal connection, medical expenses, prospective medical care, temporary disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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.

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

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

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: APR 19 2017
SJM/sj
o-4/6/2017
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

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

17IWCC0243

KASINGER, GREGORY
Employee/Petitioner

Case# 15WC002964

SOI/VIENNA CORRECTIONAL CENTER
Employer/Respondent

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:

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

0558 ASSISTANT ATTORNEY GENERAL
AARON L WRIGHT
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT SYSTEMS
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 19 2016

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

17IWCC0243

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)

Gregory Kasinger
Employee/Petitioner

v.

State of Illinois/Vienna Correctional Center
Employer/Respondent

Case # 15 WC 02964

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 14, 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, **10/24/14**, 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 **$71,123.00**; the average weekly wage was **$1,367.75**.

On the date of accident, Petitioner was **52** 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 **$any paid** for TTD, $- for TPD, $- for maintenance, and $- for other benefits, for a total credit of **$any paid**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $10,221.00, 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. Mall and Dr. Gornet, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $911.83/week for 23 4/7 weeks, commencing 10/24/14 through 11/2/14 (1 3/7 weeks), and 2/11/15 through 7/14/15 (22 1/7 weeks), as provided in Section 8(b) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Michael K. Nowak, Arbitrator — **5/3/16** Date

ICArbDec19(b)

MAY 13 2016

FINDINGS OF FACT

At the time of accident, Petitioner was a 51 year-old, employed by Respondent, Vienna Correctional Center, as a Correctional Food Supervisor. On the date of accident, October 24, 2014, Petitioner was walking down a set of steps after his 12 p.m. to 8 p.m. shift with coworker, William Colson, when he missed the second to last step and fell to the ground. (T. 13, 26). The fall occurred at 7:30 p.m. (RX2 p. 2). Coworker William Colson testified at trial, pursuant to subpoena. (T. 11). Both Colson and Petitioner testified that there was no lighting on the steps. (T. 15-16, 26-27). The steps were located at the end of a breezeway, as pictured in Respondent's exhibits #4 through #9. (RX4-9). In pictures #4-7, a can light is visible over the steps. (RX4-7). Both Colson and Petitioner testified that this can light was either burned out or empty at the time of accident. (T. 16, 26). Colson testified that the lighting conditions in the pictures do not accurately represent the lighting at the time of accident as the pictures were taken in broad daylight with the can light being on and the fall occurred in darkness with no can light. (T. 15-16).

Both Colson and Petitioner testified that the stairs adjoined to the breezeway were the only reasonable route to their working station in the dietary department. (T. 14, 28). Colson admitted that there was an alternate route via the housing units, but stated that "the main way is the steps. We could walk around by the housing units and go out, but that would be way out – or it would be out of the way." (T. 14). This testimony was corroborated by Petitioner. (T. 28). Colson stated at trial that he had been using the steps at the breezeway for 12 years. (T. 21).

Immediately after the injury, Petitioner presented to the staff nurse with pain in his left shoulder and neck and filed an injury report. (PX3; RX2). Petitioner continued to experience unresolved symptoms of pain and on February 11, 2015, presented to Dr. Nathan Mall. (PX4).

Dr. Mall noted that while Petitioner initially felt more pain in his left shoulder, as he recovered from his fall, the left shoulder pain resolved and pain in his right shoulder and neck became increasingly prevalent. *Id.* Dr. Mall ordered MRIs for Petitioner's cervical spine and right shoulder, suspecting a rotator cuff tear, labral tear, or biceps tendinitis in his shoulder and a possible disc herniation in his cervical spine. (PX4 2/11/15). In his note for February 11, 2015, Dr. Mall stated that he believed Petitioner's current condition of ill-being to be causally related to his work injury. *Id.*

On February 23, 2015, Petitioner received his MRIs from MRI Partners Chesterfield, which revealed objective findings of "a left paracentral-foraminal broad-based 3.5mm herniation" at C3-4, a "disc bulge with a central annular tear and broad-based 2.5mm herniation" at C4-5, "a central annular tear… at the apex of a broad-based central 4mm herniation" at C5-6, and "a central annular tear at the apex of a central 4mm herniation" at C6-7. *Id.* In regards to Petitioner's shoulder the MRI revealed objective findings of an "anterior supraspinatus and upper subscapularis insertional full thickness tear" of the rotator cuff, "lateral intra-articular biceps tendinopathy," and "AC joint arthropathy and hypertrophy resulting in mild supraspinatus outlet stenosis." *Id.*

On February 23, 2015, Dr. Mall reviewed the MRIs and recommended Petitioner receive rotator cuff repair, biceps tenodesis, and AC joint resection surgery. (PX4 2/23/15). Dr. Mall also referred Petitioner to Dr. Gornet for the herniated discs in his cervical spine. *Id.* Petitioner returned to Dr. Mall on April 6, 2015 and May 11, 2015, and was recommended surgery on both visits. (PX4). Petitioner is yet to receive surgery for his shoulder. (PX4; T. 28).

On May 11, 2015, Petitioner saw Dr. Gornet, who recommended no further treatment until Petitioner's shoulder pathology had been properly addressed. (PX7 5/22/15).

Petitioner testified at trial that he had no prior injuries to his shoulder before the accident. (T. 34).

Respondent presented no contrary medical evidence.

CONCLUSIONS

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

A claimant's injury is compensable under the Act only if it arises out of and in the course of the employment. (820 ILCS 305/2). Both elements must be present at the time of the claimant's injury in order to justify compensation. (*Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483 (1989). "In the course of employment" refers to the time, place, and circumstances under which the claimant is injured. (*Litchfield Healthcare Center*, 349 Ill. App. 3d at 490. Injuries sustained on an employer's premises while the claimant is working, or within a reasonable time before or after work, are generally deemed to have been received in the course of employment. *Id.* In this case, Petitioner was injured falling down a flight of stairs situated on Respondent's property at 7:30 p.m., on his way to clock out in the administration building. (T. 13-14). The Arbitrator finds that this satisfies the condition of being "in the course of employment."

A claimant's injuries "arise out of" his or her employment when the origin or cause of the injury can be traced to a risk "connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." (*Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58 (1989)). In addition, an injury is said to "arise out of" the claimant's employment if the claimant was exposed to a risk of harm beyond that to which the general public is exposed. *Brady v. Louis Ruffolo& Sons Contruction Co.*, 143 Ill. 2d 542, 548 (1991). There are three categories of risk to which an employee may be exposed: (1) risks distinctly associated with his or her employment; (2) personal risks; and (3) neutral risks which have no particular employment or personal characteristics. (*Illinois Institute of Technology Research Institute v. Industrial Comm'n*, 314 Ill. App. 3d 149, 162 (2000)). Generally, the risk of tripping or falling on stairs is a neutral risk with no particular link to the claimant's employment. *Id.* In such cases, the question of whether the claimant's injury arose out of her employment rests upon a factual determination of whether he or she was exposed to a neutral risk to a greater degree than that of the general public. *Id.* This can risk can be deemed as either qualitatively or quantitatively greater than that of the general public. (*Illinois Consolidated Telephone Co. v. Industrial Comm'n*, 314 Ill. App. 3d 353 (2000)).

In order to properly determine whether the claimant was exposed to a risk greater than the general public, it is necessary to determine whether there was a risk. In this case, Petitioner was walking the normal route from his work station to the administration building when he fell on a flight of stairs. Both Petitioner and his coworker Colson, testified that the stairs were not lit, and since it was 7:30 p.m. on an October night, the stairs were dark. The Arbitrator finds that unlit stairs constitute a risk. The Arbitrator also notes that Vienna Correctional Center is not open to the general public and that the general public would not be traversing the unlit stairs between Vienna's dietary building and the administration building at 7:30 at night after an 8 hour shift. Lastly, the

Arbitrator notes that both Colson and Petitioner testified that the can lights depicted in Respondent's exhibits, whose purpose was to illuminate the stairs, were nonfunctional. Therefore, the Arbitrator finds that Petitioner was exposed to a qualitatively higher risk than the general public as he was descending the stairs.

The Arbitrator finds that Petitioner's injury was in the course of employment as it occurred during his shift and on Respondent's property, and that the injury arose out of his employment as he was exposed to a qualitatively higher risk than that of the general public in the course of his employment.

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

The Arbitrator finds the medical opinions of Dr. Mall and Dr. Gornet to be persuasive. The Arbitrator notes that Respondent sought no medical evaluation and put forth no medical opinions concerning Petitioner's injuries. The only medical opinions contained in the record are those of Dr. Mall and Dr. Gornet, both of whom opine that Petitioner's present condition of ill-being is causally related to his work accident of October 24, 2014. (PX4 2/11/15; PX7 5/11/15). The Arbitrator therefore finds that Petitioner's current condition of ill-being is causally related to his work injury.

The Arbitrator also notes that Petitioner testified to having no prior injuries to his shoulder before October 24, 2014. (T. 34). Yet, after his fall, Petitioner had objective findings of herniated discs in his cervical spine and a full-thickness rotator cuff tear together with biceps tendinopathy. Relying then on the chain of events, the Arbitrator finds that there is a causal nexus between Petitioner's injuries and his present state of ill-being.

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 the medical services provided to Petitioner were reasonable and necessary. Objective MRI findings show a full-thickness rotator cuff tear, lateral intra-articular biceps tendinopathy, AC joint arthropathy and hypertrophy, and disc herniations at C3-4, C4-5, C5-6, and C6-7. Dr. Mall appropriately recommended surgery for Petitioner's shoulder and referred Petitioner to Dr. Gornet for his neck, who is withholding treatment until Petitioner's shoulder has been fully treated.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Respondent is liable for all reasonable and necessary medical services. Respondent shall pay reasonable and necessary medical services of $10,221.00, 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.

Issue K: Is Petitioner entitled to any prospective medical care?

The Arbitrator notes that no doctor has placed Petitioner at maximum medical improvement. Both Dr. Mall and Dr. Gornet have recommended and are awaiting further medical treatment. Dr. Mall has recommended surgery on the basis of objective MRI findings which show a full-thickness rotator cuff tear, lateral intra-articular biceps tendinopathy, and AC joint arthropathy and hypertrophy. Dr. Gornet is awaiting the resolution of Petitioner's shoulder treatment before moving forward with his neck treatment. Based on the above findings, the Arbitrator finds that Petitioner is entitled to prospective reasonable and necessary medical care as recommended by Dr. Mall and/or Dr. Gornet.

Issue L: What temporary benefits are in dispute? TTD

The Arbitrator finds that Petitioner is awarded TTD for the period of 10/24/14 through 11/2/14 and 2/11/15 through 7/14/15. The Arbitrator notes that Petitioner was off for 9 days following his injury as a suspension. Petitioner was taken off work again starting 2/11/15 by Dr. Mall and continues to be off work pending surgery. The Arbitrator notes that there is no medical opinion to the contrary.

Based upon the foregoing and the record taken as a whole, Respondent shall pay Petitioner temporary total disability benefits of $911.83/week for 23 4/7 weeks, commencing 10/24/14 through 11/2/14 (1 3/7 weeks), and 2/11/15 through 7/14/15 (22 1/7 weeks), as provided in Section 8(b) 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

Annette Neal-Ford,

Petitioner,

vs.

NO: 15WC 7485

Chicago Transit Authority,

17IWCC0212

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 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: APR 6 - 2017
o033017
SM/jrc
044

Stephen Mathis

David L. Gore

Deborah Simpson

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

NEAL-FORD, ANNETTE
Employee/Petitioner

Case# **15WC007485**

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

17IWCC0212

On 9/9/2016, 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 0.47% 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:

0293 KATZ FRIEDMAN EAGLE ET AL
KEITH SPARKS
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602-2983

0515 CHICAGO TRANSIT AUTHORITY
JEANNINE D SIMS
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

17IWCC0212

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED -ARBITRATION DECISION
19(b)

Annette Neal-Ford
Employee/Petitioner

v.

Chicago Transit Authority
Employer/Respondent

Case # 15 WC 7485

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **Chicago**, on **May 23, 2016 and proofs were closed on June 23, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **February 19, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$57,826.08**; the average weekly wage was **$1,112.04**.

On the date of accident, Petitioner was **48** 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 **$34,843.92** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$34,843.92**.

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

ORDER

Due to a finding that Petitioner's current condition of ill-being is not causally related to the accident, prospective medical care is **denied**.

Respondent shall be given a credit of **$34,843.92** for TTD, **$0** for TPD, and **$0** for maintenance benefits, for a total credit of **$34,843.92**.

Respondent shall pay Petitioner temporary total disability benefits of $741.36/week for 17 weeks, commencing 2/20/15 through 6/18/15, as provided in Section 8(b) of the Act.

Respondent shall be given a credit for any additional TTD benefits Respondent has paid towards any permanency later awarded in this case.

Respondent shall pay reasonable and necessary medical services relating to Petitioner's thoracolumbosacral injury provided through June 15, 2015 as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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.

17IWCC0212

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

_#001 *George J. Andros –corrected Decision* _____ **SEPT 9TH „ 2016**
Signature of Arbitrator Date

ICArbDec19(b)

SEP - 9 2016

FINDINGS OF FACTS

Petitioner, Annette Neal-Ford, is a bus operator for approximately 14 years. .

Petitioner testified that on February 19, 2015, she was walking out of a door held open by another CTA employee when she tripped on a rug and fell. Petitioner testified she was thrown approximately four to five feet in the air and fell on her right side on a pile of snow and/or ice. Petitioner testified that her back also hit the pile of snow and/or ice. Petitioner testified she was transported to the ER via ambulance. Petitioner testified that she complained of pain in her back and head. Petitioner testified that she began treating for her back and head pain following her discharge from the ER.

Respondent submitted an Injury on Duty ("IOD") packet. (RX 1). The packet included a Miscellaneous Incident Report and an Employee's Report of Injury on Duty form, which were both completed and signed by Petitioner. *Id.* Petitioner wrote that she tripped and fell to the sidewalk and hurt her mid back and right side. There was no mention of Petitioner hurting her neck or head in the fall, although Petitioner does list pseudotumor and serious headaches as preexisting conditions. *Id.* The IOD packet also includes a Special Occurrence Report and an Employee Interview Record. These reflect Petitioner told her supervisors that she injured her mid back and right side. Again, there is no mention of any neck pain. *Id.*

Prior Health Condition

Petitioner testified that prior to the work accident she suffered from idiopathic intracranial hypertension (pseudotumor). Petitioner testified that as a result of this condition she regularly suffers from headaches; however, Petitioner testified her headaches since the work accident are worse and more frequent. On cross-examination, Petitioner admitted that she was actively treating for her pseudotumor condition a few days prior to the work accident.

Medical records show that Dr. Mohan has been treating Petitioner since at least 2005 for her pseudotumor condition. (PX 2).

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 10, 2016
Date

ICArbDec19(b)

AUG 11 2016

According to Dr. Mohan's records, Petitioner was involved in a work accident on August 2009 and suffered from blunt trauma to the head. On January 9, 2015, Petitioner's primary care physician completed a certification stating that Petitioner would continue to suffer from flare-ups in the form of headaches that would prevent Petitioner from working. (PX 1). Dr. Mohan recommended an MRI and MRV as well as a spinal tap to relieve pressure on February 17, 2015—just two days prior to the work accident. (PX 2). It is clear that Petitioner was suffering from symptoms that required ongoing medical attention relating to her pseudotumor diagnosis at the time of the work accident.

Medical Treatment

Petitioner was treated at Norwegian Hospital ER on the date of accident. (PX 4). Petitioner told the medical professionals that she tripped over carpet while exiting a door. Petitioner complained only of pain to her low back and middle back. An x-ray of the lumbar spine was normal. The ER diagnosed Petitioner with a back strain or sprain. Petitioner was also examined by her primary care physician, Dr. De Leon, on the date of accident. (PX 1). Dr. De Leon also diagnosed Petitioner with a back strain. Petitioner followed up with Dr. De Leon on March 5, 2015. On that date, Petitioner complained of persistent back pain and radiation to her right leg with some numbness. Dr. De Leon diagnosed lumbar radiculopathy and prescribed pain medication, physical therapy and an MRI of the lumbar spine. Petitioner underwent an initial physical therapy evaluation approximately a week later.

An April 6, 2015, lumbar MRI revealed a shallow diffuse disc bulge at L5-S1 with mild effacement of the ventral thecal sac and mild encroachment of bilateral neural foramina. *Id.* There was no significant central canal stenosis. The MRI also revealed a minimal disc bulge at L4-L5 without significant compressive neuropathy. On April 9, 2015, Petitioner underwent another physical therapy evaluation. The therapist noted, "[t]he patient was inconsistent throughout the evaluation and, therefore, an assessment cannot be made of the patient's condition." *Id.* The therapist also noted, "[t]he patient overreacts with light touch from C1 to her hips bilaterally." *Id.*

Less than a week later the therapist noted that Petitioner was unable to tolerate any treatment as she complained of increased pain with every single position. Petitioner returned to Dr. De Leon on April 14, 2015, and complained of persistent upper back pain radiating to the low back and right leg with numbness. Petitioner for the first time complained of frontal headaches associated with ringing of the ears and blurring vision. Dr. De Leon noted that Petitioner had not followed up with Dr. Mohan as planned prior to the work accident. Dr. De Leon discussed Petitioner's condition with Dr. Mohan that same day and Dr. Mohan told Dr. De Leon that Petitioner's complaints of headaches, ringing ears, and blurring vision are common symptoms of her pseudotumor.

Petitioner was examined by Dr. Mohan on April 21, 2015. *Id.* Petitioner had a normal exam and Dr. Mohan told Petitioner to see an eye doctor. Petitioner saw an ophthalmologist the next week and complained of worsening headaches since her last visit to the eye doctor. The doctor noted that Petitioner had a spinal tap scheduled in March but cancelled it after her work accident. The ocular exam was stable. In mid-May Dr. De Leon recommended a second opinion from another neurologist regarding Petitioner's complaints of headaches and also referred Petitioner to an orthopedic doctor for her ongoing complaints of back pain. Dr. Mohan examined Petitioner in early June. (PX 2). He noted that Petitioner remained on her pseudotumor medicine and recently had a completely normal eye exam. Petitioner told Dr. Mohan that she still had symptoms from the apparent 2009 work accident when she hit her head. The doctor noted that Petitioner was suffering from two types of headaches, one was pseudotumor and the other was blunt trauma of the head and posttraumatic syndrome in relation to the 2009 incident. Petitioner returned to Dr. De Leon for a follow up and the doctor once again urged her to participate in physical therapy. (PX 1).

Petitioner began treatment with Dr. Chunduri in mid-June 2015. (PX 3). Petitioner told the doctor she tripped over carpet and flew approximately three feet and landed forcefully on her low back.

Petitioner complained of low back pain and pain radiating down her right leg with numbness and tingling in the first and second toes of the right foot. Dr. Chunduri told Petitioner to restart physical therapy and also recommended a right L5-S1 transforaminal ESI. Petitioner began physical therapy that same month and told the therapist that she had daily headaches and had tinnitus since the date of accident as well as vision problems. (PX 5). She also for the first time reported cervical pain to the chiropractor performing the physical therapy. *Id.* On July 2, 2015, Dr. Chunduri performed a right L5-S1 transforaminal ESI. (PX 3). Petitioner underwent an EMG of her lower extremities on July 8,, 2015. *Id.* The results revealed no electrodiagnostic evidence of a right or left (L2-S1) lumbosacral radiculopathy. There was also no electrodiagnostic evidence of peripheral neuropathy. *Id.* By mid-July Petitioner told the doctor her right leg symptoms had nearly resolved; however, she continued to complain of pain from her middle to lower back primarily on the right side. Petitioner underwent an EMG of her legs on July 8, 2015. *Id.* On July 16, 2015, Dr. Chunduri performed trigger point injections in the right paraspinus muscles. Petitioner returned to Dr. De Leon in late July 2015 and told the doctor that other than her ongoing back pain, Petitioner was doing okay. (PX 1). In August 2015, Petitioner continued to complain only of severe back pain and Dr. Chunduri recommended an L4-L5 and L5-S1 bilateral diagnostic medial branch block to evaluate for facet-mediated pain as the cause of Petitioner's complaints. (PX 3).

Petitioner returned to Dr. Mohan in mid-August 2015. (PX 2). The doctor noted Petitioner had suffered a work injury that year and complained of daily headaches. The doctor also noted that Petitioner was getting a cervical and lumbar ESI and was treating with her primary care physician and a pain specialist to relieve the pain in her neck and back. *Id.* It is unclear where Dr. Mohan received this information as it is not supported by any medical records in evidence.

Petitioner participated in an FCE on August 26, 2015 at Concentra. (PX 6). The consistency of effort results indicated "significant observational and evidence based inconsistencies resulting in self-limiting behavior and submaximal effort." *Id.*

The therapist noted the reliability of pain results were also unreliable. The therapist determined that based on the FCE result, Petitioner was able to perform within a sedentary physical demand category of work and therefore did not meet the physical capabilities of a bus operator. However, the FCE was "overall unreliable as it related to her back pain and diagnosis, as the movement patterns and objective data was disproportionate." *Id.* Due to Petitioner's lack of consistent effort the overall results of the FCE do not represent a true and accurate representation of Petitioner's physical capabilities. At best, they represent the minimal capabilities of Petitioner. *Id.* Petitioner presented with a Waddell score of five out of five which suggests a positive Waddell Sign and the potential for unreliable pain reports. *Id.* The therapist noted that Petitioner claimed she was unable to read the pain questionnaire due to blurred vision; however, Petitioner later took papers out of her purse and read them. *Id.* Petitioner also did not report pain symptoms consistent with the functional pain scale. Petitioner's pain complaints did not correspond with an appropriate physiological response and/or biomechanical change and/or associated pain behaviors. *Id.*

Petitioner returned to Dr. Chunduri in September 2015 and complained of continued severe back pain. (PX 3). Petitioner reported no improvement from the lumbar medial branch block; however, the prior ESIs had resolved her radicular symptoms. Dr. Chunduri referred Petitioner for a surgical consult. *Id.* Petitioner was evaluated by Dr. Wingate on September 30, 2015. *Id.* Once again Petitioner complained of radicular pain in to both lower extremities. Petitioner complained severe daily headaches, back pain, bilateral shoulder blade pain, ringing/tinnitus in the right ear, bilateral lumbar numbness, tingling, and weakness in the right leg greater than left. *Id.* Dr. Wingate diagnosed Petitioner with discogenic L5-S1 and L4-L5 low back pain. He recommended a cervical MRI and neurologic evaluation for Petitioner's headaches and noted that tinnitus might be a sign of a disk rupture in the upper cervical spine. *Id.*

The doctor noted that Petitioner did not have any symptoms of classical radiculopathy involving either upper extremity but did have generalized complaints of numbness and tingling to both hands and arm. He noted Petitioner had pre-existing carpal tunnel symptoms and recommended provocative discography to evaluate the discogenic source of pain. Dr. Wingate also strongly criticized the August 2015 FCE. *Id.*

An October 2015 MRI of the cervical spine revealed the following: disc dehydration at C2-C3; at C4-C5 a 1mm diffuse disc protrusion with effacement of the thecal sac; patent spinal canal and neural foramina; at C5-C6 a 1mm diffuse disc protrusion effacing the thecal sac having osteophytic complex at the lateral aspects; and, disc material and facet hypertrophy causing bilateral neuroforaminal narrowing that effaces the left and right C6 exiting nerve roots, more so on the left that right. *Id.* A lumbar discography at L2-L3, L3-L4, L4-L5, and L5-S1 was performed on November 17, 2015. The doctor diagnosed lumbar pain, lumbar facet syndrome, and lumbosacral radiculopathy. He also determined that Petitioner had discogenic pain at L4-L5 and L5-S1 with control levels at L2-L3 and L3-L4. *Id.* A CT scan of the lumbar spine taken that same day revealed the following: at L5-S1 a 3-5mm subligamentous posterior disk herniation with an extruded nucleus pulposus, noted to indent the ventral surface of the thecal sac with some stenosis and mild bilateral neuroforaminal narrowing, slightly greater on the left; at L4-L5 a 3-4mm broad-based subligamentous posterior disk herniation noted to indent the thecal sac with mild bilateral neuroforaminal narrowing; at L2-L3 and L3-L4 no significant posterior disk bulges, protrusions, or herniations and no spinal stenosis or significant neuroforaminal narrowing. *Id.*

Dr. Wingate examined Petitioner again at the end of November 2015. (PX 3). After reviewing the cervical MRI and the lumbar discography results, the doctor believed Petitioner has two ruptured disks with herniations and mild hyperlordosis in her cervical spine. He recommended cervical ESIs and/or facet blocks/rhizotomies as well as physical therapy. Dr. Wingate believed the ringing in Petitioner's ear and upper neck pain, muscle spasms, and arm symptoms are most probably related to the cervical lesions. *Id.*

He also recommended a posterior approach to the lumbar spine with radical discectomy, preparation of end plates, wide neural foraminal decompression, and instrumented interbody and posterolateral fusion using spinal instrumentation and her own bone grafting. Petitioner indicated she wanted to proceed with the recommended surgery. *Id.*

Petitioner returned to Dr. Wingate on April 7, 2016. *Id.* Although this presents as an office visit note, it is clear that Petitioner returned to Dr. Wingate solely for the doctor to respond to Dr. Troy's January 2016 IME report. Dr. Wingate made it clear that he disagrees with Dr. Troy's opinions and stood by his recommendations for surgery and ongoing treatment. This record was written on April 23, 2016. An April 19, 2016, EMG of the lower extremities revealed findings of right L5 radiculopathy localized to right L5/S1 with no neuropathy seen in the lower extremities. An April 20, 2016 EMG of the upper extremities revealed findings of bilateral C6 radiculopathy and bilateral mild carpal tunnel syndrome where no other neuropathy is seen in the upper extremities including ulnar entrapment.

Independent Medical Examinations

Dr. Troy performed an Independent Medical Examination at Respondent's request on June 15, 2015. (RX 4). Dr. Troy is board certified and fellowship trained in spinal surgery, general orthopedics, and sports medicine. Dr. Troy took a history of Petitioner's illness and noted that Petitioner claimed she injured her right shoulder, low back, cervical spine, and head on the date of accident. *Id.* Dr. Troy reviewed medical records relating to the work accident and specifically noted that Petitioner made no complaints of right shoulder pain, neck pain or any head injury at the ER on the date of accident. The doctor performed a physical examination of Petitioner.

Dr. Troy noted Petitioner had subjective complaints of pain across the paraspinalis muscles on both the right and left side of her cervical spine, greater on the right than the left. *Id.* Her left shoulder was neurologically intact; however, Petitioner had a "very emotional reaction" to the range of motion exam. *Id.*

Dr. Troy noted that taking Petitioner's right arm to approximately 90 degrees of flexion and 90 degrees of abduction actually caused tears to come to Petitioner's eyes. *Id.* Petitioner complained of thoracic and lumbar spinal pain. Dr. Troy made the following observations when attempting to examine Petitioner's back:

> "When I very lightly touched her back, as if one would just lay their hand on someone's arm, she actually was in tears from pain. She reported that this pain was across the thoracic and lumbar spine with a response that did not go hand-in-hand with the examination. Her subjectively based response did not match the objective examination, which was essentially barely touching the claimant. The claimant refused multiple times. I made it very clear to let the claimant fully know that I was barely touching her skin and placing absolutely no pressure and asked is this causing severe pain and she replied multiple times that it was causing severe pain." *Id.* at 6.

The doctor determined Petitioner demonstrated multiple Waddell factors during the examination. Petitioner also exhibited symptom magnification and reported pain that was out of proportion with the tests being performed. *Id.* Dr. Troy also reviewed available diagnostic testing results and also took additional x-rays during the examination.

The doctor noted that prior to this examination Petitioner had never complained of or reported any type of neck or shoulder pain or injury to her treating doctors. *Id.* After performing a full examination, interviewing Petitioner, and reviewing the medical records, Dr. Troy determined that Petitioner should undergo an FCE to determine the validity of her symptoms. He stated that if the FCE was invalid, Petitioner could return to work full duty; however, if the FCE was valid then Petitioner would benefit from four weeks of physical therapy. He noted that Petitioner had been discharged from two different physical therapy facilities due to her lack of participation. He opined that Petitioner at most had suffered thoracolumbosacral strain as a result of the work injury and her treatment to that point had been excessive. Dr. Troy also stated Petitioner had pre-existing degenerative changes at L5-S1 that are mild to moderate in severity. He did not find any central canal or any type of foraminal stenosis. Dr. Troy noted several times that Petitioner's pain complaints were completely out of proportion with her objective examination.

He determined that there was no objective reason for Petitioner's disability and her disability was subjectively based only.

Finally, Dr. Troy determined that while there was no objective reason why Petitioner could not return to work full duty, based solely on her subjective complaints Petitioner could return to work doing ground level work with a 10 pound lifting restriction. *Id.*

Dr. Troy performed a second Independent Medical Examination on January 11, 2016 at Respondent's request. (RX 5). He once again performed a physical examination and reviewed medical records dated after his initial June 2015 IME. Dr. Troy did not have the August 2015 FCE; thus he continued to strongly recommend an FCE to determine the validity of Petitioner's complaints and her functional capacity. Once again, Dr. Troy noted Petitioner had extreme responses to even the simplest and lightest touch and tests. *Id.* He noted that her pain was significantly magnified and significantly out of proportion. Dr. Troy was unable to perform his entire physical examination due to Petitioner's pain complaints that were significantly out of proportion.

Dr. Troy noted that Dr. Wingate recommended a two level fusion of the lumbar spine from L4 to S1 based on the November 2015 lumbar discography. *Id.* Dr. Troy noted that while the April lumbar MRI revealed a normal appearing L4-L5 level and instead revealed moderate disc disease at L5-S1, the discography was positive at the L4-L5 level. He determined that surgical intervention was not appropriate because Petitioner continued to exhibit symptom magnification and continued to demonstrate a significant number of Waddell factors. Dr. Troy also opined that because the discography had a positive L4-L5 level and thus negated the results of the lumbar MRI, the discography should not be used for a basis of surgery. *Id.* He opined that surgery also was not appropriate because there is a very high probability that Petitioner will not obtain any benefit from any type of surgical intervention. Dr. Troy once again determined that Petitioner's ongoing treatment was excessive and she only suffered a lumbosacral strain as a result of the work accident. *Id.*

On May 2, 2016, Dr. Troy provided an Addendum to his January 2016 IME. (RX 7). Dr. Troy provided a summary of the history of Petitioner's treatment and his two prior examinations of Petitioner. Dr. Troy also reviewed the August 2015 FCE performed at Concentra. Dr. Troy noted that the FCE demonstrated that Petitioner could perform 27.3% of the physical demands of her job as a bus operator. *Id.* He also noted that the consistency of effort results obtained during the FCE indicated "significant observation and evidence based inconsistencies that were resulting in self-limiting behavior and submaximal effort." *Id.* at 3. He also noted that the reliability of pain results were also borderline unreliable. Dr. Troy opined that the FCE fully supported his conclusions in the June 2015 IME that Petitioner's subjectively based complaints were completely out of proportion to her objective examination. According to Dr. Troy, the FCE "fully supports the idea that the claimant is demonstrating self-limiting behaviors and that the claimant is fully capable of performing more than she is demonstrating." *Id.* at 4. Based on the FCE and his prior opinions and observations, Dr. Troy determined Petitioner needed no further treatment or testing. He placed Petitioner at MMI and determined she could return to work full duty without restriction. *Id.*

TTD, Work Status, and Current Condition

Petitioner testified, and the medical records reflect, that her treating physicians have kept her off work since the date of accident. Petitioner testified that following Dr. Troy's June 2015 IME, Respondent did contact her and let her know Respondent could accommodate the restrictions outlined by Dr. Troy. Petitioner testified she did not return to work at that time because could not perform light duty work because she could not drive a bus. However, on cross examination Petitioner admitted that she never attempted to return and at least see if she could perform the work Respondent was willing to provide. Additionally, Petitioner admitted on cross-examination that in June 2015 Dr. Troy determined Petitioner could not drive a bus and included that in his restrictions.

Both Respondent and Petitioner presented a letter that shows Respondent let Petitioner know it was ready, willing, and able to accommodate the restrictions Dr. Troy outlined in June 2015. (PX 8; RX 6).

Respondent submitted a log of all TTD benefits paid to Petitioner. (RX 2). The log reveals that Respondent paid TTD benefits from February 20, 2015 through June 18, 2015 and from November 30, 2015 through June 26, 2016. The log reveals, and the parties agree, that at the time of the hearing Respondent paid a total of $34,843.92 in TTD benefits.

Petitioner testified that she experienced no improvement in symptoms following the injections and her low back pain was still painful following the recent EMG. Petitioner testified that her back feels like something is sticking and rising from her lower back to her neck. Petitioner testified that everything makes her pain increase and she can only sit for a few minutes at a time. Petitioner testified that prior to the work accident, she was able to walk long distances, worked out regularly, and even walked from Jackson and State St. to the Kedzie bus garage located at Kedzie and Jackson. Petitioner testified that she does want the lumbar surgery Dr. Wingate recommended. Petitioner testified that she described all of her symptoms to all of her doctors from the very beginning, but only focused initially on treating her back because her back was hurting the worst. Petitioner testified that she continues to experience pounding headaches, ringing in her ears, blurry vision, and pain radiating down her legs.

Medical Bills

Petitioner submitted bills that allegedly remain outstanding at the time of the hearing. (PX 9). Petitioner alleges there are outstanding balances owed for reasonable, necessary, and related services to the following providers: City of Chicago EMS, Dr. De Leon, Dr. Mohan, Illinois Orthopedic Network, H & M Medical; G & U Orthopedic LLC, Metro Anesthesia Consultant, Molecular Imaging/premium Healthcare Solutions, Norwegian American Hospital, EQMD, Lakeshore Open MRI, and Suburban Pain Care Center. *Id.*

The total alleged outstanding balance is $93,526.26 prior to any deductions pursuant to the fee schedule. Respondent submitted a log of all medical payments it has made relating to this case. (RX 3). At the time of the hearing, Respondent paid a total $15,627.83 pursuant to the fee schedule for medical care relating to this case. *Id.*

CONCLUSIONS OF LAW

The Arbitrator adopts the above findings of material facts in support of the following conclusions of law:

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

Based upon the totality of evidence, including the medical records, Petitioner's testimony, and the IME reports in evidence, the Arbitrator determines Petitioner's current condition of ill-being is not causally related to the injury. The Arbitrator adopts in total the medical opinion of Dr. Troy as most persuasive.

There is no dispute that Petitioner suffered a work-related injury on the date of accident. Petitioner tripped on a rug and fell on her right side and back onto a pile of snow and/or ice on the sidewalk. However, the extent of Petitioner's injuries and the ongoing need of workers' compensation benefits, both medical and financial, are at issue. Petitioner seeks an award of the lumbar surgery and other ongoing treatment recommended by her current doctor, Dr. Wingate. Respondent has relied on the opinions of its IME doctor, Dr. Troy who denies the need for any additional treatment. After carefully reviewing all the evidence, the Arbitrator notes that this case boils down to the persuasiveness of Petitioner, Dr. Wingate and Dr. Troy.

A review of the record reveals Petitioner is not at all a pursuasive witness. Petitioner testified that she hurt her neck, head, arms, and back as a result of the work accident. Petitioner testified that she reported all of her ailments immediately to her treating doctors, but ultimately chose to focus on treatment for her lumbar spine initially because her back was the most painful. However, a review of both the medical records and Petitioner's own contemporaneous report of injury tells an conflicting set of facts. It is clear that Petitioner did not complain of pain in her neck, head, and shoulders immediately after the injury.

This is clear from the IOD packet submitted by Respondent. (RX 1). Petitioner only reported an injury to her mid back and right side. Petitioner then was transported by ambulance to the ER and reported only severe low and middle back pain. The ER doctor diagnosed Petitioner with a back strain or sprain. (PX 4). Petitioner then visited her primary care doctor on the date of accident and again only reported back pain. Dr. De Leon diagnosed Petitioner with a back strain. (PX 1). Petitioner then followed up with Dr. De Leon on March 5, 2015, and complained of persistent back pain with radiation to the right leg with numbness. Again, there is no mention of any shoulder, neck, or head pain.

Petitioner continued to only complain of low back pain with radiation until April 14, 2015. On that date, Petitioner visited Dr. De Leon and complained of upper back pain radiating to the low back and right leg. For the first time, Petitioner tells Dr. De Leon that she has had on and off frontal headaches for weeks and had ringing ears and blurring vision. Again, there is no mention of any neck or shoulder pain. Dr. De Leon confers with Dr. Mohan, who was already providing ongoing treatment for Petitioner's preexisting pseudotumor condition. Dr. De Leon conferred with Dr. Mohan that same day and noted that Dr. Mohan determined Petitioner's complaints regarding headaches, ringing ears, and blurring vision were all symptoms common to her pseudotumor condition. From this point, the records show Petitioner did complain of headaches and other associated symptoms off and on to various doctors. However, again, the complaints of headaches, ringing ears, and blurring vision were not constant despite Petitioner's numerous medical appointments. Also, there is no indication that Dr. Mohan or any doctor other than her newest treating physician, Dr. Wingate, ever thought her complaints were related to anything other than the natural progression of her pseudotumor condition. In fact, Dr. Mohan explicitly connects her complaints to her apparent prior 2009 accident. (PX 1).

In fact, the first time we hear anything about injuries to Petitioner's right shoulder, cervical spine, and head is when she is interviewed by Dr. Troy in June 2015 for her first IME examination.

Dr. Troy carefully reviewed the records and noted that Petitioner never previously complained in any way about these alleged injuries despite her extensive treatment. (RX 4). Following the examination with Dr. Troy, we see Petitioner begins complaining of neck pain—not to Dr. Chunduri, her treating physician, but to the chiropractor providing physical therapy prescribed by Dr. Chunduri. A review of the records shows Petitioner never treated with Dr. Chunduri for any neck or shoulder complaints. She solely complained of severe low back pain. Petitioner also testified that the injections did not provide any relief to her. Again, a review of the medical records shows this is not accurate. Petitioner in fact told Dr. Chunduri the lumbar ESIs did provide relief and ultimately resolved her radiculopathy symptoms.

Petitioner's credibility is further damaged when one notes the rampant inconsistencies between Petitioner's September 24, 2015, exam with Dr. Chunduri and her September 30, 2015, initial visit with Dr. Wingate. On September 24, 2015, Petitioner presented with severe low back pain; however, her radicular symptoms had completely resolved. However, Petitioner inexplicably reports low back pain with radiculopathy into both lower extremities to Dr. Wingate a mere six days later. Petitioner also reports additional symptoms to Dr. Wingate including bilateral shoulder blade pain, bilateral lumbar numbness, tingling and weakness in her legs with the right worse than the left, daily severe headaches, and ringing/tinnitus in the right ear. Petitioner notably did not complain of any neck pain even during this initial visit with Dr. Wingate. There is no question that the medical records as well as Petitioner's testimony conflict on several points and show Petitioner made inconsistent reports of pain to her doctors.

After reviewing the medical records, particularly those of Dr. Wingate, and the IME reports provided by Dr. Troy, the Arbitrator finds Dr. Troy's opinions to be the most credible. Dr. Troy notes the inconsistencies of Petitioner's complaints of injury and symptoms throughout the records he reviewed. Most importantly, the examination by Dr. Troy reveals Petitioner engaged in gross symptom magnification during her IME exams to such an extent that Dr. Troy could not examine Petitioner as thoroughly as he would have liked. Petitioner's pain complaints were inconsistent and entirely disproportionate to the actual exam being performed.

As Dr. Troy note, Petitioner began to cry and complain of severe pain when Dr. Troy was only barely touching her skin without applying any pressure. Dr. Troy again determined Petitioner engaged is extreme symptom magnification when he examined her in January 2016.

Notably, Dr. Troy is not the first or the last medical professional to note Petitioner's penchant for inconsistent pain complaints and symptom magnification. In fact, the physical therapist noted on April 9, 2015, that Petitioner was inconsistent throughout the examination and exhibited an overreaction to light touch. The therapist was unable to assess Petitioner's condition due to the inconsistencies. On April 13, 2015, the therapist again tried to assess Petitioner's condition as was unable to do so. The therapist noted that Petitioner was unable to tolerate any treatment and complained of increased pain with every single position. Petitioner was discharged from therapy as the therapist could not provide treatment to her due to the complaints.

Finally, the August 2015 FCE also supported Dr. Troy's opinion that Petitioner's subjective complaints were out of proportion to her objective examination. The results of the FCE were not valid and the therapist who conducted the FCE noted significant evidence of inconsistencies resulting in self-limiting behavior and submaximal effort. The FCE also revealed Petitioner's reliability of pain results were also borderline unreliable. The therapist was unable to determine Petitioner's actual functional capacity due to Petitioner's effort discrepancies, self-limiting behaviors, and borderline unreliable pain results. The therapist even noted that Petitioner exhibited inconsistent behavior when given the McGill Pain Questionnaire. Petitioner stated she was unable to read due to blurred vision; however, the therapist noted that Petitioner later took papers out of her purse and proceeded to read them. The therapist also noted that Petitioner presented a Waddell score of five out of five which suggests a positive Waddell Sign and the potential for unreliable pain reports during functional testing.

Dr. Wingate has proposed lumbar fusion surgery from L4-S1 and also active cervical spine treatment that includes physical therapy and cervical ESIs. However, there are no indications the proposed surgery would even benefit Petitioner.

Dr. Troy notes that the discography revealed a positive result at L4-L5; however, this finding does not correlate to the findings of the lumbar MRI. Given Petitioner's inconsistent and exaggerated pain complaints and the conflicting evidence presented by the discography and the lumbar MRI, the Arbitrator agrees that surgical intervention is not warranted. Furthermore, given the compelling evidence of Petitioner's symptom magnification the Arbitrator agrees with Dr. Troy's opinion that Petitioner is at MMI and requires no further treatment.

The Arbitrator notes that given the lack of any complaints of neck and shoulder complaints prior to the June 2015 IME, Petitioner's cervical symptoms and shoulder complaints are not causally related to the work accident. Furthermore, the Arbitrator finds Petitioner continues to suffer from symptoms solely related to her preexisting diagnosis of pseudotumor. Petitioner was actively treating for her pseudotumor condition just days prior to the date of accident and even had a spinal tap scheduled in March to treat the condition. Notably, Dr. Mohan is the neurologist who has treated Petitioner for this condition since at least since 2005. A review of the records of both Dr. De Leon and Dr. Mohan reveal that, contrary to her testimony, Petitioner did not complain of daily severe headaches, tinnitus, and blurred vision since the date of accident. In fact, Dr. Mohan noted Petitioner's normal exam in April 2015 and told Dr. De Leon that Petitioner then recent complaints were normal symptoms of her pseudotumor condition. Dr. Mohan did not determine Petitioner's complaints were related to the current work accident. Instead, in June 2015 Dr. Mohan determined Petitioner's complaints were related to a prior work accident in 2009 where Petitioner suffered blunt trauma of the head and posttraumatic syndrome.

For the foregoing reasons, the Arbitrator finds Petitioner current condition of ill-being is not related to the work accident. Petitioner suffered a thoracolumbosacral strain only as a result of the accident and that resolved by June 15, 2015, the date of Dr. Troy's initial IME.

J. Were 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 has already found that Petitioner only suffered a thoracolumbosacral strain as a result of the work accident. The Arbitrator has also already found that Petitioner reached MMI for that injury by June 15, 2015.

For the foregoing reasons, the Arbitrator finds only medical services provided for Petitioner's thoracic and lumbar spine prior to June 15, 2015 are reasonable and necessary. Respondent must pay any outstanding balances for thoracic and lumbar spine treatment provided prior to June 15, 2015 pursuant to the fee schedule.

K. Is Petitioner entitled to any prospective medical care?

The Arbitrator has already found that Petitioner only suffered a thoracolumbosacral strain as a result of the work accident. The Arbitrator has also already found that Petitioner reached MMI for that injury by June 15, 2015. Thus, Petitioner is not entitled to any prospective medical care.

L. What temporary benefits are in dispute? and,

N. Is Respondent due any credit?

The Arbitrator has already found that Petitioner only suffered a thoracolumbosacral strain as a result of the work accident. The Arbitrator has also already found that Petitioner reached MMI for that injury by June 15, 2015. The Arbitrator also finds that Petitioner should have returned to work pursuant to Dr. Troy's June 2015 IME as there is no dispute that Respondent was willing and able to accommodate the restrictions Dr. Troy outlined in the report pending the FCE.

As such, the Arbitrator finds Petitioner was only entitled to TTD benefits from February 20, 2015 through June 18, 2015, or 17 weeks. At a TTD rate of $741.36 per week, Respondent is responsible for a total of $12,603.12 in TTD benefits. As of the date we closed proofs, Respondent paid a total of $34,843.92. The Arbitrator further finds Respondent is currently entitled to a credit of $22,240.80.

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

John Kluever,

Petitioner,

vs.

NO: 15 WC 08373

17IWCC0197

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 medical, 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 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.

17IWCC0197

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: APR 3 - 2017

KL/mas
o:3/9/17
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Kevin W. Lamborn

David L. Gore

Stephen Mathis

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

KLUEVER, JOHN
Employee/Petitioner

Case# **15WC008373**

17IWCC0197

KROGER
Employer/Respondent

On 8/25/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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:

0225 GOLDFINE & BOWLES PC
K ELDER/M MARINCIC
4242 N KNOXVILLE AVE
PEORIA, IL 61614

1739 STONE & JOHNSON CHARTERED
MURRAY PINKSTON
111 W WASHINGTON ST SUITE 1800
CHICAGO, IL 60602

17IWCC0197

STATE OF ILLINOIS)
)SS.
COUNTY OF MCLEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JOHN KLUEVER,
Employee/Petitioner

v.

KROGER,
Employer/Respondent

Case # **15** WC **8373**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Bloomington**, on **7/26/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **12/30/14**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 **$26,072.28**; the average weekly wage was **$501.39**.

On the date of accident, Petitioner was **53** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of **$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

The treatment for petitioner's left knee from 12/30/14 through 7/26/16 was reasonable and necessary to cure or relieve petitioner from the effects of his injury on 12/30/14. The arbitrator finds the respondent shall pay all reasonable and necessary treatment for petitioner's left knee from 12/30/14 through 7/26/14 pursuant to Sections 8.2 and 8(a) 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.

Petitioner is entitled to the left knee arthroscopy, possible chondroplasty evaluation, and anterior medial plica excision with evaluation of the articular cartilage and menisci with possible chondroplasty recommended by Dr. Below. The respondent shall pay all reasonable and necessary medical expenses associated with this procedure pursuant to 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.

Signature of Arbitrator

8/15/16
Date

ICArbDec19(b)

AUG 25 2016

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 53 year grocery clerk, alleges he sustained an accidental injury to his left knee that arose out of and in the course of his employment by respondent on 12/30/14. Petitioner denied any problems with his left knee prior to 12/30/14. Petitioner began working for respondent on 5/3/01. His duties remained the same from date of hire until 12/30/14.

Petitioner's duties as a clerk in the frozen food department include facing aisles (bringing everything up to the front of the shelf and rotating stock) and stocking new products that came in. Petitioner testified that his job duties require him to bend down and kneel at ground level to stock shelves.

On 12/30/14, about 5 minutes before his shift ended, petitioner was stocking chickens in the frozen foods department. Petitioner was kneeling on the floor taking chicken out of a box on his right side, and placing them on the bottom shelf of the freezer. After petitioner had been working on his knees for about 45-60 seconds he attempted to stand up and injured his left knee as he was getting up. Petitioner testified that as he was standing up from a kneeling position he twisted his left knee when he turned a little to the right. Petitioner did not know what caused his knee to twist. After he twisted his knee while getting up petitioner experienced severe pain in his left knee. Thereafter, petitioner had difficulty walking.

Following the incident petitioner reported his injury to Kelly Ward, and Joe Sparks, head grocery clerk. Given that the incident occurred about 5 minutes before his shift ended petitioner did not return to work after the incident.

Petitioner presented to work on 1/1/15. He testified that he reported to Sparks that his left knee hurt really bad and he was going to the doctor. Before leaving work that day petitioner stocked some shelves and did some aisle facing. Petitioner also completed an accident report. He alleged that he twisted his knee while stocking. He reported "I was stocking when I twisted my knee. I felt pain called Dr. Iced knee on 12/31/14. Knee started to swell. I iced it and put it up all day."

After leaving work petitioner presented to the emergency room at OSF. Petitioner presented with left knee pain. Petitioner reported that he twisted his knee while at work 2 days ago. Petitioner stated that he tried to continue to work but was unable to walk or work on 1/1/16. He reported pain over the anterior knee inferior to the patella and over the antero-medial knee joint line. No history of any prior left knee injuries was given. X-rays of the left knee showed small suprapatella joint effusion and no acute fracture or subluxation. Petitioner was assessed with a left knee strain. An ACE wrap was applied and he was given a crutch.

On 1/5/15 petitioner presented to his primary care physician Dr. Alfred Rodenburg. Petitioner reported that he suffered an injury to his left knee at work on 12/30/14. He reported that he twisted his knee while he was stocking foods on shelves. He reported that he could not put much weight on the left knee and it was swollen. He reported that his knee was most tender in the medial aspect in the popliteal area of the knee. Dr. Rodenburg took petitioner off work and referred petitioner to an orthopedic specialist. He also prescribed Norco. He noted that since petitioner has Crohn's disease he cannot tolerate non-steroidal anti-inflammatory medication.

On 2/9/15 petitioner presented to Dr. Below at Great Plains Orthopedics. Petitioner gave a history of a left knee injury on 12/30/14 when he was stocking some shelves in the frozen food department. He stated that he felt a sharp pain in his left knee. He reported pain going up and down stairs and getting in and out of the car and pain with squatting and sleeping. He also reported some burning pain with twisting and pivoting. Dr. Below noted some swelling and tenderness over the anterior and medial aspect and some on the posterior and medial aspect. X-rays of the left knee showed some medial joint line narrowing and minimal patellofemoral spurring. Dr. Below assessed left knee primary osteoarthritis with knee pain, and probable meniscal tear. An MRI of the left knee was ordered. Dr. Below took petitioner off work.

On 2/13/15 petitioner followed-up with Dr. Rodenburg. Petitioner still reported pain in his left knee in the same areas. Petitioner was walking with a walker. Dr. Rodenburg continued petitioner off work and renewed his prescription for Norco.

On 2/24/15, petitioner underwent an MRI of his left knee. The impression was joint effusion, and no internal derangement identified in the left knee.

On 3/2/15 petitioner returned to Dr. Below. Dr. Below noted that the MRI showed no signs of any internal derangement, but did show some small joint effusion. An examination revealed some tenderness over the medial and lateral joint lines; some very minimal mechanical symptoms; and no definite signs of any instability in the knee. Petitioner was able to actively flex and extend the knee and put some weight on it. Dr. Below assessed left knee primary osteoarthritis with some knee pain. He also performed a cortisone injection into petitioner's left knee. Dr. Below prescribed physical therapy. He ordered a low profile knee sleeve. He took petitioner off work.

On 3/27/15 petitioner returned to Dr. Rodenburg. He stated that he returned to work as directed by Dr. Below. Petitioner reported ongoing left knee swelling and discomfort. He stated that as the day progresses his left knee gets more swollen. He reported that he wears a knee brace for a while at work.

On 3/30/15, petitioner followed-up with Dr. Below. Dr. Below noted that petitioner's MRI was normal. Petitioner reported pain over the anteromedial aspect of the knee, and medial and lateral aspect of the knee. Petitioner reported no significant relief from the injection. An exam revealed full range of motion of the knee; no effusion; very minimal Apley grind test; minimal active and passive plica test; no definite medial or lateral joint line tenderness; negative McMurray test to pain or mechanical symptoms; and stable knee. Dr. Below diagnosed primary osteoarthritis of the left knee. Dr. Below recommended continued physical therapy and non-operative course of treatment.

On 5/20/15 petitioner returned to Dr. Below. Petitioner continued to report pain and instability, almost like he had a hyperextended knee. Dr. Below was of the opinion that petitioner had some inflammation in the knee, probable inflamed plica, and some chondromalacia. Dr. Below recommended a left knee arthroscopy with evaluation of the articular cartilage, possible chondroplasty, evaluation of the menisci, and anterior and medial plica excision.

On 5/28/15 petitioner followed-up with Dr. Rodenburg. He reported that Dr. Below had taken him off until after surgery. Petitioner complained of left knee pain. He noted that his knee seems to lock backwards with severe pain along the lower and medial aspect of the knee and it feels as if the knee is collapsing backwards. He stated that he was told that it was in a hyper-extended position. Petitioner stated that when he walks he feels as if the knee is going to collapse backwards on him. He stated that he was still wearing a brace, and has chronic pain. He also reported that his left knee swells when he is up and walking.

On 7/2/15 Dr. Below drafted a letter to Sedgwick Claims Management in response to some questions he was asked. He informed them that petitioner has a diagnosis of left knee pain with left chondromalacia and primary osteoarthritis with probable inflamed plica and inflammation, and had been through physical therapy and injection with no significant relief. He was of the opinion that the petitioner is in need of surgery, and the surgery is related to his work injury. He was of the opinion that petitioner probably had some chondromalacia or degenerative changes prior to the injury, and this injury aggravated his condition, if not caused the inflammation of the medial patellar plica. Dr. Below was of the opinion that petitioner was not at MMI with respect to his left knee injury. Dr. Below recommended a left knee

arthroscopy, possible chondroplasty evaluation, and anterior medial plica excision with evaluation of the articular cartilage and menisci with possible chondroplasty.

On 7/21/15 petitioner returned to Dr. Rodenburg after his visit to Dr. Below was denied by worker's comp. He complained of lot of pain in his left knee medial aspect. Dr. Rodenburg was of the opinion that petitioner was disabled from work.

On 8/20/15 petitioner underwent a Section 12 examination performed by Dr. Lawrence Li, at the request of the respondent. Petitioner reported twisting his left knee while stocking a shelf on 12/30/14. He gave a history of his treatment to date. Petitioner denied any prior problems with his left knee. He noted a history of Crohn's disease and irritable bowel syndrome, and stated that he cannot take any anti-inflammatories. Dr. Li reviewed the emergency room record and the notes of Dr. Rodenburg on 1/5/15 to 7/22/15, notes of Dr. Below from 2/9/15 to 7/2/15, MRI report dated 2/24/15, and therapy notes from 3/3/15 to 4/24/15.

Following an examination, Dr. Li opined that petitioner sustained a work related knee strain, and a significant component of his pain was coming from left knee osteoarthritis, and also possibly arthritis related to Crohn's disease and irritable bowel syndrome. He further opined that petitioner has underlying Crohn's disease, irritable bowel syndrome, which can lead to arthritis, as well as underlying osteoarthritis per Dr. Below's evaluation. He opined that these can contribute certainly in part and possibly in whole to his symptoms. Dr. Li saw no internal derangement of petitioner's left knee. He further noted the MRI showed no evidence of any meniscal, chondral, or ligamentous pathology, and based on petitioner's history of osteoarthritis, as well as Crohn's disease and irritable bowel syndrome, he believed that petitioner had reached MMI for a knee strain and that his current symptoms are solely related to any arthritis that he has as a result of primary osteoarthritis or Crohn's disease or irritable bowel syndrome. He opined that the treatment to date has been reasonable and necessary, and that petitioner could return to work with restrictions on squatting and kneeling. He should not kneel or squat and should limit his standing and walking to 4 hours a day, and one hour at a time. Dr. Li was of the opinion that these restrictions are related to his Crohn's disease and underlying arthritis. He recommended no further treatment for petitioner's knee strain.

On 9/16/15 petitioner returned to Dr. Below. Petitioner's condition was unchanged from May 2015. Dr. Below referred petitioner to a rheumatologist. He again recommended a left knee arthroscopy.

On 9/30/15 petitioner returned to Dr. Rodenburg. He continued to complain of left knee pain. He stated that he was told to go back to work and has been working for three weeks, 16 hours a day, 4 days a week. He stated that he was doing markdowns on products and avoiding any lifting, squatting, or kneeling. Dr. Rodenburg noted that petitioner was referred to rheumatology by orthopedics.

On 11/16/15 petitioner presented to Dr. Mark Getz, a rheumatologist, for pain in left knee after twisting injury of the left knee when getting up from a squatting position at work. He stated that his knee had been painful ever since. Dr. Getz noted that petitioner was not having any significant activity to his Crohn's disease at that time and had no other joints that were bothering him.

On 12/9/15 petitioner followed up with Dr. Getz. Due to petitioner's Crohn's disease an evaluation was done for inflammatory disease, and his labs were okay. Dr. Getz recommended aquatic therapy. He did not see any inflammatory disease.

On 2/23/16 petitioner followed-up with Dr. Rodenburg. Petitioner told Dr. Rodenburg that Dr. Li told him that he had to go back to work and that his knee problems are related to his Crohn's disease. Petitioner reported that he was forced to return to work and uses a shopping cart to lean against. He reported that he is in constant pain at work. He stated that he stands six hours a day. He reported that by the end of every day his knee swells up. Petitioner reported that he was going to followup with Dr. Below on 2/29/16.

On 2/29/16 petitioner followed-up with Dr. Below. Dr. Below noted that Dr. Getz had drawn labs and they were within normal limits. Dr. Getz gave petitioner some aquatic therapy and said that he did not see any inflammatory disease. Dr. Below examined petitioner and assessed a left medial knee pain and possible plica. Dr. Below recommended a repeat MRI of the left knee.

On 3/16/16 petitioner underwent a repeat MRI of the left knee. The impression was new medial compartment chondral degeneration, medial plica, and intact menisci and cruciate ligaments.

On 4/6/16 petitioner followed up with Dr. Below. Petitioner's complaints remained unchanged. Dr. Below assessed left knee primary osteoarthritis with inflamed suprapatellar medial plica. Dr. Below again recommended surgery.

On 5/12/16 Dr. Li drafted an addendum report after reviewing additional records including the images of the 2 MRIs, and notes of Dr. Below from 2/9/15 to 4/6/16. Dr. Li diagnosed underlying left knee osteoarthritis over the medial aspect of the left knee, which had progressed in 13 months. He reiterated his opinion that petitioner only suffered a knee strain as a result of his work injury. Dr. Li

noted that petitioner could not treat petitioner with anti-inflammatories because of his Crohn's disease. He noted that Dr. Getz opined that petitioner does not have any inflammatory arthritis. He opined that an arthroscopic surgery is reasonable. However, he opined that petitioner's pain is related to his preexisting osteoarthritis that has naturally gotten worse over the last 13 months as evidenced by the MRI of March 2016, and that is the reason why he has symptoms.

Currently, petitioner uses a cane if he has nothing to hold onto. Petitioner does not use the cane when he is pushing a cart. He also does not use the cane when he is walking to the door to get his mail. Petitioner testified that Dr. Getz prescribed the cane. Petitioner complained of severe pain on the right side of his left knee. He also reported that his left knee goes backwards sometimes. Petitioner testified that his left knee is painful when walking on it. He stated that after being on his left leg for a long times his pain increases. Petitioner takes prescription Norco for his pain. This pain medication was prescribed by Rodenburg. Petitioner follows up occasionally with Dr. Rodenburg.

Petitioner had one prior work comp claim with respondent for an injury to his low back in 2011. That claim was resolved. Petitioner denied he ever had any personal injury claims with respect to his left knee.

Petitioner's is currently working light duty for respondent based on his restrictions. Petitioner's duties include doing markdowns on merchandise and placing it on the shelves. While on light duty, petitioner no longer bends and kneels to put things on the bottom shelf.

Ben Mark Henry, Director of Investigations, Delta Associated Associations, was called as a witness on behalf of respondent. Henry laid a foundation for respondent's exhibits 3 and 4. Henry is the custodian of evidence. He is in charge of all physical and digital evidence. Henry testified that there were 7 days of surveillance taken at petitioner's home from 11/19/15-11/26/15 from 6am to sometime in the evening. During that total time petitioner was seen on surveillance a total of 2 minutes and that surveillance is on respondent's exhibit #4. Henry testified that the surveillance on respondent's exhibit 4 was surveillance taken inside and outside of Kroger on 1/1/15, in which petitioner is seen at times. On 1/1/15 petitioner is seen walking across a parking lot into work and performing his work duties without any apparent difficulty. Surveillance video from 11/19/15-11/26/15 showed Petitioner walking with a slight limp without the use of a cane.

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

Petitioner alleges he sustained an accidental injury to his left knee that arose out of and in the course of his employment by respondent on 12/30/14. Petitioner is a grocery clerk for respondent and his duties involve working in the frozen foods department facing aisles and stocking new products. Petitioner's duties require him to face aisles and stock new products on all shelves from the lowest the highest on a regular basis. These duties require petitioner to have to bend, kneel and squat at ground level to stock the lower shelves on a regular basis. Petitioner has performed these duties for respondent since 5/3/01. Petitioner denied any prior problems with his left knee.

On 12/30/14 petitioner was kneeling on the floor stocking chicken on the bottom shelf of the freezer. He was taking the chickens out of a box on his right side and placing them in the freezer. He was doing this particular activity for about a minute. As he attempted to stand up he twisted his left knee and experienced severe pain in his left knee.

Petitioner immediately reported the incident to Kelly Ward, and his supervisor Joe Sparks, the head grocery clerk. Since the incident occurred about 5 minutes before the end of his shift petitioner did not perform any further work that day, but did return to work on 1/1/15 to tell Sparks his left knee was still hurting really bad and he was going to the doctor. Before leaving work that day he stocked some shelves and did some aisle facing. He also completed an accident report. The accident report included an accident history that was consistent with his testimony at trial, which was that he twisted his knee while stocking.

Petitioner presented for treatment on 1/1/15 at OSF. He again reported pain in his left knee. Petitioner again presented a consistent history of the accident. He again reported that he twisted his left knee while at work.

On 1/5/15 petitioner presented to his PCP, Dr. Rodenburg and reported that he twisted his left knee while stocking foods on shelves for respondent. On 2/9/15 he presented to Dr. Below and gave a history of a left knee injury on 12/30/14 when he was stocking some shelves in the frozen food department. He stated he felt a sharp pain in his left knee.

Even when petitioner presented to Dr. Li for a Section12 examination at the request of respondent he reported twisting his left knee while stocking a shelf on 12/30/14.

Based on the above, as well as the credible evidence the arbitrator finds that petitioner has proven by a preponderance of the credible evidence that he sustained an injury to his left knee that arose out of and in the course of his employment by respondent on 12/30/14. The arbitrator bases this finding on the fact that petitioner's work for respondent often requires him to kneel, bend and squat to face shelves or stock shelves that are at or near ground level. The arbitrator finds these duties are incidental to his employment for respondent. Additionally, the arbitrator finds although the act of kneeling and getting back up is an activity of daily living that the general public may partake, however, the arbitrator further finds the frequency with which petitioner has performed this activity since May of 2001 put him at a greater risk for injury than those in the general public.

For these reasons the arbitrator finds the petitioner has proven by a preponderance of the credible evidence that he sustained an accidental injury to his left knee that arose out of and in the course of his employment by respondent on 12/30/14.

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

The petitioner claims his current condition of ill-being is causally related to the injury he sustained on 12/30/14. The respondent claims his current condition of ill-being is not causally related to the injury he sustained on 12/30/14, and bases this finding primarily on the opinions of its Section 12 examiner, Dr. Li.

Petitioner presented unrebutted evidence that he had no problems with his left knee, and did not receive any treatment for his left knee prior to 12/30/14. However, following the incident on 12/30/14 petitioner has remained symptomatic and under active treatment through the date of trial.

Following the accident on 12/30/14 petitioner first sought treatment on 1/1/15. An x-ray of the left knee taken that day revealed small suprapatella joint effusion and no acute fracture or subluxation. He was assessed with a left knee strain. On 1/5/15 petitioner's primary care physician referred petitioner to an orthopedic specialist.

Petitioner presented to Dr. Below on 2/9/15. Dr. Below noted some swelling and tenderness over the anterior and medial aspect and some posterior medial aspect. X-rays showed some medial joint line narrowing an minimal patellofemoral spurring. Dr. Below assessed left knee primary osteoarthritis with knee pain, and probable meniscal tear. An MRI taken 2/24/15 of the left knee showed joint effusion and no internal derangement. On 3/2/15 Dr. Below performed a cortisone injection and other conservative treatment including a knee sleeve and physical therapy.

In May of 2015 Dr. Below was of the opinion that petitioner had some inflammation in the knee, probable inflamed plica, and some chondromalacia. Thereafter, petitioner's knee continued to lock backwards and he had severe pain along the lower and medial aspect of the left knee. He stated that he felt like his knee was collapsing backwards. Petitioner reported that his left knee swells up when he is up and walking.

On 7/2/15 Dr. Below drafted a letter to respondent's insurer informing them that petitioner has a diagnosis of left knee pain with left chondromalacia and primary osteoarthritis with probable inflamed plica and inflammation. He opined that petitioner was need of surgery and the surgery was causally related to his work injury. He opined that petitioner probably did have some chondromalacia or degenerative changes prior to the injury, but the injury aggravated his condition, if not caused the inflammation of the medial patellar plica.

On 8/20/15 Dr. Li examined petitioner on behalf of respondent. Dr. Li opined that petitioner sustained a work related strain and a significant component of his pain was coming from his left knee osteoarthritis, as well as underlying Crohn's disease and irritable bowel syndrome. He opined that petitioner's underlying Crohn's disease and irritable bowel syndrome can lead to arthritis, as well as underlying osteoarthritis. In response to these opinions petitioner was seen by Dr. Getz, a rheumatologist, who performed tests of petitioner and opined that the tests were within normal limits and there was no inflammatory disease. Dr. Li opined that petitioner had no internal derangement of his left knee, and the MRI showed no evidence of any meniscal, chondral, or ligamentous pathology. Dr. Li opined petitioner had reached MMI with respect to his left knee strain, and his symptoms are solely related to any arthritis that he has as a result of primary osteoarthritis, Crohn's disease or irritable bowel syndrome.

On 2/29/16 Dr. Below assessed left knee medial knee pain and possible plica. A repeat MRI of the left knee done 3/16/16 showed a new medial compartment chondral degeneration, medial plica and intact menisci and cruciate ligaments. On 4/6/16 dr. Below assessed left knee primary osteoarthritis with inflamed suprapatellar medial plica.

Dr. Li reviewed additional treatment records and the repeat MRI and on 5/12/16 diagnosed underlying left knee osteoarthritis over the medial aspect of the left knee, which had progressed in 13 months. He reiterated his finding that petitioner only suffered a knee strain as a result of his work injury.

Based on the above, as well as the credible evidence, the arbitrator finds the opinions of Dr. Below more persuasive than those of Dr. Li, specifically given the fact that although petitioner had preexisting

osteoarthritis prior to 12/30/14, he had no problems with his left knee and had never undergone any treatment for his left knee. It was not until after the injury on 12/30/14 that petitioner immediately began experiencing severe pain in his left knee that has continued to this date. Based on these facts the arbitrator adopts the findings and opinions of Dr. Below and finds that although petitioner had preexisting osteoarthritis prior to the accident on 12/30/14, he was asymptomatic. However, after the accident on 12/30/14 petitioner's condition became symptomatic and his condition has worsened over time. Petitioner has remained symptomatic since 12/30/14. The arbitrator also finds it significant that although petitioner has a history of Crohn's disease and irritable bowel syndrome, when Dr. Getz examined him and performed lab tests, there was no evidence of any inflammatory disease, and his lab tests results were within normal limits. The arbitrator finds the petitioner has proven by a preponderance of the credible evidence that his current condition of ill-being, as it relates to his left knee, is causally related to the injury he sustained on 12/30/14.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Having found petitioner has sustained an accidental injury to his left knee that arose out of and in the course of his employment by respondent on 12/30/14, and that his current condition of ill-being as it relates to his left knee is causally related to the injury he sustained on 12/30/14, the arbitrator finds the treatment petitioner has undergone between 12/30/14 and 7/26/16 was reasonable and necessary to cure or relieve petitioner from the effects of his injury to his left knee he sustained on 12/30/14.

The arbitrator bases this finding on the opinions of Dr. Below and Dr. Li, who both opined that petitioner's treatment to date has been reasonable and necessary. Although Dr. Li only opined that petitioner sustained a strain of his left knee as a result of the injury, he further opined that petitioner's treatment to date had been reasonable and necessary for his preexisting condition. Given the fact that it is unrebutted that petitioner probably had some chondromalacia or degenerative changes prior to the injury, the arbitrator finds Dr. Below's findings and opinions that the injury on 12/30/14 aggravated this condition, if not caused the inflammation of the medial patellar plica more persuasive than Dr. Li's, especially given the fact that petitioner was asymptomatic before the injury and had remained symptomatic since the date of injury.

Based on the above, as well as the credible evidence, the arbitrator finds the treatment for petitioner's left knee from 12/30/14 through 7/26/16 was reasonable and necessary to cure or relieve petitioner from the effects of his injury on 12/30/14. The arbitrator also finds the respondent shall pay all

reasonable and necessary treatment for petitioner's left knee from 12/30/14 through 7/26/16 pursuant to Sections 8.2 and 8(a) of the Act.

K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

Having found the petitioner's current condition of ill-being as it relates to his left knee causally related to the injury petitioner sustained on 12/30/14, the arbitrator also finds the left knee arthroscopy, possible chondroplasty evaluation, and anterior medial plica excision with evaluation of the articular cartilage and menisci with possible chondroplasty is reasonable and necessary to cure or relive petitioner from the effects of the injury on 12/30/14. The arbitrator bases this finding on the opinions of both Dr. Below and Dr. Li who both agreed this surgery was reasonable and necessary. The arbitrator notes that although Dr. Li agreed this recommended surgery was reasonable and necessary, his objection to this surgery being authorized by Worker's Compensation was that he believed it was not related to the injury on 12/30/14, but solely to his preexisting condition. Having found petitioner's current condition of ill-being causally related to the injury on 12/30/14, the arbitrator finds the surgery being recommended by Dr. Below is reasonable and necessary to cure or relieve petitioner from the effects of his injury.

The arbitrator finds the petitioner is entitled to the left knee arthroscopy, possible chondroplasty evaluation, and anterior medial plica excision with evaluation of the articular cartilage and menisci with possible chondroplasty recommended by Dr. Below. The respondent shall pay all reasonable and necessary medical expenses associated with this procedure pursuant to Sections 8(a) and 8.2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Donald Lohman,
Petitioner,

vs. NO: 15WC 11532

State of Illinois/Menard Correctional Center,
Respondent,

17IWCC0207

DECISION AND OPINION ON REVIEW

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

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

DATED: APR 6 - 2017
o032317
SM/jrc
044

Stephen Mathis

David L. Gore

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LOHMAN, DONALD
Employee/Petitioner

Case# **15WC011532**

STATE OF ILLINOIS/MENARD CORR CENTER
Employer/Respondent

17IWCC0207

On 10/13/2016, 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 0.49% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 RICH RICH COOKSEY PC
THOMAS C RICH
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FAIRVIEW HTS, IL 62208

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

0558 ASSISTANT ATTORNEY GENERAL
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CARBONDALE, IL 62901

0498 STATE OF ILLINOIS
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CHICAGO, IL 60601-3227

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

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

OCT 13 2016

REINALH A. HADDIN, Acting Secretary
Illinois Workers' Compensation Commission

17IWCC0207

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

DONALD LOHMAN
Employee/Petitioner

v.

STATE OF ILLINOIS / MENARD CORR. CENTER
Employer/Respondent

Case # **15** WC **11532**

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Herrin**, on **June 14, 2016**. By stipulation, the parties agree:

On the date of accident, **September 17, 2013**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**67,618.20**, and the average weekly wage was $**1,300.35**.

At the time of injury, Petitioner was **49** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**ALL PAID** for TTD, $**N/A** for TPD, $**N/A** for maintenance, and $**N/A** for other benefits, for a total credit of $**ALL TTD PAID**.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$721.66 per week**, the maximum allowable rate, for **87.5 weeks**, because the injuries sustained caused the loss of **17.5% 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 **September 18, 2013** through **June 14, 2016**, and shall pay the remainder of the award, if any, in weekly payments.

The parties have stipulated that all of the claimed temporary total disability has been paid by the Respondent, and that the Respondent either has paid, or will pay directly to the providers, all causally related reasonable and necessary medical expenses related to the September 17, 2013 accident.

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

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

Signature of Arbitrator

October 5, 2016
Date

OCT 13 2016

STATEMENT OF FACTS

On 9/17/13, the Petitioner was working for Respondent as a maintenance craftsman. He was putting up razor wire in the chapel when the wire came off a pole and struck the Petitioner, causing him to fall backwards. He testified that he injured his head, shoulder, back, right hip and elbow. The Respondent's incident report, dated 9/17/13, indicates he fell on the concrete floor, landing on his right side. (Px11; Rx1). Witness statements indicated he fell between two rows of seating, and one noted that he struck his hip and head. (Rx1). The initial medical records indicate the Petitioner fell onto his buttocks and right hip, and that he reported leg, hip, back, neck and arm pain. (Px3). At his initial 12/18/13 visit to the Chester Clinic, the Petitioner reported that he fell onto concrete, hitting his right hip, head and back, with primary complaints of neck stiffness and pain. (Px4).

The Petitioner testified that he reviewed the medical records and bills contained in the exhibits he submitted into evidence, and that they are accurate. He indicated he had no prior workers' compensation claims regarding his neck, and testified he had no prior neck problems or treatment. He testified that the injuries to his elbow and the other body parts have resolved, and his claim for permanency is based on the neck.

The Petitioner testified he had neck pain shooting through his neck with posterior headaches, neither of which he had prior to the accident. 2/12/14 cervical x-rays reflected disc space narrowing at C5/6 with degenerative disc disease and slight right sided osseous neuroforaminal encroachment. (Px3). 3/27/14 cervical MRI reflected severe left and moderate to severe neuroforaminal stenosis at C5/6, mild to moderate C5/6 and mild C3 to C5 central canal stenosis, as well as loss of lordosis suggesting spasm. (Px5). After initially attempting physical therapy (Px3) and medication, the Petitioner was referred to orthopedic surgeon Dr. Gornet. He testified that Dr. Gornet was recommended by a coworker.

The initial 6/2/14 report of Dr. Gornet indicates complaints of neck pain into the left shoulder with no significant arm pain or numbness. The Petitioner was continuing to work. A C5/6 injection was performed at on 6/16/14 (Px7), and on 7/21/14 Dr. Gornet noted the Petitioner had no significant relief. Noting the MRI showed a large C5/6 herniation, left greater than right, but did not reflect foraminal views, repeat testing was prescribed, along with a CT myelogram. (Px6).

The 9/22/14 cervical MRI report noted a circumferential C5/6 disc bulge with superimposed central and left foraminal herniations, resulting in mild central canal stenosis and severe left greater than right foraminal stenosis. Also noted were a right paracentral focal C4/5 herniation resulting in right ventral cord and mild central canal stenosis, and a likely annular tear at C6/7. (Px9). The 9/22/14 CT myelogram reportedly showed left lateral recess stenosis at C5/6, but no high grade central canal stenosis or lateralizing cord displacement. The post-myelogram CT indicated C5/6 herniation and endplate spurring extending into the neuroforamina, left greater than right, and a central C4/5 herniation with no definite canal or foraminal stenosis. (Px8).

Petitioner underwent a Section 12 examination at the Respondent's request on 9/9/14 with Dr. Wilkey. (Rx5). Dr. Wilkey's review of the cervical MRI indicated a moderate C5/6 herniated disc which clearly impinged on the neural structures and spinal cord. He confirmed a causal relationship to the 9/17/13 accident. While he recommended injections first, he noted a guarded prognosis due to the size of the herniation. It was his opinion that cervical fusion was indicated, and he questioned disc replacement, noting there is no evidence that it is beneficial in an older patient like Petitioner. This was particularly the case, in his opinion, if the CT myelogram showed facet arthropathy. (Rx5).

Petitioner continued to work without restrictions. On 9/22/14, Dr. Gornet noted the MRI showed C4/5 herniation with cord compression, and a C5/6 herniation with foraminal fragmentation, mostly left sided, which

correlated with his left arm symptoms. He noted the CT myelogram also correlated with this and showed no facet arthritis. Noting the C4/5 herniation was large enough to produce some cord compression, he recommended disc replacement surgery at both C4/5 and C5/6. (Px6).

On 12/15/14, Dr. Gornet noted the same surgical recommendation, and indicated that because the Petitioner was retiring, the speed and rapidity of returning to work was not an issue. The Petitioner underwent C4/5 and C5/6 disc replacement surgery with decompression on 1/20/15. The report notes a foraminal herniation was found at left C5/6, which Dr. Gornet indicated correlated with Petitioner's left shoulder and arm symptoms. Foraminotomies were also performed at both levels. (Px7). The Petitioner testified this surgery helped his symptoms.

On 2/9/15, Dr. Gornet noted the Petitioner reported dramatic improvement in his neck and arm symptoms, and that he was "exceedingly pleased", and the Petitioner was held off work. On 3/9/15, Dr. Gornet noted Petitioner continued to do remarkably well, with a normal exam "for the most part". The Petitioner wanted to try to return to full duty, and Dr. Gornet released him to do so as of 3/31/15. (Px7).

On 6/22/15, Dr. Gornet noted Petitioner was "somewhat off his follow up", and while he had retired from the Respondent, he was working full duty mowing lawns. He again noted the Petitioner reported dramatic improvement, and "in fact, he feels his life is so much better after cervical surgery." His examination was normal with good strength and range of motion, and x-rays were noted to show excellent positioning of the replacement discs. (Px7). Post-surgical CT scans were performed on 6/22/15 and 1/21/16. The 6/22/15 report notes the disc replacements with satisfactory alignment, with mild persistent but improved bilateral C5/6 foraminal stenosis. 1/21/16 films again noted satisfactory positioning, with a broad based C3/4 protrusion that was unchanged versus 6/22/15. This report noted mild residual C5/6 foraminal stenosis was due to endplate spurring. (Px8). On 1/21/16, Dr. Gornet indicated the Petitioner continued to do very well, was working full, unrestricted duties, and opined that he had reached maximum medical improvement. (Px7). The Petitioner agreed that he had a six month follow up scheduled with Dr. Gornet in June, 2016.

The Petitioner had retired on 12/31/14, prior to the surgery, and he testified his decision to retire was not based on this injury. On cross examination the Petitioner agreed that he worked cutting approximately 30 lawns per week going back to 1990, and that he continues to do so through the date of hearing, to give himself something to do, and that this ongoing work played a role in his decision to retire.

While the Petitioner agrees he improved with surgery, he still notices symptoms. His neck gets sore with long days of activity. He takes ibuprofen at night two to three times per week, but does not use prescription medication for this problem. He testified that his neck gets tired with mowing and weed whacking, and he therefore has to rest every 30 minutes. He has trouble turning his neck to the left when driving, noting he does it slower and cant turn it as far as he used to. He sleeps 5 to 6 hours a night, noting he awakens three or four times per night and has to adjust his pillow for his neck. He still gets occasional numbness in his hands.

The Petitioner testified he last saw Dr. Gornet in January, 2016, but had a six month follow up appointment scheduled in June, 2016.

The Petitioner underwent a Section 12 examination with Dr. Katz on 4/25/16, which included an AMA impairment evaluation. (Rx2). Dr. Katz noted the Petitioner reported ongoing 5 out of 10 pain, but at that moment his pain was mild. There was no radiating pain or numbness. Various activities reportedly increased the Petitioner's pain. He still reported moderate but infrequent headaches. Dr. Katz indicated the Petitioner specifically stated: "I don't really notice any difference with the surgery. I have the same pain in my neck."

Examination reflected normal range of motion, strength, reflexes and sensation. Dr. Katz issued an impairment rating of 6% of the person as a whole. (Rx2).

Dr. Katz was deposed on 6/9/16 (Rx3). A physical medicine specialist, he testified that he is one of the editors of the 6th edition of the AMA impairment guide, and testified that he performed an average of 2 to 3 such impairment ratings per week. Dr. Katz explained the basis for how he determined the 6% impairment rating, most significantly based on the fact the Petitioner had multilevel instability and no evidence of ongoing radiculopathy. (Rx3).

The Arbitrator notes that, prior to testimony in this case, the parties stipulated that all claimed TTD had been paid by Respondent, and that Respondent either has paid of will pay directly to the providers all reasonable and necessary causally related medical expenses.

WITH RESPECT TO THE ISSUE OF THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

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

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of 6% of the person as a whole, as determined by Dr. Katz pursuant to the 6th edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. (Rx2). 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.

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 maintenance craftsman for the Respondent. The Petitioner voluntarily retired from this employment prior to his disc replacement surgery, and testified that his retirement was not based on his work injury. Dr. Gornet released the Petitioner to unrestricted work duties and, consistent with

Petitioner's testimony, indicated he was working full duty cutting lawns. He testified that he had been performing this activity since 1990. There is no evidence to indicate the Petitioner was unable to return to work in his prior capacity as a result of said injury.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 49 years old at the time of the accident.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that there is no evidence that his injury and resulting condition has impacted his earning capacity.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that there appear to be some significant discrepancies in this case.

The Arbitrator gives significant weight to the AMA impairment rating in this case. Dr. Katz' explanation of how he reached his determination was, in the Arbitrator's view, understandable and valid. He testified that he is clearly very experienced in providing such impairment ratings. While some of the cross examination of Dr. Katz was with regard to how often he was retained by one side or the other to perform such ratings, the Arbitrator fails to see how this is relevant given how the AMA rating is determined. Additionally, the Petitioner had an opportunity to obtain his own AMA rating if there was a belief that Dr. Katz' determination was somehow incorrect pursuant to the rules of the Guide, and this was not done.

Because the Petitioner retired prior to his surgery and final release at MMI, there simply is no evidence which would indicate that he was either unable to return to his regular job with the Respondent, or that his earning capacity was negatively impacted as a result of this accident and injury. In fact, the Petitioner testified that he continued and continues to mow 30 lawns per week, just as he had prior to the accident. The Arbitrator notes that he did testify that his neck would get sore after doing this for a while.

The Arbitrator gives little weight in determining permanency to the Petitioner's age, as there really is no evidence to indicate how his age would impact his disability determination.

The discrepancies in the case with regard to subsection (v) are somewhat difficult to reconcile. The post-surgical records of Dr. Gornet specifically reference dramatic improvement and excellent results. The report of Dr. Katz indicates the Petitioner specifically stated that he was no better after the surgery than he was before. His testimony is that he has ongoing problems, particularly with weed whacking. But meanwhile, he continues to cut, and assumedly weed whack, 30 homes per week. He testifies to ongoing but intermittent subjective pain, and some rare hand numbness, but the reports of both Dr. Gornet and Dr. Katz reflect normal examinations, both physically and neurologically.

Overall, the Arbitrator believes the Petitioner has undergone a significant surgery, in that he has two disc replacements. At the same time, it appears that he has had a rather good result. Again, there appears to be a difference in his ongoing complaints to Dr. Katz versus his complaints to Dr. Gornet and what he testified to. There also is no real indication that the injury has impacted his function, as he had normal examinations, no work restrictions and has continued to mow 30 lawns per week. He does have some ongoing complaints, but it appears he is able to work through those. The Arbitrator must also take into account the impairment rating in conjunction with the precedential value of similar injuries and outcomes. Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 17.5% loss of use of the person as a whole pursuant to §8(d)(2) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

☒ 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

Stuart Sanders,
Petitioner,
vs.

17IWCC0261
NO: 15 WC 12506

State of Illinois/Centralia Correctional Center,
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, 8(j) 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 13 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: APR 25 2017
KWL/vf
O-4/11/17
42

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

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

17IWCC0261

SANDERS, STUART
Employee/Petitioner

Case# 15WC012506

SOI/CENTRALIA CORRECTIONAL CENTER
Employer/Respondent

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:

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

0558 ASSISTANT ATTORNEY GENERAL
KYLEE J JORDAN
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
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 13 2016

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

17IWCC0261

STUART SANDERS
Employee/Petitioner

Case # 15 WC 012506

v.

Consolidated cases: N/A

STATE OF ILLINOIS/CENTRALIA CORRECTIONAL 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 **Michael Nowak**, Arbitrator of the Commission, in the city of **Herrin**, on **July 14, 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, **February 4, 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 **$55,980.00**; the average weekly wage was **$1,076.54**.

On the date of accident, Petitioner was **27** years of age, *single* with **0** dependent children.

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

Respondent shall be given a credit of **$12,625.68** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$12,625.68**.

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

ORDER

Because Petitioner failed to establish that he sustained an accidental injury which arose out of and in the course of his employment with Respondent benefits are denied.

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

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

Signature of Arbitrator

5/3/16
Date

ICArbDec19(b)

MAY 13 2016

FINDINGS OF FACT

At the time of injury, Petitioner was a 27 year-old employed by Respondent, Centralia Correctional Center, as a Correctional Officer. On the date of injury, January 4, 2015, Petitioner was playing basketball with his fellow officers on his lunch break when he came down on another officer's leg, injuring his right foot and right knee. (T. 13). Petitioner was taken to the ER at St. Mary's Good Samaritan Hospital where x-rays were taken of his right knee and right foot, which revealed no fractures in his knee and fractures of his distal 2nd, 3rd, and 4th metatarsals. (PX3). Petitioner was prescribed hydrocodone and tramadol, given a boot, and released. *Id.*

On January 5, 2014, Petitioner saw Dr. Angela Freehill at the Orthopedic Center of Southern Illinois, who took his medical history and placed Petitioner off work pending an MRI. (PX4 1/5/14). On February 26, 2015, Petitioner received an MRI which revealed objective findings of a complete ACL tear, a mild MCL sprain, a displaced bucket-handle tear medial meniscus, a sever chondromalacia posterior central medial femoral condyle and posterior medial aspect medial tibial plateau, a 6mm in depth impaction fracture lateral femoral condyle, and a large hemarthrosis. (PX4 2/26/15).

On March 20, 2015, Petitioner came under the care of Drs. Brian Wegman and Richard Rames at Woods Mill Orthopedics. (PX6 3/20/15). Dr. Wegman took Petitioner's history, reviewed his MRIs, recommended conservative treatment in the form of anti-inflammatory drugs and home exercises, and suggested he see Dr. Rames for possible knee surgery. *Id.* On March 25, 2015, Petitioner met with Dr. Rames, who recommended knee surgery. (PX6 3/25/15).

On April 1, 2015, Dr. Rames performed ACL reconstruction surgery and a partial medial meniscectonomy on Petitioner's right knee. (PX7). Intraoperative objective findings revealed a torn ACL and a bucket-handle medial meniscus tear. *Id.*

Following surgery, Petitioner performed physical therapy at the Orthopedic Center of Southern Illinois for a period of April 14, 2015 through July 13 2015. (PX4 4/14/15 – 7/13/15).

Petitioner testified at trial that he had no prior injuries to his right knee or right foot.

Petitioner testified that on January 4, 2015, he was playing basketball with other officers on his lunch break when he "came down on another officer's leg" which resulted in injury to his right foot and knee. Petitioner stated that he is not allowed to leave the premises during his lunch break. Petitioner was not the gym officer on the date of his accident. Petitioner testified that he was paid during his lunch break and that he was a salaried employee. Petitioner testified he had been working at Centralia Correctional Center for six months, and that he had been playing basketball for at least two months. Petitioner testified that he had never gotten in trouble for playing basketball. Petitioner testified that Respondent provides both the court and the basketballs for the use of the Correctional Officers during their break hours. Petitioner testified that he had to stay in good physical shape to be able to perform his job duties. Although he testified that he had to take and pass a physical to secure employment with the State of Illinois approximately three and a half years prior, he had not undergone any physical testing for fitness since then. On cross-examination Petitioner admitted that there was no official mandate or memorandum asking correctional officers to work out or play basketball on their lunch periods. Petitioner testified that he did not receive any kind of monetary bonus or incentive to work out or play

basketball on his lunch break. Petitioner testified that he did not have to report to anyone that he was working out on his lunch break, and agreed that the facility would not know whether he was eating lunch or working out.

Former Warden, Julius Flagg, testified on behalf of Respondent. Mr. Flagg testified that correctional officers are paid for seven and a half hours, and that they are not paid for their lunch break. Mr. Flagg agreed that what correctional officers do on their lunch was their own time "per contract". Mr. Flagg testified that there was no mandate from the Department of Corrections, or Centralia Correctional Center, requiring the Petitioner to do any type of physical activities to stay in shape for his job. Mr. Flagg testified that over the course of his career at the Department of Corrections there had never been a mandate requiring a correctional officer to perform physical activities to stay in shape for their job. Mr. Flagg testified that there were correctional officers who were overweight and who were physically fit, and that it was their own choice. Mr. Flagg testified that although the officers were allowed to use them, the basketballs were provided by Leisure Time Service (LTS) and bought by the Inmate Benefit Fund for inmate use, not Centralia Correctional Center

CONCLUSIONS

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

The Petitioner bears the burden of proving each and every element of his case in order to recover under the Illinois Workers' Compensation Act. *Shelton v. Indus. Com'n*, 267 Ill. App. 3d 211, 221, 641 N.E.2d 1216, 1224 (5th Dist.). In order to satisfy the "arising out of" portion of the Act, the Petitioner must show that the injury was derived from 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. v. Indus. Comm'n, 207 Ill.App.3d 193, 203, 797 N.E.2d 665, 672 (3rd Dist.). The "in the course of requirement speaks to the time, place, and circumstances of the injury". *Orsini v. Indus. Com'n*, 117 Ill. 2d 38, 45, 509 N.E.2d 1005. "An injury is received in the course of employment where it occurs within a period of employment, at a place where the worker may reasonably be in the performance of his duties, while he is fulfilling those duties or engaged in something incidental thereto." *Scheffler Greenhouses, Inc. v. Indus. Com'n*, 66 Ill. 2d 361, 367, 362 N.E.2d 325.

Petitioner did not allege a defect on the employer's premises, or more specifically the basketball court, that caused or contributed to his fall and lead to his injury. In fact, Petitioner testified, and Respondent's Exhibits 1, 4, and 5 corroborate, that his fall was due to the fact that he came down on another player's foot while playing a game of basketball. Therefore, the issue then becomes whether Petitioner's participation in a purely voluntary recreational activity during an authorized unpaid lunch break is compensable under the Illinois Workers' Compensation Act.

The Arbitrator finds that Petitioner's activities in this case fell outside the protections of the Act. The Arbitrator finds Petitioner was engaged in a voluntary recreational activity as outlined under Section 11 of the Act. Section 11 provides:

> Accidental injuries incurred while participating in voluntary recreational programs including but not limited to athletic events, parties and picnics do not arise out of

> and in the course of employment even though the employer pays some or all of the cost thereof. This exclusion shall not apply in the event that the injured employee was ordered or assigned by his employer to participate in the program.

If Petitioner's participation in the basketball game was deemed to be involuntary he would be entitled to benefits under the Act, however, in this instance Petitioner's participation in the basketball game on January 4, 2015, was purely voluntary. Petitioner admitted that on the day of his injury that he was not assigned to be the gym officer. Petitioner admitted that there was no official mandate or memorandum asking correctional officers to work out or play basketball on their lunch periods. Petitioner testified that he did not receive any kind of monetary bonus or incentive to work out or play basketball on his lunch break. Petitioner testified that he did not have to report to anyone that he was working out on his lunch break, and agreed that the facility would not know whether he was eating lunch or working out.

Additionally, Petitioner admitted on cross-examination that the basketballs and basketball court were actually there for the inmates use. Petitioner agreed that the facility allowed him to use the basketballs and basketball court on his lunch break as a courtesy. Respondent's witness, Mr. Julius Flagg, later testified that the basketballs were provided by Leisure Time Service (LTS) and bought by the Inmate Benefit Fund, not Centralia Correctional Center. Mr. Flagg testified that the Inmate Benefit Fund purchased things for inmate use.

On cross-examination Petitioner admitted that, while he had to take a physical to get his job approximately three and a half years prior, he had not undergone any physical testing for fitness since then. Petitioner testified that the Department of Corrections did not test his physical fitness throughout his career, just at his time of hire. Petitioner testified that his current height was 6"3 and his current weight was 265 pounds. Therefore, Respondent did not require Petitioner to maintain a certain level of fitness.

Mr. Flagg testified that correctional officers are paid for seven and a half hours, and that they are not paid for their lunch break. Mr. Flagg testified that correctional officers are paid for 37.5 hours. Mr. Flagg agreed that what correctional officers do on their lunch was their own time "per contract". Therefore, Petitioner's injury while participating in the basketball game occurred during his unpaid lunch break.

Mr. Flagg testified that there was no mandate from the Department of Corrections, or Centralia Correctional Center, requiring the Petitioner to do any type of physical activities to stay in shape for his job. Mr. Flagg testified that over the course of his career at the Department of Corrections, which was thirty two years, there had never been a mandate requiring a correctional officer to perform physical activities to stay in shape for their job. Mr. Flagg testified that there were correctional officers who were overweight and correctional officers who were physically fit, and that it was their own choice.

The Arbitrator finds that there was no compulsion on the part of the Respondent to have Petitioner use or participate in the playing of basketball. There were no factors introduced at trial to indicate that Respondent offered the recreational facilities as anything other than on a completely voluntary basis as a courtesy to Respondent's employees.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner has failed to prove that he sustained an accident that arose out of and in the course of his employment with Respondent on January 4, 2015. Benefits are, therefore denied.

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

Petitioner testified at trial that he had no prior injuries to his right knee or right foot. "A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury." *International Harvester v. Industrial Comm'n*, 93 Ill.2d 59, 63-64, 66 Ill.Dec. 347, 442 N.E.2d 908 (Ill.,1982)). The Arbitrator notes that Petitioner suffered an immediate injury and symptoms. Therefore, the Arbitrator relies on the medical records and the credible testimony of Petitioner, who stated at trial that prior to his accident he had no right knee or foot injuries. The Arbitrator finds that this evidence establishes a causal nexus between the accident and the employee's injury. However, based upon the Arbitrator's finding with regard to Issue C, benefits are denied.

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?

The Arbitrator finds that all medical services provided to Petitioner have been reasonable and necessary. Petitioner had x-rays and MRIs which revealed objective findings of a 3 fractures in his right foot, a torn ACL, and a torn meniscus. Petitioner wore a boot for his foot and underwent an appropriate surgery for his knee injury. Following surgery Petitioner completed physical therapy. However, based upon the Arbitrator's finding with regard to Issue C, benefits are denied.

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

The Arbitrator finds Petitioner was temporarily and totally disabled beginning 1/12/15 through the date of hearing. However, based upon the Arbitrator's finding with regard to Issue C, benefits are denied.

STATE OF ILLINOIS	)	☒ Affirm and adopt	☐ 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

Willard Houk,

Petitioner,

17IWCC0260

vs.

NO: 15 WC 13177

Village of Harristown,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 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 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: APR 25 2017
KWL/vf
O-4/11/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

17IWCC0260

HOUK, WILLARD
Employee/Petitioner

Case# **15WC013177**

VILLAGE OF HARRISTOWN
Employer/Respondent

On 9/20/2016, 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 0.50% 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:

0333 SHAY & ASSOCIATES
TIMOTHY M SHAY
260 E WOOD ST
DECATUR, IL 62523

2904 HENNESSY & ROACH PC
PAUL N BERARD
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

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)

17IWCC0260

Willard Houk
Employee/Petitioner

Case # 15 WC 13177

v.

Consolidated cases: _____

Village of Harristown
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **June 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 _____

17IWCC0260

FINDINGS

On the date of accident, **December 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 **$22,678.49**; the average weekly wage was **$755.95**.

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.

Respondent is entitled to a credit of for all amounts paid by Healthlink under Section 8(j) of the Act.

ORDER

Credits

Respondent shall receive a credit in the amount of $3,240.00, to be applied towards the award for temporary total disability, representing a permanent partial disability advance paid on July 31, 2015.

Respondent is not entitled to any additional credits under Section 8(j) of the Act, other than the above stated credit for amounts paid by Healthlink towards Petitioner's medical bills.

Medical benefits

Respondent shall pay reasonable and necessary medical services as set forth in Petitioner's Exhibit 10, as provided in Section 8(a) of the Act.

Respondent is further ordered to pay for the medical treatment recommended by Dr. Rahman, including sacroilialic injections and physical therapy.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $503.97/week for 73 2/7 weeks, commencing 6/27/14 through 8/3/14 and 3/6/2015 through 6/22/15 , as provided in Section 8(b) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

17IWCC0260

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

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

Edward Lee
Signature of Arbitrator

9/9/16
Date

ICArbDec19(b)

SEP 20 2016

FINDINGS OF FACT

Petitioner testified he is a 57 year old high school graduate employed by Respondent. Petitioner began his employment with Respondent in May or June of 2013. His job title is Superintendent of Public Works and he testified that his job duties included plowing snow, mowing, and patching roads, as well as other odd jobs for the village. He testified that his job occasionally involved heavy lifting. He testified that he had one employee working under him in public works.

Petitioner testified that leading up to December 11, 2013, the village had been redoing the filters and softeners at the water plant. As part of his job duties, Petitioner was lifting bags of rock to be used in the softeners and throwing them into a back hoe. Petitioner testified that the front of the bags indicated that they were 100 pounds. He further testified that while another employee was helping move the bags, he was independently lifting 100 pound bags. Petitioner testified he picked up the fifth or sixth bag and when he lifted he noted a sharp pain right at or just above the belt line that "put me down to at least one knee." He testified that he reported this accident to the Mayor.

Petitioner testified that he had sustained a back injury in approximately 1988 while he was working for the Mueller company, which resulted in surgery. Petitioner testified that after the surgery, he had "a little bit of trouble" which varied depending on his activities. He testified that he would have occasional flare-ups, and that at those times he would treat with his primary care physician Dr. Rademacher. He testified that these flair ups usually resolved quickly. Petitioner also saw a chiropractor during 2008 and 2009. Petitioner testified that up until the time of his accident he was able to perform the functions of his job and had been working without restrictions ever since he had the surgery.

On December 13, 2013, Petitioner presented to Dr. Rademacher. Petitioner reported that he had injured his back after lifting 100 pound bags of rock two days prior at work. Dr. Rademacher did not evaluate Petitioner, noting in his records that he does not evaluate for workman's compensation, and referred Petitioner to Corporate Health. PX 2.

Petitioner presented to Decatur Memorial Hospital's emergency department on December 15, 2013. He reported he had an onset of back pain on Wednesday at work, indicating he was picking up 100 pound bags of rocks and the pain started while moving them. PX 1. He further reported moderate sharp low back pain that radiated into his bilateral legs. PX 1. Physical examination revealed bandlike lower back pain. PX 1. Petitioner underwent an x-ray of the lumbar spine, which ruled out any fracture, and was prescribed Norco and Flexeril.

After his release from Decatur Memorial Hospital, Petitioner contacted Dr. Rademacher's office again. PX 2. He was informed that if he wanted Dr. Rademacher to treat him, it would have to be billed through his health insurance and that Rademacher "will not comply with any work comp issue related to this injury now or in the future." PX 2. Petitioner agreed to treat with Dr. Rademacher under these conditions. PX 2.

Petitioner returned to Dr. Rademacher's office and as seen by a physicians assistant. Physical examination revealed a decreased range of motion secondary to pain and positive straight leg raise

bilaterally. PX 2. Petitioner was placed on light duty restrictions of no excessive lifting, bending or straining and prescribed Hydrocodone and Prednisone. PX 2. Petitioner was provided work within these restrictions.

Petitioner continued to treat exclusively with Dr. Rademacher until June 3, 2014. At that visit, it as noted that Petitioner was continuing to have lumbar radiculopathy symptoms that appeared to be getting more frequent. PX 2. Petitioner reported that the pain interfered with sitting and sometimes with movement. PX 2. Petitioner continued to have a positive straight leg test on the right. PX 2. Dr. Rademacher recommended Petitioner undergo an MRI of his lumbar spine and referred Petitioner to Dr. Ra'Kerry Rahman, a back surgeon. PX 2.

Petitioner underwent an MRI of his lumbar spine at St. Mary's Hospital in Decatur, Illinois on June 6, 2014. PX 2. The MRI revealed severe central spinal stenosis at L4-5 due to disc bulge, as well as impingement upon the left SI nerve root sheath and severe left foraminal stenosis at L5-S1 caused by a disc/osteophyte complex. PX 2.

On June 6, 2014, Petitioner presented to Dr. Rahman for initial evaluation. PX 3. Dr. Rahman testified via his evidence deposition, taken on November 16, 2015 and entered into evidence as Petitioner's Exhibit 9. Rahman testified that he is a board certified orthopedic surgeon and that over 90 percent of his practice constitutes treatment of the spine. PX 9, p. 7. Petitioner completed intake forms indicating that he had been injured in December of 2013 when he was picking up a 100-pound bag of rock. PX 9, p. 12. Petitioner reported pain in the back, which he rated as 2 out of 10, but indicated on a severe day his pain would be 9 out of 10. PX 3. He further noted numbness in tingling in the bilateral legs. PX 3.

Dr. Rahman testified that Petitioner reported undergoing a decompressive spinal surgery in 1988 at the L5-S1 level. PX 9, p. 13. He further indicated that Petitioner had reported a history of waxing and waning back pain, which he testified was very common in back patients. PX 9, p. 36. Physical examination revealed decreased sensation in the right lateral thigh and lateral and dorsum of the right foot. PX 3. Dr. Rahman reviewed the x-ray taken at the hospital, which he noted showed disc space narrowing, as well as the MRI, which noted L4-5 disc herniation, bilateral foraminal stenosis, and moderate central stenosis. PX 3.

Dr. Rahman diagnosed Petitioner with lumbar spinal stenosis at L4-5 and L5-S 1. PX 9, p. 14. He testified that spinal stenosis is a degenerative condition that the Petitioner likely had spinal stenosis at L4-S1 prior to his date of accident. PX 9, p. 15. However, Dr. Rahman noted that the MRI, which he independently reviewed, showed a disc herniation at L4-5, which could possibly have resulted from his injury. PX 9, p. 15. Dr. Rahman further noted that the MRI revealed central stenosis at L4-5 which was undoubtedly coming from his disc herniation. PX 9, p. 16. Dr. Rahman testified that a person can have spinal stenosis and have no pain or symptoms. PX 9, p. 17. He further testified that an injury or trauma can caused spinal stenosis to become symptomatic. PX 9, p. 17. Dr. Rahman opined that Petitioner's spinal stenosis became symptomatic after his lifting injury. PX 9, p. 17.

Dr. Rahman recommended Petitioner undergo a L4-5 bilateral hemilaminotomy, which was performed on June 27, 2014. PX 3, PX 5. Dr. Rahman testified that he performed at bilateral hemilaminectomy with partial inferior and superior medial facetectomy and lateral recess decompression. PX 9, p. 24. He testified that a hemilaminotomy is a partial removal of the lamina, or the spinous process of the first bone one the prone side of the vertebral body. PX 9, p. 25. Dr. Rahman agreed that removing a portion of the lamina changes the structure of the spine. PX 9, p. 25. Dr. Rahman further testified that a medial facetectomy involves the removal of the inside half of the facet joint, which he also agreed changes the structure of the spine. PX 9, p. 25. Dr. Rahman testified a lateral recess decompression involves removing bone and ligament on the dorsal side of the nerves that traverse the lateral recess, resulting in indirect decompression. PX 9, p. 25. Lateral recess decompression also changes the structure of the spine. PX 9, p. 26. Dr. Rahman testified that the changes made to Petitioner's spine can affect the levels above and below the level of surgery; specifically, there may be reactive or compensatory changes at the adjacent spinal levels. PX 9, p. 26-27.

Subsequent to surgery, Petitioner was placed off work by Dr. Rahman. PX 3, PX 9, p. 18. Petitioner testified he worked up until the date of his surgery. After his surgery, he used approximately eight weeks of sick time to receive pay while he was restricted from working, from the date of surgery until August 4, 2014. He did not receive any temporary total disability payments.

Petitioner underwent post-surgical care with Dr. Rahman. Petitioner was returned to work on August 4, 2014 with light duty restrictions of no lifting over 30 pounds. PX 3. Petitioner testified he returned to his pre-injury job within his restrictions. However, he testified that "once in a while" he had to perform duties outside of his 30 pound lifting restriction. He testified that he carried a pump that weighted 35 to 40 pounds, as well as a five gallon gas can that he estimated weighted 42-43 pounds.

On August 7, 2014, Dr. Rahman noted Petitioner's postoperative course was notable for resolving seroma. PX 3. Also at that visit, Petitioner noted his pre-operative symptoms had been alleviated. PX 3. On November 21, 2014, Petitioner reported to Dr. Rahman that he had no pain. PX 3. His physical examination that date was unremarkable and Dr. Rahman noted he was recovering "remarkably." PX 3. Petitioner testified that he "was doing real good" after the surgery, and believed it had gone very well. He testified he did not have much pain and felt the best he had for a long time.

On February 23, 2015 Petitioner was working and was that the Village Hall in the office. He testified that he was talking to the village clerk, Heather Urbanowicz when the Mayor, Rose Ross, kicked Petitioner in the back of the leg behind the knee in a playful manner. Petitioner testified that he was not paying attention when Ms. Ross kicked him and was not expecting it. He testified that the kick was not very hard, but it was enough that he had to put his hands down on a 4 foot table to catch himself and grab ahold of a counter to support himself. He testified that he subsequently sat down in a desk chair. Petitioner testified that after the incident of February 23, 2015, his back became progressively worse.

Petitioner returned to Dr. Rahman on March 6, 2015. Petitioner reported pain in his lower back of moderate severity with reset alleviating and walking and standing aggravating. PX 3. Physical examination revealed decreased sensation in the right lateral foot and sole. PX 3. Dr. Rahman testified that lateral right foot desensitization is indicative of an S1 compression. PX 9, p. 23. Dr. Rahman had x-

rays taken in office which revealed a slight decrease in disc height at L5-S1 with mild foraminal stenosis at that level. PX 3. Petitioner was prescribed Cyclobenzaprine and Methylprednisolone and was taken off work. PX 3.

Dr. Rahman testified that Petitioner had originally presented with some decreased disc height t L5-S1 and that he had undergone a prior surgery at that level. PX 9, p. 23. He opined that Petitioner underwent rapid degeneration of the L5-S1 level due to the stress created by the L4-5 decompression. PX 9, p. 23. Dr. Rahman testified that a surgery in and of itself constitutes a trauma. PX 9, p. 24. He testified it was his opinion that reactive or compensatory changes occurred at the L5-S1 as a result of the structural changes to the spine made to the L4-5 level during the June 27, 2014 surgery, which caused Petitioner's symptoms at the L5-S1 level. PX 9, p. 27.

On April 3, 2015, Petitioner returned to Dr. Rahman's office, and was evaluated by a physician's assistant. He reported worsening of his pain. PX 3. Petitioner was ordered a TENS unit and referred for physical therapy. PX 3.

Petitioner began physical therapy at St. Mary's Hospital on April 14, 2015. He continued to receive physical therapy at St. Mary's until May 6, 2015. PX 6. Petitioner testified that he participated in physical therapy, but that it was discontinued. On May 6, 2015, the physical therapist, Jennifer Johnston, noted that she was waiting to continue therapy until Petitioner's appointment with Dr. Rahman on May 15, 2015, as he was not progressing. PX 6.

Dr. Rahman testified that in April of 2015, he diagnosed Petitioner with chronic back pain. PX 9, p. 38-39. He testified that chronic back pain is back pain that is beyond the acute and subacute phase, and that it can describe someone with back pain for three to four months or someone with back pain for 16 years. PX 8, p. 39. He testified that he diagnosed Petitioner with chronic back pain because he was having back pain for a prolonged period after initial treatment for his acute presentation. PX 9, p. 39.

On May 15, 2015, Petitioner returned to Dr. Rahman. PX 3. Petitioner reported he had felt great for the first six months. PX 3. He noted a dull toothache-type lumbosacral pain that he rated at 5 out of 10 that was only alleviated with laying down or bending over. PX 3. Petitioner noted most of the pain was in his lumbosacral spine and he had some associated tingling in his toes. PX 3. Dr. Rahman recommended Petitioner undergo a lumbar MRI with contrast. PX 3. He further kept Petitioner off work. PX 3.

Petitioner underwent an MRI to his lumbar spine on September 24, 2015. PX 7. Petitioner testified that his MRI was delayed because, as of May 15, 2015, he no longer had health insurance through Respondent. Petitioner testified that he subsequently applied for and received coverage through Medicaid, which allowed him to undergo the September 24, 2015 MRI.

On October 16, 2015, Petitioner returned to Dr. Rahman for review of his MRI. PX 3. Dr. Rahman noted Petitioner had back and leg pain that was worse with walking and standing. PX 3. He further noted that Petitioner had been experiencing these symptoms since December 2014 when he reinjured his back after surgery. PX 3. Dr. Rahman noted the surgery was successful until the second injury. PX 3.

Dr. Rahman reviewed the MRI which showed central disc herniation at L4-5 and L5-S1, with severe foraminal stenosis of the left L4 to L1 foramens. PX 3. On examination, Dr. Rahman noted decreased trunk range of motion and decreased and painful trunk extension. PX 3. Dr. Rahman recommended Petitioner undergo a transforaminal lumbar interbody fusion across L4-5 and L5-S1. PX 3. Dr. Rahman testified that he recommended the fusion to reestablish the height between the foramen that was causing compression and to decompress the central part of the nerves. PX 9, p. 31-32.

Dr. Rahman testified that the recommended fusion was related to the initial injury and surgery. PX 9, p. 32-33. He testified that Petitioner initially presented to him for an exacerbation of a degenerative problem. PX 9, p. 33. He testified that the first surgery at L4-L5 had resolved his symptoms, but that he had suffered additional, exacerbated degeneration after the first surgery. PX 9, p. 33.

Petitioner testified that his surgery was initially scheduled for January of 2016. However, prior to surgery he was required to undergo a physical examination, and the results blood work performed as part of the pre-surgical clearance procedure resulted in a delay in surgery in order to adjust Petitioner's medications and ensure he was healthy enough for surgery.

Petitioner was subsequently cleared to proceed with surgery and underwent and L4-L5 and L5-S1 interbody fusion with Dr. Rahman on February 8, 2016 at Memorial Medical Center. PX 8. The surgery included bilateral lateral recess decompression and Ponte osteotomy at both levels, as well as placement of an intravertebral synthetic device, in form of a titanium-coated PEEK interbody cage over L4-S1, placement of a titanium rod across L4-S1, placement of screws into L4, L5 and S1, and bone grafting. PX 8.

After surgery, Petitioner was admitted to the hospital at Memorial Medical Center for recovery, and was discharged on February 12, 2016. PX 3. During his stay, Petitioner developed tachycardia, which was, after evaluation by hospitalists, ford to be due to missed medications. PX 3.

Petitioner returned to Dr. Rahman on February 19, 2016 for post-surgical evaluation. PX 3. Petitioner reported some post-surgical pain with improvement of leg symptoms. PX 3.

Petitioner last saw Dr. Rahman on May 20, 2016. Petitioner complained of low back pain in the lumbosacral area. PX 3. He denied any improvement since his last visit, and noted difficulty walking and sitting. PX 3. Physical examination revealed tenderness to the sacroiliac joint and positive Faber test on the left. PX 3. Dr. Rahman diagnosed Petitioner with sacroiliitis secondary to fusion. PX 3. He recommended Petitioner undergo two injections to the sacroiliitis, and that if the injections were successful, that he would continue with injections. PX 3. He also recommended physical therapy. PX 3.

In his testimony, Dr. Rahman noted that Petitioner smokes and that smoking can cause degeneration. PX 9, p. 4s. However, he testified that Petitioner was smoking and pain free after his initial surgery, and therefore it was hard to causally link Petitioner's smoking and back pain. PX 9, p. 43. Dr. Rahman also agreed that Petitioner had degenerative disc disease, noting "He definitely - - he does. We – you do; I do; we all do." PX 9, p. 44. Dr. Rahman testified that Petitioner's degenerative disc disease contributed to Petitioner's need for his two level fusion, but that the trauma of the initial surgery and the

structural changes made caused Petitioner to rapidly deteriorate. PX 9, p. 45. Dr. Rahman testified that while smoking and degenerative disc disease played factors in Petitioner's rapid degeneration, the surgical trauma was a larger factor in the rapid degeneration. PX 9, p. 45. He testified that absent the surgical trauma, he would not have expected this rapid of degeneration. PX 9, p. 47.

Petitioner testified that subsequent to this visit, he has undergone two sacroillialic injections at Memorial Medical Center. He testified that he had received approximately a week and-a-half of relief from the injections. He further testified that he had begun physical therapy at St. Mary's Hospital, but that he had only been to one visit as of the time of arbitration.

Petitioner testified that he is not currently on any medications because Dr. Rahman wants to ensure the injections are effective, and that Petitioner is not simply receiving relief from his medications. Petitioner further testified that he is currently on restrictions of 10 pounds with no bending, lifting, twisting, pulling, or pushing. No work has been made available for the Petitioner within these restrictions by Respondent. Petitioner has not worked since March 6, 2015. Petitioner has not received any temporary total disability at any time.

Petitioner testified that he began receiving benefits from the Illinois Municipal Retirement Fund (IMRF) for non-occupational disability beginning in July or August of 2015. He testified that he received approximately $1,600.00 gross per week and $1,400.00 net from IMRF. Petitioner testified that he must repay IMRF if he receives a settlement.

Petitioner testified that he continues to have pain in his low back right at the belt line, in the same place it was before his surgeries. He testified that the pain travels down his legs and that at the time of trial his toes were tingling.

Petitioner was evaluated by Dr. Carl Graf on August 3, 2015 for a Section 12 Examination at the request of the Respondent. Dr. Graf's deposition was taken on February 11, 2016, and is entered into evidence as Respondent's Exhibit 1. Dr. Graf, an orthopedic spine surgeon, opined that Petitioner's initial lumbar disc herniation at L4-5, and the need for the 2014 spinal surgery, was causally related to his work injury of December 11, 2013. RX 1, p. 6, 14. However, Dr. Graf testified that Petitioner reached MMI approximately three months after the lumbar decompression, and that his subsequent symptoms and second surgery were not causally related to the December 11, 2013 accident. RX 1, 15, 17. Rather, Dr. Graf opined that Petitioners recurrence of symptoms was "purely degenerative" and attributed to the preexisting degenerative condition. RX 1, p. 17.

Of note, a series of questions were asked of Dr. Graf in his deposition by Respondent's counsel regarding literature that Dr. Graf had reviewed in rendering his opinions, which were objected to by Plaintiff's counsel, as no specific literature was set forth in Dr. Graf's report nor disclosed or provided to counsel prior to the deposition, contrary to the requirements under Section 12. RX 1, p. 18-22; 71-72. Dr. Graf relies on these studies, which are not disclosed by name in his deposition, to discredit the opinions of Dr. Rahman regarding adjacent level degeneration after lumbar decompression. RX 1, p. 20.

Dr. Graf did testify that Petitioner's symptoms on examination were consistent with his physical examination and his review of the diagnostic studies, and that Petitioner exhibited no nonorganic signs of pain. RX 1, p. 26, 28. Dr. Graf testified that a lumbar fusion was not reasonable and necessary for Petitioner as his symptoms were primarily in the back, and that a fusion would not help back pain; however Dr. Graf admitted that Petitioner did state that 20% of his pain was in the legs. RX 1, p. 30-32. Further, later in his deposition, Dr. Graft states "A lumbar fusion isn't performed...to help leg pain. A lumbar fusion is performed to help back pain, which is his predominant complaint right now...and that's why it's being recommended, a two-level lumbar fusion." RX 1, p. 62. Further, Dr. Graf was unable to provide any particular alternative treatment options, other than providing diagnostic injections. RX 1, p. 31. Dr. Graf also was unable to give any opinion as to whether Petitioner required any ongoing work restrictions. RX 1, p. 32.

Dr. Graf testified that, over that past eight years, his has probably performed more than 50 IME's for Respondent's counsel's firm. RX 1, p. 67.

Heather Urbanowicz presented for testimony pursuant to subpoena by the Petitioner. Ms. Urbanowicz testified that she was employed as the Deputy Clerk for Respondent in February of 2015. She testified she had an office located in the Village Hall. Ms. Urbanowicz testified that she witnessed the incident involving Ms. Ross and the Petitioner. She testified that she was sitting at her desk and Petitioner was leaning over the counter talking to her. She testified that Ms. Ross came up behind him and hit him on the back of the leg, causing Petitioner to fall forward and go down on his elbows. She testified Petitioner hit the counter to hold him up and started screaming. Petitioner then sat in a chair and complained that his back hurt. Ms. Urbanowicz testified that Petitioner did not do anything to provoke Ms. Ross and that she did not believe Petitioner and Ms. Ross had spoken immediately prior to the incident.

Ms. Urbanowicz testified that the Petitioner told her his back was sore after the February 2015 incident and that it was getting worse. Ms. Urbanowicz testified that she called Ms. Ross and informed her that Petitioner wanted to file a workman's compensation claim. She testified that she filed that accident report regarding this claim on February 23, 2015.

Ms. Rose Ross testified on behalf of the Defendant. She testified that she is Respondent's Mayor and has held that position for three years. She testified that her job duties include overseeing the Village and overseeing Respondent's employees to ensure that they are completing work. Ms. Ross testified she had known Petitioner for three years and that she swore him in as Superintendent of Public Works on the fourth Monday of May of 2013.

Ms. Ross testified that she knew that Petitioner had undergone a back surgery in June of 2014. She testified that she believed the incident where she kicked Petitioner occurred in December 2014. She testified that Petitioner was standing leaning over a table with his elbows on the counter of Ms. Urbanowicz's workspace. She testified that Petitioner leaned over and bumped her in the shoulder, said something funny, and she lifted her right leg and swung it around behind her left leg and tapped him on the back side of his leg. She testified that Petitioner bent over and said that he hurt his back. He subsequently sat down in a chair.

CONCLUSIONS OF LAW

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

After a review of the totality of the evidence, the Arbitrator finds that the Petitioner's current condition of ill-being is causally related to his accident of December 11, 2013. Of note, it has been stipulated by the parties that there is no dispute as to causal connection up until September 27, 2014, or approximately three months after Petitioner's initial lumbar surgery. The Arbitrator further notes that there is no real dispute as to Petitioner's symptoms after September 27, 2014, as Dr. Graf, Respondent's Section 12 Evaluator found Petitioner credibly reported his symptoms and such symptoms were consistent with the exam and radiological findings. Thus, causal connection becomes an issue for the experts.

The Arbitrator primarily relies on the records, testimony, and opinions of Dr. Rahman, and gives more weight to the opinions of Dr. Rahman than those of Dr. Graf. The Arbitrator first sustains Petitioner's objection regarding the line of questioning set forth on pages 18-22 and 71-72 of Dr. Graf's deposition as being both outside of the scope of Dr. Graf's report and a violation of the rule set forth in *Ghere v. Industrial Comm'n.* The testimony set forth on those pages, and any testimony regarding "medical literature" has been disregarded. Also, Dr. Graf testified that he has been employed by Respondent's counsel's employer in over 50 cases in the past 8 years, which is an average of 6.25 cases per year, or approximately one every two months. The Arbitrator finds that this significant use by Respondent's counsel's firm of Dr. Graf also decreases his credibility.

Looking to the testimony of Dr. Rahman, the he opined, within a reasonable degree of medical certainty, that the need for Petitioner's two level spinal fusion was due to degeneration of the disc at L5-S1. Dr. Rahman, credibly admits that the reason for Petitioner's post-surgical disc degeneration is multifactorial, and includes pre-existing degenerative disc disease, as factors such as Petitioner's smoking. PX 9, p. 42-43. Dr. Rahman also testified that he would have expected Petitioner to possibly have problems several years later at L5-S1 even without the surgery. PX 9, p. 47. However, Dr. Rahman testified that the trauma of Petitioner's original surgery and the structural changes made during that surgery caused rapid degeneration of the L5-S1 joint space. PX 9, p. 45. He testified that he would not have expected such rapid degeneration absent the surgery. PX 9, p. 47. Further, Dr. Rahman testified that the Petitioner's surgical trauma was the largest factor in his rapid degeneration. PX 9, p. 45.

Further, Dr. Rahman notes that the Petitioner's condition was likely further aggravated by a "subsequent accident" that occurred in February 2015. Petitioner, Ms. Urbanowicz and Ms. Ross each testified regarding this incident, where Ms. Ross kicked Petitioner in the back of the leg in a playful manner. All three testified that Petitioner reacted to this kicking by studying himself on a table and sitting down in a desk chair. Petitioner testified that after this incident, his back became progressively worse.

When a fellow employee engages in horseplay with a petitioner, of which the petitioner was not a participant, and the horseplay results in an injury to the petitioner, said injury is considered compensable. *American Brake Shoe Co. v. Industrial Comm'n,* 20 Ill. 2d 132 (1960). In this case, both Petitioner and Ms. Urbanowicz both testified that the Petitioner had not done anything to provoke Ms. Ross, and Ms. Urbanowicz testified she did not believe Petitioner and Ms. Ross had spoken prior to the incident. The Arbitrator finds that the February 2015 incident between Petitioner and Ms. Ross may have aggravated the Petitioner's condition, but did not constitute an intervening event.

The Arbitrator does recognize that Petitioner had several months of relief from his initial surgery and, in fact, had a remarkable result. However, this initial positive result does not contradict the opinions of Dr. Rahman, who testified that during the period of post-surgical relief, the Petitioner was undergoing rapid disc degeneration caused by the changes made to the L4-5 vertebral bodies.

Finally, since the second surgery, the Petitioner has had consistent pain complaints to his low back, which Dr. Rahman has continued to treat with injections and physical therapy. The Arbitrator finds that, as there has been no evidence provided to the contrary and the Petitioner's ongoing pain indicates that the condition has not stabilized since the second surgery, that the Petitioner's current condition of ill being is causally related to his December 11, 2013 accident.

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

Based on the finding that Petitioner's current condition of ill-being is causally related to the December 11, 2013 work related accident, the Arbitrator finds that all the medical services Petitioner has received, as set forth in Petitioner's Exhibits 1-8, constitute reasonable and necessary medical treatment causally related to the December 11, 2013 accident.

Petitioner's medical bills for the above services are set forth in Petitioner's Exhibit 10. The Arbitrator finds that the charges set forth in Petitioner's Exhibit 10 constitute charges for reasonable and necessary medical treatment related to the December 11, 2013 accident.

Respondent is ordered to pay Petitioner's medical bills, as set forth in Petitioner's Exhibit 10, according to the fee schedule, as set forth in the Act. Per stipulation of the parties, Respondent shall receive a credit pursuant to Section 8(j) of the Act for any and all medical bills paid by Healthlink, Respondent's group health carrier. Respondent shall hold Petitioner harmless for any credit receive under Section 8(j). Respondent shall also receive a credit for bills previously paid by CCMSI, as set forth in Respondent's Exhibit 2.

Issue K: Is Petitioner entitled to any prospective medical care?

Based on the find that Petitioner's current condition of ill-being is causally related to the December 11, 2013 work related accident, the Arbitrator finds that the Petitioner is entitled to prospective medical care, as recommended by Dr. Rahman, including sacroilialic injections and physical therapy.

Issue L: Is Petitioner entitled to any temporary total disability benefits?

The Arbitrator finds that the Petitioner is entitled to temporary total disability benefits. As an initial matter, there is no dispute that Petitioner was temporarily and totally disabled as a result of his work related injury from June 27, 2014 and August 3, 2014; however, Petitioner was not paid temporary total disability benefits for that period. Therefore, the Arbitrator awards temporary total disability benefits of 5 and 3/7 weeks, at the rate of $503.97 per week representing the period of June 27, 2014 to August 3, 2014.

Second, as the Arbitrator has found that Petitioner's current condition of ill-being is causally related to the December 11, 2013 accident, any reasonable and necessary work restrictions for his current condition would also be causally related to the accident. The Arbitrator notes that the only evidence of what Petitioner's current restrictions are comes from Dr. Rahman; Dr. Graf specifically testified that he could not give an opinion

regarding Petitioner's current work restrictions. RX 1, p. 32. Therefore, the Arbitrator relies on the work restrictions provided by Dr. Rahman.

The Arbitrator finds that Petitioner has not worked since March 6, 2015, when he was taken off work by Dr. Rahman. Since that time, Petitioner's restrictions have been increased to 10 pounds with no bending, lifting, twisting, pulling or pushing. No work has been provided to Petitioner within these restrictions by Respondent and Petitioner has not received any temporary total disability.

As such, Respondent is ordered to pay Petitioner temporary total disability benefits of $503.97 per week for a period of 67 and 6/7 weeks, representing the period of March 6, 2015 to June 22, 2016, the date of Arbitration.

In summary, the Arbitrator awards temporary total disability benefits of $503.97 per week from June 27, 2014 to August 3, 2014 and from March 6, 2015 to June 22, 2016, for a total of 73 2/7 weeks.

Respondent shall receive a credit against the award for temporary total disability of $3,240.00, as set forth in Respondent's Exhibit 3, for a permanent partial disability advance that was paid July 31, 2015.

Issue N: Is the Respondent due any credit?

As set forth above, the Respondent is due an 8(j) credit for medical bills paid by Healthlink and for bills previously paid by CCMSI. Further, as set forth above, Respondent is entitled to a permanency credit of $3240.00, which shall be reserved for a determination on permanency.

For the following reasons, the Arbitrator finds the Respondent is not due any additional credit. Respondent has claimed a credit of $100.00 in non-occupational indemnity disability benefits and $9,093.53 in "other benefits." Of note, the Respondent did not specify on the stipulations sheet what the "other benefits" constitute and did not provide any evidence to prove up their entitlement to such credit.

There appear to be two possible areas where the request for credit may originate, neither of which would, in fact, entitle Respondent to a credit. First, the Petitioner testified that he received benefits from IMRF for non-occupational disability. IMRF is Petitioner's retirement fund and benefits were paid specifically for non-occupational disability. Petitioner testified that he must repay IMRF in the event of settlement of his case. Second, Petitioner testified that between June 27, 2014 and August 4, 2014, he received vacation pay while he was restricted from working, but did not receive any temporary total disability benefits.

In *Wood Dale Elec. v. Illinois Workers' Compensation Com'n*, 986 N.E. 2d 107 (1st Dist. 2013), the employer claimed it was entitled to a credit for benefits paid by Petitioner's pension. In rendering it's decision, the Court of Appeals reviewed seminal case of *Tee-Pak, Inc., v. Industrial Comm'n*, 141 Ill. App. 3d 520 (1986). In *Tee-Pak, Inc.*, the petitioner was paid his full salary under benefit program that insured a full salary to employees who were off work due to an accident or illness. *Tee-Pak*, 141 Ill. App. 3d at 522. The Court held that an employer does not receive a credit for benefits that would have been paid irrespective of the occurrence of a workers' compensation accident. *Id.* at 529. In other words, because the petitioner would have had access to her sick time for an accident *not* related to a work accident, the respondent was not entitled to a credit. The Court in *Wood Dale* followed the reasoning set forth in *Tee-Pak*, noting that as the pension was wholly unrelated to the claimant's workers' compensation accident, those payments did not entitle the employer to an 8(j) credit.

Similarly, in this case, no evidence has been presented by Respondent that indicates that Petitioner would not have been able to use his sick leave for an injury or illness unrelated to a work injury. Additionally, no evidence has been presented that indicates that Petitioner would only be able to collect benefits from IMRF due to a work related injury. In fact, Petitioner testified that, in the event of a settlement or award, he will be required to repay IMRF for the benefits he received, which would indicate that Petitioner, in fact is *only* entitled to benefits from IMRF in the case of a *non-occupational* disability.

For the reasons set forth above, the Arbitrator find that the Respondent is not entitled to a credit pursuant to Section 8(j) of the Act for non-occupational indemnity benefits or "other benefits."

15WC13558
Page1

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

Adam Compton,

Petitioner,

vs.

NO: 15 WC 13558

17IWCC0235

City Of Herrin Police Department,

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 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 September 21, 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: APR 13 2017
o040617
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

COMPTON, ADAM
Employee/Petitioner

Case# **15WC013558**

CITY OF HERRIN POLICE DEPARTMENT
Employer/Respondent

17IWCC0235

On 9/21/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.50% 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:

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

0299 KEEFE & DePAULI PC
ANDREW J KEEFE
2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

17IWCC0235

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)

ADAM COMPTOM
Employee/Petitioner

v.

CITY OF HERRIN POLICE DEPARTMENT
Employer/Respondent

Case # 15 WC 13558

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Collinsville**, on **May 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 _____

17IWCC0235

FINDINGS

On the date of accident, **March 13, 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 **$59,368.92**; the average weekly wage was **$1,141.71**.

On the date of accident, Petitioner was **41** 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 **$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** under Section 8(j) of the Act.

ORDER

As explained in the Arbitration Decision, Petitioner's current condition of ill-being with regard to his lumbar spine is causally related to the accident at work on March 13, 2015. Petitioner has not reached maximum medical improvement.

Respondent shall pay reasonable and necessary medical services as reflected in Petitioner's Exhibit 1 that remain unpaid, except for those itemized in the Arbitration Decision, pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for amounts paid, including those paid through its group medical plan, for which credit is allowed under Section 8(j) of the Act. Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving credit.

Respondent shall pay for prospective medical treatment, including surgery, related to Petitioner's lumbar spine, pursuant to Section 8(a) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Signature of Arbitrator

September 20, 2016
Date

SEP 21 2016

17IWCC0235

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

ADAM COMPTON
Employee/Petitioner

v. Case #: 15 WC 13558

CITY OF HERRIN POLICE DEPARTMENT
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated that on March 13, 2015, Petitioner sustained an accident which arose out of and in the course of his employment with Respondent, resulting in an injury to his lumbar spine. The parties further stipulated that Respondent has paid all medical bills through September 9, 2015, and is entitled to a credit for such payments, including those made pursuant to Section 8(j). The parties agreed that Petitioner has not missed any time from work to date.

On the date of accident, March 13, 2015, Petitioner was 41 years old, married, with two dependent children. He was employed by Respondent as a 911 Dispatch Supervisor, and had been so employed for 13 years. Petitioner testified that part of his duties included maintaining equipment, and on the date of accident there was a computer tower that was malfunctioning. He got down on his knees underneath the desk, picked up the tower and began to move it out, and felt a sharp pain in his back shooting down his right leg.

Petitioner candidly testified that he had a prior back surgery, a microdiscectomy, in 2005. Following the surgery he was released from care with no restrictions, and returned to full duty work, which included police dispatcher and active police officer. He characterized the surgery as successful, in that he recovered and was no longer in pain. He testified that in 2013 he was hospitalized for 28 days for ruptured intestines, which caused him to become septic and he "about died". Following the hospitalization he tried to get back into shape and started working out with a trainer. In the process of working out he strained his low back. He went to his primary physician, who diagnosed a pulled muscle and ordered an MRI. He did not miss any work as a result of the incident. He testified he had no other injury following that, and no treatment to his low back in 2014 or 2015, until the accident at work on March 13, 2015.

Petitioner testified he continues to have pain in his low back, right hip, and right leg, as well as tingling and numbness in his right foot. He has continued to work and has not missed any time other than to attend doctor appointments. He can no longer mow his yard, cannot walk long distances, and has difficulty sleeping. He has been able to continue as a school board member, a den leader for his son's Scouts, and a tee-ball coach. He testified he takes Excedrin for the pain, as Dr. Gornet did not want him taking narcotic pain medication.

Petitioner testified he was seen by Dr. Brett Taylor at his employer's request and informed him of the prior low back surgery in 2005. However, he did not mention the incident in 2013 and resulting MRI, as he simply did not remember and did not think the incident was a big deal.

On cross-examination, Petitioner agreed he had had intermittent low back pain for about six years prior to his surgery in 2005. He acknowledged that in his initial visit with Dr. Gornet he did not mention the low back incident in 2013, as he had forgotten about the incident. He disagreed with Dr. Gornet's testimony that he had provided him a copy of the 2013 MRI at that time. He also disagreed with Dr. Gornet's testimony that people who had undergone back surgery would continue to have symptoms, as he had not continued to have low back symptoms.

Petitioner agreed that his low back pain in 2013 was significant enough that he sought out treatment, but denied that he had undergone any treatment prior to that time. Following that incident he went to physical therapy for a couple weeks. Respondent's attorney questioned Petitioner regarding records received from Herrin Hospital pursuant to subpoena. The records were from 2007 to 2015, were voluminous, and reflected 25 to 30 visits to the hospital during that time. Following the 2013 incident, the records indicated seven or eight visits to the hospital, for conditions unrelated to his low back. Petitioner did not recall those visits, but did not dispute the information. The Arbitrator notes that these records were not admitted at trial, with the exception of the MRI report of April 11, 2013, following the incident with the trainer.

With regard to his accident, Petitioner testified he was moving the computer tower and actually picked it up when he felt the pain in his back. When it occurred, he stopped what he was doing and someone else took over for him. He was first treated by a Nurse Practitioner on March 19, 2015, though testified he had attempted to seek treatment before then. He was prescribed physical therapy, which he attended at Rehab Unlimited. He continued working at that time, and testified his job as dispatcher consisted of sitting 90% of the time during his ten-hour shift, which he agreed was primarily sedentary. Petitioner testified that when he returned to the Nurse Practitioner on March 26, 2015, he requested an MRI, but she refused.

Petitioner testified that the following day, March 27, 2015, he presented to Dr. Gornet, an appointment his attorney had arranged. He had an MRI that day as well. Dr. Gornet allowed him to work and wanted to treat him conservatively at that point. He underwent some injections, and returned to Dr. Gornet on May 28, 2015. He testified the injections helped at first, but wore off over the next month. Dr. Gornet discussed surgery at that point, and advised Petitioner to consider whether he wanted to live with the pain or undergo surgery. He continued working his regular duties, and continued performing his duties on the school board and pension board, coaching his daughter's softball team, and activities with his son's Boy Scouts.

Petitioner returned to Dr. Gornet on July 30, 2015, and it was documented that therapy had failed. Petitioner acknowledged, however, that he had undergone only one week of therapy, prior to coming under Dr. Gornet's care. He testified that the physical therapist told him she did not feel therapy was doing any good. Petitioner agreed Dr. Gornet did not prescribe any therapy. Under Dr. Gornet's care he has undergone a CT discogram, an MRI spectroscopy, and a repeat MRI. He testified that he had "been checked over" every time he had been seen by Dr. Gornet.

On re-direct, Petitioner clarified that he had not recalled the incident with the trainer in 2013 until questioned about it by Respondent's attorney during a conference between all the parties in January 2016. He then personally obtained the MRI films and gave them to Dr. Gornet. He testified that although he is able to continue working and participating in his other activities, he remains in pain, and for that reason he would like to undergo the additional treatment recommended.

On the day of his accident, March 13, 2015, Petitioner completed an Employer's Report of Injury. He indicated he was removing a computer tower from beneath a work station for repair when he had pain to his lower back, right hip, and right leg. He noted he had made an appointment with a physician. PX10.

On March 19, 2015, Petitioner presented to WorkCare and was examined by Nurse Practitioner Dena Kommer. He reported he was removing a computer tower from underneath a work station while on both knees and that while twisting to lift the tower out he felt a pull in his low back. He stated the back pain radiated to the right hip and down the right leg, and the pain was aching and moderate. He also complained of loss of range of motion in the lumbar region. Neurologic examination was positive for tingling in the right lower extremity. On examination, Petitioner could not perform toe walking, heel walking, or squatting. He had pain to palpation over the lumbar spine, right sacroiliac joint, and lower lumbar spine. He had pain on motion over the lumbar spine, lower lumbar spine, and right sacroiliac joint. There was no swelling noted. NP Kommer's assessment was sprain and pain of the lumbar spine. She prescribed Medrol Dose Pak, Cyclobenzaprine, and physical therapy, and allowed Petitioner to work on light duty, with no carrying or lifting more than ten pounds, no squatting, stooping, or twisting, limited bending, and the option to sit or stand as needed. PX3.

Later that same day, Petitioner presented to Herrin Hospital/Rehab Unlimited for an initial physical therapy evaluation. He gave a consistent history of the accident, and related that after the accident he called his primary physician who referred him to WorkCare. He gave a previous history of low back pain, for which he underwent a discectomy in 2005 at L4-5. He reported he was working full time and that his job as a dispatch supervisor involved sitting for 90% of his 10 hour shift. He complained of pain, numbness, and tingling down his right lower extremity, and increased pain with twisting and rolling over in bed. Therapy was recommended for two to three times a week for four weeks. PX4.

Petitioner attended physical therapy on March 20, 2015, and reported continued pain and radicular symptoms in his right lower extremity, slightly improved. He continued to have numbness in his right foot, which was cold to the touch. Treatment was unable to change his

radicular symptoms. Petitioner returned to therapy on March 25, 2015, and reported the pain down his right leg had improved, but he continued to have numbness and tingling in the right foot. Symptoms were not relieved with treatment. He returned to therapy on March 26, 2015, and continued to report pain in his right low back, down his right leg to the foot, as well as continued numbness and tingling. At that time the therapist noted Petitioner would benefit from further diagnostic testing, due to numbness remaining in his right foot and down his leg. The Discharge Note from later that day indicates Petitioner called to advise he was going to a doctor in St. Louis regarding his pain and that therapy would be on hold. PX4.

Petitioner returned to WorkCare on March 26, 2015, with continued pain in the low back that radiated down the right leg into the foot, with tingling and numbness in the foot. Patient was offered Neurontin but declined, stating he was already on a lot of medications. On examination, heel walking could not be performed on the right, range of motion was limited, and toe walking resulted in pain to the right lumbar area. There was pain with motion and to palpation over the lumbosacral area and the right sacroiliac joint. There was no swelling noted. NP Kommer continued Petitioner's restrictions and he was to return in one week. The Arbitrator notes this is the final record from WorkCare. PX3.

On March 27, 2015, Petitioner presented to Dr. Matthew Gornet of The Orthopedic Center of St. Louis. He testified the appointment was arranged by his attorney. He gave a consistent history of the accident and his treatment to date. He complained of low back pain to the right buttock and hip and down the right leg to his foot, with numbness and tingling and giving out of his right leg. Petitioner reported a prior back problem and discectomy in 2005 by Dr. Kevin Vaught, which he believed was on the left side. He stated he recovered from that and did well until the recent injury at work. Past surgical history also included abdominal mesh and multiple previous abdominal procedures. On examination, Petitioner was able to bend and forward flex with his hands to the mid-lower legs, but had significant right leg pain with forward bend. Sensation was decreased to the S1 dermatome on the right. Lumbar x-rays were taken in the office, which revealed some mild loss of disc height at L4-5, but no instability and normal hips. Lumbar MRI was done as well (PX6), which revealed, as read by the radiologist: (1) L4-5 left laminectomy and microdiscectomy with post-surgical changes; and (2) L4-5 and L5-S1 central and right paracentral disc protrusions, with mild to moderate stenosis of right lateral recess at L4-5. Dr. Gornet reviewed the MRI as well, and opined that there was a possible right-sided annular tear at L5-S1. Dr. Gornet's overall impression was that Petitioner had a new disc injury at L4-5 in the form of an annular tear and herniation, possible aggravation of degenerative changes at L4-5, and possible disc injury at L5-S1. Dr. Gornet opined Petitioner had a new injury, as his previous surgery and symptoms had been on the left side. He prescribed higher dose oral steroid and allowed Petitioner to continue working. He indicated if the oral steroids failed after two weeks he would move to steroid injections on the right at L5-S1 and transforaminally at L4-5. He opined Petitioner's current symptoms were causally connected to his work accident of March 13, 2015. PX5.

On April 15, 2015, Petitioner presented to Dr. Steven Granberg and underwent a lumbar translaminar epidural steroid injection at L5-S1. He returned to Dr. Granberg on May 8, 2015, and reported he had good relief initially following the injection, but was not improved overall. He underwent a selective nerve root injection at right L4 and L5. PX7.

On May 28, 2015, Petitioner returned to Dr. Gornet and reported that the injections gave him some temporary relief but that his symptoms were slowly returning. Dr. Gornet noted that the next step would be a two-level fusion from L4 to S1, and recommended Petitioner see if he could live with his symptoms. It was noted he was continuing to work full duty, but that his pain and symptoms were affecting his quality of life. He recommended weight loss for Petitioner and follow up in two months. Petitioner followed up with Dr. Gornet on July 30, 2015, and reported he still had pain which affected his quality of life and most aspects of his life, though he was continuing to work. It was noted he had tried and failed injections and physical therapy. It was also noted Petitioner had lost 22 pounds, and Dr. Gornet recommended continued weight loss and advised Petitioner he would likely require a fusion. Petitioner was to think things over and return in six to eight weeks. PX5.

On September 9, 2015, Petitioner was evaluated by Respondent's Section 12 examiner, Dr. Brett Taylor of Town & Country Crossing Orthopedics. He gave a consistent history of the accident and his treatment to date. He related he began treating with Dr. Gornet, who prescribed injections and weight loss, and reported he had lost 30 pounds since March. Petitioner completed a spine questionnaire, referred to in Dr. Taylor's report but not included in the records submitted. On the questionnaire he described his pain as being 40% in the back and 60% in the leg, with the leg pain being 90% on the right and 10% on the left. The right sided pain was present in the buttock, back of thigh, calf, and foot. He also complained of weakness and numbness in the right calf, foot, and ankle. He reported no prior problems on the questionnaire, but during the verbal history he advised he had had prior surgery in 2005. RX1, Dep. RX2.

Dr. Taylor reviewed records from Dr. Kevin Vaught, who performed Petitioner's surgery in 2005. The records noted low back pain down the left leg, an MRI which revealed a left paracentral disc protrusion at L4-5, and left L4-5 microdiscectomy on April 21, 2005. Four months after surgery Petitioner reported complete resolution of his lower extremity pain. He also reviewed current records following Petitioner's accident, including those from NP Kommer, Dr. Gornet, and Dr. Granberg, as well as the MRI's. On examination, Petitioner had an antalgic gait and decreased range of motion, and was able to take only a few steps on his heels and toes. Dr. Taylor's impressions were: (1) congenital stenosis; (2) Bertolotti segment (lumbar transitional vertebrae at L5-S1); (3) post laminectomy syndrome at L4-5 due to left laminotomy for left radiculopathy; and (4) lumbar instability and recurrent disc pathology at L4-5. RX1, Dep. RX2.

Dr. Taylor opined that Petitioner's symptomatic condition was due to his preexisting lumbar congenital stenosis and his lumbar decompression, causing post laminotomy instability. He further opined that Petitioner's work accident of March 13, 2015, caused an exacerbation of the preexisting degenerative condition at L4-5, but that the current need for treatment was not related, as the accident caused no more of an exacerbation than did his activities of daily living. He noted that if surgery was required for the lumbar instability, a lumbar fusion was the appropriate approach. However, he opined that the fusion was not due to Petitioner's work injury. Dr. Taylor estimated recovery from a two-level fusion would be three to six months to return to work with restrictions, and six to twelve months for maximum medical improvement with a solid fusion. RX1, Dep. RX2.

Dr. Taylor detailed that individuals who have lumbar surgery for disc herniations are at an increased risk of developing over time further aging and degeneration of the affected disc. The rate of degeneration and clinical symptomatology less than 10 years after a decompression is as high as 37 percent. He opined that in Petitioner's case, his present condition was the result of congenital stenosis, further degeneration, and post-laminotomy instability. He noted that no acute pathology was identified. RX1, Dep. RX2.

On October 1, 2015, Petitioner returned to Dr. Gornet. It was noted he continued to lose weight. Dr. Gornet recommended a CT discogram at L5-S1, and if it did not show any concordant pain he would recommend a fusion at L4-5 only. If it was positive, he would consider L3-4 as a control. He allowed Petitioner to continue working full duty. PX5. The following day, October 2, 2015, Petitioner underwent a lumbar spine "MRS". In looking at the report, it is unclear to the Arbitrator what the results of this test actually were, as there is no summary or findings section on the report. PX6.

On October 28, 2015, a discogram was attempted at L3-4, but was aborted because Petitioner could not tolerate the pain. It was not attempted at L5-S1, and a facet block at L3-4 was administered in an attempt to reduce the pain. PX9. Following the discogram, a lumbar CT scan was done, which revealed degenerative disc disease with facet arthropathy and central herniations at L4-5 and L5-S1, with associated foraminal stenosis at both levels. PX8.

Petitioner returned to Dr. Gornet on November 9, 2015, who noted the aborted discogram and recommended fusion from L4 to S1. He noted Petitioner had lost over 40 pounds and should continue to lost weight. Dr. Gornet reviewed Dr. Taylor's Section 12 report and disagreed with his conclusions regarding causation, stating Dr. Taylor "did not provide any explanation as to why Mr. Compton was doing well and seeking no medical care between his recovery from his surgery in 2005 by Dr. Vaught and his subsequent injury." Dr. Gornet opined that Petitioner's symptoms were causally connected to his work injury, as described. PX5.

Dr. Taylor testified by way of deposition on December 2, 2015. He is a Board Certified Orthopedic Surgeon and Independent Medical Examiner. He testified Petitioner provided an oral history of work accident when he went to lift and slide a computer tower from under his desk and felt pain in his right hip. Petitioner also completed a standard spine questionnaire, on which he answered that he had never had back or neck symptoms prior to the current episode. He did, however, verbally report to Dr. Taylor that he had surgery in 2005. RX1.

Dr. Taylor testified consistent with his report regarding Petitioner's history, work status, activity limitations, treating records, diagnostic studies, and physical examination. He testified Petitioner had a BMI of 40, which is considered obese, and that some studies suggest obesity may play a role in low back pain. Dr. Taylor noted that Petitioner's MRI showed changes at L4-5 which were not consistent with an acute right-sided disc herniation, but rather were consistent with a prior decompression and the progression of degenerative changes at L4-5. RX1.

Dr. Taylor diagnosed Petitioner with lumbosacral transitional vertebrae at L5-S1, congenital stenosis, post laminectomy syndrome at L4-5, lumbar instability at L4-5, and disc

pathology at L4-5. He testified Petitioner had a lumbosacral transitional vertebra. He explained this occurs during development when the L5 vertebra does not separate completely from the sacrum, creating varying degrees of autofusion of a portion of L5. The person is then born with a very stiff L5-S1 segment, and at an early age develops instability and advanced degeneration. Petitioner also had congenital stenosis, a condition in which the hole for the spinal cord in the nerves inside the bone is smaller than it should be. Petitioner's MRI of April 6, 2005, showed L4-5 degenerative disc disease with a left paracentral disc protrusion, or age-related arthritis. He testified it is not common for a 31 year old to have arthritis, but for individuals who have a lumbosacral transitional vertebra and congenital stenosis, it is more common. Post laminectomy syndrome occurs following surgery, which has removed some structures, and the lack of those structures can contribute to pathology in the future. Finally, Petitioner has advanced disc degeneration and instability at L4-5. RX1.

Dr. Taylor testified that Petitioner's work accident of March 13, 2015, caused an exacerbation of his preexisting degenerative condition at the L4-5 level, but no more than his activities of daily living. It did not cause a permanent alteration of his condition and did not change slope of his pathologic process. Petitioner's significant preexisting conditions of instability, congenital stenosis, and advanced arthritis at L4-5 were the main reason he had persistent symptoms. His work accident caused only a temporary alteration of his condition, and no structural damage. Dr. Taylor was unable to retrospectively say, however, when the exacerbation was resolved. RX1.

Dr. Taylor agreed that Dr. Gornet's treatment recommendation of a two-level fusion was a reasonable one; however, he testified that the need for the surgery or any ongoing treatment was not causally related to Petitioner's work accident. He recommended a pre-operative 3T MRI, which is a very strong magnet for a better quality image, or a CT scan. He did not recommend a discogram, nor did he believe it would be reasonable or necessary for diagnostic purposes, as it was clear what Petitioner's preexisting diagnosis was. RX1.

On cross-examination, Dr. Taylor testified he was Dr. Gornet's partner for nine and half years and that Dr. Gornet was an excellent surgeon. He also testified that Petitioner appeared to be straightforward and very genuine during his evaluation, and he did not detect any symptom magnification or inconsistencies in his presentation. He agreed that an individual could have pathology on an MRI and be asymptomatic, thus needing no treatment. He further agreed an individual could have an increase in symptoms without necessarily having a change on an MRI. He acknowledged that Petitioner had several findings on his physical examination, which was approximately six months after the event at work, and that there was no record of him having returned to a "baseline" well-being. He agreed that Petitioner's subjective symptoms temporally began following the event at work. Dr. Taylor testified it was critical to assess Petitioner for cervical stenosis prior to him being put under anesthesia and positioned for multiple-step lumbar surgery, as it could potentially pose a significant risk to Petitioner. RX1.

On January 21, 2016, Petitioner underwent another lumbar MRI, which revealed no changes on the left L4-5 from the prior exam, and revealed unchanged central broad-based protrusion at L5-S1. PX6. Following the MRI, Petitioner was re-examined by Dr. Gornet, who compared the new MRI with the MRI from 2013. He noted the scans were of different quality,

so not directly comparable. However, he indicated more significant annular tear and lesion at L5-S1 and L4-5, possibly due to imaging quality rather than actual changes. The herniation at L5-S1 appeared to be more significant centrally and abutted up to the left nerve and closer to the right nerve than in the past. Dr. Gornet continued to recommend a two-level fusion and noted that unless Petitioner had active ongoing issues just prior to his work injury, there is no other plausible explanation other than to associate his current symptoms to his work injury. PX5.

Dr. Gornet testified by way of deposition on February 25, 2016. He is a Board Certified Orthopedic Surgeon whose practice is devoted to spine surgery. Dr. Gornet testified consistent with his treating records, and diagnosed Petitioner with a new disc injury at L4-5 in the form of an annular tear and herniation. In addition, he believed Petitioner aggravated his underlying degenerative changes at L4-5, and possibly had a new disc injury at L5-S1. Dr. Gornet testified that all of Petitioner's symptoms were causally connected to his work injury. Dr. Gornet found it significant that Petitioner's current symptoms are right-sided, as opposed to left-sided from the 2005 surgery. His symptoms correlated objectively with his physical examination and the MRI. In that the subjective symptoms and objective findings were on the right side, they were not related to Petitioner's previous problem. PX11.

Dr. Gornet testified that Petitioner underwent injections, which gave some temporary relief, after which his symptoms returned. Dr. Gornet did not believe further injections would help, and recommended a fusion from L4 to S1. He recommended a CT discogram, which was attempted but aborted. The CT portion of the discogram showed other facet changes which supported his belief that Petitioner would require a fusion at the lowest level. He also recommended an MRI spectroscopy, an objective measure for painful chemicals in the disc, which also supported that there were painful chemicals in the disc at L5-S1. Dr. Gornet testified that all the objective tests, the MRI, the CT, and MRI spectroscopy, supported the recommendation of spinal fusion from L4 to S1. PX11.

Dr. Gornet testified he reviewed Dr. Taylor's report and disagreed with his conclusions. Specifically, he disagreed that Petitioner's findings were inevitable just because he had had a previous surgery. The statistic Dr. Taylor mentioned, 37 percent, was not more probable than not. Dr. Gornet agreed that microdiscectomy does weaken the disc, and that Petitioner did have a weakened disc relative to someone who had not had a microdiscectomy. That weakness, coupled with the mechanical loading Petitioner had when he bent over and moved the computer tower, exceeded the mechanical load that the disc could handle, injuring the disc. He agreed with Dr. Taylor that Petitioner's only real treatment option is spinal fusion, and he testified that the need for surgery is causally related to his work accident. He testified Petitioner should be able to return to work full duty as a police dispatcher following the surgery. PX11.

On cross-examination, Dr. Gornet testified he had not seen Petitioner's 2005 MRI, which Dr. Vaught interpreted as revealing multilevel facet arthropathy and L4-5 degenerative disc disease with a left paracentral disc protrusion. He would disagree with the assessment of multilevel facet arthropathy, as Petitioner's CT from October 28, 2015, showed arthropathy at only L5-S1. He agreed Petitioner had a lumbosacral transitional vertebrae, but not in the normal sense. Usually a bridging bone is seen between the transverse process at L5 and the S1 vertebral body, but in Petitioner's case the CT scan shows there is a separation of those two structures.

Dr. Gornet agreed that segment would be somewhat stiffer, but disagreed that it would result in advanced degeneration of the spine and at an earlier age than most. He testified it would, however, result in increased mechanical loading, which could possibly cause further degeneration. Dr. Gornet agreed that people with congenital stenosis are more likely to potentially have problems overall, but testified that Petitioner's stenosis is not severe. He agreed that individuals who have surgery for disc herniations are at an increased risk of developing further degeneration of the affected disc. PX11.

Dr. Gornet testified there was no indication that Petitioner had any significant symptoms for almost ten years, from the time of the surgery in 2005 until the work event in 2015. However, he noted that obviously Petitioner had some treatment because he had the MRI in 2013. He would not consider working out with a trainer to be an activity of daily living. He further testified that Petitioner did not have advanced or severe degenerative disc disease, but rather moderate changes. He explained that Petitioner's problem was caused by mechanical loading of the disc that exceeded what the disc could handle. PX11.

Dr. Gornet testified that he identified a "new right sided annular tear" when he reviewed Petitioner's March 27, 2015, MRI during his initial visit. He indicated he believed he reviewed the 2013 MRI at that time. The Arbitrator notes, however, that Petitioner testified he did not provide Dr. Gornet with the 2013 MRI until January 21, 2016. PX11.

On March 31, 2016, Dr. Taylor generated an addendum report following review of updated medical records, films, and the April 2013 MRI. He indicated his opinions regarding medical causation and treatment had not changed. In comparing the April 2013 MRI to the March 2015 MRI, Dr. Taylor opined there were no structural changes at L4-S1, and that therefore the work incident of March 13, 2015, caused only a temporary exacerbation of Petitioner's symptoms. He opined that the CT discogram might have been a reasonable pre-surgical test. However, he noted that there is no peer reviewed data confirming the efficacy of the MRI spectroscopy, and that it has not been proven beneficial. RX2.

Petitioner last returned to Dr. Gornet on April 21, 2016, who continued to recommend weight loss, strengthening and conditioning prior to spinal fusion. The Arbitrator notes it is not clear from Dr. Gornet's record whether an examination actually took place on this date, though Petitioner testified he was "check over" at each visit. PX5.

Respondent submitted the MRI report of April 11, 2013. The MRI revealed the following with regard to Petitioner's spine: (1) thoracolumbar minimal spondylosis, mild facet arthropathy, and mild degenerative disc disease; (2) minimal bilateral foraminal narrowing at L4-5, with no nerve compression; (3) no lumbar central canal stenosis; (4) status post left hemilaminectomy at L4-5; and (5) chronic Schmorl's nodes, thoracic through lumbar. RX3.

Respondent also submitted Petitioner's Facebook post of November 10, 2013, regarding using leftover prescription painkillers to fight periodic bouts of RLS (restless leg syndrome). Several others commented on his post as well. RX4. Petitioner testified he did publish the post, but indicated it was in jest. He admitted to having restless leg syndrome that woke him at night, and that he required medication for it.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After review of the evidence and due deliberations, the Arbitrator finds on the issues presented at trial as follows.

The parties stipulated that Petitioner sustained an accident which arose out of and in the course of his employment which caused injury to his lumbar spine. The parties dispute whether Petitioner's current condition and need for treatment, including surgery, is related to the accident.

In support of the Arbitrator's decision relating to issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

A claimant has the burden of proving by a preponderance of the credible evidence all elements of the claim, including that any alleged state of ill-being was caused by a workplace accident. *Parro v. Industrial Commission*, 260 Ill.App.3d 551, 553 (1st Dist. 1994).

It has long been recognized that, in preexisting condition cases, recovery will depend on the employee's ability to show that the work-related accidental injury aggravated or accelerated the preexisting disease, such that the employee's current condition of ill-being can be said to have been causally connected to the work injury and not simply the result of a normal degenerative process of the preexisting condition. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 204-206 (2003). The existence of health problems of an employee prior to a work-related injury neither deprives the employee of a right to benefits nor relieves the employee of the burden of proving a causal connection between the employment and the subsequent health problems. *Neal v. Industrial Comm'n*, 141 Ill.App.3d 289, 296 (1st Dist. 1986). A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. *International Harvester v. Industrial Comm'n*, 93 Ill.2d 59, 63-64 (1982).

The Arbitrator finds Petitioner's current condition of ill-being with regard to his lumbar spine is causally related to his work accident of March 13, 2015. In so concluding, the Arbitrator finds significant that the record is void of any evidence that Petitioner was having lumbar problems or symptoms temporally close to the date of his accident. The Arbitrator also finds significant that the record is consistent throughout with regard to Petitioner's complaints and objective findings, which started immediately after his accident. Petitioner credibly testified as to the facts of the accident and his complaints. Although Dr. Taylor disagreed with the causation, he testified that Petitioner appeared to be straightforward and very genuine, and he did not detect any symptom magnification or inconsistencies in his presentation.

It is undisputed that Petitioner had a previous microdiscectomy in 2005. However, the Arbitrator does not find the surgery to be of much relevance, as it is temporally remote from the

work accident in 2015, Petitioner's symptoms and the surgery were left-sided, and his symptoms completely resolved within four months of surgery.

It is also undisputed that Petitioner underwent a lumbar MRI in April 2013, after straining his back while working out with a trainer. Petitioner credibly testified that the incident was minor, and that he did not even recall it occurring until Respondent's counsel recently questioned him about it. The Arbitrator notes that the only record in evidence from this incident is the MRI report, which supports Petitioner's testimony that the event was minor.

The Arbitrator finds significant that, despite Respondent's questions regarding Petitioner's 25 to 30 visits to the hospital over eight years, no medical records were introduced for those visits. Logic would dictate that if the records were germane to the issues at hand, they would have been introduced at trial. As they were not, the Arbitrator is not persuaded by Respondent's argument, and finds significant that the only record submitted for medical treatment prior to Petitioner's accident was the MRI from April 2013.

With regard to the 2013 MRI itself, the Arbitrator notes that the findings included mild degenerative disc disease, minimal foraminal narrowing at L4-5 without nerve compression, no central canal stenosis, status post left hemilaminectomy, and no significant findings. By contrast, the MRI of March 27, 2015, showed L4-5 and L5-S1 central and right paracentral disc protrusions, with mild to moderate stenosis of the right lateral recess at L4-5. Dr. Gornet opined that the MRI further revealed an annular tear at L4-5. He found it significant, as does the Arbitrator, that Petitioner's prior symptoms in 2005 were left-sided, and that his current symptoms were right-sided. Although Respondent questioned the date on which Dr. Gornet reviewed the 2013 MRI for comparison purposes, the Arbitrator finds it is of no consequence, as there were new findings on the 2015 MRI, regardless of the date of the comparison.

Dr. Taylor opined that Petitioner's current symptoms and need for treatment were related to his preexisting degenerative disc disease, congenital stenosis, and prior decompression, all of which caused lumbar instability. He opined that Petitioner's work accident caused only a temporary exacerbation of his condition, but no more so than the activities of daily living. The Arbitrator notes, however, that Petitioner's accident occurred when he was underneath his desk, on his knees, pulling and picking up a computer tower that weighed 20 to 50 pounds, which appears to be more than "normal activities of daily living". Dr. Taylor further opined that Petitioner's accident did not cause a permanent alteration of his condition. The Arbitrator notes, however, that there were new findings on the 2015 MRI, as compared to 2013, and that there is no record of any treatment or symptoms in the two years in between the studies. In addition, Dr. Taylor agreed that Petitioner had positive objective findings on his examination six months after the accident and that Petitioner had not returned to his pre-injury baseline. The Arbitrator does not find Dr. Taylor's opinion with regard to causation to be persuasive.

Dr. Gornet based his causation opinion primarily on four factors. First, Petitioner's symptoms were on the right, versus his prior surgery being on the left. Second, Petitioner's complaints and symptoms correlated objectively with the MRI and physical examinations. Third, the weakness in his disc from the prior discectomy combined with a mechanical loading when he bent over and moved the computer tower, and that combination exceeded the

mechanical load the disc could handle. Fourth, Petitioner had no treatment or documented symptoms for his low back for at least two years prior to his work accident. The Arbitrator finds Dr. Gornet's causation opinion to be consistent with the record and to be more persuasive than that of Dr. Taylor.

The Arbitrator finds significant the chronology of this case. Petitioner had no complaints or treatment for his low back for two years prior to the accident, and the treatment at that time was minimal. Prior to 2013, there is no evidence to suggest he had treatment for his low back since 2005, ten years prior to his work accident. He was working full duty prior to the work accident, he sustained the accident, and he sought medical treatment within days. His complaints and objective findings were consistent throughout his treatment, there was new pathology on the MRI, and his symptoms were consistent with a new injury. In addition, the Arbitrator found Petitioner to be very straightforward and credible, as did Respondent's examining physician.

The Arbitrator is persuaded by the record as a whole and by the causation opinion of Dr. Gornet and finds that Petitioner has met his burden of proof on the issue of causal connection with respect to his lumbar spine.

In support of the Arbitrator's decision relating to issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

Under Section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury. *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill.App.3d 463, 470 (4th Dist. 2011).

In light of the Arbitrator's findings with respect to issue (F), the Arbitrator finds that medical services rendered to date were reasonable and necessary in Petitioner's care and treatment relative to his accident of March 13, 2015. The Arbitrator finds that Respondent is liable for outstanding medical bills as set forth in Petitioner's Exhibit 1, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act, with the following exceptions.

The Arbitrator declines to award charges billed by any medical provider for CPT code 99080, Special Report. A provider may not charge a fee for writing a standard report that is generated in the normal course of treatment. Although a provider may charge an additional fee for a special report that is unusual or outside the standard reporting form, the Arbitrator finds that none of the medical reports admitted into evidence meet this standard. As such, charges for such reports are not reasonable and the Arbitrator finds that Respondent is not liable for them.

The Arbitrator declines to award any interest charges, to the extent that they are being claimed, in Petitioner's Exhibit 1. The record does not substantiate and Petitioner did not proffer evidence that interest was properly charged pursuant to Section 8.2(d)(3).

The Arbitrator declines to award the bill from MRI Partners of Chesterfield for the MRS (MRI spectroscopy) performed on October 2, 2015. The Arbitrator notes, as did Dr. Taylor, that this testing has not been proven beneficial and that there is no peer reviewed data confirming the efficacy of the testing. In addition, the report from the test gives no indication or explanation as to the summary and/or findings of the testing.

The parties stipulated and the Arbitrator finds that Respondent is entitled to a credit for all payments previously made to medical providers, including those made pursuant to Section 8(j), for which a credit is allowed. Respondent shall hold Petitioner harmless from any claims arising out of the expenses for which it claims credit.

In support of the Arbitrator's decision relating to issue (K), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

Upon establishing causal connection and the reasonableness and necessity of recommended medical treatment, employers are responsible for necessary medical care required by their employees. Specific medical procedures or treatments that have been prescribed by a medical service provider have been "incurred" within the meaning of the statute, even if they have not yet been paid for. *Plantation Mfg. Co. v. Industrial Commission*, 294 Ill.App.3d 705 (2nd Dist. 1997).

In light of the Arbitrator's findings with respect to issue (F), the Arbitrator finds that Petitioner is not currently at maximum medical improvement and is in need of further care, including lumbar surgery. Further, the Arbitrator finds that the need for prospective medical care is causally related to the work accident of March 13, 2015. Although Dr. Taylor disagreed with Dr. Gornet as to causation, he agreed with him that a two-level fusion was a reasonable recommendation.

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

Calvin Lee Brown ,

Petitioner,

vs.

NO: 15 WC 18402

Travis Oil Service, Inc.,

17IWCC0201

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Dayton Pharr was a repeat customer and former employee of the Respondent. He was a customer of Respondent in August or September of 2014. A verbal incident occurred on the aforementioned date involving Mr. Pharr, the Petitioner, and an unnamed woman. The Petitioner allegedly said something to the woman that angered Mr. Pharr. On April 24, 2015, Mr. Pharr again returned to the Respondent's premises. He recognized the Petitioner and instructed the Petitioner not to work on his car. Francis Ramsay, the Petitioner's manager, testified that she ordered the Petitioner to remain in the lower bay of the facility, which he did.

However, after Mr. Pharr left the premises, he then returned and requested to speak with the owner of the facility. The Petitioner was again instructed by the manager to remain in the lower bay, but he ignored her order. The Petitioner then pushed his manager out of the way when she tried to intervene. He approached Mr. Pharr, and then tried to strike Mr. Pharr with a hammer multiple times. The Petitioner did not make contact with Mr. Pharr. Mr. Pharr held up a stool to keep the Petitioner at a distance from him. At some point, Mr. Pharr threw the stool at the Petitioner, pulled out a knife from his pocket, and subsequently stabbed the Petitioner in the left arm. After the Petitioner was stabbed, Mr. Pharr left the premises, and the Petitioner then threw a hammer at Mr. Pharr's vehicle. Ms. Ramsay testified that Mr. Pharr did not have a problem with any other employee of the Respondent besides the Petitioner.

17IWCC0201

In *Franklin v. Industrial Comm'n*, 211 Ill. 2d 272, 279-280 (2004), the Illinois Supreme Court held that when an assault arises from a purely personal dispute, the resulting injuries do not arise out of employment. Furthermore, in *Rodriguez v. Industrial Comm'n,* 95 Ill. 2d 166, 171 (1983), the Illinois Supreme Court stated: "This court has held that injuries suffered in assaults, the motives for which are unexplained, are not compensable if there is evidence to sustain a finding by the Industrial Commission that the motive was personal to the victim rather than work related, or if claimant cannot demonstrate a reason for the assault."

The Petitioner and Ms. Ramsay testified at the Arbitration trial and provided different versions of the altercation that led to the Petitioner's injury. The Commission finds that Ms. Ramsay's version of the events on April 24, 2015 is more credible than the Petitioner's version. However, the testimony of both witnesses demonstrates that the Petitioner's injuries arose out of an assault motivated by personal reasons that were not work related.

The Commission further finds that the Petitioner was the aggressor in the altercation that led to the Petitioner's injury on April 24, 2015. Injuries sustained by the aggressor in a work-related altercation, traceable to his own voluntary actions, are not within the scope of his employment and therefore not compensable. *Armour Co. v. Industrial Com.* 397 Ill. 433, 436 (1947). Therefore, even if the Petitioner's injury arose out of and in the course of his employment, his injury would not be compensable.

Since the altercation was grounded in a personal feud, and the Petitioner was the aggressor, the Commission finds that there was not a compensable accident and that the Petitioner is not entitled to workers' compensation benefits.

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 shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

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

DATED: APR 4 – 2017

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

TJT: gaf
O: 2/28/17
51

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

BROWN, CALVIN LEE
Employee/Petitioner

Case# **15WC018402**

TRAVIS OIL SERVICE INC
Employer/Respondent

17IWCC0201

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:

1315 DWORKIN & MACIARIELLO
GERALD F CONNOR
134 N LASALLE ST SUITE 1515
CHICAGO, IL 60602

1739 STONE & JOHNSON CHTD
PATRICK DUFFY
111 W WASHINGTON ST SUITE 1800
CHICAGO, IL 60602

17IWCC0201

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)

Calvin Lee Brown
Employee/Petitioner

v.

Travis Oil Service, Inc.
Employer/Respondent

Case # 15 WC 18402

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Chicago**, on **December 11, 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, **April 24, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$17,160.00**; the average weekly wage was **$330.00**.

On the date of accident, Petitioner was **37** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

Petitioner failed to establish that he sustained an accident arising out of and in the course of his employment. Benefits under the Act are hereby denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Jessica C. Myatt

Signature of Arbitrator

2/18/16
Date

ICArbDec19(b)

FEB 25 2016

17IWCC0201

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CALVIN LEE BROWN JR., Petitioner,	)	
v.	)	Case No: 15 WC 18402 Chicago
TRAVIS OIL SERVICE Respondent,	)	

ADDENDUM TO THE DECISION OF THE ARBITRATOR

Petitioner filed an Application for Adjustment of claim pursuant to the Illinois Workers' Compensation Act ("Act") 820 ILCS 305/1 (West 2008) seeking benefits for an alleged work related injury in which he claims he was stabbed by a customer suffering injuries to his left arm. On December 11, 2015, the matter proceeded to a hearing before Arbitrator Jessica A. Hegarty in which the parties disputed the following issues:

- Accident
- Causal connection
- Medical bills
- TTD

STATEMENT OF FACTS

Respondent is in the business of quick oil change. They have about five employees. (T 39.) The Respondent's facility is two story building where cars enter the top floor at street level and pull into one of three bays. Each bay has an opening in the floor. Some of the employees, known as upper bay technicians, work on the top floor to service cars while the lower bay technicians service cars on the lower floor. (T 40, 41.)

On August 24, 2015 Petitioner was employed by Respondent as an oil technician and automatic car wash worker and had worked for the Respondent since February 2012. (T 9.) He testified that he was an oil technician and an automatic car wash worker. Initially, he testified that on April 24, 2015 he was working in the pit; i.e., as a lower bay technician. (T 22.) Francis Ramsay testified that on April 24, 2015 Petitioner worked as a lower bay technician. (T 41, 43.)

On August 24, 2015 Petitioner was stabbed at work; he testified that he did not know the person who stabbed him—Dayton Pharr. He denied knowing Pharr's name on April 24, 2015. (T 22.)

Petitioner had contact with Dayton Pharr in either August or September 2014. Pharr was a customer of the Respondent on that occasion. After Dayton Pharr left the facility in August/September 2014, he called Respondent, Hillard Travis, the owner of Travis Oil Service and complained about Petitioner talking to his girlfriend. Dayton Pharr thought Petitioner said something inappropriate to his girlfriend. (T 23.) At no time between August/September 2014 and April 24, 2015 did Petitioner see Pharr. (T 27.)

Following Pharr's telephone call to Mr. Travis in August/September 2014, Mr. Travis talked to Petitioner and said that Dayton Pharr said that he was going to kill Petitioner. Mr. Travis said Pharr was angry because Petitioner said something to Pharr's girlfriend. Mr. Travis did not reprimand or punish the Petitioner. (T 9-11, 47, 48.)

Petitioner testified that on April 24, 2015, while at work, he recognized Dayton Pharr. Pharr said that Petitioner should not work on his car. (T 12, 18.) At some point Pharr became irate and said that he "would kill (Petitioner)". It is part of Petitioner's job to deal with customers. (T 13, 14.)

Ramsay, the Respondent's manager, knows Dayton Pharr. He used to work for the Respondent about 11 years ago. Petitioner and Pharr never worked together. After Pharr stopped working for the Respondent, he became a customer. (T 42.)

On April 24, 2015 Pharr arrived at the Respondent's facility at about 12:30 p.m. He pulled his car into a bay. Pharr asked for Antoine Smith, another technician, to check his car. (T 43.) At some point Petitioner came up from the lower bay because Pharr had mentioned his name. Neither Pharr nor Petitioner had anything in their hands at that time. Pharr was cursing about Petitioner. Ramsay told Petitioner to return to the lower level and he did. (T 44-46.)

Pharr pulled the car out of the building and then returned. (T 49.) When he entered the facility for the second time, he was cursing about Petitioner. Pharr had nothing in his hand. He wanted to speak with the owner. (T 49.) Petitioner was in the basement and then came up and had a hammer in his hand. (Petitioner testified that he was upstairs when Pharr arrived. (T 24.) Ramsay told Petitioner to return to the basement, but Petitioner kept coming toward Pharr. Ramsay put his arms on Petitioner to stop him from approaching Pharr, and Petitioner pushed her aside. He then met Pharr, and Pharr had picked up a stool. Petitioner swung the hammer at Pharr and Pharr kept Petitioner at a distance with the stool. Petitioner swung the hammer three or four times but never struck Pharr. At some point Pharr's girlfriend came in and said "I will mace

him." Everyone stood back, but Petitioner kept attacking Pharr. Pharr threw the stool at Petitioner. He picked up his keys from the counter and put them in his pocket and pulled a knife from the pocket. Petitioner swung again with the hammer, and then Pharr stabbed his left arm. There was blood everywhere. (T 50-54.)

Petitioner testified that when Pharr returned, he had a knife in his hand. Petitioner picked up a hammer to defend himself. (T 26.) He denied ever swinging the hammer. (T 26.) Petitioner denied Francis Ramsay ever told him to go downstairs. (T 26.) Petitioner denied that Frances Ramsay tried to stand in front of him to block his path to Pharr. (T 27.)

After the stabbing, Pharr and his girlfriend ran to his car. Petitioner followed him out and threw the hammer through the back window. (T 55.)

When Petitioner first came upstairs, Ramsay directed another worker to call 911. The ambulance was the first to arrive, and then the police. The police investigated the incident. To her knowledge Pharr was not arrested. Neither Petitioner nor Ramsay have been subpoenaed to appear at a criminal trial. (T 28, 56.)

Pharr has been a customer of the Respondent over the years. He never argued with any employee other than Petitioner. (T55, 56.) Petitioner agreed that on the two days that he saw Pharr, Pharr was belligerent toward Petitioner but not toward any other employee of the Respondent. (T 28.)

On cross-examination Ramsay testified that part of Petitioner's job was dealing with customers. Pharr was a customer and he had a problem with Petitioner. Initially, she testified that Pharr was not irate; he was protecting himself. (T 58.) She then testified that he was irate. (T 59.) The stabbing took place in the building. Petitioner was generally a good employee. On April 24, 2015 Petitioner was performing his duties. (T 60.)

On re-direct examination Ramsay testified that from the time Pharr arrived until the time of the stabbing about 20 minutes elapsed. When Pharr first arrived, he was not irate. By the time of the stabbing, he was irate. When she told Petitioner to go downstairs and he refused, he was not doing his job. When she tried to block Petitioner from advancing on Pharr and he pushed her aside, he was not doing his job. (T 61, 62.)

After the stabbing, Petitioner was taken to the emergency room and admitted into the hospital for two days. He had a surgery to close the wound and two additional surgeries before being discharged. He continues to seek treatment from Dr. Stogin. Dr. Stogin has kept Petitioner off work. (T 15-18.) He last saw Dr. Stogin on December 3,

2015 and is scheduled to see him again on January 6, 2016. (T 21.)

Per his attorney's request, Petitioner removed the cast and displayed his scarring. (T 19.)

Petitioner acknowledged being convicted of attempted murder and attempted armed robbery in 1999. Petitioner was released from incarceration in 2011. (T 32; RX 1.)

On re-direct examination, Petitioner testified that he had worked for the employer before he went to prison, and the employer knew of the conviction. (T 33.)

CONCLUSIONS OF LAW

Accident & Causal Connection

When addressing the issue of the compensability of injuries sustained from an assault by a third party, the Illinois appellate court held that a claimant must establish that the employment environment increased the risk of attack or that the attack was motivated by something related to claimant's employment. Holthaus v. Industrial Commission, 127 Ill. App. 3d 732, 737 (1984). In the instant case the environment certainly did not increase the risk of this attack. Therefore, the issue is whether Petitioner established that the attack was motivated by something related to his employment.

The Supreme Court has held that when an assault arises from a purely personal dispute, the resulting injuries do not arise out of employment. Franklin v. Indus. Comm'n, 211 Ill. 2d 272, 279-280 (2004). Likewise in Rodriguez v. Industrial Comm'n, 95 Ill. 2d 166, 171 (1983) the Supreme Court stated, "this court has held that injuries suffered in assaults the motives for which are unexplained are not compensable if there is evidence to sustain a finding by the Industrial Commission that the motive was personal to the victim rather than work related or if claimant cannot demonstrate a reason for the assault".

Most of the litigation regarding an assault from a third party involves an assault by an unknown assailant. An exception is Paul Hagler v. Franklin Hospital, 10 IWCC 597. In Hagler, petitioner was working on the premises of another company and an employee of the other company attacked him for no known reason. The Commission denied benefits because petitioner was unable to establish that the assault was motivated by something related to employment.

Petitioner and Francis Ramsay described two very different scenarios regarding the events leading up to the stabbing. However, the testimony of both witnesses described injuries arising from an assault motivated by purely personal reasons. Specifically, the assault was motivated by Pharr's anger toward Petitioner for saying something to

Pharr's girlfriend six months earlier. Pharr's anger may not be rational, but it was based on a purely personal motive.

Pharr had been a customer of the Respondent for many years. Frances Ramsay testified that Pharr was never angry at any employee of the Respondent other than Petitioner. On the day of the stabbing Petitioner had not worked on Pharr's car. The motivation for this assault was not motivated by Petitioner's employment.

Consequently, regardless of whose testimony about the events leading up to the stabbing is deemed credible, the Arbitrator concludes Petitioner's injuries arise from a personal dispute with Dayton Pharr. These injuries did not arise out of Petitioner's employment.

The Arbitrator adds that she finds Frances Ramsay's testimony regarding the events leading up to the stabbing to be credible. Ramsay described Pharr entering the Respondent's facility. He was angry with Petitioner and wanted to call the Respondent's owner. Petitioner was in the basement and for no reason other than to confront Pharr, came upstairs. Petitioner had a hammer in his hand. Petitioner ignored Ramsey's direction to return to the basement. When Ramsay tried to block Petitioner's path, he pushed her aside and tried to attack Pharr. He swung the hammer multiple times at Pharr before being stabbed. Pharr was acting in self-defense when he stabbed Petitioner. (Pharr has not been arrested for this incident.)

The Arbitrator concludes Petitioner's injuries did not arise out of his employment. Benefits are thereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brian Tripp,

Petitioner,

vs. NO: 15 WC 19760

Galaxy One Marketing, Inc.,

17IWCC0253

Respondent.

DECISION AND OPINION ON REVIEW

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

17IWCC0253

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 $25,900.00. 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: APR 24 2017
TJT:yl
o 4/11/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

TRIPP, BRIAN
Employee/Petitioner

Case# **15WC019760**

GALAXY ONE MARKETING INC
Employer/Respondent

17IWCC0253

On 6/9/2016, 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 0.43% 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:

0969 THOMAS C RICH PC
MICHELLE M RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

0507 RUSIN & MACIOROWSKI LTD
TRICIA J SHELTON
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

17IWCC0253

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Brian Tripp
Employee/Petitioner

v.

Galaxy One Marketing, Inc.
Employer/Respondent

Case # **15** WC **19760**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[x] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **June 13, 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.

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$30,800.58**; the average weekly wage was **$1,184.64**.

On the date of accident, Petitioner was **32** 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 **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0.**

Respondent is entitled to a credit **for all benefits paid through group insurance** under Section 8(j) of the Act.

ORDER

Respondent shall authorize the treatment recommended by Dr. Mall, including, but not limited to, the recommended surgery.

Respondent shall pay the reasonable and necessary medical services in the amount of **$10,953.29** (as included in Petitioner's Exhibit 1) as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner. Respondent is entitled to a credit for all benefits paid under its group health plan under Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$789.76**/week for **0 5/7** weeks, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of **$492.23**/week for **29** weeks, commencing **June 23, 2015** through **January 11, 2016**, as provided in Section 8(a) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Melinda M. Rowe-Sullivan
Signature of Arbitrator

6/7/16
Date

ICArbDec19(b)

JUN 9 - 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Brian Tripp
Employee/Petitioner

Case # 15 WC 19760

v.

Consolidated cases: N/A

Galaxy One Marketing, Inc.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that on June 13, 2015, he was employed by Galaxy One Marketing but testified that he was no longer employed there. He testified that as of January 12, 2016, he went to work for Terminex.

Petitioner testified that on June 13, 2015, he sustained an injury at work. He testified that he was in Sesser, Illinois, doing an internet service call. He testified that the dish was on the roof, so he put his ladder up and sighted the dish in. He testified that when he finished up, he was going to take his ladder off the house. He testified that as it was leaning against the house, he lifted it up and away from the house and had his right arm fully extended. He testified that as he got the weight of the ladder, he felt a pop and the ladder fell down on him on his right shoulder. He testified that he had severe pain and a tingling that went all the way down his fingertips, and that he could not move his arm very well as it was hurting badly.

Petitioner testified that after it happened his arm basically gave out, so after he closed the job he called his boss. He testified that he told his boss what happened, that he had a popping in his shoulder and that his hand hurt was tingling, and that his boss' response was to take it easy and "don't baby it." He testified that he went to his next job and tried to finish it up as it continued to hurt, and then at that point he went home and put ice on it. He testified that his supervisor was Evan Pierce.

Petitioner testified that he sought treatment at approximately 8:30 p.m. that night when he went to St. Joseph's Memorial Hospital. He testified that the hospital reviewed his prior MRI, but he denied that they performed a physical examination of his right shoulder. He testified that he had prior issues with his right shoulder before this accident and that back in 2011, he had shoulder surgery while he was in the Air National Guard. He testified that Dr. Davis performed the surgery in 2011, and that after surgery he did really well. He testified that he was able to do everything that he could do in activities of daily living like lifting objects and did not have major issues. He testified that when he got out of the military, he lost his insurance through the military so he went to the VA and was being cared for by them and had not seen his doctor for quite some time. He testified that when he got insurance through Respondent he continued to go back to his primary care physician. He testified that he told her that he had some stiffness in his shoulder and a "clicking," so she ordered an MRI in May of 2015.

Petitioner testified that his primary care physician moved his shoulder around, did some tests and ordered an MRI. He testified that his symptoms in May and early June of 2015 in his right shoulder included some stiffness whenever he had his arm fully extended up above his head and a clicking in his shoulder that happened periodically. He testified that he was able to work full duty up until June 13, 2015, and that he was able to do normal activities of daily living with no issues.

Petitioner testified that since the accident, he cannot lift anything with his right arm. He testified that he cannot pick up his two-year old son, and that he has a lot of problems sleeping and has to sleep in a recliner. He testified that he cannot work full duty. He testified that he has a large "clunking" whenever he gets his arm about shoulder height, and that this was tremendously different than before.

Petitioner testified that he sought medical care and treatment with Dr. Davis again and that he eventually came under the care of Dr. Mall. He testified that he came under the care of Dr. Mall because Dr. Davis's office informed him that he was going to be out on a family leave, so he immediately contacted his attorney and let them know about the situation. He testified that Dr. Clare Fadden made the referral to Dr. Mall. He admitted that he asked her to refer him to Dr. Mall, and that he got Dr. Mall's name from his attorney's office.

Petitioner testified that Dr. Mall recommended surgery, and that wished to have it done. He testified that while he was still employed with Galaxy One, in exchange for returning to work in some capacity he signed an agreement with them indicating he would work for a certain amount, and that it was for $12 an hour at 40 hours a week. He testified that this was tremendously less than what he was making, and that while on light duty he was doing office work and helping out the warehouse personnel to fill drop boxes for the technicians.

Petitioner testified that he attended an examination at the request of Respondent with Dr. Milne, and that he answered all of his questions. He testified that he was cooperative during the exam. He testified that he gave Dr. Milne the same history as what he had told all of his other doctors. He testified that he was never able to return to full duty at Respondent. He testified that with Terminex, he is able to inspect homes and sell pest control services. He testified that it was a less physically demanding job than Respondent.

On cross-examination, Petitioner agreed that he was employed as a satellite technician with Respondent. He testified that he was hired in July of 2013 through KCI, and that at some point he became an employee of Respondent who bought KCI. He testified that he was paid at the same rate that he was earning under KCI. He testified that his hourly rate fluctuated depending on the size of the job. He testified that as a satellite technician, his job duties included installation of new services, service work for existing customers that were having issues, and selling products like HDMI cables and surge protectors. He testified that installation involved installing satellite dishes on the roof, on the side of the house or in the ground. He testified that he typically did 5-8 jobs per day. He testified that he would leave home about 6:30 in the morning and got home anywhere from 5:00 – 8:00 at night. He testified that he was classified as hourly, but that it was piece work so they would break it down into hours worked.

On cross-examination, Petitioner testified that he was not sure how much the dishes weighed, but that the heaviest things he lifted were the ladders and concrete. He testified that concrete was used whenever they installed poles in the ground. He agreed that he was in the National Guard for six years. He testified that his service ended in January of 2014.

On cross-examination, Petitioner agreed that June 13, 2015 was a Saturday. He testified that the accident occurred at his first call of the day, where he had to service the internet. He testified that the dish was on the roof. He testified that he could not recall when the accident happened. He agreed that he was

working with an extension ladder, and that the total length of the ladder was 32 feet fully extended but it was not fully extended at the time that he lowered it. He agreed that he was in the process of lowering the ladder, and that his arm was at full extension. He testified that at the moment he experienced the pop, he was removing the ladder from the house and lowering it down to get it to arm level to take back to the truck. He testified that he pulled the ladder away from the house and then switched positions to the side, and that as he was lowering it his shoulder popped. He denied having lifted it above his head.

On cross-examination, Petitioner agreed that his arm went out and that was when the ladder hit his shoulder. He testified that he was hit right at the top of his shoulder towards the edge and away from his neck. He agreed that he finished his shift that day and went to one more job after he was hurt. He testified that his job duties at the next job included a service repair and that the dish was out of alignment on the TV side. He testified that he had to get his ladder out for that job as well. He testified that he did not remember how long that job lasted because he was taking his time because he was hurting so badly. He testified that this was the last job that he did that day. He testified that he did not have to install a new dish, he had to just sight the dish in.

On cross-examination, Petitioner agreed that he testified that he reported the accident to Evan. He testified that Evan was the field service manager. He testified that he called him on the phone before he went to the next job, immediately after he left the house. He testified that he told Evan exactly what he testified to at the time of arbitration and that the ladder fell into his shoulder. He testified that after work he went home and put ice on his shoulder. He denied taking any type of medication. He admitted to having had two beers. He agreed that when he went to the emergency room, he provided a description of his condition and how he was injured.

On cross-examination, Petitioner agreed that on Respondent's Exhibit No. 6 on the Employee Description of Accident, this was the description of the accident that he provided to his employer. He testified that he thought he submitted it on an e-mail and that Evan then put it on the form. He testified that he believed it was within a week that the form was completed.

On cross-examination, Petitioner testified that his shoulder was injured in 2011 while doing military fighting drills through the Guard. He agreed that he was employed by Dowell Police Department at that time, but that the injury occurred during military drills. He agreed that he treated with Dr. Davis at the Orthopaedic Institute of Southern Illinois, and that he underwent conservative care involving some physical therapy but denied having undergone an injection prior to surgery. He agreed that he underwent surgery in 2011, but that he did not recall how long he was off work because he was working an office position and writing estimates for auto body repair. He testified that he was a part-time police officer and worked one night a week and that he also worked full time at Ike Auto Parts. He testified that after working for Ike Auto Parts for approximately 1.5 years, he worked at Auto Zone and then worked at KCI. He testified that his police officer position ended at the time of his surgery. He testified that after he had his surgery and was released, he worked for Southern Illinois Airport Authority which was a police department. He testified that he worked for them for extra cash for Christmas gifts, and that he would have worked there in 2012 through the first part of 2013.

On cross-examination, Petitioner agreed that during the after care from his surgery to the time that he was released, he experienced some popping and pain but did not recall having received an injection after the surgery. He agreed that he testified on direct examination that his only continued issue with his shoulder was some stiffness, and that he had some soreness with it if he was doing a lot overhead. When asked if he described popping in addition to clicking when he presented to Dr. Fadden prior to the accident, Petitioner responded that he did not recall how he exactly said that. He agreed that he may have said popping. He testified that in May of 2015, he believed he saw Jill Wilson that day at his primary care physician's office. He agreed that he mentioned some shoulder pain and stiffness, and

that she ordered an MRI. He agreed that he underwent the MRI on June 2, 2015, at Memorial Hospital. When asked if he was asked questions about his complaints when he presented for the MRI, Petitioner testified that he probably was but did not recall. He agreed that if he was asked those questions, he would have answered them truthfully. He denied having been given an examination by anyone prior to having the MRI performed. He testified that he did not have a follow-up appointment scheduled with Dr. Fadden to discuss the results of the MRI, and further denied at some point between June 2, 2015, and June 13 of 2015, scheduling any follow-up because he was waiting on the results. He agreed that he did not know the results or what the MRI was interpreted as showing prior to his arrival at the emergency room. He agreed that it was the doctor in the emergency room that reviewed the test and told him.

On cross-examination, Petitioner testified that he could not remember whether he had something scheduled with Dr. Fadden after his treatment in the emergency room on June 13, 2015, but agreed that he scheduled an appointment with Dr. Davis and that he saw him on Monday. He agreed that he gave Dr. Davis a description of what occurred. When shown Respondent's Exhibit No. 10, Petitioner agreed that he filled out several consent forms and the patient questionnaire. He agreed that he gave Dr. Davis a description of what occurred, and that he specifically told him that the ladder fell onto his shoulder. He testified that he was placed under restrictions at that time, and that he returned to work at Respondent about 1.5 weeks later, which was the day when he signed the agreement to come back under light duty.

On cross-examination, Petitioner denied that he earned a base rate of $12.00 per hour. Petitioner agreed that he attended physical therapy, and that he talked to the therapist about the accident. He testified that he provided the same accident description. He agreed that he also mentioned to them that the ladder fell onto his shoulder. He agreed that he was notified by Dr. Davis that he was taking some kind of leave so he contacted his attorney, who recommended Dr. Mall. He agreed that he requested a referral through his primary care physician, but did not recall when it went through. He agreed that he was asked on the intake paperwork with Dr. Mall to describe how the injury occurred, and that he told Dr. Mall why he had an MRI of his right shoulder 11 days before the alleged accident date. He testified that he told Dr. Mall that he was experiencing stiffness and admitted that he probably told him he was experiencing pain, but did not recall. He further testified that he believed he would have also reported clicking, but was not sure.

On cross-examination, Petitioner testified that he was currently taking Meloxicam for his shoulder as prescribed by Dr. Mall. He testified that it was prescribed at the time of the follow-up visit. He agreed that during his visit on February 8th, Dr. Mall recommended surgery. He agreed that he was given an injection, which provided some relief initially.

On cross-examination, Petitioner testified that he started working for Terminex on January 12th. He denied that there was any overlap in his employment. He agreed that he had originally requested a later date for his resignation to take effect, but that Terminex was able to accommodate him and start right away. He testified that with home inspections, he was required to check the interior and exterior of the home looking for bugs. He testified that he has had to crawl under the home and has done so with his left arm, dragging his right arm beside him. He testified that Terminex was aware of the restrictions. He agreed that he was currently working normal hours.

On cross-examination, Petitioner agreed that he signed the Application for Adjustment of Claim on June 17, 2015. He testified that he has two children, that his stepson is nine and that his biological son will be two in July. He testified that his stepson lives with him.

On cross-examination, Petitioner agreed that he completed the next job after his accident. He testified that he was told that he was going to take $12 an hour or not work. He agreed that he was seen

by Dr. Milne at the request of his employer, but testified he did not recall denying any popping prior to June 13, 2015.

Evan Pierce was called to testify as a witness on behalf of Respondent at the time of arbitration. Mr. Pierce testified that he is the field service manager at Respondent and has held the position for nearly one year. He testified that he previously was a technician and has been in the business for nearly 10 years. He testified that as field service manager, his job duties include getting routing, helping the warehouse when needed, taking calls and getting out in the field and helping when needed. He testified that if there were a work injury, it would be reported to either him or Michelle Price, the area manager. He testified that once he gets a call, he does a preliminary e-mail which goes out to upper management. He testified that after he sits down with the injured worker and collects information, it usually goes to Human Resources.

Mr. Pierce testified that he was familiar with Petitioner and knew him through work. He agreed that Petitioner was employed by Respondent on June 13, 2015, and that Petitioner contacted him with reference to an incident that occurred while he was on a job that day. He testified that it was approximately 12:30 that day when Petitioner contacted him. He agreed that he prepared some documentation and that he reviewed documentation pertaining to the jobs that Petitioner went to on that date in preparation for his testimony.

Mr. Pierce testified that when Petitioner contacted him, it was his understanding that Petitioner was retrieving a ladder from a house, and that he was pulling it away from the house when he felt a pop in his shoulder. He denied that when he initially spoke with Petitioner that Petitioner mentioned anything about the ladder falling onto his shoulder. He testified that to his knowledge, Petitioner completed his job duties on that date. He testified that Petitioner completed another job before the end of the day, and that he had reviewed the job order. He testified that after the accident, Petitioner completed another job which was a high definition upgrade which consisted of replacing an existing dish with a new dish and replacing a receiver. He testified that after Petitioner finished the last job, he texted him saying that he was going home to put ice on it and that later he texted again, saying he wanted documentation. He testified that he believed that he called Petitioner and said to just go ahead and go to the emergency room and get it looked at. He testified that during the initial call, he did not think it was anything that big so he told him not to "baby it" and let it tighten up on him, and that he should try to use it.

Mr. Pierce testified that when Petitioner contacted him and said he needed to officially report it, he then generated the Form 45. He testified that he requested a statement concerning what occurred from Petitioner, and that he received that statement by e-mail which he cut and paste into the report. He denied that Petitioner provided any further information regarding the specifics of the accident when he had contact with Petitioner while he was at the emergency room that night. He denied that Petitioner at any time reported to him that the ladder fell onto his shoulder. He testified that the manager on site supervised Petitioner while he was on light duty.

On cross-examination, Mr. Pierce agreed that Petitioner was a good employee. He testified that he did not really hear a lot from him other than when he had an issue with a case. He testified that he was not aware of any issues with Petitioner's work performance.

On cross-examination, Mr. Pierce agreed that he was not with Petitioner when the accident happened. He agreed that it was fair to say that he did not know for sure whether the ladder fell onto Petitioner's shoulder or not because he was not there. He testified that during the telephone conversation he got as much detail as he could, and that they talked for 5-10 minutes.

Lisa Wombles was called to testify as a witness on behalf of Respondent at the time of arbitration. She testified that she is currently employed in Human Resources with Repsondent, and that she held a similar position with Ketterman Communications. She testified that she handled workers' compensation claims.

Ms. Wombles testified that she was familiar with payroll. She testified that Petitioner started working light duty for Respondent on June 23, 2015, and that under light duty he made $12 an hour. She testified that payroll was done bi-weekly, and that if Petitioner was paid on Friday it was for the two weeks prior. She testified that the pay periods ran from Sunday to Saturday. She testified that Petitioner's employment ended with Respondent on January 11th, and that the next paycheck was issued on January 29, 2016. She testified that the check would have covered his last day for his hours worked, and any accrued "PTO" time that he would have had. She testified that "PTO" referred to sick and vacation time, which was bundled into "PTO."

Ms. Wombles testified that unproductive hours were any time that an employee was not at a customer's home. She testified that this could be used for meetings, but that it was paid at the same rate. She testified that the top entry for light duty hours were for the first week, and that the bottom one was for the second week for that pay period. She testified that there were occasions that Petitioner may not have received 40 hours. She testified that when they had an employee that was on light duty they had to have a manager present at the office, so if there was a situation where Michelle or Evan were not able to be present, Petitioner would not have been able to work those days and his hours would have been cut short. She testified that she made every effort to try to assure Petitioner at least 40 hours.

On cross-examination, Ms. Wombles agreed that when Petitioner was on light duty, he was paid at the rate of $12 an hour. She agreed that there were some occasions where Petitioner was not able to work 40 hours a week and they were documented on Respondent's Exhibit 7.

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 June 13, 2015, that Petitioner was lowering a ladder and that Petitioner's right arm/shoulder was affected. Petitioner signed the Application on June 17, 2015. (AX2).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Medical Records List was entered into evidence at the time of arbitration as Petitioner's Exhibit 2.

The medical records of St. Joseph's Memorial Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. Petitioner was seen on June 13, 2015 at 21:33. It was noted that Petitioner complained that his right shoulder popped, and it was noted that he had surgery done about three years ago. Petitioner reported that he had an MRI done 10 days ago, which showed chronic changes of arthritis and a partial tear of the biceps. The primary impression was that of a rotator cuff (capsule) sprain, and Petitioner was discharged home in stable condition. (PX3).

The medical records of Murphysboro Healthcare Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records noted that Petitioner had been set up for an MRI at Carbondale Hospital on May 31, 2015. The notation dated June 15, 2015 indicated that Petitioner's wife requested a call from the nurse in regards to the MRI of the shoulder, and that she stated that the patient was hurting worse and was in the emergency room. It was also noted that Petitioner's wife reported that Petitioner hurt his shoulder at work over the weekend and went to the emergency room, and that his arm was placed in a sling and was given Hydrocodone. (PX4).

The medical records of Orthopaedic Institute of Southern Illinois were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. Petitioner was seen on June 15, 2015 for a chief complaint of right shoulder pain. It was noted that Petitioner underwent left [*sic*] shoulder posterior labral and SLAP repair on September 2, 2011, that he did well post-operatively and that he was having some recent soreness in the shoulder. It was noted that he had an MRI scan that showed no obvious tearing but some arthritis in the shoulder, cuff tendinosis, long head of the biceps partial tear and was waiting follow-up when on June 13, 2015 he was lifting an extension ladder and felt a significant pop in the shoulder. It was noted that Petitioner had significant pain since then anteriorly and posteriorly where he could not use the arm. The assessment was that of a 32-year-old male status post prior posterior labral and SLAP repair done on September 2, 2011 with a new injury and a recent MRI scan that showed partial tearing, long head of the biceps, and rotator cuff tendinosis, glenohumeral joint osteoarthrosis, and degenerative fraying or tear unlikely in the posterior labrum in the area of the prior surgery. It was noted that Petitioner was to undergo physical therapy and start anti-inflammatory medications, and that he would be kept on modified work duty of no lifting, pushing or pulling more than 5-10 pounds, waist level work only. The Addendum pertaining to review of the x-rays suggested no obvious fracture or dislocation of the right shoulder. (PX5).

The records of Orthopaedic Institute of Southern Illinois reflect Petitioner was seen on July 13, 2015, at which time he presented with persistent right shoulder pain, and popping in the shoulder with limitations in motion. The office note contained a causation opinion indicating that Petitioner's work injury caused his pain and was either new structural tearing or exacerbating an underlying previous condition and that the work-up and treatment was necessary and reasonable. An MRI arthrogram was ordered at that time, and it was noted that injection therapy would be discussed following physical therapy. At the time of the September 9, 2015 visit, the results of the MR arthrogram were reviewed and compared to his previous MRI that he had pre-injury. The assessment was that of a 32-year-old male status post previous posterior labral and SLAP repair done in September 2011 with a new injury at work showing a posterosuperior to posteroinferior labral tear, rotator cuff tendinosis, glenohumeral joint osteoarthritis, and a partial tear with medial subluxation of the long head of the biceps tendon. It was noted that Petitioner had failed to improve and was interested in surgical management. The plan was to schedule Petitioner for the right shoulder arthroscopy with superior and posterior labral repair, open biceps tenodesis and rotator cuff debridement once worker's compensation approval and medical clearance had been obtained. The note also contained a causation opinion, indicating that Petitioner's current complaints were causally related to his work injury that he sustained. A pain medication refill was issued, and Petitioner was placed under work restrictions of no overhead work, no repetitive pushing or pulling, and no lifting more than 5-10 pounds. (PX5).

The records of Orthopaedic Institute of Southern Illinois indicate that Petitioner was seen on November 30, 2015, at which time he stated he was no better and had increased pain that he was localizing along the anterior aspect more medial along the region of the coracoid process. It was noted that Petitioner felt a lump there, and that he was also getting some numbness and tingling into the arm as well as progression of pain in the scapular region. The assessment was that of a 32-year-old male status post work injury with a posterior superior and posterior inferior labral tear, rotator cuff tendinosis, exacerbation of post-traumatic glenohumeral joint osteoarthritis as well as partial tear with medial subluxation of long head of biceps tendon. It was noted that Petitioner had elected to proceed with surgical management that was pending worker's compensation approval. It was noted that Petitioner would continue with his current work restrictions and protective body mechanics. It also appears that authorization was requested for an EMG/nerve conduction study of the right upper extremity. (PX5).

Included within the records from the Orthopedic Institute of Southern Illinois were various physical therapy records pertaining to treatment rendered during the timeframe of June 16, 2015 through June 30, 2015. (PX5).

The medical records of Memorial Hospital of Carbondale were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. Petitioner was seen on August 31, 2015, at which time he underwent an MRI arthrogram. The images were interpreted as revealing (1) status post attempted reconstruction of the glenoid labrum; tear/re-tear involving the posterior and inferior glenoid as described as well as suspected small tear/retear of the posterosuperior labrum; sublabral foramen (anatomic variant); (2) marked glenoid chondrosis posteriorly and inferiorly; chronic-appearing deformity of the posteroinferior glenoid rim suggesting sequela of old trauma without an acute fracture or dislocation; (3) mild to moderate rotator cuff tendinosis with bursal surface fraying of the supraspinatus; no full-thickness rotator cuff tear or tendon retraction; (4) small amount of fluid in the subacromial/subdeltoid bursa related to bursitis or recent injection; there is some contrast overlying the rotator interval related to the recent injection without evidence of a full-thickness rotator cuff tear to account for the abnormality; (5) medial subluxation of the long head of the biceps within the bicipital groove with tendinosis/partial tear. (PX6).

The medical records of Dr. Nathan Mall were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. Petitioner was seen on February 8, 2016, at which time it was noted that on June 13, 2015 he was picking up a ladder and lowering it away from the house and felt a pop into the shoulder which caused immediate loss of function of his right upper extremity, and that the ladder landed directly onto the shoulder. It was noted that prior to this incident, Petitioner was working full duty without any significant shoulder symptoms, other than some generalized stiffness in the shoulder. It was noted that Petitioner stated he was unable to even pick up small objects and that he could not sleep. It was further noted that Petitioner had seen his primary care physician approximately one week before his accident, and that he had undergone an MRI evaluation at the request of his primary care physician even though he had full range of motion and no substantial loss of function in the shoulder. It was noted that Petitioner was seen for reevaluation of the right shoulder as well as regarding his right shoulder and current pain and symptoms. The assessment was that of (1) right shoulder AC joint arthrosis; (2) right shoulder biceps tendinitis, possible superior labral tearing with posterior extension; (3) mild glenohumeral osteoarthritis. It was noted that Dr. Mall believed there were some changes on the MRI of August 2015 as compared to the June 2015 MRI. He noted that there was more AC joint edema present, which made sense based on the injury mechanism of the ladder landing on top of the shoulder, which was noted to have likely caused additional worsening of his symptoms to the AC joint. He noted that the biceps tendon appeared to be slightly subluxed on the August 2015 MRI, which was not present on the June 2, 2015 MRI. He noted that it was impossible determine if there was substantially more fluid on the biceps tendon compared to the pre-injury MRI. Having reviewed Dr. Milne's IME report, Dr. Mall indicated that he did not believe that the MRI findings represented substantial osteoarthritis of the glenohumeral joint, as the humeral head cartilage was relatively well preserved and the x-rays did not demonstrate any substantial amount of arthritis. In addition to indicating that Petitioner was able to articulate the difference in symptoms and the dramatic worsening of his right shoulder complaints, Dr. Mall also indicated that he recommended a cortisone injection into the glenohumeral joint as well as an AC joint injection, and that Petitioner return to physical therapy for some range of motion and strengthening. Work restrictions were issued on that date, including avoiding constant repetitive use of the right upper extremity, primarily one-handed work with the injured hand assisting on light tasks, no pushing/pulling, no lifting greater than 5 pounds overhead/above chest and no lifting greater than 15 pounds from floor/waist/chest to waist/chest. (PX7).

The records of Dr. Nathan Mall reflect that Petitioner was seen on March 18, 2016, at which time he asked for another cortisone injection as he stated this gave him a substantial benefit for a two-week period. It was noted that Petitioner had dramatic improvement in his pain and symptoms in his right shoulder, but his pain had subsequently returned. The assessment was that of (1) right shoulder AC joint arthrosis; (2) right shoulder superior labral tear with biceps tendinitis: (3) mild glenohumeral osteoarthritis. At this point in time, surgery was recommended and was noted to include right shoulder arthroscopy, biceps tenodesis and AC joint resection. It was noted that Petitioner continued to have his significant labral "clunk" on examination that date as well, which was abnormal. It was noted that

Petitioner was not recommended to proceed with another cortisone injection given that he only had some mild osteoarthritis of the shoulder. (PX7).

The transcript of the evidence deposition of Dr. Nathan Mall was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. Dr. Mall testified that he is board certified in orthopedics as well as in independent medical evaluations. He testified that he predominantly treated knee and shoulder conditions, and that 30-40% of his patients were treated for shoulder problems. (PX8).

Dr. Mall testified that he saw Petitioner on February 8, 2016, and that he believed Petitioner's primary care physician referred him at Petitioner's request. He testified that the history given by Petitioner was that he was working for a satellite installation company and was picking up a ladder and lowering it away from the house, when he felt a pop in the shoulder which caused immediate pain and loss of function in his right upper extremity. He testified that Petitioner stated that the ladder, because he was unable to hold it, landed directly on top of the shoulder. He testified that Petitioner reported that prior to the incident he was working full duty and that he had seen his primary care physician just a few weeks before the accident and had an MRI performed of the shoulder, but that his symptoms were significantly different following the work accident. (PX8).

Dr. Mall testified that when he saw Petitioner on February 8th, he thought they had a "decent amount" of records from Dr. Davis's office where Petitioner had treated for his prior shoulder surgery. He agreed that Petitioner brought a copy of the IME report with him to the appointment. He testified that the history that Petitioner had given to the other providers was consistent with what he told him. He testified that on physical examination, when he was passively elevating Petitioner's shoulder in forward elevation there was a large "clunk" that happened in the shoulder which was different than the classical kind of crepitus or popping in the subacromial space. He testified that Petitioner had pretty severe pain with forward flexion, and that he had weakness in his rotator cuff muscles. He testified that Petitioner had a positive O'Brien's test, which was a test for superior labral pathology. He further testified that Petitioner had pain over his biceps tendon within the bicipital groove and pain over the AC joint as well. (PX8).

Dr. Mall testified that he understood that Petitioner was working full duty up until the June 13, 2015 accident, and that prior to the accident, Petitioner had more of the generalized stiffness or soreness and perhaps some slight popping but nothing as traumatic as this. He testified that he was able to look at Petitioner's MRIs that he had done in June 2015 and August 2015, and that the first was not an arthrogram study whereas the second was. He testified that the MR arthrogram gave a better understanding of more intra-articular structures and the ability to see the labrum better. He testified that he reviewed the actual films as well as the reports. He testified that there was more substantial swelling in the AC joint on the August MRI, and that there was biceps subluxation, indicating an upper border subscapularis tear. (PX8).

Dr. Mall testified that Petitioner reported that his symptoms changed following the June 2015 injury, including not being able to work and his arm hurting severely when he tried to lift his arm up overhead. He testified that based on the history, the physical examination performed, and his review of the medical records and diagnostic studies, he made a diagnosis of right shoulder superior labral tearing with posterior extension, biceps tendinitis and AC joint arthrosis. He testified that his recommendations were to put injections into the glenohumeral joint and the AC joint, and to get Petitioner into some physical therapy to work on his range of motion and strengthening. He testified that the injection was performed, which confirmed for him at the correct location where Petitioner's pain symptoms were coming from. (PX8).

Dr. Mall testified that he believed that the June 13, 2015 accident caused, contributed to or aggravated Petitioner's right shoulder condition and symptoms, and that something changed during the accident where Petitioner was no longer able to work and that he had a big "pop" when he tried to lift his

arm up. He testified that Petitioner had a significant change in his ability to work and to do various light tasks, and that on the MRI there was suggestion of some differences in terms of the biceps tendon subluxing and some tearing of the posterior labrum which appeared to be different from one to the other. He denied getting the sense from Petitioner that he was being dishonest or trying to exaggerate any of his symptoms. He testified that Petitioner has not returned to his baseline or pre-injury level of function. (PX8).

Dr. Mall testified that his current recommendation for Petitioner was continued conservative treatment and if it worked, then return back to work and be back to his pre-injury level of function and pain. He testified that if Petitioner continued to have symptoms with trying to return back to work or activities of daily living, then surgery was probably going to be required. He testified that Petitioner had an appointment scheduled for March 7th. He further testified that the work restrictions given were outlined in the Work Status Report. (PX8).

Dr. Mall testified that he believed Dr. Davis who followed Petitioner after his 2011 surgery was in a good position to understand the kind of symptoms Petitioner was having prior to the accident versus afterwards. He further agreed that he believed Petitioner would be able to explain the difference between his pre-injury symptoms versus those he experienced post-injury and how they changed. (PX8).

On cross-examination, Dr. Mall testified that he has been in practice for 3.5 years. He testified that he received his board certification in orthopedic surgery in July of 2014, and that he received his IME certification in April of 2015. He agreed that he examined Petitioner on one occasion. He testified that he had no idea whether Petitioner was referred from his primary care physician or his attorney. He also testified that he did not know if Petitioner's primary care physician faxed his office the records, but it is noteworthy that Petitioner's attorney indicated that she was sure her office sent most of them. (PX8).

On cross-examination, Dr. Mall testified that it was not uncommon for him to get a referral from Mr. Rich's office, and that he gets referrals from defense attorneys, plaintiffs' attorneys, employers, other orthopedic surgeons, physical therapists and primary care physicians. He agreed that the basis of his testimony concerning Petitioner's prior treatment with Dr. Davis was based on what was told to him by Petitioner or anything he would have seen in Dr. Davis's notes after June 13, 2015. (PX8).

On cross-examination, Dr. Mall agreed that Petitioner reported that the ladder landed directly onto the shoulder. He confirmed that he reviewed the records from St. Joseph's Memorial Hospital emergency room documenting treatment on June 13th, but indicated that he did not look at the emergency room examination findings because they did not usually do a very good job of examining the patient. He agreed that he reviewed records from the Orthopaedic Institute of Southern Illinois documenting treatment with Dr. Davis, testified that he did not spend a lot of time reviewing the intake sheet but agreed that he reviewed the initial treatment record of June 15, 2015 from Dr. Davis. He agreed that he did not see reference to any impact or dropping of a ladder onto the shoulder in any reports other than that of Dr. Milne. He testified that Dr. Davis's note of June 15, 2015 did not describe any swelling, bruising or redness of the shoulder when examined two days after the alleged accident, but also indicated that it did not specifically say there was no swelling or redness. (PX8).

On cross-examination, Dr. Mall agreed that when Petitioner presented for the evaluation, he was forthcoming and told him that he had an MRI prior to the alleged accident date. He agreed that Petitioner told him that he was working full duty without any significant shoulder symptoms at that time, and that he disclosed the prior right shoulder surgery with Dr. Davis. He agreed that he did not review the operative report or any of the aftercare following that surgery, and that Petitioner informed him that his primary care physician ordered the MRI. He testified that he did not review the records from Petitioner's primary care physician documenting the referral for the MRI. (PX8).

On cross-examination, Dr. Mall agreed that Dr. Milne did not report any particular type of popping in his report, and that he examined Petitioner in November of 2015. He agreed that to his knowledge, Petitioner had been off work since June. He denied having any discussions with Dr. Davis about Petitioner's treatment. He agreed that the MRI of June 2015 was a good quality study. He testified that he did not see the tendon out of the groove at any point during that study, but saw it on the MR arthrogram. He testified that he did not know whether the MRI was used as a basis for comparison for the MR arthrogram. He also testified that there was a different amount of fluid present in the June study versus the August study. (PX8).

On cross-examination, Dr. Mall agreed that Petitioner reported some relief after the injection, which he stated suggested that his symptoms were coming from the glenohumeral joint and the AC joint. He testified that on the June MRI they saw some degenerative changes which they always see, and that on the August MRI there was a lot more swelling in the joint than was seen in June. He testified that he believed this was consistent with the fall of the ladder onto his shoulder. When asked if the evidence showed that the ladder did not fall on his shoulder and whether that would change his opinion, Dr. Mall responded that it would not entirely do so. He testified that as long as the other injury mechanisms were consistent with an AC joint problem, he did not have any issue. (PX8).

On cross-examination, Dr. Mall testified that he did not specifically recall whether Petitioner finished his job duties on June 13th but thought Petitioner stated that he did. He testified that they could not be 100% positive that Petitioner had a superior labral tear until the time of surgery. (PX8).

On redirect examination, Dr. Mall testified that the mechanism of injury as described in Dr. Davis's June note was consistent with what Petitioner reported to him and Dr. Milne. He testified that there was nothing in the mechanism of injury that would cause him to change any of his opinions. (PX8).

The Light Duty Work Agreement was entered into evidence at the time of arbitration as Petitioner's Exhibit 9.

The transcript of the evidence deposition of Dr. Michael Milne was entered into evidence at the time of arbitration as Respondent's Exhibit 1. Dr. Milne testified that he is an orthopedic surgeon who is board-certified in orthopedic surgery, and that he is fellowship trained in sports medicine with an emphasis in knee and shoulder surgery. (RX1).

Dr. Milne testified that approximately 50% of his practice was devoted to treatment of the shoulder, and that on an annual basis he commonly performed 250-350 shoulder surgeries. He testified that he was the head team physician for the St. Louis Cardinals. He testified that less than 10% of his practice was medical/legal. (RX1).

Dr. Milne testified that he examined Petitioner on November 10, 2015. He testified that he obtained a history from Petitioner. He testified that the history was both taken from Petitioner and as contained in the records that he reviewed. He testified that Petitioner reported that his chief complaint was right shoulder pain, and that he was a 33-year-old, left-hand dominant satellite television installer and had worked there for 2.5 years. He testified that Petitioner stated that on June 13, 2015, he was pulling a ladder that was leaning up against the side of a house and was lowering it with his right arm up above the head when all the weight came back onto his right arm and his arm popped and gave out. He testified that the ladder dropped, landing on top of his right shoulder, and that he had immediate pain and numbness down into his fingers. He testified that Petitioner stated that he reported the injury to his boss immediately but tried to go to the next job that day and had significant pain, weakness and decreased function. He further testified that Petitioner went to the emergency room where x-rays were taken, and that he followed up with Dr. Davis who knew him from a prior right shoulder surgery. (RX1).

Dr. Milne testified that Petitioner provided a history of right shoulder complaints prior to the alleged accident, and that Petitioner told him he was injured in 2011 while in the military. He testified that he was seen and evaluated by Dr. Davis, was told that he had a torn labrum and that he underwent a labral repair. He testified that Petitioner stated that from 2011 until his work injury he had been doing fairly well, but he did mention that he had been seeing his primary care physician in May and mentioned that he was having some stiffness in the shoulder. He testified that Petitioner denied having any pain or popping sensation of the shoulder at that time, and that an MRI was ordered and was told that it was normal. (RX1).

Dr. Milne testified that he performed a physical examination, which revealed that Petitioner had significant tenderness to palpation over the bicipital groove and the rotator footprint, that he had decreased active and passive range of motion with forward flexion to 145 degrees, abduction to 145 degress, external rotation to 85, and internal rotation to midline at L2, that he had severe pain and guarding throughout all planes in range of motion, that there was a palpable labral "clunk" throughout his range of motion, that he had a positive Neer's impingement sign, a positive cross-arm adduction test, positive Hawkins test, positive O'Brien's maneuver, and a positive sulcus sign. He testified that x-rays were obtained of the right shoulder and that he reviewed the films, which he found to reveal a type II/III acromion with mild osteoarthritic changes at the AC joint, no significant osteoarthritic changes in the glenohumeral joint, the humeral head was well-maintained in the glenoid, and that there were no signs of any acute fracture, subluxation or dislocation. (RX1).

Dr. Milne testified that he reviewed the films for both MRIs that were performed in this case and opined that he did not believe that any structural change took place in Petitioner's shoulder as a result of the work injury. He testified that he believed that Petitioner's previous surgical report and plain x-rays, his MRI arthrogram and clinical notes all supported pre-existing disease in this case, and felt that Petitioner had a temporary aggravation of his symptoms. He testified that the MRI arthrogram was the test of choice after someone had had surgery or when looking for labral pathology, so it was difficult to compare the non-contrast study to the contrast study. (RX1).

Dr. Milne testified that after examining Petitioner, reviewing the medical records and imaging studies and conducting his physical examination, his diagnosis was that of right shoulder chronic appearing glenohumeral arthritis – chronic; right shoulder tendinosis/partial tear of the long head of the biceps with medial subluxation, chronic; right shoulder mild to moderate right rotator cuff tendinosis – chronic; right shoulder status post previous arthroscopic superior posterior labral repair – chronic; and status post acute contusion right shoulder dated June 13, 2015. He testified that he believed that Petitioner suffered a contusion as a result of the work injury, and that it may have caused a temporary increase in his symptoms. He testified that he did not believe that any structural changes took place in Petitioner's shoulder as a result of the work injury based on Petitioner's history, his surgical history, his plain x-rays, his MRI arthrogram and the clinical notes reviewed. (RX1).

Dr. Milne testified that he compared the MRI and the MR arthrogram, and he did not observe any changes that could not be accounted for for the difference in the technique of the tests. He testified that he believed that the evaluation by the orthopedist was necessary and that the MRI arthrogram was necessary for diagnosis, but did not believe that any of the treatment after the MRI arthrogram was necessary for the work injury but further added that he had no criticism of Petitioner's overall medical treatment regardless of causation. He testified that the basis of his diagnosis for the contusion was Petitioner's indication that as he was lifting the ladder away, it dropped down and struck him on the top of the shoulder. He further testified that the emergency room note made no mention of a work injury, there was no mention of a ladder, and there was no mention of anything striking him. (RX1).

Dr. Milne testified that he believed that Petitioner should continue with his treatment under Dr. Davis' recommendation for a repeat shoulder arthroscopy and probable biceps tenodesis, but did not

believe that it had any relationship to the alleged work injury. He testified that from the perspective of Petitioner's work injury, he believed that Petitioner was capable of work full duty, but from his overall medical condition Petitioner may not be able to do so. He testified that he believed at the time of his evaluation that Petitioner was at maximum medical improvement for the alleged work injury. (RX1).

On cross-examination, Dr. Milne agreed that Petitioner was 33 years old when he saw him. He agreed that Petitioner was a pretty young individual to have such a history of shoulder injuries, but testified that the injury from 2011 in the military was not unusual and was not age-affected. He testified that there were different histories given to different people in this case, and that when Petitioner stated to him that the ladder dropped and landed on top of his shoulder after which he felt immediate pain and numbness down into the fingers, it would make him think of a contusion or a proximal brachial plexus stretch or injury to the nerves, and not a SLAP tear, biceps tendon subluxation or partial subscapularis tear. He testified that he has not seen a subscapularis tear or labral tear occur that way before. He admitted that in his report from November of 2015, he did not make any comment about the fact that he thought Petitioner may have given different histories to different people about his injury, but further testified that he did not have the Murphysboro note at that time and that the emergency room record made no mention of any mechanism of injury. He testified that he believed that he had the emergency room record at the time that he saw Petitioner in November because he referred to it. He testified that no one asked him whether Petitioner gave different histories or was his history inconsistent among providers, so therefore he did not comment. (RX1).

On cross-examination, Dr. Milne agreed that it was not until he received a letter from Respondent's attorney that he made any comment about differing mechanisms of injury. He agreed that emergency room records and primary care physicians' notes were oftentimes computer-generated, and testified that he had no way to verify whether Petitioner told the emergency room personnel that he did not have an injury or if they just did not record it. He agreed that Petitioner was forthcoming about the fact that he had prior injuries and symptoms to his medical providers throughout his care and treatment. He testified that thought Petitioner was a "nice guy" and that he was honest, but he did not think Petitioner had a full understanding of what was going on with his shoulder. (RX1).

On cross-examination, Dr. Milne testified that he could not say that Petitioner did not show any signs of symptom magnification or malingering because he would no longer expect Petitioner to respond positively to certain palpation and that he had severe pain and guarding throughout all planes of motion, and that those should not stay positive for 4-5 months. He agreed that when he saw Petitioner in November, he agreed that Petitioner needed surgery regardless of causation. (RX1).

On cross-examination, Dr. Milne testified that they could not be sure that Petitioner had a physical examination of his shoulder in reviewing the Murphysboro Health Clinic note of May 19, 2015. He testified that Petitioner said something to the nurse practitioner or the doctor that made the person "pull the trigger" on an MRI, which in his experience family care physicians and nurse practitioners were not quick to do. (RX1).

On cross-examination, when asked whether he could testify within a reasonable degree of medical certainty that there were no changes between the MRI and the MR arthrogram given that they were two different studies and the first was not great quality, Dr. Milne responded that he could not tell within a reasonable degree of medical certainty that there were no changes but that the majority of the things that were seen that could be clinically relevant in this case were mentioned in the non-arthrogram study read by the same radiologist prior to the injury date. (RX1).

On cross-examination, Dr. Milne agreed that in addition to MRIs, one of the other things that physicians had to use to make treatment recommendations for patients was their symptoms, and he agreed that it was fair to say that he based treatment recommendations not only off of what was seen on the MRIs

but also what a patient told him about their symptoms. He agreed that Petitioner would be in the best position to tell how his symptoms had changed, if at all, following the June 13, 2015 injury. He agreed that it was his understanding that prior to the June 13, 2015 injury, Petitioner was able to work full duty. He further testified that he was not sure if Petitioner was physically able to work full duty or not. (RX1).

On cross-examination, Dr. Milne agreed that regardless of causation, he felt that Petitioner may not be capable of returning to work in a full duty capacity when he saw him in November. He agreed that Dr. Davis saw Petitioner both before and after the accident and that he had been treating him since 2011. When asked if that gave Dr. Davis the unique position of being able to evaluate Petitioner both before and after the injury in terms of telling how his condition had progressed, if at all, between the injuries, Dr. Milne testified that he did not know if it was a terribly unique position and that the medical records showed that Dr. Davis saw him last in 2012 when he injected Petitioner. He testified that Dr. Davis did not see him again until the new work injury, so there was no evidence that he saw Petitioner at any time in that 3-year period. He did note, however, that the nurse practitioner who saw Petitioner 11 days before the work injury noted that he had had physical therapy multiple times since his previous surgery, so he could not help but wonder if Petitioner had been treating his shoulder with the family physician. (RX1).

On cross-examination, Dr. Milne testified that he was made aware before the deposition that Petitioner had been seen by Dr. Mall who he knew worked with Petitioner's attorney's firm often, but admitted that he was told he was treating with Dr. Mall because of a family leave for Dr. Davis. He testified that he only reviewed one note for Dr. Mall for an evaluation and treatment, but did not recall the date of the record. He testified that x-rays of Petitioner's shoulder showed joint space narrowing of his AC joint and that there was mild narrowing of the glenohumeral joint, and that both MRIs made reference to cartilaginous damage primarily to the inferior or posterior aspect of the glenoid so he would consider that mild to moderate osteoarthritis, more post-traumatic in nature, and would make sense based on his mechanism of injury back in 2011. (RX1).

On cross-examination, Dr. Milne testified that Dr. Davis decided on July 13, 2015, before he had seen the MRI arthrogram that this was work-related and that he had made his decision that this would be a worker's compensation injury before he had even ordered or seen the MRI arthrogram. He agreed that surgery was a consideration at that point but was not a firm recommendation as of July 13, 2015. He agreed that he disagreed with the causation opinion included within the September 9, 2015 note of Dr. Davis that was signed by Jeremy Palmer, PA-C and co-signed by Dr. Davis. (RX1).

On cross-examination, Dr. Milne testified that he opined that Petitioner sustained a temporary increase in his symptoms. He testified that the only thing that he saw that was acute was status post acute contusion of the right shoulder dated June 13, 2015. He testified that he would have expected the symptoms from a shoulder contusion to persist for 2-3 weeks. He agreed that when he saw Petitioner in November of 2015, approximately five months after the injury, Petitioner was still having symptoms. He testified that he did not recall specifically whether the MR arthrogram showed any additional increased AC joint edema. After reviewing the interpretive reports, he testified that the MRI before the alleged injury did not talk about any edema and that the MR arthrogram afterwards did not discuss any edema. He testified that he respectfully disagreed with Dr. Mall on that issue. (RX1).

On redirect examination, Dr. Milne testified that the history in the June 2, 2015 MRI report made reference to popping of the shoulder, but the physician's assistant or Dr. Davis did not recall or Petitioner did not give them that history. (RX1).

The medical records of Murphysboro Health Clinic were entered into evidence at the time of arbitration as Respondent's Exhibit 2. Petitioner was seen on June 13, 2011, at which time it was noted that he injured his right shoulder and had decreased range of motion and complaints of pain. Petitioner was assessed with a right rotator cuff injury and was scheduled for an MRI. (RX2).

Included within the records of Murphysboro Health Clinic was the interpretive report for an MRI of the right shoulder performed on June 15, 2011 at St. Joseph Memorial Hospital, which was interpreted as revealing: (1) linear hyperintense signal undercutting the posterior/posteroinferior glenoid labrum raising concern for a labral tear/detachment, which could be further evaluated with MR arthrography; no paralabral cyst; (2) low-level marrow edema involving the posterior portion of the glenoid as well as the anteromedial portion of the humeral head suggesting marrow contusion; this in conjunction with suspected posterior labral tear raises concern for recent posterior dislocation; (3) minimal degenerative changes of the acromioclavicular joint with minimal lateral downsloping of the acromion; (4) minimal supraspinatus tendinosis without evidence of a partial or full-thickness rotator cuff tear. (RX2).

The records of Murphysboro Health Clinic reflect that Petitioner was seen on June 23, 2011 for a blood pressure recheck. It was also noted that Petitioner had a partial tear in the right shoulder, had seen an orthopedic physician and was starting with physical therapy. At the time of the August 29, 2011 visit, it was noted that Petitioner was undergoing surgery on the right shoulder for which he needed medical clearance. At the time of the November 29, 2011 visit, Petitioner was seen for hypertension-related concerns and tinnitus. (RX2).

The records of Murphysboro Health Clinic reflect that Petitioner was seen on February 7, 2012, at which time Petitioner was seen for hypertension-related concerns as well as ringing in his ears. At the time of the August 28, 2012 visit, Petitioner indicated that he wanted to quit smoking. At the time of the January 29, 2013 visit, Petitioner was seen for follow-up for hypertension and low blood pressure. At the time of the March 5, 2013 visit, Petitioner was seen in follow-up for back pain and hypertension. At the time of the April 2, 2013 visit, Petitioner was seen for a recheck on fatigue and to discuss a recent sleep study. At the time of the April 16, 2013 visit, Petitioner was seen for hormone and weight-related concerns, and was seen for the same issues again on May 28, 2013. (RX2).

The records of Murphysboro Health Clinic reflect that Petitioner was seen on June 25, 2013 for issues unrelated to the right shoulder. At the time of the January 3, 2014 visit, Petitioner was seen for back pain. At the time of the May 19, 2015 visit, Petitioner was seen for hypertension issues as well as abdominal pain. The records also indicate that Petitioner had undergone physical therapy multiple times for his right shoulder, that his pain was improved from the initial pain but he was having pain, especially with lifting his arm past 180 degrees, and that a repeat MRI was ordered. (RX2).

Included within the records of Murphysboro Health Clinic was the interpretive report for an MRI of the right shoulder performed on June 2, 2015 at Memorial Hospital of Carbondale, which was interpreted as revealing (1) status post attempted reconstruction of the glenoid labrum; overall diminished size of the posterior/posteroinferior glenoid labrum related to previous surgery and/or degenerative type tear; abnormal signal involving the labral remnant which may be related to degenerative fraying and/or tear on this non-arthrographic study with suspected tiny paralabral cyst; (2) glenohumeral joint osteoarthrosis; chronic-appearing deformity of the posterior/posteroinferior glenoid rim related to degenerative remodeling versus sequel of old trauma; minimal posterior subluxation of the humeral head within the glenoid fossa suggesting instability without a frank dislocation; (3) tendinosis/partial tear of the long head of the biceps with some medial subluxation of the tendon within the bicipital groove; (4) mild to moderate rotator cuff tendinosis with minimal bursal surface fraying involving the supraspinatus; no full-thickness rotator cuff tear or tendon retraction; (5) small amount of fluid in the subacromial/subdeltoid bursa. (RX2).

The medical records of Orthopaedic Institute of Southern Illinois were entered into evidence at the time of arbitration as Respondent's Exhibit 3. Petitioner was seen on June 22, 2011 for a chief complaint of right shoulder pain. It was noted that on June 6, 2011 Petitioner was at Scott Air Force Base doing baton training, and that he had an injury to the shoulder that persisted with respect to pain. It was noted that Petitioner had had some non-focal numbness and pain radiating down the arm. The assessment

was that of a 28-year-old male with a right shoulder posterior labral tear. Petitioner was placed on work restrictions and was instructed to undergo physical therapy. At the time of the August 3, 2011 visit, Petitioner was noted to have persistent right shoulder pain. Surgery was discussed and Petitioner was instructed to obtain medical clearance in order to undergo right shoulder posterior labral repair. (RX3).

Included within the records was the Operative Report dated September 2, 2011, which referenced a pre-operative diagnosis of right shoulder posterior labral tear and post-operative diagnoses of (1) right shoulder posterior labral tear; (2) SLAP tear; (3) bursitis. The procedures performed included right shoulder arthroscopic posterior labral repair, right shoulder arthroscopic SLAP repair and bursectomy. The procedure was performed at Memorial Hospital of Carbondale. (RX3).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on September 15, 2011, at which time it was noted that he had been having some pain but it was not intolerable. The assessment was that of status post right shoulder posterior labral and SLAP repair done on September 2, 2011. Petitioner was instructed to undergo physical therapy. At the time of the November 7, 2011 visit, it was noted that Petitioner was progressing well. Petitioner was instructed to continue with protective body mechanics, home exercises and medications. At the time of the January 9, 2012 visit, it was noted that Petitioner was progressing well, had some aches and pains and was better than he was before surgery. Petitioner was issued work restrictions and was allowed to participate in modified duty. (RX3).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on April 9, 2012, at which time it was noted that he had been doing well and that he still gets a little sore predominantly with overhead activity at one certain position but otherwise worked through it and did well. It was noted that Petitioner wanted to progress to try to get back to police work, and that he still gets some occasional popping but no pain. It was noted that Petitioner still needed to progress with his activities. At the time of the June 11, 212 visit, it was noted that Petitioner had aches and pains anteriorly and laterally following a posterior labral and SLAP repair and that he felt like he hit a plateau over the last couple of months. Petitioner was instructed to continue protective body mechanics, home exercises and medications, and he was given an injection into the subacromial space. (RX3).

The records of Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on August 13, 2012, at which time it was noted that he felt much better. A work slip was issued on that date, allowing Petitioner to gradually increase into push, pull and lifting activities. (RX3).

The medical records of Memorial Hospital of Carbondale were entered into evidence at the time of arbitration as Respondent's Exhibit 4. Petitioner was seen on October 18, 1999 after having been injured while striking his right shoulder against another player while playing football two days prior to admission. The clinical impression was noted to be that of acute strain of the right shoulder and musculoskeletal strain. X-rays performed on the same date were interpreted as normal. (RX4).

The records of Memorial Hospital of Carbondale reflect that Petitioner was seen on September 3, 2011, at which time it was noted that he had surgery yesterday by Dr. Davis and that his pain medications were not working. The diagnosis was noted to be that of post-operative pain. (RX4).

Included within the records of Memorial Hospital of Carbondale was the MRI History Form dated June 2, 2015, which noted a history of posterior labrum repair, 2012; pain upon 90 degrees abduction and 90 degrees frontal arm raise; pops each time arm moves up/out. (RX4).

The Employer's First Report of Injury, Accident Investigation Form and Employee Description of Accident were entered into evidence at the time of arbitration as Respondent's Exhibit 6. The Employer's First Report of Injury was dated June 14, 2015 and noted a date of accident of June 13, 2015

at 12:30 p.m. It was noted that Petitioner was performing a service call and was retrieving a ladder from the side of the house. It was noted that Petitioner felt a pop in the right shoulder when lowering the extension ladder. When asked what object of substance, if any, that directly harmed the employee, the response was "n/a." (RX6).

The Accident/Investigation Form dated June 14, 2015 noted that Petitioner was completing a service call and when retrieving his extension ladder from the side of the house, he felt a pop in his right shoulder with numbness in his fingers. It was noted that Evan Pierce had called Petitioner on a different matter at the approximate time of the accident, and that Petitioner told him about it and said he was going to finish out the day and then go home and ice it. Pierce indicated that he told Petitioner to try and not let it stiffen up. Pierce noted that later at 8:20 p.m., Petitioner called him to have something documented about the incident and that he was prompted to go to the emergency room. Pierce noted that extension ladders were heavy, especially when extended out and the center of gravity was compromised. (RX6).

The Employee Description of Accident noted that Petitioner was finishing up a service call at 12:20 and was putting his things back in the truck. He noted that he went to get his extension ladder from where he was working on the dish, and that he started lowering the ladder down from the right side of the ladder where it was leaning against the house. He indicated that he got it approximately half way down when he felt a pop in his shoulder and some pain. He noted that he finished getting the ladder to the truck and then called "closeout" and talked to Patricia telling her about the issues having to replace the modem and tria for the Internet and then made a comment "to top it off I took my ladder down my shoulder popped and started hurting." Petitioner indicated that he got off the phone with her and called Evan and informed him of what had happened as his fingers had started tingling. After describing an exchange with Pierce about icing his shoulder, Petitioner noted that at 1:33 he sent Pierce a test stating that he was going to put ice on his shoulder as it was hurting bad. He noted that at 8:00 p.m. he sent Pierce a text message asking what form he had to fill out, and that Pierce informed him that he needed to be seen at the emergency room and that he would need to take a post-accident drug test. (RX6).

The Employee Detail Earnings were entered into evidence at the time of arbitration as Respondent's Exhibit 7.

The medical records of St. Joseph's Memorial Hospital were entered into evidence at the time of arbitration as Respondent's Exhibit 8. The records reflect that it was noted that Petitioner was on his cell phone, stating that he was upset and that the doctor upset him because he was not doing anything. Nurse Naas noted that she asked what he wanted done, and that Petitioner indicated that he did not think his arm was broken but indicated he wanted more done than plain x-rays. Nurse Naas noted that she explained that MRIs were rarely done through the emergency department, to which Petitioner responded that there was no reason for him to be there. Nurse Naas noted that she explained to Petitioner that the physician was working on the paperwork and that they could send him to the lab for the drug screen he stated his boss wanted him to have while he was there. The remaining records were duplicative of those as contained in Petitioner's Exhibit 3. (RX8; PX3).

The medical records of Regeneration Orthopedics were entered into evidence at the time of arbitration as Respondent's Exhibit 9. The records were duplicative of those as contained in Petitioner's Exhibit 7. (PX7; RX9).

The intake from Orthopaedic Institute of Southern Illinois from June 5, 2015 was entered into evidence at the time of arbitration as Respondent's Exhibit 10. When asked how it happened, it was noted that Petitioner was lifting an extension ladder. (RX10).

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 June 13, 2015.

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he has suffered a disabling injury arising out of and in the course of his employment. 820 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013 (2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 57 (1989). However, the fact that an injury arose "in the course of" the employment is not sufficient to impose liability, for to be compensable, the injury must also "arise out of" the employment. *Id.* at 58.

The "arising out of" component refers to an origin or cause of the injury that must be in some risk connected with or incident to the employment, so as to create a causal connection between the employment and the accidental injury. *Id.* There are three categories of risk to which an employee may be exposed: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks, which have no particular employment or personal characteristics. *Springfield Urban League v. Illinois Workers' Compensation Comm'n*, 2103 IL App (4th) 120219WC, ¶ 27; *Young v. Illinois Workers' Compensation Comm'n*, 2014 IL App (4th) 130392WC. Injuries resulting from a neutral risk are not generally compensable and do not arise out of the employment unless the employee was exposed to the risk to a greater degree than the general public. *Id.*

The "in the course of" component refers to the time, place and circumstances under which the accident occurred. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483 (1989). If an injury occurs within the time period of employment, at a place where the employee can reasonably be expected to be in the performance of her duties, and while she is performing those duties or doing something incidental thereto, the injuries are deemed to have been received in the course of the employment. *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. "Injuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work, or within a reasonable time before and after work, are generally deemed to have been received in the course of the employment." *Johnson v. Illinois Workers' Compensation Comm'n*, 2011 IL App (2d) 100418WC, ¶ 21.

In the case at hand, the Arbitrator finds that Petitioner was performing a task incidental to his employment when his injury occurred. The Arbitrator notes that the detail that Petitioner was lifting a ladder or taking the weight of the ladder when he heard a loud pop in his shoulder with pain is in nearly every detailed history of injury contained in the record with the notable exception of the emergency room history, which contained little information except reference to "R shoulder injury," "work," and "taking down a ladder". (PX3; PX5-PX7). The Arbitrator finds that the histories of accident of Dr. Mall and Dr. Milne contain the most detail and reflect that after Petitioner felt the pop with immediate pain, the ladder fell into his right shoulder, which was consistent with Petitioner's testimony at the time of arbitration. (PX7; RX1).

As the Arbitrator finds Petitioner to have been a credible witness at the time of arbitration and notes that he appeared to testify in a forthright manner, the Arbitrator finds that Petitioner met his burden of proof in establishing that he sustained accidental injuries that arose out of and in the course of his employment with Respondent.

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner has met his burden of proving that his current condition of ill-being is causally related to the accident.

The Arbitrator notes that the undisputed facts demonstrate that Petitioner was working full duty prior to this accidental injury. Petitioner testified that although he had some right shoulder complaints prior to the accident, these symptoms of stiffness and clicking were of minimal concern and he was able to perform all activities of daily living and work full duty up until his accident on June 13, 2015. Even Dr. Milne acknowledged that for Petitioner's post-accident condition, which he stated was unrelated to the accident, restrictions were reasonable. (RX1). Therefore, it is evident to the Arbitrator that, while Petitioner did suffer from a pre-existing condition with respect to his right shoulder, the work accident of June 13, 2015 aggravated and/or accelerated his condition of ill-being in the right shoulder.

Dr. Davis noted in his records that he believed that Petitioner's work injury caused his pain and was either new structural tearing or exacerbating an underlying previous condition. (PX5). When Dr. Davis obtained Petitioner's post-accident MRI completed on August 31, 2015, showing tearing or re-tearing of the labrum and glenoid, fraying of the supraspinatus and infraspinatus, and fluid in the subacromial/subdeltoid bursa aside from the biceps tearing shown on Petitioner's pre-injury MRI, he noted the significant differences on the new MR arthrogram. (PX5). Dr. Mall observed on the post-accident MRI indications of an upper border subscapularis tear and tearing of the posteroinferior and posterosuperior labrum, which he noted to be different than Petitioner's pre-accident MRI, as well as more substantial edema within the AC joint on the post-accident MRI. (PX7). As such, the Arbitrator finds the opinions of both Dr. Davis and Dr. Mall to be more persuasive in this case.

Furthermore, the Arbitrator finds Petitioner's testimony concerning his change in symptoms following the accident to be credible. Petitioner testified that the accident caused a tremendous difference in the sound his shoulder makes with motion, as well as his pain and level of function. The medical records support Petitioner's testimony, as both Dr. Mall and Dr. Milne noted a significant "clunking" in Petitioner's shoulder during their physical examinations. (PX7; RX1). The Arbitrator agrees that Dr. Davis is in the best position to evaluate any change in Petitioner's condition of ill-being as a result of the accident, and his notation that there was a new development of symptoms corroborates Petitioner's report that his "clicking" turned into "clunking" that has negatively affected his ability to use his right arm.

Based upon the foregoing, the Arbitrator finds that Petitioner met his burden of proving that his current condition of ill-being is causally related to the accident of June 13, 2015.

With respect to disputed issue (J) pertaining to necessary medical services, in light of the Arbitrator's aforementioned conclusions, the Arbitrator finds that Petitioner's care and treatment was reasonable, necessary, and causally related to his work accident of June 13, 2015. As a result thereof, Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With respect to disputed issue (K) pertaining to prospective medical treatment, in light of the Arbitrator's finding as to the issue of causation, the Arbitrator finds that Respondent shall authorize the treatment recommended by Dr. Mall, including, but not limited to, the recommended surgery.

With respect to disputed issue (L) pertaining to temporary total disability benefits and temporary partial disability benefits, the Arbitrator notes that Petitioner seeks temporary total disability benefits from

June 14, 2015 through June 22, 2015, and that Petitioner also seeks temporary partial disability benefits from June 23, 2015 through January 11, 2016. (AX1).

The Arbitrator notes that Petitioner was placed under work restrictions on June 15, 2015 by Dr. Davis. (PX5). Ms. Wombles testified at the time of arbitration that Petitioner started working light duty for Respondent on June 23, 2015. As a result thereof, the Arbitrator finds that Petitioner was temporarily and totally disabled for the timeframe of June 15, 2015 through June 22, 2015, a total of 1 1/7 weeks. The Act states, however, that "[i]f the period of temporary total incapacity for work lasts more than 3 working days, weekly compensation as hereinafter provided shall be paid beginning on the 4th day of such temporary total incapacity and continuing as long as the total temporary incapacity lasts." 820 ILCS 305/8(b). As a result thereof, the Arbitrator finds that Petitioner is entitled to 0 5/7 weeks of temporary total disability benefits.

The Arbitrator notes that Respondent began accommodating Petitioner on June 23, 2015, but at a rate significantly less than his average earnings. Petitioner testified that Respondent had him sign a wage agreement for $12/hour in exchange for working in any capacity. Ms. Wombles confirmed that Petitioner was paid just $12/hour when he began working light duty, and that Petitioner was not guaranteed 40 hours a week. Although Respondent suggested that $12/hour was Petitioner's normal wage, the Arbitrator finds this unsupported by the detailed earnings summary entered into evidence. (RX7) Furthermore, the rate of $12/hour is inconsistent with the parties' agreement as to Petitioner's average weekly wage of $1,184.64. The Act states that "[w]hen 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). Even if the Arbitrator were to take Respondent at its word, the evidence is clear that any time Petitioner would be earning such an hourly rate he was not engaged in the full performance of his duties. Moreover, according to Respondent's exhibit, Petitioner was not paid at such an hourly rate at any time prior to his accident. (RX7). That said, the Arbitrator finds Petitioner's testimony credible and finds him entitled to temporary partial disability benefits.

Respondent's records show that Petitioner was compensated $12/hour for a total of 1,213.36 hours over the course of 17 weeks, yielding an average weekly wage of $480.00, when excluding any time in which Petitioner collected paid time off, which was paid at a higher rate. The parties stipulated at the time of arbitration that Petitioner's average weekly wage prior to the accident was $1,184.64, which results in a difference of $704.64. As a result, Petitioner's temporary partial disability rate equals $469.76. As Petitioner's employment with Respondent ended on January 11, 2016, the period of Petitioner's temporary partial incapacity lasted 29 weeks, which addresses the timeframe of June 23, 2015 through January 11, 2016. As a result thereof, Respondent shall pay the sum of $469.76/week for a period of 29 weeks, as provided in § 8(a) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Perry Brent,
Petitioner,
vs.

NO: 15 WC 22144

Extra Help, Inc.,
Respondent,

17IWCC0234

DECISION AND OPINION ON REVIEW

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 13 2017
o040617
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PERRY, BRENT
Employee/Petitioner

Case# **15WC022144**

EXTRA HELP INC
Employer/Respondent

17IWCC0234

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:

1167 WOMICK LAW FIRM CHTD
CASEY VANWINKLE
501 RUSHING DR
HERRIN, IL 62948

1433 McANANY VAN CLEVE & PHILLIPS
ANDREW J SHEEHAN
5054 N 7TH ST SUITE 2100
ST LOUIS, MO 63101

17IWCC0234

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

BRENT PERRY
Employee/Petitioner

v.

EXTRA HELP, INC.
Employer/Respondent

Case # **15** WC **22144**

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 14, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **June 8, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $; the average weekly wage was **$400.00**.

On the date of accident, Petitioner was **40** years of age, ***single*** with **4** dependent children.

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

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

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

ORDER

As explained in the Arbitration Decision, Petitioner had four dependents at the time of the accident. Respondent shall pay Petitioner the sum of **$330.00**/week for a further period of **5 weeks**, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **1% 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.

Signature of Arbitrator

July 14, 2016
Date

JUL 18 2016

17IWCC0234

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

BRENT PERRY
Employee/Petitioner

v. Case #: **15 WC 22144**

EXTRA HELP, INC.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated that on June 8, 2015, Petitioner sustained an accident which arose out of and in the course of his employment with Respondent which caused injury to his right shoulder. The parties further stipulated that Respondent has paid or will pay medical bills incurred as a result of said accident, as outlined in Petitioner's Exhibit 5, and that Respondent will receive credit for any prior payments, including those paid pursuant to Section 8(j). The only issues in dispute are Petitioner's number of dependents and the nature and extent of Petitioner's permanent partial disability.

On his date of accident, Petitioner was 40 years old and single. He testified he had four dependent children, two sets of twin boys, ages ten and twelve. Petitioner testified he was picking up fifty pound bags of concrete and putting a pallet together. As he picked up a bag, he felt a pop and burn under his right arm and his arm went weak. He sought treatment with Dr. Smith, who prescribed Naproxen and physical therapy, and placed restrictions on his physical activities. The treatment did not help, and Dr. Smith recommended Petitioner see an orthopedic surgeon. Petitioner began treatment with Dr. Treg Brown in July 2015, who also placed restrictions on his right arm activities. Petitioner had an MRI which showed a partial thickness supraspinatus tear in the right shoulder. Petitioner continued with physical therapy, had two rounds of injections, and limited his lifting to no more than five to ten pounds. He was released by Dr. Brown to return to full duty work on October 20, 2015.

Petitioner testified he continues to have pain in his right arm and shoulder. His arm sometimes gets very weak and "feels like it's just going to fall off". He was scheduled to return to the doctor for a cortisone injection in about two weeks. He testified he cannot do repetitive work because his right arm gets weak due to the tear.

Petitioner testified that prior to this injury he had two previous surgeries on his right shoulder. In 2009 he had a decompression procedure, and in 2010 he had a rotator cuff repair. He testified he was getting cortisone injections by Dr. Brown in both shoulders every six months as a result of the prior surgeries and prior to the accident at work. The injections were for impingement syndrome and were to help the joint move more freely, without tightness.

On cross-examination, Petitioner testified his supervisor on the date of accident was Jeff, but he could not remember his last name. Jeff was in the building and Petitioner reported the accident to him. Jeff told him to finish out the day and see if the injury would be better the next day. He worked another four hours, until the end of day. He returned to work the following day and filled out an accident report. He testified he later got a text message telling him they no longer needed him since he was hurt and that he should report back to Extra Help.

Petitioner agreed with Respondent's characterization that he had a long history of bilateral shoulder complaints, dating back to April 2007. On April 19, 2007, he reported a history of right arm weakness, neck pain, and right shoulder pain. An MRI of the right shoulder revealed a supraspinatus tear and impingement of the AC joint. Petitioner agreed he had completed a patient questionnaire in Dr. Brown's office on February 26, 2009, and indicated he had pain that was sharp and throbbing. He agreed he completed another patient questionnaire in October 2009 and indicated there was burning and aching in the right shoulder. He acknowledged he had surgeries in in 2009 and 2010 for right shoulder decompression and rotator cuff repair, and that he had received cortisone injections about every six months since then.

Petitioner acknowledged that on August 9, 2011, he reported clicking and pain over the right shoulder, and that on January 4, 2012, he reported weakness in the right arm after shoveling crushed corncobs into a horse stall. He testified that Dr. Brown diagnosed a degenerative right shoulder at that time, which had become a chronic condition. Petitioner acknowledged that on November 28, 2012, he reported pain, popping, and a catching sensation in both shoulders. On April 14, 2013, his pain got so bad he reported he was unable to perform any of his daily routine activities.

Petitioner acknowledged that he had a history of elbow and hand complaints, and that he had cubital tunnel and carpal tunnel surgeries to correct those. He testified he had left elbow complaints a couple of weeks after he turned in the accident report for this case. He reported this to the company doctor and was told he had tendonitis because he was overusing his left arm to compensate for his right arm. Petitioner did not know why there would not be any reference to his left elbow in the company doctor's notes, as he was told by Respondent to clock out and go to the company doctor for his complaints.

Petitioner testified that following the MRI he recalled Dr. Brown telling him he had an acute tear of the rotator cuff. Dr. Brown released him from care for the accident on October 20, 2015. Petitioner testified that since that time he had tried to do things, such as play catch with his kids or use a lawnmower, but that his arm would get weak and he would quit. Respondent's counsel asked Petitioner if he would dispute surveillance footage of him pushing a lawnmower on July 3, 2015, and Petitioner testified he would not, as he did attempt to do things.

Following his accident, Petitioner sought treatment with Dr. Mark Smith at WorkCare on June 12, 2015. He reported that on June 8, 2015, he was lifting 75 pound concrete bags and transferring them onto pallets when he felt a pop and then a burning sensation in his right shoulder. He complained of pain in the right upper extremity from the shoulder blade to the chest and rated his pain at 10/10. He reported he had been off work the rest of the week due to a slow down at work. He had been at the job for a month, and prior to that he was a stay-at-home dad to two sets of twins. He reported no weakness. On examination, there was no bruising, no effusion, and no swelling. Range of motion was normal, with pain, and there was pain to palpation over the anterior wall of the axilla. Dr. Smith diagnosed a shoulder strain and recommended Petitioner be on light duty with restrictions of no carrying or lifting over 10 pounds, no repetitive lifting, no overhead work, no pushing or pulling over 25 pounds, no vibrational work, and no work longer than 8 hours a day. Dr. Smith ordered physical therapy and follow up for three weeks. PX1.

Petitioner participated in physical therapy at Nova Care on June 16, 18, 23, 25, 30, and July 2, 2015. He continued to complain of pain, increased with activity. PX2.

On June 18, 2015, a First Report of Injury was completed by Respondent, which noted a history of accident consistent with Petitioner's testimony. RX2.

On July 1, 2015, Petitioner underwent a right shoulder MRI which revealed (1) mild to moderate tendinopathy of the supraspinatus with partial thickness tear of the rotator cuff; (2) fluid in the subacromial/subdeltoid bursa, suggesting bursitis; and (3) fatty replacement of the teres minor muscle, suggesting quadrilateral space syndrome. PX1.

Respondent entered into evidence copies of two still photos of Petitioner taken by GCS Investigative Services on July 3, 2015. The pictures are time stamped at 11:19:38 a.m. and 12:28:21 p.m. The earlier picture depicts Petitioner standing on the ground with another person standing in the bed of a truck, handing something to Petitioner. It is unclear what the item is, but Petitioner's right arm is shown extended out and elevated up to about the level of the top of his head. The later picture depicts Petitioner pushing a push lawnmower with both arms extended in front of him. RX3.

On July 7, 2015, Petitioner returned to WorkCare and was examined by Nurse Practitioner Dena Kommer. He continued to complain of pain in the right shoulder and underneath the shoulder and rated his pain at 8/10. His MRI results were discussed and he was referred to Dr. Treg Brown at his request. PX1.

On July 9, 2015, Petitioner presented to Dr. Treg Brown of The Orthopedic Institute of Southern Illinois. He completed a patient intake form and reported a consistent history of the accident on the form and to Dr. Brown. Dr. Brown noted prior surgeries as rotator cuff repair on October 1, 2010, and subacromial decompression in 2009. Examination revealed popping with palpation over the greater tuberosity on passive range of motion, positive impingement sign, weakness of the supraspinatus, positive Speed's test, negative O'Brien's test, and no AC joint tenderness. PX3, RX1.

On July 23, 2015, Petitioner underwent a limited diagnostic ultrasound of the breast and right shoulder. It reviewed intrasubstance partial-thickness supraspinatus tendon tear. RX1.

Petitioner returned to Dr. Brown on July 30, 2015, with continued complaint of right shoulder pain. Dr. Brown reviewed the MRI and ultrasound and his impression was tendinopathy that would improve with time and therapy. He noted Petitioner should consider a vocational change, as he had had multiple surgeries on multiple joints over the past several years and did not seem to be able to tolerate heavy or repetitive type lifting. He was to continue in therapy and transition to work conditioning. PX3, RX1.

On August 18, 2015, Petitioner followed up with Dr. Brown and reported continued pain with no improvement. On examination, he had 3/3 impingement signs and weakness in the supraspinatus. Dr. Brown's impression was bursitis of the rotator cuff and persistent tendinopathy. He recommended a subacromial cortisone injection and discontinuance of therapy. PX3, RX1.

On August 19, 2015, Petitioner returned to Dr. Brown for "follow up of a left lateral - epicondylitis". He reported his symptoms had been exacerbated "due to work-related issues", but gave no further details. He stated the numbness and tingling he was previously having in the left upper extremity were resolved. Dr. Brown administered a corticosteroid injection of the left elbow. On August 27, 2015, Petitioner presented to Dr. Richard Morgan, also of The Orthopedic Institute, for unrelated right knee pain. Dr. Morgan recommended arthrotomy and lateral capsular window of the right knee. Petitioner returned to Dr. Brown on September 1, 2015, for unrelated left lateral epicondylitis. PX3.

On September 15, 2015, Petitioner was again seen by Dr. Brown for his right shoulder. He continued to report pain and a feeling of heaviness of his arm. On examination, he had tenderness in the lat and trapezius regions. Dr. Brown's impression was referred pain in the lat/trap region from either the thoracic or scapular region. He did not believe Petitioner's symptoms were necessarily rotator cuff related. He recommended additional physical therapy and work restrictions of 25 to 30 pounds lifting, no overhead and no repetitive chest high activity. PX3, RX1.

On October 20, 2015, Dr. Treg completed a "Work Status and Restrictions" form, noting Petitioner was MMI, could work without restrictions, and was released from care. RX1.

Respondent entered into evidence medical records from Dr. Brown which pre-date the work accident of June 8, 2015, and which are hereby addressed in reverse chronological order. Petitioner was seen on January 21, 2015, with complaint of bilateral shoulder pain. It was noted he had surgery in 2010 for repair of partial thickness rotator cuff tear on the right, and another surgery in 2010 for repair of partial thickness rotator cuff tear on the left. Dr. Brown noted Petitioner had failed to improve significantly and still continued to struggle with bilateral shoulder pain, and believed his symptoms were chronic and would likely not improve. RX1.

On September 16, 2014, Petitioner presented to Dr. Brown for bilateral shoulder pain which he stated was chronic and had been going on for several years. On the patient intake form,

Petitioner characterized his pain as achy and burning and noted he had associated fatigue and numbness. It was noted he had no new injury. Dr. Brown noted he was previously diagnosed with an impingement syndrome and underwent surgery on both shoulders without significant relief. Petitioner reported difficulty with overhead activity and with pushing, pulling, and lifting. He was diagnosed with chronic bilateral impingement syndrome, which was unlikely to improve. Dr. Brown administered a steroid injection for symptom relief. RX1.

Petitioner was seen by Dr. Brown on September 4, 2013, for bilateral shoulder pain, which he had previously had. He reported some stiffness and soreness, which he related to working with horses again, and which started one month prior. The pain was worse overhead and better at rest. Petitioner reported he had been treating it with stretching exercises and ibuprofen, without relief. The diagnosis was bilateral impingement syndrome and Petitioner underwent an injection into each subacromial subdeltoid space. On April 24, 2013, Petitioner presented with continued complaints of right shoulder pain and no relief since the last visit. He was concerned that he was unable to perform many of his normal routine activities. Dr. Brown's diagnosis was possible proximal biceps tendinitis, and he administered an intraarticular injection. On March 6, 2013, Petitioner was seen for pain and weakness of the right shoulder. On February 28, 2013, he underwent injection of the right biceps tendon sheath for bicipital tendonitis. RX1.

On December 11, 2012, he reported mild pain and difficulty with reaching overhead or behind his back. The diagnosis was mild biceps tendonitis. On November 30, 2012, an MRI of the right shoulder revealed tendinopathy of the supraspinatus and to a lesser degree of the infraspinatus with no tear, tendinopathy of the long head of the biceps with a subtle partial tear possible, and small amount of fluid in the subacromial/subdeltoid bursa suggesting bursitis. On November 28, 2012, Petitioner presented with pain, popping, and catching in the right shoulder. He had been doing fairly well and had returned to more normal activities, but reported he had a setback a few weeks prior. He was unaware of any injury. He stated he no longer dealt with horses and thought he had been improving secondary to his decreased activity. Dr. Brown's impression was rotator cuff tear. RX1.

On May 30, 2012, Petitioner was seen by Nurse Practitioner Natalie Phelps for an updated examination prior to diagnostic facet injection. He had complaints of pain in both shoulders, both arms, and the neck. He was cleared for the injection. On May 19, 2012, Petitioner was seen by Dr. Michael Hammer with complaints of pain in the right arm, neck, and left arm, which was noted to be chronic. Treatment plan included diagnostic facet block injection/medial branch nerve block for the cervical spine. RX1.

On February 8, 2012, Petitioner presented to Dr. Brown following a cervical MRI. He reported his symptoms were better and he got relief from his shoulder pain with the injection. He continued to complain of bilateral numbness and tingling with overhead activities and reaching. Impression was degenerative cervical spine and he was referred to Dr. Juergens for possible injections. He was released on an as needed basis for his shoulder. On January 4, 2012, Petitioner presented to Dr. Brown for follow up of right shoulder pain and reported he had quite a bit of problems. He had shoveled about 1000 pounds of crushed corn cobs into a horse stall and noticed weakness in both shoulders. He reported both hands would go numb at times, especially at night, which he related to having bad shoulders. He also complained of popping

and catching in the right shoulder. Impression was degenerative right shoulder and probably cervical disc disease. He underwent an injection into the right shoulder joint. RX1.

Medical records from Dr. Brown's office were reviewed from 2007 through 2011, throughout which Petitioner complained of and underwent treatment for right shoulder problems. Treatment consisted of injections, arthroscopic repair of partial thickness rotator cuff tear, and subacromial decompression. RX1.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After review of the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows.

The parties stipulated that Petitioner sustained an accident which arose out of and in the course of his employment on June 8, 2015, and that he injured his right shoulder as a result of the accident. The parties further stipulated that Respondent has paid or will pay for medical treatment related to the right shoulder, as outlined in Petitioner's Exhibit 5.

In support of the Arbitrator's decision relating to issue (L), the nature and extent of Petitioner's injury, the Arbitrator finds the following:

With regard to the nature and extent of disability, for accidents occurring after September 1, 2011, pursuant to Section 8.1b of the Act, in determining the level of permanent partial disability the Arbitrator must look at the following five factors.

In regard to factor **(i) the reported level of impairment pursuant to Subsection (a)**, although this accident was after the effective date of Section 8.1b of the Act, neither party offered into evidence a reported level of impairment pursuant to subsection (a). As such, the Arbitrator gives no weight to this factor.

In regard to factor **(ii) the occupation of the injured employee**, the record reveals Petitioner was employed as a temporary general laborer at the time of the accident and that he was released to return to work in his prior capacity without restrictions as a result of said injury. Petitioner testified he did not return to the same temporary assignment, as the client indicated they did not need him anymore due to his injury. The record further reveals that Petitioner appears to have a varied work history, including previously working with horses. There is no indication that he had a long work history in any particular occupation. The Arbitrator notes that Dr. Brown recommended Petitioner consider a vocational change, "as he has had multiple surgeries on multiple joints over the past several years and never seems to be able to tolerate heavy or repetitive type of lifting". The Arbitrator gives some weight to this factor.

In regard to factor **(iii) the age of the employee at the time of the injury**, Petitioner was 40 years old at the time of the accident. He was released to return to his laborer position without restrictions. Given his age, he will have to work with the ill effects of his injury for a substantial number of years. However, the record is clear that Petitioner's multitude of prior problems and

surgeries, including to his right shoulder, contribute more substantial ill effects than this particular work accident does. There was no evidence offered to indicate with any degree of likelihood how Petitioner's age would impact his disability, and the Arbitrator does not speculate as to same. The Arbitrator gives some weight to this factor.

In regard to factor **(iv) the employee's future earning capacity,** Petitioner was released to return to his prior position full duty, with no restrictions. Neither party offered any evidence to show that Petitioner's future earning capacity has been impacted, and the Arbitrator has no basis to expect he will have any decreased earning capacity in the future as a result of this accident. The Arbitrator places little weight on this factor.

In regard to factor **(v) evidence of disability corroborated by the treating medical records,** the medical records document Petitioner's complaints of pain and limitations throughout his treatment. However, the Arbitrator notes that Petitioner's extensive right shoulder complaints prior to the work injury are nearly identical to his current complaints, symptoms, and disability. His treatment before and after the accident are likewise nearly identical, that being injections, therapy, and temporary limitations on activity. In addition, the Arbitrator finds it significant that Petitioner treated for a total of only four months following the accident. The Arbitrator places significant weight on the entire medical record as a whole.

The Arbitrator notes that consideration of the factors enumerated in Section 8.1b does not simply require a calculation, but rather a measured evaluation of all five factors, of which no single factor is the sole determinant on the issue of permanency. Taking the above five factors into consideration, and based on the record in its entirety, the Arbitrator finds that with respect to Petitioner's right shoulder, he has sustained a 1% loss of use of the person as a whole (5 weeks) pursuant to Section 8(d)2 of the Act. The parties stipulated that Petitioner's average weekly wage was $400.00. As explained in more detail below, the Arbitrator finds that Petitioner's permanent partial disability rate is $330.00, the statutory minimum rate in effect at the time of his accident with four or more dependents.

In support of the Arbitrator's decision relating to issue (O), the number of dependents for Petitioner, the Arbitrator finds the following:

The Arbitrator finds that Petitioner has four dependents. In so concluding, the Arbitrator notes there are no inconsistencies in the record with regard to the number of children Petitioner has. He testified he has four sons, two sets of twins, ages 10 and 12. The Employer's Report of Injury completed by Respondent on June 18, 2015, lists Petitioner as having four dependents. Dr. Smith's record of June 12, 2015, noted Petitioner had worked at his current job for a month and that before that he was a stay-at-home dad to two sets of twins. Respondent presented no evidence to rebut the consistent record and has no basis for disputing same.

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

Janet Kroeschel,
Petitioner,

vs.

NO: 15 WC 22310

Carlinville CUSD #1,
Respondent,

17IWCC0198

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 9, 2016 is hereby affirmed and adopted.

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

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

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

DATED: APR 3 – 2017

Kevin W. Lamborn

Stephen J. Mathis

David L. Gore

KL/mas
o:3/9/17
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KROESCHEL, JANET
Employee/Petitioner

Case# **15WC022310**

17IWCC0198

CARLINVILLE CUSD #1
Employer/Respondent

On 8/9/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1539 DRUMMOND LAW OFFICE
PETER C DRUMMOND
703 W UNION SUITE 3 PO BOX 130
LITCHFIELD, IL 62056

0481 MACIOROWSKI SACKMAN & ULRICH
ROBERT MACIOROWSKI
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60603

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

Janet Kroeschel
Employee/Petitioner
v.
Carlinville CUSD #1
Employer/Respondent

Case # 15 WC 22310

17IWCC0198

An *Application for Adjustment 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 McCarthyy, Arbitrator of the Commission, in the city of Springfield, on July 21, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On February 19, 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 N/A given to Respondent.

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

In the year preceding the injury, Petitioner earned $21,918.00; the average weekly wage was $562.00.

On the date of accident, Petitioner was 50 years of age, single, with no dependent children under age 21.

Respondent is entitled to a credit of N/A.

ORDER

PETITIONER FAILED TO PROVE THAT SHE SUSTAINED ACCIDENTAL INJURIES ARISING OUT OF AND IN THE COURSE OF HER EMPLOYMENT.

CLAIM FOR COMPENSATION DENIED.

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

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

D. Dyan McCarty

8/5/2016

Signature of Arbitrator

Date

AUG - 9 2016

Janet Kroeschel v. Carlinville School District #1
15 WC 22310 D/A: 02/19/15

STATEMENT OF FACTS

The petitioner began her employment as a part-time Cook with Carlinville School District in September of 1995. Prior to that time, the petitioner was mainly a housewife. At the time she started working for Carlinville School District, she was 31 years of age.

In August of 2000, the petitioner became a full-time Head Cook. She testified that her job duties from August of 2000 through August of 2015 remained the same. She testified that after August of 2015, the job duties were not as hand intense.

The petitioner testified that her hours of employment as the Head Cook were from 6:30 a.m. to 2:30 p.m. She testified that there was a half hour for lunch and a 15-minute break. The lunch break was 9:30 to 10:00 and the 15-minute break was from 1:00 to 1:15 p.m. She testified that she worked five days a week during the school year and she would have off for holidays, Christmas breaks and other scheduled break periods. There was no overtime involved in her job. She testified that she was one of five people who worked in the kitchen.

The petitioner testified that in 2004, she was diagnosed as a diabetic.

The petitioner testified that she was 5'8" and weighed approximately 200 pounds, from 1995 through 2015. She testified that she recently lost weight and now weighed 185 pounds.

The petitioner testified that some time prior to receiving treatment for a left-hand/wrist injury, September 19, 2013, she did experience some numbness and tingling in the hands but could not give a date. There was no testimony as to what activities initially brought about those symptoms.

On September 19, 2013, the petitioner was seen in the emergency department of Jersey Community Hospital for an injury to the left hand and thumb when a freezer door closed on same. The impression was sprain injury. The petitioner underwent x-rays to the left wrist on September 19, 2013 and came under the care of Dr. John Palcheff. His assessment was sprain, left wrist.

Treatment was physical therapy. Treatment by Dr. Palcheff and Carlinville Hospital Physical Therapy continued.

On October 9, 2013, the petitioner complained of right wrist pain. Examination revealed the right wrist was tender on palpation and she continued with physical therapy. The petitioner at this time also started treating with a Dr. Mark Greene and on March 12, 2014, Dr. Green released her to return to her normal work activities without restrictions, with the exception that she wear thumb splints as needed.

The petitioner returned to Dr. Palcheff on April 14, 2014 indicating that her hands were getting worse instead of better. She had complaints of numbness and tingling.

The petitioner was seen by a Dr. Cecil Becker at Springfield Clinic on June 10, 2014 for complaints of pain and numbness in the hands. An EMG/NCV study was ordered and performed on June 20, 2014. The EMG was suggestive of severe median mononeuropathy at the right wrist (carpal tunnel syndrome), mild median mononeuropathy at left wrist (carpal tunnel syndrome) and mild ulnar mononeuropathy at the right elbow (cubital tunnel syndrome).

The petitioner was evaluated by Dr. David Fletcher on January 5, 2015 for the traumatic injury to the left hand and thumb. The petitioner did give Dr. Fletcher a history of sustaining the injury to the left hand and thumb, not both hands. Dr. Fletcher performed an examination on that date. The petitioner at the time of the examination was 5'7-1/2" tall, 201 pounds and was 50 years of age with a date of birth September 8, 1964. The petitioner at this time gave a history of a specific injury on September 19, 2013, when a freezer door injured her left hand and thumb. She gave a history of often dropping objects due to pain. Physical examination was performed. The impression was resolved left thumb/hand contusions, bilateral carpal tunnel syndrome, bilateral cubital tunnel syndrome and obesity. Dr. Fletcher opined that the petitioner recovered with no residual from her acute injury of September 19, 2013, and that the mechanism of that injury would not cause a bilateral nerve entrapment condition that developed months later. He identified her as having multiple risk factors for the development of nerve entrapment conditions, those being of middle age peri-menopausal female that was obese (31.5 BMI), and diabetic which are known risk factors for nerve entrapment conditions. The doctor noted that the condition was bilateral and not limited to the

injured left side. The indication was that she would benefit from nerve compression surgical procedures but those were not related to the injury in question.

The petitioner then came under the care of Dr. Mark Greatting. The records of Dr. Greatting were admitted into evidence and show that she was initially seen on January 12, 2015. At that time, she was noted to be 5'8", weighing 201.6 pounds (BMI 30.65). The petitioner was examined and the assessment was carpal tunnel syndrome, bilateral and cubital tunnel syndrome on the right. The recommendation was surgery.

Dr. Greatting on February 20, 2015 performed a right cubital tunnel release and a right carpal tunnel release for a pre- and post-operative diagnosis of right cubital tunnel syndrome, right carpal tunnel syndrome.

On April 3, 2015, Dr. Greatting performed a left carpal tunnel release and left cubital tunnel release.

The petitioner continued to follow with Dr. Greatting with no mention in his records of the condition being work related until he responded to a letter from Attorney Peter Drummond dated May 19, 2015, his response dated June 15, 2015.

The petitioner was released to return to work by Dr. Greatting, no restrictions, on August 17, 2015.

Thereafter, the petitioner was seen by Dr. Greatting on three occasions – September 21, 2015, November 2, 2015 and December 21, 2015. On December 21, 2015, the petitioner was still complaining of problems with her hands and for that reason an EMG was done November 5, 2015 that showed mild right carpal tunnel syndrome, which was significantly improved over previous study. She had mild left carpal tunnel syndrome which was basically unchanged from previous study. On December 21, 2015, she still complained to Dr. Greatting of some numbness in her hands and felt that she had weakness, but was working without restrictions and basically adapting and getting along.

On September 25, 2015, Dr. Fletcher went to Carlinville School District for purposes of performing a job site analysis on the petitioner's job as a Head Cook. He did have an opportunity to review a

written job description for Head Cook/Food Service, Carlinville Community School District #1 dated April 28, 2014. He set forth that job description in his report. He had an opportunity to discuss the petitioner's job with her supervisor and testified that he actually observed the petitioner over a 3-hour period, actually do her job and, in fact, perform some of the job duties himself. Dr. Fletcher wrote a very detailed report and opined that the job was not repetitive or forceful enough, with no exposure to vibration to cause the carpal tunnel or cubital condition. He testified that he was actually there on two separate occasions, the first being September 25, 2015 for period of three hours and the subsequent time period being the last Friday in September. In his report, Dr. Fletcher documented the petitioner's work schedule and breaks.

The deposition of Dr. David Fletcher was taken on March 22, 2016. Dr. Fletcher, in his deposition, testified to his qualifications as Board Certified in Occupational and Preventative Medicine. He testified to his initial evaluation of the petitioner on January 5, 2016, his review of the job description for Head Cook for April of 2014, his discussion with the petitioner's supervisor at the time of his visits in September of 2015 to the work site, and his observations and opinions as to lack of causal connection between the workplace and the petitioner's bilateral carpal tunnel and cubital tunnel conditions, and the basis for same. In his deposition, Dr. Fletcher identified the risk factors of diabetes, female gender, age, and obesity.

The deposition of Dr. Greatting was taken on March 28, 2016. Dr. Greatting testified to his initial evaluation of the petitioner on January 12, 2015, and the bilateral carpal tunnel and bilateral cubital tunnel releases, and his care and treatment through December 21, 2015. Dr. Greatting testified that he did not review any of the prior treatment records other than the EMG, and had no knowledge of the specifics of the petitioner's work activities other than the letter from Attorney Peter Drummond dated May 19, 2015, and his opinion as to causal connection by report dated June 5, 2016. Dr. Greatting in his deposition admitted that diabetes, female gender, age and obesity were risk factors in the development of nerve entrapment injuries. Dr. Greatting testified that the petitioner's work activities that she performed over many years were sufficiently forceful and repetitive enough to contribute to her nerve entrapments.

The petitioner testified to the care and treatment she received for the left hand and thumb injury. She testified that she began noticing numbness and tingling in her hands, providing the then-treating

physicians with the history and of undergoing an EMG on June 20, 2014 and then coming under the care of Dr. Mark Greatting who eventually performed surgery.

She testified that her work schedule was from 6:30 in the morning to 2:30 in the afternoon. She testified to a half-hour lunch break from 9:30 to 10:00, and a 15-minute break from 1:00 to 1:15. She testified that there were five employees in total who worked with her in the kitchen.

She testified that when she arrived in the morning at 6:30, she may have to unload the truck and take the supplies from the truck to a place to physically store, either on shelves or the freezer. She testified that this may take up to one-half hour of her time. She testified that she would then assist in the preparation of breakfast that went from 7:30 to 8:00 and that she would be required to physically stand from 7:30 to 8:00 to serve the students who were present for breakfast. She testified that in terms of the fruit and juices, they were canned or prepackaged and that someone else would put out the fruit and juices and she would be responsible for the hot items such as bagels. She testified that after breakfast, she would clean the trays with a hand sprayer and that she would also assist in washing the pots and pans. The testimony revealed that other workers would assist in cleaning the trays and the pots and pans with the petitioner's supervisor testifying that there was a specific employee who was responsible for cleaning the pots and pans.

After breakfast, the petitioner would then start preparing lunch with a lunch break herself from 9:30 to 10:00. She testified then to four different lunch periods, beginning at 10:40 that would last approximately one-half hour, and that she would be responsible, during these lunch breaks, to serve the hot main course or hot sides like macaroni and cheese.

She testified that in preparing meals, she would have to stir by hand soups or sauces, but was unable to give a specific time period in way of minutes as to how much time she spent stirring in the course of her day. Her supervisor, Kim McGuire, testified that the stirring would be maybe ten to fifteen minutes a day.

The petitioner testified that at times she had to work with her hands in meat with her supervisor, Kim McGuire, not recalling where she would have to physically handle meat with her hands. The petitioner testified that the handling of meat would not occur every day.

The petitioner testified that she did use a knife to chop onions or peppers. The petitioner's testimony was that "this may take ten to fifteen minutes a day, but it was not done on a daily basis." The petitioner's supervisor testified that when she chopped onions or peppers, it may be one onion or pepper for purposes of adding flavor to the sauces.

The petitioner testified that she would have to cut up 50 pounds of potatoes once a month with that taking an hour and a half on a Thursday and one-half hour on a Friday. The petitioner's supervisor testified that this would occur maybe once a month.

The petitioner testified that she would have to clean the trays that the students used to carry their food after breakfast and lunch and that this may take ten minutes in the morning and maybe another 20 minutes after lunch. The petitioner's supervisor testified that all employees use the hand sprayer and that there was no vibration involved.

The petitioner's testified that she prepared some meals from scratch, and provided several menus in support of her testimony. She said that prior to the 2015-2016 school year, she prepared more lunches from scratch than during that year. In preparing items from scratch, she said that she used her hands in a more repetitive manner. In terms of the activities she described she was responsible for, she testified that there was more stirring involved and more chopping. The stirring involved, prior to 2015, based on her testimony, was limited probably to 15 minutes and the chopping involved was also limited to probably no more than 15 minutes, with the exception of the days she chopped potatoes. The hand spraying of up to one-half hour appeared to be the same before and after 2015.

In reviewing the menus that were offered by the petitioner for 2014-2015, and 2015-2016, the Arbitrator notes as to breakfast in 2014-2015, on Friday she was responsible for, according to her, one-hand intense activity (gravy), and in 2015-2016, no hand-intense activities. In terms of lunch, she identified on each of the days of the week, some hand-intense activities wherein 2015-2016, there were some days where there were no hand-intense activities in her opinion. Again, the hand-intense activities would be the stirring or chopping which was limited to ten to fifteen minutes a day.

The Respondent submitted into evidence the number of meals served for breakfast and lunch from 2012 through 2015. The Arbitrator would note that the number of meals for breakfast and lunch increased from 2012 through 2015 and the number of meals served for breakfast and lunch actually increased from 2015 through 2016, meaning that the petitioner was actually serving more students after August 2015 than she did before August 2015.

The petitioner testified that she continues to have on-going numbness and tingling in her hands to include, by her testimony, and that of her daughter, problems holding a glass, using a straw to drink, problems doing laundry and problems holding the steering wheel of a car. The petitioner testified to no problems doing her work as a Cook other than the self-accommodations she is making in the way she carries the pots or the ways that she lifts items.

The petitioner's supervisor testified that she notices no current problems with the way the petitioner performs her work but that she has, on occasion, complained of loss of feeling in her hands.

Dr. Fletcher felt it was safe for the petitioner to return to work as a Cook and Dr. Greatting released the petitioner to return to work as a Cook with no restrictions.

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

AND

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

The Arbitrator finds the following:

The petitioner began her employment as a Cook in September of 1995 with the Respondent on a part-time basis. She became a full-time Cook in August of 2000.

The petitioner was diagnosed as being a diabetic in 2004. The petitioner between 2000 and 2015 weighed approximately 200 pounds.

The petitioner testified that when she had symptoms of numbness and tingling in both hands prior to 2013, but was unaware of exactly when. There were no medical records to show that she had treatment or documented symptoms prior to 2013.

The petitioner testified to a traumatic injury to her left hand and thumb on September 19, 2013 alleging that the injury was to both hands, with the records from the emergency room of Jersey Community Hospital indicating "left hand and thumb" and a history to Dr. Fletcher when she was examined on January 5, 2015 of "left hand and thumb." The petitioner initially complained of numbness and pain in the wrist in 2013 and of undergoing an EMG in June of 2014.

From 2000 through 2015, the petitioner worked as a Head Cook, Mondays through Fridays, from 6:30 in the morning to 2:30 in the afternoon, during the school year which lasted approximately nine months. The petitioner was off for holidays and Christmas and Easter breaks. She did not work any overtime.

The petitioner testified that the work she did as a Head Cook was similar from 2000 to 2015. The petitioner did that work for a period of approximately 13 years without any complaints to the wrist. During that period of time, the petitioner weighed 200 pounds, was a diabetic, was of female gender and was advancing in years of age.

The petitioner testified that her job duties were more hand-intense from 2000 through August of 2015, than they were in August of 2015 through present. She used a menu to identify what she felt to be more hand-intense activities with her testimony indicating that the more hand-intense activities would be the amount of time she would be required to stir soups or sauces or meat, the amount of time she would have to cut onions, peppers or potatoes, and the amount of time that she would have to use a hand sprayer. The amount of time that she would have to stir was unknown in terms of her testimony with the supervisor testifying ten to fifteen minutes. The amount of time that she would spend using a knife to chop would be ten to fifteen minutes, other than once a month, when she chopped potatoes that would take two hours. The amount of time that used the hand sprayer would be ten to thirty minutes with the supervisor testifying that all employees used the hand sprayer to clean off trays, and there was no vibration present. The petitioner testified that she would be required to use her hands to work with meat with the supervisor testifying that she was unaware of when the petitioner would use her hands to work with meat.

In reviewing the petitioner's work day, she worked seven hours and fifteen minutes if you exclude her break and lunch. There was a half-hour breakfast and four half-half lunch periods identified where she would have to stand behind the counter and serve the hot-food item or sides to the student. In reviewing the chart regarding the number of meals serves, there were more meals served in the calendar year of August, 2015 through May, 2016, than in the prior calendar years. The chart shows that if we were to assume a five-day work week in the 2012 school year, there was approximately 51 breakfasts served a day, and 199 lunches, and that in the calendar year 2014-15 there were approximately 64 breakfasts served, and 301 lunches, and in the calendar year 2015-16 there were 59 breakfasts served and 307 lunches served a day. The Arbitrator would note that there were actually more breakfasts and lunches served in the school year of 2015-16 than in prior school years. The Arbitrator would note that the petitioner identified, at most, thirty minutes of using the hand sprayer a day, thirty minutes to unload the truck; and that out of the eight-hour work day, the break, lunch, stirring, chopping, spraying, serving lunch, and unloading the truck accounts for 4.25 hours of her day with the remaining time being spent either sweeping or mopping on alternate days, washing pots or pans which the supervisor testified that was designated to another person, or merely walking to and from a place in the kitchen to place the pre-prepared items in the oven, or perform other activities were walking back and forth for the items she was taking from the freezer or the shelves for the various food items.

Dr. Fletcher identified as risk factors her age, female gender, diabetes and obesity (BMI), as risk factors, ruling out her job as being repetitive or forceful enough to cause the nerve entrapment injuries. Dr. Greatting agreed that diabetes was a risk factor along with her female gender, age and obesity.

Dr. Greatting, in giving an opinion as to causal connection, admitted that he did not review any of the prior treatment records, did not review a job description, did not go to the work site and had no knowledge of the petitioner's work activities until Attorney Drummond's letter of May 19, 2015. Dr. Greatting admitted that he was not familiar with the repetition or force involved in the petitioner's job. He released the petitioner back to the same job without restrictions.

In reviewing the letter of May 19, 2015 from Attorney Drummond to Dr. Greatting, he contained in that letter the fact that the petitioner had to mix with her hands up to 120 pounds of beef at one time, had to use slicers and peelers, serve 700 people at lunch each day, and had to use a large paddle to stir pots, and was exposed to vibration. The Arbitrator would note that there is no evidence offered as to her having to work with 120 pounds of beef at one time; there is no evidence of her using a slicer, no evidence of her using a peeler, no evidence of her ever serving 700 people at a time, and no specific information as to the degree of vibration or the repetition of her job other than to indicate that it was repetitive and intense. The Arbitrator also notes that the petitioner's testimony concerning the repetition and force used in her job duties differs significantly from the information she provided to Dr. Green on December 18, 2013. Dr. Green was the orthopedic specialist to whom the petitioner was referred after her specific accident in September 2013. In her description of work activities, the petitioner wrote that she lifts and carries several pans on a daily basis and puts away 20 to 40 cases of food two times a week. (PX 3)

In looking at the opinion of Dr. Fletcher, he had the opportunity to review a job description from 2014, he had the opportunity to discuss the petitioner's job duties with the petitioner's supervisor, he had the opportunity to actually go out to the job site and observe the petitioner do her job and he had the opportunity to actually perform some elements of the petitioner's job. He identified as known risk

factors the petitioner's female gender, age, obesity and diabetes. He, too, like Dr. Greatting, felt that it was safe for the petitioner to return to work as a Cook.

As to the issues of accident and causal connection, the only documented difference in terms of time periods that the Arbitrator can rely on in terms of the petitioner's job duties were that there may have been more stirring, chopping and hand use prior to 2015 but to what degree is unknown, other than there were more items on the menu where she claimed her activities were hand intense. The Arbitrator would note that in 2015-16, there were actually more meals served than in the years prior. The Arbitrator would note that there are five people in total that work in the kitchen with the petitioner and that there was one person in particular who had the responsibility to clean the pots and pans.

The Arbitrator would note that from 2000 through 2013, the petitioner basically did the same thing in terms of work activities per her testimony and that during that period of time, she had no symptoms of numbness and tingling. The Arbitrator would note that during that period of time, she was advancing in age which is a risk factor. The Arbitrator would note that all physicians who testify identified the risk factor of age, female gender, diabetes and obesity.

The Arbitrator would find that the petitioner failed to prove that she sustained accidental injuries arising out of and in the course of her employment given the identified risk factors and the lack of any true repetition or force in her job with her job duties being varied and not the same over and over. The Arbitrator finds Dr. Fletcher's testimony to be more credible than that of Dr. Greatting. He clearly had a better understanding of the Petitioner's job duties, and his opinion that her job involved no high frequency with high force, no awkward hand or wrist positions and that she did a variety of tasks throughout the work day was supported by the evidence submitted at arbitration.

The petitioner's claim for compensation is denied. All other issues become moot.

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

Charles Reavis,
Petitioner,

vs.

NO: 15WC 26597

Windy City Drilling,
Respondent,

17IWCC0209

DECISION AND OPINION ON REVIEW

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

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

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: APR 6 - 2017
o033017
SM/jrc
044

Stephen J. Mathis
Stephen Mathis

David L. Gore
David L. Gore

Deborah L. Simpson
Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

REAVIS, CHARLES
Employee/Petitioner

Case# **15WC026597**

WINDY CITY DRILLING
Employer/Respondent

17IWCC0209

On 11/7/2016, 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:

0365 BRIAN J McMANUS & ASSOC, LTD
30 N LASALLE ST
SUITE 2126
CHICAGO, IL 60602

5265 WOLF LAW LTD
ZAINAB A MEHKERI
25 E WASHINGTON ST SUITE 801
CHICAGO, IL 60602

17IWCC0209

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
CORRECTED ARBITRATION DECISION

Charles Reavis
Employee/Petitioner

v.

Windy City Drilling
Employer/Respondent

Case # 15 WC 26597

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 **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Waukegan**, on **September 28, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **January 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*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$96,994.04**; the average weekly wage was **$1,865.27**.

On the date of accident, Petitioner was **40** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$33,572.58** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$33,572.58**.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $735.37/week for 41 weeks, because the injuries sustained caused the 20% loss of the Right Hand, as provided in Section 8(e) of the Act. Respondent shall be given credit for $1,774.25 against the permanent partial disability awarded herein for an overpayment of TTD benefits paid.

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

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

Signature of Arbitrator

October 31, 2016
Date

NOV 7 - 2016

Statement of Facts

Petitioner Charles Reavis testified that on January 17, 2015, he was employed by Respondent Windy City Drilling as a heavy equipment operator. He was a member of Local 150 of the Operating Engineers Union. Respondent's business is drilling the shafts for hydraulic elevators. On January 17, 2015 he was trying to get a hydraulic jack out of a hole in the ground when a cable broke and hit his hand.

Petitioner testified he was taken by ambulance to Lake Forest Hospital emergency room. The records of Lake Forest note Petitioner was seen on January 17, 2015 for a traumatic thumb injury. X-rays of the right thumb found a severely comminuted and displace fracture of the base of the proximal phalanx of the first digit with intra-articular extension (PX 1).

Petitioner testified he saw Dr. Murphy in Joliet who referred him to Dr. Cohen. Dr. Murphy's records document an office visit on January 19, 2015 for a closed fracture of the proximal phalanx (PX 5). A CT scan of the right hand performed January 19, 2015 found a markedly comminuted fracture involving the majority or the proximal phalanx of the thumb with complete disruption of the entire articular surface at the metacarpal phalangeal joint and a non displaced longitudinal fracture base of the first metacarpal bone (PX 2). Petitioner was seen by Dr. Cohen on January 21, 2015. His examination noted the laceration and deformity of the thumb. He noted the extensively comminuted fracture. There was no motion in the IP joint. Dr. Cohen stated there was significant damage to the extensor mechanism in addition to the fracture. He notes Petitioner was very close to losing the thumb. He discussed surgical options including the possibility of multiple surgeries and loss of function (PX 2).

Petitioner underwent surgery on January 21, 2015. The surgery consisted of an open fracture dislocation with debridement, open reduction and internal fixation of the proximal phalanx shaft fractures as well as intra-articular extensively comminuted fracture dislocation of the MP joint and repair of the APL and EPB tendons. The operative report notes that there was significant missing bone. The head of the metacarpal was in reasonable shape but the articular surface of the proximal phalanx had significant damage including missing pieces. K wires were used rather than plate and screws to avoid further devitalizing the remaining soft tissue (PX 3).

Petitioner had post operative care by Dr. Cohen. He was taken off of work unless work with no use of the right hand was available beginning January 26, 2015. Dr. Cohen removed the pins on March 17, 2015. X-rays showed continued healing. Petitioner was kept in a thumb spica cast. On April 28, 2015, Dr. Cohen notes some progress with motion at the MP and IP joints. He states that they will get him set up with therapy (PX 2). Petitioner had therapy at Midwest Hand Care beginning May 6, 2015 (PX 4). On June17, 2015, Dr. Cohen notes some collapse and angulation at the proximal end of the proximal phalanx causing significant angulation just distal to the articular fragment. Petitioner is still having pain. Petitioner was allowed to work with a 10 pound restriction and use of the splint as needed (PX 2). Petitioner was discharged from therapy on July 13, 2015. The note indicates he had reached a plateau. His right grip strength was less on his dominant right hand than the opposite left side. He complained of difficulty using his thumb to turn a key. The discharge note states that thumb IP motion remains extremely limited and hinders functional pinch. There is pain in the MCP joint intermittently with resistive pinching, heavier hand use and vibratory tools (PX 4). On July 15, 2015, Dr. Cohen notes Petitioner is not reporting any pain and has surprisingly good range of motion in the thumb. There is no pain with stressing the thumb, good stability. Petitioner was released to return to his full duty. He was to use his splint as needed. Petitioner saw Dr. Cohen on August 11, 2015. The notes record some pain at the MP

joint with good stability. There is minimal motion at the IP joint related to scar tissue. Dr. Cohen discussed options including therapy or surgery, including possible fusion of the MP joint.

Petitioner had additional therapy at ATI from March 21, 2016 through May 11, 2011. The discharge summary notes continued loss of strength in the right hand although improvements in range of motion and strength are documented. Petitioner was able to work his full duty regular job (PX 6). On May 25, 2016, Dr. Cohen saw Petitioner for a follow up after physical therapy. He records that the complaints of pain are resolved. There is no numbness or tingling. The record documents that Petitioner is back to his normal job activities without difficulty. He has occasional aching, but is otherwise asymptomatic other than decreased range of motion and moderate decreased strength. Petitioner was discharged to be seen as needed (RX 1).

Petitioner testified that he is doing his regular job, but it is more difficult. It is hard to hold items and he does not have the strength to turn bolts and nuts with a wrench. He testified he used his left hand. Petitioner testified he no longer plays softball. He has trouble holding the bat.

Petitioner demonstrated a scar on the back of his thumb from the IP joint to the MP joint. He demonstrated no motion in the IP joint. He cannot make a fist with the thumb inside the fingers. He can move the thumb to the base of the web between the index and middle finger on the right hand. His right thumb is between ¼" and ½" shorter.

Conclusions of Law

In support of the Arbitrator's decision with respect to (L) Nature and Extent, the Arbitrator finds as follows:

Petitioner's date of accident is after September 1, 2011 and therefore the provisions of Section 8.1b of the Act apply to the determination of partial permanent disability.

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a union heavy equipment operator at the time of the accident and that he is able to return to work in his prior capacity as a result of said injury. The Arbitrator notes Petitioner's job is considered in the medium/heavy physical demand level. He testified he is required to use hand tools which he finds difficult. Because of these facts, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 40 years old at the time of the accident. Petitioner is a younger individual and will likely be in the workforce performing physical activity for at least 20-25 years. Because of this, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner has returned to his regular work as an operating engineer. He is a member of the Operating Engineers Union. Petitioner's earning and job are protected by the union agreements. Because of these facts, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the initial x-rays and CT scan confirm severe comminuted fractures of the proximal phalanx of the thumb with displacement of the articular fragment at the MCP joint. The CT scan also notes a nondisplaced linear fracture of the metacarpal bone that extends to the first carpal metacarpal joint. Dr. Cohen stated there was significant damage to the extensor mechanism in addition to the fracture. He notes Petitioner was very close to losing the thumb. Petitioner underwent surgery on January 21, 2015 consisting of an open fracture dislocation with debridement, open reduction and internal fixation of the proximal phalanx shaft fractures as well as intra-articular extensively comminuted fracture dislocation of the MP joint and repair of the APL and EPB tendons. The operative report notes that there was significant missing bone. The head of the metacarpal was in reasonable shape but the articular surface of the proximal phalanx had significant damage including missing pieces. The physical therapy discharge note indicates right grip strength was less on his dominant right hand than the opposite left side. The discharge note states that thumb IP motion remains extremely limited and hinders functional pinch. There is pain in the MCP joint intermittently with resistive pinching, heavier hand use and vibratory tools. On August 11, 2015, Dr. Cohen discussed options including therapy or surgery, including possible fusion of the MP joint. On May 25, 2016, Dr. Cohen records that the complaints of pain are resolved. There is no numbness or tingling. He has occasional aching, but is otherwise asymptomatic other than decreased range of motion and moderate decreased strength. Petitioner demonstrated a scar on the back of his thumb from the IP joint to the MP joint. He demonstrated no motion in the IP joint. He cannot make a fist with the thumb inside the fingers. He can move the thumb to the base of the web between the index and middle finger on the right hand. His right thumb is between ¼" and ½" shorter. Because of these facts and findings, the Arbitrator therefore gives greater weight to this factor.

Although Petitioner's primary injury and treatment were to the right thumb, and the most significant disability is the loss of motion in the thumb IP joint and shortening of the thumb itself, Petitioner's CT scan also documented a nondisplaced linear fracture of the metacarpal bone that extends to the first carpal metacarpal joint and Petitioner has loss of grip strength in the right hand at his final examination by Dr. Cohen on May 25, 2016. Petitioner also testified to difficulty with the use of tools in his right hand and demonstrated an inability to make a fist. Based upon this evidence, the Arbitrator finds that this matter is more properly evaluated as a loss of use of the hand rather than the thumb.

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) of the Act.

In support of the Arbitrator's decision with respect to (N) Credit, the Arbitrator finds as follows:

The parties stipulated to an average weekly wage of $1865.27 per week. They further stipulated that Petitioner was entitled to 25 4/7 weeks of temporary total disability for the period from January 18, 2015 through July 17, 2015 and that Respondent had paid total benefits of $33,572.58. Based upon the average weekly wage agreed, Petitioner's temporary total disability rate is $1,243.51 per week and total benefits owing are $31,798.33. Respondent is therefore entitled to a credit for an overpayment of $1,774.25 against the permanent partial disability awarded herein.

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

John Bumphus,
Petitioner,
vs.

NO: 15WC 27577

17IWCC0240

Unique Personnel Consultants,
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, temporary total disability, medical, average weekley wage, permanent partial 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 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.

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: APR 19 2017

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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MJB/jrc
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BUMPHUS, JOHN
Employee/Petitioner

Case# **15WC027577**

UNIQUE PERSONNEL CONSULTANTS
Employer/Respondent

17IWCC0240

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:

0000 BUMPHUS, JOHN
221 S MYRTLE
EDWARDSVILLE, IL 62025-1510

2795 HENNESSY & ROACH PC
JENNIFER YATES WELLER
415 N 10TH ST SUITE 200
ST LOUIS, MO 63101

17IWCC0240

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

John Bumphus
Employee/Petitioner

v.

UniQue Personnel Consultants
Employer/Respondent

Case # **15** WC **27577**

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 23, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

On **July 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.

On the date of accident, Petitioner was **61** years of age, ***single*** with **0** dependent children.

17IWCC0240

ORDER

Petitioner failed to prove that he sustained an accident that arose out of and in the course of his employment with Respondent and, as such, all benefits are denied. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

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

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

Melinda M. Price-Sullivan

Signature of Arbitrator

4/19/16

Date

ICArbDec p. 2

APR 25 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

John Bumphus
Employee/Petitioner

Case # 15 WC 27577

v.

Consolidated cases: N/A

UniQue Personnel Consultants
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that on July 17, 2015 he sustained an injury to his psyche due to being denied a reasonable accommodation. He testified that on his first day of employment with Respondent which was June 21st at the Yazaki plant, he was working on the rework table, that there was one particular component which was large and awkward and that he felt pain in his lower back. He testified that he went to Dana Felton, his supervisor, and told her that if his table was going slow, it was because of a rod and two pins in his back that were causing pain when he was lifting.

Petitioner testified that for the next nine days he continued on the third shift working the rework tables and that after the ninth day he was promoted from a line table rework operator to line product coordinator ("LPC") which had the responsibility of supervising the tables. He testified that he worked a week as an LPC on the third shift at Yazaki, and that as he began to prepare to work the fourth week he was at the Yazaki plant he could not get into the warehouse. He testified that he called Ms. Felton to find out if a problem. He testified that he learned that the third shift had been disbanded and that he had to choose between a second shift transfer or a first shift transfer. He testified that he wanted to know if his pay rate would remain the same and learned that it would be reduced to a $10.00 an hour position for first shift or to a $10.25 position for the second shift, so he decided to take the second shift appointment.

Petitioner testified that on July 13th he worked as an LPC at Yazaki, and that after auditing and supervising the production of that table for his shift he came to understand that there was mandatory overtime. He testified that up until that time he had never been made aware of any mandatory overtime, but he worked for about 1-1.5 hours, again experienced pain in his back and indicated that he could not go any further and was going to leave.

Petitioner testified that after not being able to contact Ms. Felton the next morning on July 14th, he contacted his employer's Glen Carbon office and spoke to a phone receptionist named "Jamie" about his lower back pain, the mandatory overtime, and the situation about his leaving due the night before. He testified that he was then referred to Krista Findley, to whom he relayed the same issues. He testified that he thought they had resolved the issue and that he was pleased.

Petitioner testified that he continued to work that week as an LPC, and that he stayed after work on Tuesday, July 14th and Wednesday, July 15th, to make sure that his auditing paperwork was ready for presentation to Yazaki. He testified that on Thursday at the end of shift it was discovered that a component at one of the two tables he was supervising was lost or was placed wrongly into another box,

so he worked overtime to find the lost part. He testified that as he was about to leave, the same "conflict" which had arisen on Monday came up again.

Petitioner testified that on the morning of July 17th he went to the Glen Carbon office and wanted to find out about his reasonable accommodation which he thought he had received on July 14th. He testified that he got the impression that there was doubt about his having a rod and two pins in his back, so he offered to get medical evidence. He testified that he went to his primary care physician, Dr. Yablonsky, and obtained the medical documentation which described the rod and two pins in his back. He testified that his documentation was not accepted as being pertinent to the establishment of his reasonable accommodation, so he then began to feel flustered. He testified that he has "post-traumatic disorder" and had written a book about it, so he went to the trunk of his car and pulled out a copy of his book which described his being treated as a disabled person at Wellspring Resources. He testified that he was told to get different medical documentation and that unless he came up with this documentation, his employment would no longer be considered. He testified that he was offered no reason why his position was taken from him.

Petitioner testified that on July 23rd he brought the requested letter on the doctor's stationery to that same office and still had not been offered any employment or reasonable accommodation. He testified that on July 28th he presented a letter of concern that described the interactions, and that on August 6th after hearing nothing he went to the EEOC and filed a charge of discrimination. He testified that on August 14th he wrote a letter to the workers' compensation corporate specialist for his employer, David Scheibel, letting him know that he had tried wrongly to deliver a written note for notice of his injury and that he did not feel that he received any help with filing his claim from anyone at the office. He testified that on August 18th he spoke with his employer's insurance provider representative, Cathy Gober, and was interviewed about his medical provider, Wellspring Resources. He testified that he then received a denial letter for this claim.

Petitioner testified that his earnings were $10.50 an hour which was then reduced to $10.25 an hour, and that he earned $400.00 per week before taxes. He testified that he has not received any temporary total disability payments and is still receiving treatment at Wellspring (which he testified is now known as Centerstone). He testified that he tried to provide medical information in order to receive his temporary total disability benefits and that he felt that he was misled. He testified that he believed he was eligible for benefits under Section 8(d)2 for loss of use of the person-as-a-whole, and that he has an outstanding bill for Centerstone related to his claim.

On cross-examination, Petitioner denied that when he went to the Glen Carbon office on July 17, 2015 he was offered a job as a table person with a wage of $8.50. When asked if it was his testimony that he declined to work any job at UniQue making less than $10.00 an hour, Petitioner responded that when he first interviewed with UniQue he explained that he did not want to even be called out for a job less than $10.50 an hour.

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 July 17, 2015, that the alleged accident occurred related to being denied a reasonable accommodation for spinal fusion surgery, that Petitioner sustained stress and anxiety due to "bullying and duplicity" and that the nature of the injury was "mental-mental." (AX1).

The October 13, 2015 letter from the Social Security Administration was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The letter indicated that Petitioner was entitled to hospital insurance under Medicare beginning March 2011, and that he was entitled to medical insurance under Medicare beginning March 20112. (PX1).

The office note of Dr. Mirza Baig dated January 20, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. It was noted that Petitioner was making his own progress, that he had no stressors and that he had no major behavioral or management problems. The note indicated that Petitioner's current diagnoses included under Axis I a history of PTSD, a history of generalized anxiety disorder, a history of polysubstance abuse and a history of alcohol abuse. (PX2).

The medical records of Washington University Physicians were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on June 15, 2015 related to his thoracoabdominal aortic aneurysm and infrarenal abdominal aortic aneurysm, and that diagnostic imaging suggested that he had previously undergone an anterior and posterior fusion with instrumentation at L4-5. (PX3).

The script dated July 23, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The script requested that Petitioner be exempt from mandatory overtime that involved heavy lifting. (PX4).

The *Position Statement of UniQue Personnel Consultants, Inc. to Notice of Charge of Discrimination Filed by John Bumphus* was entered into evidence at the time of arbitration as Petitioner's Exhibit 6.

The August 14, 2015 letter of complaint to David Scheibel was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The letter pertained to a purported lack of assistance provided regarding the filing of Petitioner's claim for benefits and alleged issues pertaining to workplace notices. (PX8).

The medical bills exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The Arbitrator notes that the corresponding medical records for the bills were not entered into evidence at the time of arbitration, nor were they even proffered.

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

CONCLUSIONS OF LAW

With respect to disputed issue (C), the Arbitrator finds that Petitioner failed to prove that he sustained an accidental injury on July 17, 2015 that arose out of and in the course of his employment with Respondent.

In Illinois, psychological injuries are compensable under one of two theories, either "physical-mental," when the injuries are related to and caused by a physical trauma or injury (*Matlock v. Indus. Comm'n, 321 Ill. App. 3d 167, 171, 746 N.E.2d 751, 253 Ill. Dec. 930 (2001)*), or "mental-mental," when the claimant suffers a "sudden, severe emotional shock traceable to a definite time, place and cause which causes psychological injury or harm…though no physical trauma or injury was sustained" (*Pathfinder Co. v. Indus. Comm'n*, 62 Ill.2d 556, 563, 343 N.E.2d 913 (1976); *Matlock, 321 Ill. App. 3d at 171*). The Arbitrator notes Petitioner filed an Application for Adjustment of Claim alleging a mental-mental injury occurring on July 17, 2015. "Mental-mental" claims are not compensable in Illinois unless there is a sudden, severe emotional stress. *Pathfinder Co. v. Indus. Comm'n*, 62 Ill.2d 556, 343 N.E.2d 913 (1976) (where the petitioner saw a co-worker have a hand amputated, fainted, and later developed a

psychological condition). The Arbitrator notes that in the case at hand, Petitioner is not alleging a sudden, severe emotional stress, nor was any testimony provided of a sudden, severe emotional stress, and as such is distinguishable from the holding in *Pathfinder*.

Two 2013 appellate decisions have helped refine the "mental-mental" area of law: *Chi. Transit Auth. v. Ill. Workers' Comp. Comm'n*, 2013 IL App (1st) 120253WC, and *Diaz v. Ill. Workers' Comp. Comm'n, 2013 IL App (2d) 120294WC*. In *Chicago Transit*, the petitioner was a bus driver and her bus hit a pedestrian who was chasing after it. The petitioner did not witness the actual contact with the pedestrian, but was informed by a passenger that someone had been hit. The petitioner saw the pedestrian laying on the ground in a fetal position with his mouth moving before he was taken away by emergency personnel. The petitioner was notified later at work the same day that the pedestrian had died. The petitioner claimed psychological injuries stemming from a single, traumatic, work-related incident, and sought treatment approximately two months later. The court held that to prevail on a mental-mental claim, the petitioner must present objective evidence supporting inferences of psychological injury, causation and disability. A petitioner is not compelled to prove that the psychological injury resulting from the emotional shock was "immediately apparent." In *Chicago Transit*, the petitioner's claim was found to be compensable because hitting and killing a pedestrian and later developing psychological injury was objectively reasonable and traceable to a definite, sudden emotional event.

In *Diaz*, the petitioner was a police officer and filed a claim for post-traumatic stress disorder after a standoff with a citizen holding what appeared to be a handgun but was later determined to be a BB gun. The petitioner testified that he did not immediately experience anxiety after the incident, but, during the next few days, began to have more nervousness and anxiety when he was responding to calls. The petitioner eventually told the deputy chief supervisor that he did not think he could perform the job of a police officer due to his anxiety he was experiencing. The petitioner was diagnosed with post-traumatic stress disorder. The court held, "whether a worker has suffered the type of emotional shock sufficient to warrant recovery should be determined by an objective, reasonable person standard, rather than a subjective standard that takes into account the claimant's occupation and training." *Id.* In *Diaz*, the police officer was allowed to potentially recover for his post-traumatic stress disorder because he was exposed to a citizen pointing what appeared to be a gun in his direction.

In addition, in *Chicago Bd. of Educ. v. Ill. Workers' Comp. Comm'n*, 169 Ill.App.3d 459, 523 N.E.2d 912 (1988), the petitioner first sought benefits under the Workers' Compensation Act, but then amended his application to allege an injury under the Occupational Diseases Act. The petitioner was a school teacher who was diagnosed with "great psychological debilitation" by his treating counselor due to the gradual deterioration of the petitioner's work environment, chaos in the classroom, lack of support from the administration, physical assault by students, inability to comply with school regulations, unmanageable students, inability to control the classroom and physical isolation in a mobile classroom detached from the main school facility. The petitioner's counselor diagnosed him with reactive depression characterized by feelings of hopelessness, failure and inadequacy. The court held that the petitioner did not suffer an occupational disease within the meaning of the Act due to the conditions allegedly producing the injury being no greater than those any teacher might face in an education setting. It went on to state that mental disorders not resulting from trauma must arise from a situation of greater dimensions than the day-to-day emotional strain and tension which all employees must experience; the conditions producing disability must also, from an objective standpoint, exist in reality; and the employee must establish that the stressful conditions actually exist on the job, and are "the major contributory cause" of the condition. It is not sufficient that the employee believe, although mistakenly, the conditions exist, as there must be an actual risk connected with the employment which produces the injury. The court stated that "to recognize that our occupational disease law would allow compensation for any mental diseases and disorders caused by on-the-job stressful events or conditions would, in the words of one court, open a flood gate for workers who succumb to the everyday pressures of life." *Id.*

In the case at hand, the Arbitrator finds that Petitioner has failed to present evidence of a single, traumatic, work-related incident. Petitioner alleges injury on July 17, 2015 and that on that date he went to the Glen Carbon office of Respondent to discuss his "reasonable accommodation" due to back pain. Petitioner testified that he became "flustered" but there was no evidence of a definite, sudden emotional event. Furthermore, Petitioner did not present any objective medical evidence supporting a psychological injury, causation and disability. That said, the Arbitrator finds that this case is distinguishable from *Chicago Transit*.

Furthermore, the Arbitrator finds that both *Diaz* and *Chicago Board of Education* are also distinguishable from the case at hand as well. First, the Arbitrator notes that Petitioner's claim was filed under the Workers' Compensation Act and not the Occupational Diseases Act. Second, the Arbitrator finds that Petitioner's alleged interactions with his co-workers did not rise to a level greater than day-to-day emotional strain and tension which all employees must experience and that Petitioner has failed to present objective evidence of any psychological condition or disability. In addition, any alleged injury is not the "major contributory factor" of his mental disorder given his admitted pre-existing PTSD condition. Finally, Petitioner presented no evidence at trial of a work-related, psychological condition.

Based upon the foregoing and the record as a whole, the Arbitrator concludes that Petitioner has failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on July 17, 2015. All benefits are denied. The remaining issues of average weekly wage, medical bills, temporary total disability, nature and extent, and penalties are moot, and the Arbitrator makes no conclusions as to those issues.

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mark Grady,
Petitioner,

vs.

NO: 15 WC 28154

City of Bloomington
Respondent.

17IWCC0224

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 sole issue of nature and extent of Petitioner's permanent partial disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The underlying facts of this claim were well laid out in the Arbitrator's Decision, which is incorporated herein, and the Arbitrator's findings of fact are adopted. With regard to the nature and extent of the injury, however, the Commission reviews and weighs the facts somewhat differently than did the Arbitrator. Specifically, the Commission takes note of the fact that while the claimant did suffer an avulsion fracture to the left wrist, he was prescribed light duty and lost no time from work prior to his release to full duty on April 27, 2015. While at trial the claimant asserted persistent symptoms, the Commission finds it more informative that his treating physician, Dr. Oakey, assessed the claimant at MMI on July 20, 2015, and that the claimant has continued to work in his pre-accident employment through the date of the hearing without incident. Indeed, the claimant testified he had received raises since the accident.

17IWCC0224

The Commission notes the factors identified in Section 8.1b of the Act, as did the Arbitrator. The claimant had an AMA impairment rating of 4% to the left upper extremity (or 2% loss to the whole person). The Commission particularly notes this as a relevant distinction from the case of *Continental Tire of the Americas, LLC v. Workers Compensation Commission*, 43 N.E.3d 556 (5th Dist. 2015). In *Continental Tire*, the claimant also suffered a wrist fracture but lost no time from work. That petitioner was found by the Commission to have a 5% loss to the hand as permanent partial disability; however, that claimant had been assessed with a 0% AMA rating. The Arbitrator further noted the petitioner's employ as a mechanic, his age, and the petitioner's complaints as corroborated by the medical records, and assigned these issues appropriate weight. However, the Arbitrator gave no weight to the fact that there was no evidence that this injury had any effect on the petitioner's future earning capacity. The Commission finds that there was affirmative evidence presented on this point, specifically his ongoing employment and the raises he had received since the injury, which also weighed in on the petitioner's job history. The Commission assigns this some weight.

In light of the above, the Commission finds an award of permanent partial disability of 10% loss to the left hand to be more in line with the extent of the injuries sustained, and modifies the Arbitrator's award accordingly. All other findings of the Arbitrator are affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $726.92 per week for a period of 20.5 weeks, as provided in §8(e) of the Act, as the injuries sustained caused the loss of use of the left hand to the extent of 10%.

IT IS FURTHER ORDERED BY THE COMMISSION that, other than as noted above, the Decision of the Arbitrator filed October 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.

The party commencing 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: APR 13 2017

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

o-04/05/17
jdl-jl
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GRADY, MARK
Employee/Petitioner

Case# **15WC028154**

CITY OF BLOOMINGTON
Employer/Respondent

17IWCC0224

On 10/26/2016, 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 0.47% 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:

0564 WILLIAMS & SWEE LTD
JEAN A SWEE
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

2674 BRADY CONNOLLY & MASUDA PC
GRANT M CAMPBELL
211 LANDMARK DR SUITE C2
NORMAL, IL 61761

STATE OF ILLINOIS)
)SS.
COUNTY OF MC LEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Mark Grady
Employee/Petitioner

v.

City of Bloomington
Employer/Respondent

Case # 15 WC 28154

Consolidated cases: n/a

17IWCC0224

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Bloomington, on September 29, 2016. By stipulation, the parties agree:

On the date of accident, January 5, 2015, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $63,000.08; the average weekly wage was $1,211.54.

At the time of injury, Petitioner was 51 years of age, married, with 1 dependent child(ren).

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

At trial, the parties stipulated that temporary total disability benefits were paid in full.

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

ORDER

Petitioner's demand for payment of bills for medical services provided subsequent to July 20, 2015, is denied.

Respondent shall pay Petitioner the sum of $726.92 per week for 30.75 weeks because the injury sustained caused the 15% loss of use 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.

William R. Gallagher, Arbitrator

October 16, 2016
Date

OCT 26 2016

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on January 5, 2015. According to the Application, Petitioner fell and sustained an injury to the left wrist and upper extremity (Arbitrator's Exhibit 2). There was no dispute that Petitioner sustained a work-related injury and the primary disputed issue at trial was the nature and extent of disability. There was also a dispute regarding medical bills of $1,059.56 (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a mechanic and, on January 5, 2015, he was directed by Respondent did get a snow plow truck ready. The door to the driver's side of the truck was frozen shut so Petitioner had to use the door on the passenger's side. When Petitioner was in the process of walking in front of the truck, he slipped and fell on an accumulation of ice and injured his left wrist.

Petitioner initially sought medical treatment at IWIN (Integrated Work Injury Network) on January 6, 2015. X-rays were performed which revealed the presence of an avulsion fracture of the pisiform. Petitioner was also diagnosed with a left wrist contusion. A wrist brace was prescribed (Petitioner's Exhibit 2).

Petitioner was subsequently referred to Dr. Jerome Oakey, an orthopedic surgeon. Dr. Oakey initially saw Petitioner on January 12, 2015. Dr. Oakey diagnosed Petitioner with an avulsion fracture of the triquetral and prescribed a cock up wrist splint. He also imposed a one pound lifting restriction (Petitioner's Exhibit 3).

Dr. Oakey ordered physical therapy and continued to see Petitioner. When he saw Petitioner on April 27, 2015, Petitioner still had complaints of pain in the wrist with full extension as well as some swelling. Dr. Oakey released Petitioner to return to work without restrictions at that time (Petitioner's Exhibit 3).

When Dr. Oakey saw Petitioner on July 20, 2015, Petitioner still had some complaints of pain in the wrist. Dr. Oakey opined that Petitioner was at MMI (Petitioner's Exhibit 3).

At trial, Petitioner testified that he continued to have pain and swelling after Dr. Oakey discharged him from care. Petitioner sought treatment from Dr. Eric Farinas, his family physician, on September 18, 2015. At that time, Dr. Farinas ordered additional physical therapy (Petitioner's Exhibit 4).

Petitioner received physical therapy from November 24, 2015, through December 17, 2015, and his condition gradually improved (Petitioner's Exhibit 7). Respondent disputed liability for the medical bills incurred subsequent to Dr. Oakey's finding that Petitioner was at MMI as of July 20, 2015.

At the direction of Respondent, Petitioner was examined by Dr. Lawrence Li on April 28, 2016. In connection with his examination of Petitioner, Dr. Li reviewed medical records provided to

him by Respondent. On examination, Dr. Li noted some tightness in the joint capsule. Petitioner also advised Dr. Li that he had difficulties and experienced pain in his left wrist while performing various activities. Dr. Li opined that Petitioner had an AMA impairment rating of four percent (4%) of the left upper extremity and whole person impairment of two percent (2%). Dr. Li also opined that the physical therapy Petitioner received in November and December, 2015, was not medically reasonable or necessary.

At trial, Petitioner testified that he had no prior left wrist injuries or symptoms. Petitioner is right hand dominant; however, he testified that he still used his left hand while performing his work as a mechanic. Petitioner complained of soreness in the left hand when using various tools and that the range of motion of the left wrist is limited usually in the morning, but that it does improve over the course of the day.

Petitioner is still employed by Respondent as a mechanic. He has received some cost-of-living raises since the time of the accident.

Conclusions of Law

The Arbitrator concludes that Respondent is not liable for the medical bills for treatment received by Petitioner subsequent to July 20, 2015. Petitioner's treating physician, Dr. Oakey, opined that Petitioner was at MMI as of July 20, 2015. Further, Respondent's Section 12 examiner, Dr. Li, opined that the physical therapy Petitioner received in November and December, 2015, was not medically reasonable or necessary.

The Arbitrator concludes that Petitioner has sustained permanent partial disability to the extent of 15% loss of use of the left hand.

In support of this conclusion the Arbitrator notes the following:

Dr. Li opined that Petitioner had an AMA impairment rating of four percent (4%) of the left upper extremity and two percent (2%) of the whole person. The Arbitrator gives this factor moderate weight.

Petitioner was employed as a mechanic at the time of the accident and continues to work for Respondent in that capacity. Petitioner's occupation required the active and regular use of both hands. The Arbitrator gives this factor significant weight.

Petitioner was 51 years of age at the time of the accident. He will have to continue to work with the effect of this injury for the remainder of his working life as well as the remainder of his natural life. The Arbitrator gives this factor moderate weight.

There was no evidence that the injury had any effect on Petitioner's future earning capacity. The Arbitrator gives this factor no weight.

The medical records indicated that Petitioner sustained an avulsion fracture of the triquetral. The injury required splitting and physical therapy. Petitioner's complaints are consistent with the injury he sustained. The Arbitrator gives this factor moderate weight.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Salvador Maldonado,

Petitioner,

vs. No. 15 WC 28235

Berkeley School District #87,

17IWCC0238

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses and temporary disability, and being advised of the facts and law, corrects and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation, medical benefits or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327 (1980).

The Commission corrects the clerical errors in the Order part of the Arbitrator's Decision to reflect, consistently with the Findings, an award of temporary total disability benefits of $542.56 per week for a period of 34 6/7 weeks, from February 24, 2015 through March 26, 2015, and from October 19, 2015 through May 18, 2016. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 1, 2016, is hereby corrected as stated herein, and otherwise affirmed and adopted.

17IWCC0238

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

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

DATED: APR 14 2017
o-03/23/2017
SM/sk
44

Stephen J. Mathis
Stephen Mathis

David L. Gore
David L. Gore

Deborah L. Simpson
Deborah Simpson

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

MALDONADO, SALVADOR
Employee/Petitioner

Case# **15WC028235**

BERKELEY SCHOOL DISTRICT #87
Employer/Respondent

17IWCC0238

On 8/1/2016, 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 0.42% 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:

4788 HETHERINGTON KARPEL BOBBER
ALAN KARPEL
120 N LASALLE ST SUITE 2810
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA PC
PETER J STAVROPOLOUS
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

17IWCC0238

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)

SALVADOR MALDONADO
Employee/Petitioner

v.

BERKELEY SCHOOL DISTRICT #87
Employer/Respondent

Case # **15** WC **28235**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **Chicago**, on **05/17/2016 and 05/18/2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **02/01/2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$42,319.68**; the average weekly wage was **$813.84**.

On the date of accident, Petitioner was **61** 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 **$2,402.76** for TTD, **$-0-** for TPD, **$-0-** for maintenance, and **$-0-** for other benefits, for a total credit of **$2,402.76**.

Respondent is entitled to a credit of **$-0-** under Section 8(j) of the Act because it did not sustain its burden of proof on this issue.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$542**/week for **3467** weeks, commencing **02/24/2015** through **03/26/2015** and **10/19/2015** through **05/18/2016**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$2,402.76** for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of **$86258**, which shall be reduced pursuant to the fee schedule or negotiated rate, 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.

#001 George J Andros
Signature of Arbitrator

July 14th, 2016
Date

ICArbDec19(b)

AUG 1 - 2016

Mr. Maldonado was the only witness on the issue of accident. However, both doctors referenced their understanding of the body mechanics of his activities on 2/01/2015 in the snow storm. His job requires that he keep the school building and grounds clean and safe. When it snows he has to remove the snow from the entryways so that students and faculty can safely enter and exit the building.

On Sunday, February 1, 2015 upon awakening he discovered a foot and a half of snow on the ground. It was still snowing when he arrived at the school to clear snow which continued that day.

The description of the job site plus mechanics of throwing snow to clear the entrance was of utmost importance on the causation issue. He used two shovels. Both shovels had shafts about three feet in length. One shovel had a plastic curved blade and the other was equipped with a metal blade. Petitioner began shoveling at the front entrance. He pushed the snow down the stairs onto the pavement where a snow plow could later remove it. The snow was wet and heavy. Petitioner testified that it took him almost two hours to remove the snow from the front entrance, an area about 25 feet wide with four steps leading down to street level. No indications were made nor was any reasonable inference possible that a building engineer or his supervisor who filled out the accident report (mentioned infra) would describe the facilities any differently. No supervisor or building engineer testified.

Next Petitioner went to the side of the building to clear the snow from the side entrances. The snow had drifted at the side of the building and was much deeper than at the front entrance. The side entrances were narrower than the front with six steps and hand rails on each side. Petitioner testified that he had to shovel snow away from the bottom of the entryway to gain access to the stairs. He said the snow was very deep. He testified it took him 45 minutes to clear the snow from the first side entrance.

Petitioner is five feet four inches tall. He is right handed. He demonstrated to the arbitrator how he shoveled the snow. He held the handle of the shovel in his right hand and grabbed the shaft with his left hand. He picked up the snow with the blade of the shovel and heaved it to his left side. At times he had to raise the blade above his left shoulder to throw the snow over handrails and to clear a wall adjacent to the loading dock. No photo nor supervisor rebutted his description of why he lifted the blade over his left shoulder.

Petitioner took a break after he finished clearing the snow from the side entrances. He went into the school building and changed out of his sweaty clothes. He had noticed some pain in his left shoulder while shoveling but thought he was just sore from the strenuous work. When he pulled his sweaty shirt over his head he found it difficult to raise his left arm. Although he had right shoulder surgery several years earlier, Petitioner testified that he had never experienced any problems in his left shoulder until that day.

After his break Petitioner resumed working by shoveling snow through the afternoon. Despite shoveling all day, continuing snow fall prevented clearance of all snow from the entry ways. No timesheets nor school surveillance rebutted these two assertions. By the end of the day his left shoulder ached. When he got home he took some medication for his pain. He testified that the pain in his left shoulder woke him up that night.

Despite four days of school closure due to heavy snowfall, Petitioner returned to the school on Monday morning to continue shoveling the snow. Later that day his supervisor arrived and Petitioner told him about the pain in his left shoulder. His supervisor helped him fill out an accident report and asked whether he needed medical attention. Petitioner declined thinking the pain would improve. When it didn't, he decided to see his primary care physician. The supervisor did not rebuke his testimony regarding the sites requiring the specific body mechanics of snow throwing nor the hours he worked nor the type of shovels.

On February 5, 2015 Petitioner saw his primary care physician at DuPage Medical Group. The note relates that Petitioner presented with pain in his left shoulder for the past four to five days since shoveling snow. Petitioner's Exhibit Two, page 73 ("PX2@73"). The doctor's assessment was left shoulder pain, probably rotator cuff tendinitis, less likely tear or impingement. He told Petitioner if there was no improvement he would refer him to the orthopedic department. PX2@75. According to the radiologist x-ray showed calcifications in the region of the rotator cuff suggestive of calcific tendinopathy. The radiologist noted that if clinically warranted, further evaluation with MRI would be more definitive. PX2@92. The calcification finding or artifact is important in the causation issue; Dr. Burra's lack of finding in situ is determinative of its non -existence. The Arbitrator adopts Dr. Burra's findings and clinical determination of an MRI artifact. See dep p. 38; Lines 3-8 plus Lines 21-24.

His shoulder did not improve; he was referred to Raghu Pulluru, M.D., an orthopedic surgeon. On February 23, 2015 Dr. Pulluru recorded a history consistent with the shoveling. He found limited active range of motion, significant rotator cuff weakness, a positive impingement sign, and tenderness around the biceps and periscapular region with muscle spasm. Dr. Pulluru noted the x-ray from the initial visit showed a small amount of calcification. He diagnosed a left shoulder sprain and calcific tendinitis. He injected Petitioner's left shoulder, ordered physical therapy and took him off work. PX2@65-66. On March 13 he was better with help from PT. The cuff weakness and positive impingement sign were still present but improving. He ordered additional therapy and kept Petitioner off of work. PX2@41-42. On March 27 he felt better. He recorded good range of motion, a negative impingement sign, and excellent strength. Dr. Pulluru released Petitioner to go back to work and encouraged him to continue with a home exercise program. He cautioned him to return, however, if the injection wore off and he had a recurrence of symptoms. PX2@13-14.

Petitioner testified he resumed working full duty and performed his home exercise program but his symptoms returned. He went back to see his primary care physician on July 14, 2015. The doctor noted a history of recurrent left shoulder pain and referred him back to Dr. Pulluru. PX2@10. Petitioner saw Dr. Pulluru a week later on July 17. Dr. Pulluru noted that Petitioner's "shoulder pain has come back again as the injection has worn off." PX2@6.Iimpingement sign was now positive. Dr. Pulluru also found moderate rotator cuff weakness, significant subscapularis weakness, a positive Speed's test, a markedly positive O'Brien test, and a positive apprehension sign and relocation test. Dr. Pulluru was concerned about a possible subscapularis tear, biceps subluxation, and a possible SLAP tear. He gave Petitioner a subacromial injection to help with the pain and ordered an MRI. He thought there was a good chance that Petitioner would require surgical treatment. He allowed Petitioner to continue working without restriction. PX2@6.

The MRI of 7/18/15 via the radiologist showing a full-thickness tear of the supraspinatus without retraction. There were no other significant findings noted by the radiologist. In particular, he did not identify any calcifications or degenerative changes. PX2@89.
Dr. Puluru read it as showing a full thickness rotator cuff tear. He noted that Petitioner continued to have pain and weakness in his shoulder which had not improved with conservative care. He concluded that Petitioner required surgical treatment including a rotator cuff repair and a subacromial decompression. He stated that he would also address any other pathology that he found at the time of surgery.

He allowed Petitioner to continue working full duty but noted that he may have difficulty with strenuous activities. PX2@2.

G. Klaud Miller, M.D. performed a section 12 exam for Respondent on September 9, 2015. The Arbitrator read and re-read his two depositions along with the deposition of Dr. Burra. The Arbitrator adopts the opinion of Dr. Burra given the specificity of his surgical findings over the sweeping generalizations of Dr. G.K. Mller; Dr. Miller's opinion of prior pathology is totally rejected. Based upon the totality of the evidence the Arbitrator finds no preexisting condition a supportive of Respondent's theory of no causation. As stated below, Dr. Miller opined the cause was an age related onset of calcific degeneration of the rotator cuff that had nothing to do with the alleged accident at bar.

Dr. Miller was provided with some of Petitioner's medical records and a surveillance video that recorded Petitioner's activities on August 18, August 22, and August 24, 2015. The video shows Petitioner working at the school and at home, and attending church. The images from August 22, 2015 show Petitioner carrying heavy cinder blocks in each hand with his arms hanging at his sides. There are no images of Petitioner using his left arm above shoulder level. The Arbitrator carefully observed the video at the hearing looking for any overhead lifting as opposed to mere carrying in hand. Although the initial viewing at the IWCC was striking, no medical opinion exists proving 1) intervening cause, 2) not the medical proposition that Petitioner would be unable to grasp and carry such weights with his significant shoulder pathology.

Dr. Miller concluded that Petitioner had calcific rotator cuff tendinitis and "perhaps even a rotator cuff tear." He stated that the treatment was reasonable and customary but that Petitioner did not need any further treatment related to the alleged injury. Dr. Miller opined that Petitioner's condition was simply the age related onset of calcific degeneration of the rotator cuff and that it had nothing to do with the alleged accident. Respondent's Exhibit One ("RX1"). The Arbitrator rejects this opinion based upon Dr. Burra's testimony and surgical findings.

On October 16, 2015 Petitioner sought a second opinion from Giridhar Burra, M.D. at Hinsdale Orthopaedics. Dr. Burra per exhibit A of Px 5 is a physician at Hinsdale Orthopedics and formerly of Parkview Orthopedics. His fellowship training was by Dr. James R. Andrews, the sports medicine physician in Birmingham Alabama. Dr. Burra had operated on Petitioner's right shoulder several years earlier. Dr. Burra took a detailed history from Petitioner which included having him demonstrate how he used his arms while shoveling snow on February 1, 2015. He reviewed all the prior medical records and the MRI films and conducted a very detailed physical examination. PX3@1-5.

Dr. Burra's findings were largely consistent with Dr. Pulluru's exam three months earlier. He found a limited range of motion in the left arm. Rotator cuff strength was 4/5. He found tenderness in the long head of the biceps tendon. Neer, Speed's, O'Brien's, crank and Kim tests were all positive. PX3@3-4.

Dr. Burra also found some abnormalities in Petitioner's neck. He noted a painful range of motion, a positive Spurling's test, and some diminished sensation along the C5-7 dermatome on the left. PX3@4.

He ordered x-rays of Petitioner's left shoulder which he interpreted as "suggestion of calcification subacromial space." PX3@5. Dr. Burra reviewed the MRI images which he interpreted as showing "fairly clear-cut evidence of a full-thickness tear of the rotator cuff especially the anterior supraspinatus." PX3@5. He noted that the degree of retraction was minimal which favored a relatively acute or recent tear. He thought the MRI also suggested "involvement of the proximal subscapularis perching of the biceps tendon" which was consistent with Petitioner's findings on exam. He did not see any evidence of a labral tear. PX3@5.

Dr. Burra's primary diagnosis was a rotator cuff tear involving the supraspinatus with a very strong possibility of an associated subscapularis tear. He felt there was early biceps instability and tendinitis as well as some secondary impingement and these were Petitioner's primary pain generators. He concluded that the AC joint pain Petitioner exhibited on exam was probably traumatic rather than degenerative or chronic because there were no signal changes in the AC joint on the MRI. Dr. Burra expressed strong confidence in his diagnosis because it was supported both by Petitioner's clinical exam and radiological studies. PX3@5. The Arbitrator adopts this diagnosis.

Dr. Burra recommended arthroscopic surgery to repair the underlying rotator cuff and/or subscapularis pathology. He would also address Petitioner's secondary pain generators which would likely require an acromioplasty and a biceps tendon tenotomy or tenodesis. He would assess Petitioner's AC joint both by preoperative exam and intraoperatively to determine whether surgical treatment was indicated. PX3@6. He referred Petitioner to Dr. Darwish, a spine specialist, to evaluate and manage the cervical spine findings. He released Petitioner to work with restrictions. PX3@6.

Dr. Burra addressed causation near the end of his detailed seven page progress note:

> As far as causation is concerned this was an asymptomatic individual till he was exposed to a highly repetitive manual task and he developed symptoms immediately following this highly repetitive manual task. After evaluating all of the data that's available to me including the history, the physical examination findings as well as the radiological findings which do not suggest a chronic rotator cuff pathology I do believe that his condition of ill-being of the left upper extremity is causally related to his work-related activity on the date of injury. PX3@6.

Petitioner testified that he elected to treat with Dr. Burra after the initial office visit. The following day he brought Dr. Burra's Work Status Note into his supervisor and was informed that Respondent would not accommodate the restrictions. Petitioner has been off work under Dr. Burra's restrictions since that time.

On November 10, 2015 Petitioner saw Ashraf Darwish, M.D. a spinal surgeon at Hinsdale Orthopaedics. Dr. Darwish found some limitation of cervical spine motion but otherwise the exam was benign. He cleared Petitioner for shoulder surgery and recommended that neck therapy be included with the post-operative rehabilitation following his shoulder surgery. PX3@16-18.

Dr. Burra operated on Petitioner's left shoulder at Silver Cross Hospital on 12/2/15. The supraspinatus tendon was intact but he found a near full-thickness tear of the subscapularis tendon. The biceps tendon was erythematous, frayed and had longitudinal fissures. He surgically repaired the damaged tendons with anchors and sutures. He also performed an acromioplasty to eliminate impingement. The AC joint was fairly well preserved and did not warrant a distal clavicle resection. PX3@19-21.

Petitioner's first post-operative visit was on December 14, 2015. He had already initiated a physical therapy program with John Lewenczuk, a therapist that Dr. Burra recommended. Dr. Burra noted that Petitioner's exam indicated a normal post-operative course. He made specific mention of the fact that he did not find any calcific tendinitis during the surgery. PX3@22.

Petitioner testified that he stopped PT by Mr. Lewenczuk in January 2016 because the therapist was not covered by his HMO with formal PT stopping. Petitioner performed a home exercise program during this

time but testified that it was not as effective as the treatment he was receiving from Mr. Lewenczuk. Dr. Burra then referred Petitioner to a therapist at Silver Cross Hospital that was covered by the HMO. Petitioner began receiving therapy from this provider but the hospital is a long distance from his home so he switched to a therapist at Bolingbrook Hospital which is closer to his home. Unfortunately the new therapist was not effective and Petitioner began to lose motion and strength in his shoulder. In May 2016 he switched back to the therapist he had seen at Silver Cross Hospital.

The physician's assistant indicated on the 4/29/16 visit that work conditioning would be considered at the next visit. PX3@40-41.

G. Klaud Miller, M.D. testified by deposition on 12/7/25. RX2. Dr. Miller is a board certified orthopedic surgeon. His practice involves all aspects of orthopedics but he does not perform spine surgery. About half of his practice is devoted to sports medicine which is primarily knees and shoulders. RX2@5. His testimony is akin to sweeping generalities; his responses avoid very direct answers at times making no sense.

Dr. Miller testified that he evaluated Petitioner on September 9, 2015. As part of his evaluation he reviewed medical records and surveillance video taken of Petitioner in August 2015. The doctor noted that the video showed Petitioner carrying cement blocks in both hands. This was significant to the doctor because Petitioner told him he could only lift five to ten pounds at the time of his examination. Dr. Miller also said the video showed Petitioner loading lumber on top of a truck using his left arm. According to the doctor Petitioner lifted his left arm up to 140 degrees without any apparent difficulty. The arbitrator viewed the surveillance video and did not see any images of Petitioner loading lumber on top of a truck. In fact, the video does not contain any images of Petitioner using his left arm above shoulder level.

Dr. Miller testified that his physical examination of Petitioner only revealed minimal abnormalities consistent with mild tendinitis. He found a little tenderness over the lateral shoulder, mild weakness, 20 to 30 degrees of limited adduction but otherwise normal motion, and a positive impingement sign. Otherwise his left shoulder was normal.

He interpreted Petitioner's MRI images as showing rotator cuff tendonitis. RX2@10. He reviewed the radiologist's report of Petitioner's MRI. He was aware that the radiologist described a full thickness rotator cuff tear. When asked whether he disagreed with the radiologist he said:

> No. I'm saying that's right in the area of the calcific density, and that can be misinterpreted as a rotator cuff tear. I said it was possible there -- There was an increased signal right where the biceps tendon comes through the rotator cuff, and that could be a rotator cuff tear or it could be just simply degeneration. I don't think you can say based on that MRI whether there was a true rotator cuff tear or not. RX2@20.

Dr. Miller concluded that Petitioner had calcific rotator cuff tendonitis that was degenerative and pre-existed his claimed work accident. He felt Petitioner had a good prognosis because "there is no rotator cuff tear, and his examination was relatively benign." RX2@11. According to Dr. Miller, Petitioner only required an exercise program and some anti-inflammatory medication, and work restrictions were not warranted. RX2@11. Dr. Miller did not review Dr. Pulluru's July 24, 2015 progress note. He was not aware that Dr. Pulluru recommended surgery.

Dr. Miller acknowledged that his examination of Petitioner included a test of the subscapularis tendon which was "weakly positive." RX2@23. He admitted that other tests were positive as well. He agreed that he found a painful and limited range of motion in Petitioner's left shoulder. He also found weakness. He agreed that these findings were not subjective complaints but rather objective findings. RX2@25.

In his report Dr. Miller opined that shoveling snow could not cause injury to the rotator cuff. In cross examination he admitted that he did not ask Petitioner for any details about the activities he was performing on the date of the claimed accident. He did not ask how much snow there was because:

> unless he was throwing it over his head -- and I don't think we had any snow over our head last year -- I would say that would be irrelevant. RX2@26.

Dr. Miller agreed with a publication of the American Academy of Orthopedic Surgeons which states that lifting heavy snow can put you at risk for serious orthopedic injury including shoulder strains. He also agreed that a person can develop rotator cuff tears through repetitive stress. He then claimed that if Petitioner developed a rotator cuff tear while shoveling snow it would have occurred suddenly and he would not be able to continue working:

> I have no idea how much snow shoveling he was doing. But even he said it was just sore afterwards. He didn't feel any -- If he had torn his rotator cuff, he would have had a single episode. He would have said ouch. He would have had to quit work. Okay. None of that happened. RX2@29.

Petitioner's counsel very successfully challenged the doctor's response:

> Q When one injures their rotator cuff … through repetitive stress, there isn't neither necessarily one ouch or a pop or a discernible event that someone perceives, is there?
>
> A Well, there isn't necessarily; but as I said, I would expect it. If he was attributing it to a work injury, then I would expect it to have been related to the work chronologically.
>
> Q Wasn't the symptoms that he developed and described to you in his shoulder related to the work event chronologically?
>
> A Chronologically they were according to his history, yes. RX2@30.

Dr. Miller agreed that if Petitioner has a rotator cuff tear the symptoms could include pain, loss of motion, and weakness. RX2@31.

Petitioner completed a form in connection with the IME which stated that he was still working at the time of the exam and that he was constantly lifting 10 to 50 pounds. RX2@32. This contradicted the doctor's earlier testimony that Petitioner claimed he could only lift five to ten pounds at the time of the examination.

In redirect examination Respondent's counsel asked Dr. Miller whether an MRI arthrogram should be ordered to confirm the presence of the rotator cuff tear before proceeding to surgery. Dr. Miller agreed

that the MRI arthrogram could prove the existence or absence of a tear. In re-cross Petitioner's counsel asked whether arthroscopy is a better diagnostic tool. Dr Miller agreed:

> Arthroscopy is not a hundred percent, but it's probably the best single test for rotator cuff tears, yes. RX2@39.

Dr. Burra gave his evidence deposition on May 6, 2016. PX5. Dr. Burra is an orthopedic surgeon specializing in sports medicine. He was fellowship trained in sports medicine at the American Sports Medicine Institute in Birmingham, Alabama. It was one of the highest ranking sports medicine fellowships in the country at the time. There were 1200 applicants for the six fellowships in the program. Dr. Burra trained under Dr. James Andrews, an internationally recognized shoulder and elbow surgeon. Dr. Burra's fellowship training emphasized treatment of shoulder injuries. Dr. Burra did 3,000 to 4,000 operative cases a year with Dr. Andrews.

Dr. Burra began his private practice at Parkview Orthopaedics in 2001. In 2004 he joined Hinsdale Orthopaedics. He is currently president of Hinsdale Orthopaedics. There are close to 30 orthopedic surgeons in that practice. Seventy to eighty percent of Dr. Burra's current practice involves treatment of shoulders. He sees at least 40 patients a week with shoulder conditions. He performs in excess of 350 shoulder surgeries a year. Dr. Burra does not perform medical-legal work. He devotes all of his professional time to treating patients. He gives depositions, but only as a treating physician.

Dr. Burra first saw Petitioner for his left shoulder on October 16, 2015. He took a detailed history and reviewed all of his prior medical records. Dr. Burra asked Petitioner to demonstrate how he was shoveling snow on the day he was injured because he wanted to evaluate the positioning of Petitioner's left arm while performing this repetitive task. He observed Petitioner's left arm going into abduction and forward flexion as he was tossing the snow. This was significant to Dr. Burra because his left arm elevated above shoulder level during this maneuver. Dr. Burra concluded that the snow shoveling that Petitioner demonstrated was a competent cause of an injury to his left shoulder and, in particular, was causally related to his diagnosis of subscapularis tear, rotator cuff tear, biceps tendinitis, and impingement.

He explained that the subscapularis and supraspinatus behave as one unit at their junction even though they are two separate muscles. That junction functions at its highest mode when the arm is abducted as it was when Petitioner was shoveling snow. If Petitioner had done the motion just one time he may have tolerated it. But when you do that kind of activity repetitively the cumulative injury crosses the threshold where it becomes a structural deficit. Dr. Burra analogized it to bending a paper clip. If it is done once or twice it will weaken, but if you keep doing it enough times it snaps in two. Dr. Burra testified that shoveling snow could have caused Petitioner's shoulder injury even if he did not raise his arm above shoulder level. He explained that the injury resulted from a combination of force multiplied by the number of repetitions and the position of the arm. Dr. Burra's explanation of the biomechanics at the shoulder in context of the accident at bar is adopted in total by this Arbitrator.

Dr. Burra testified that his physical examination of Petitioner at the initial visit revealed weakness in multiple planes, and weakness specifically traceable to Petitioner's anterior supraspinatus, and to the subscapularis. He also had a very tender biceps tendon and positive impingement tests.

Dr. Burra reviewed the images from Petitioner's MRI as well as the radiologist's report. His preference is to at least look at the images, but if the report is also available that is even better. He interpreted the images as showing a suggestion of a tear of the proximal subscapularis. There were findings that suggested a tear in the anterior supraspinatus as well. There was no atrophy in either of these muscles and there were no degenerative changes or signal changes in the AC joint. There were no degenerative

changes in the glenohumeral joint and there were no loose bodies. These findings further erode Dr. Miller's opinion of pre-existing conditions.

Dr. Burra diagnosed Petitioner as having a left shoulder rotator cuff tear, subscapularis tear, biceps tendinitis, impingement and possible AC joint pain, as well as cervical radiculopathy. He explained that he uses the term "rotator cuff" to describe the anterior supraspinatus. However, some people use the term to collectively describe three tendons; the supraspinatus, infraspinatus and subscapularis. The doctor used a model of the shoulder to demonstrate the anatomy he was describing. He pointed out that all three tendons intersect at a particular portion of the shoulder. The anterior supraspinatus and the subscapularis tendons are only separated by five to six millimeters at this junction. The anterior supraspinatus and the proximal subscapularis act as one unit when it comes to holding the humeral head down when you are trying to raise your arm. The junction of these two tendons envelops the biceps tendon.

Dr. Burra explained the significance of the anatomy in Petitioner's case. Since the anterior supraspinatus and the proximal subscapularis are within millimeters of each other at their junction, and some of their tendon fibers intermingle, signal changes in this region on a non contrast MRI can be misinterpreted as a tear of one tendon when in fact the other is torn. MRI images are done five to ten millimeters apart. If the anatomy is separated by only three to five millimeters and there are minor anatomic variations, you can miss the tear on the MRI and interpret it as a tear of the other tendon. This is especially true when you are talking about the narrow zone between the anterior supraspinatus and proximal subscapularis. So what the radiologist saw as a rupture of the supraspinatus was in fact the rupture of the subscapularis tendon that Dr. Burra found at the time of surgery.

Dr. Burra ordered surgery for Petitioner because he does not believe that conservative treatment is appropriate for a manual worker with a rotator cuff tear. Moreover, by the time Petitioner had come to see him he had already attempted conservative treatment and it was not successful. Dr. Burra did not believe that Petitioner's temporary improvement with conservative care undermined his opinion that the condition was related to the snow shoveling incident. He explained that the steroid injection Petitioner received can temporarily mask symptoms and with exposure to activities over time the effects of the injection will wear off and there will be recurrence of symptoms. He felt that Petitioner's course was very characteristic of what happens with a steroid injection. Dr. Burra was not surprised that Petitioner could perform his full duties at work with a rotator cuff tear. He has a lot of patients in his practice who continue to function normally with a rotator cuff tear and ask why they need surgery. He explains that the surgery will improve their pain and the tear can get worse. Dr. Burra spent an hour and a half with Petitioner at that first visit which he documented in his progress note.

Dr. Burra's surgical findings did not change his opinion regarding the causal relationship between Petitioner's shoveling of snow and the condition of his left shoulder. He did not see any degenerative findings in the shoulder at the time of the surgery, such as a tendon that was extremely thin in quality. He did not find any atrophy of the muscles in Petitioner's initial exam, which would be consistent with a long standing tear.

Dr. Burra was asked whether he found any evidence of calcification at the time of surgery. He said that when you see a calcium deposit on an x-ray it is usually very clear. When he took x-rays of Petitioner's left shoulder at his initial visit there was only a suggestion of calcification in the subacromial space. Dr. Burra conducted further investigation at the time of surgery. In the operating room he used a fluoroscope and physically positioned the C-arm over the location where the calcification was suggested. It did not reveal any calcifications. He also probed the area arthroscopically. He did not find any calcifications. He explained that an x-ray is a reasonable tool to diagnose a calcium deposit but when the x-ray is not clear, there are better tools. The MRI did not show any calcium deposit, the fluoroscope did not show it, and the arthroscopic inspection did not show it. According to Dr. Burra, those measures are far superior to an x-

ray. He explained that he looked for the calcium deposit at the time of surgery because if it was there he would have evacuated it.

In cross-examination, Dr. Burra explained that he did not comment on the absence of the calcification in his operative report because he simply forgot to include it. He caught the omission when he saw the x-ray taken with the fluoroscope at the time of surgery and thought that he better include in the record. That is why he put it in the first post-operative note. Dr. Burra provided Respondent's counsel with copies of the intraoperative photos.

Dr. Burra explained that he had not released Petitioner to return to work at his last visit because he is engaged in manual labor and he was having issues with his range of motion which was causing secondary impingement pain. He did not want him to reinjure his shoulder doing a repetitive manual job because of these issues. He explained that he had changed physical therapy providers and he wanted to get Petitioner's range of motion corrected before he exposed him to work that may cause a flare-up of symptoms.

Respondent's counsel took Dr. Miller's second evidence deposition on May 13, 2016. RX7. Between the time of his first deposition and the second Dr. Miller reviewed additional records, including Dr. Burra's operative report. Dr. Miller prepared a report dated February 20, 2016 that stated the new records did not change any of the opinions that were expressed in his September 9, 2015 IME report. RX6.

Respondent's counsel provided Dr. Miller with the intraoperative photos that Dr. Burra gave him at the time of his deposition. Dr. Miller could not determine whether there were any calcifications by looking at the photos because calcification would be inside the tendon for the most part. He explained that you have to probe the area with a needle or a knife and unearth or open up a pocket where the calcification is located. It usually looks like toothpaste and just kind of squirts out like toothpaste.

Dr. Miller noted that there was a discrepancy between the Dr. Pulluru and the radiologist who interpreted the initial x-ray who both noted calcific tendinitis, and Dr. Burra who said there was no calcific tendinitis. Dr. Miller testified that he had not seen the x-rays or the MRI himself to confirm or deny it.

He argued that Petitioner's condition after the snow shoveling incident was consistent with rotator cuff tendinitis because Dr. Pulluru gave him a cortisone injection and his symptoms resolved. He claimed that Dr. Burra treated a partial thickness tear that was degenerative. According to Dr. Miller, all of Petitioner's conditions were degenerative which meant that they pre-existed the accident.

Respondent's counsel reminded him that he had reviewed the MRI films. He responded that he saw increased signal at the biceps hiatus and the supraspinatus tendon. It was not clear to him whether that was a tear or some kind of fluid in the tendon. According to Dr. Miller, there was rotator cuff degeneration and cyst formation in the greater tuberosity which was pre-existing. He said you may see calcifications on an MRI but it is much easier to see on a plain x-ray. There was abnormality on the MRI but he could not say whether it was calcification or just degeneration.

Dr. Miller stated that the findings at surgery confirmed that Petitioner had degeneration in his rotator cuff that pre-existed the alleged accident. He explained that a partial thickness tear is degenerative. When Respondent's counsel asked him about the basis of his opinion, he responded by once again questioning how snow shoveling could cause a rotator cuff tear since it is not overhead work. He argued that even if there was no calcification, then Petitioner merely suffered from rotator cuff tendinitis aggravated by the accident which resolved after Dr. Pulluru gave him a cortisone injection. He could not say the surgery was unreasonable, only that it was not related to the accident.

In cross-examination Dr. Miller conceded that the surgery was reasonable and appropriate for Petitioner's symptoms and findings. He believed the subscapularis tear was degenerative because rotator cuff tears, whether partial or full, in a man of Petitioner's age are more likely due to degenerative causes than acute trauma. Dr. Miller did not believe that shoveling snow could cause a rotator cuff tear even if the snow was lifted overhead. He agreed that it was appropriate for Dr. Burra to look for calcifications at the time of surgery and, if found, to evacuate them. In his second report Dr. Miller said that Dr. Burra's initial examination was virtually identical to his at the time of the IME. He also said that Dr. Burra's interpretation of the MRI was virtually identical to his own. He explained that even though Dr. Burra interpreted the MRI as showing a rotator cuff tear and he saw rotator cuff tendinitis, they were describing the same signal changes. He said the signal changes could be interpreted as fraying or a tear; it was a continuum. He agreed that he and Dr. Burra were looking at the same location on the MRI; and that is ultimately where Dr. Burra located the torn subscapularis tendon. Dr. Miller agreed that the signal changes on the MRI were not calcifications.

CONCLUSIONS OF LAW

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

Petitioner alleges that he tore his subscapularis and biceps tendons while shoveling snow on February 1, 2015. Respondent claims that Petitioner merely aggravated a pre-existing degenerative condition in his shoulder which improved with two months of conservative care. For the following reasons, the arbitrator finds that Petitioner suffered an acute tearing of his tendons as a result of his occupational activities on February 1, 2015.

Given the totality of the evidence, the arbitrator finds the opinions of Dr. Burra more persuasive than those expressed by Dr. Miller. As such he adopts the findings and conclusions expressed by Dr. Burra in his records and deposition testimony; In this particular case and facts , I reject those of Dr. Miller.

Dr. Burra has observed and considered Petitioner's condition over a considerable period of time; Dr. Miller has given it only minor attention

Dr. Burra has surgically inspected Petitioner's left shoulder and seen the pathology he describes firsthand while Dr. Miller merely reviewed the operative report.

Dr. Burra's findings and recommendations for treatment are entirely consistent with Petitioner's prior treating orthopedist, Dr. Pulluru. No other physician has expressed the opinions and conclusions offered by Dr. Miller.

Dr. Burra responded directly and rationally to questions asked during his evidence deposition. Dr. Miller was vague and obtuse in his answers, at times evasive by not answering the question but making a generalized medical truism, and when he was presented with evidence that undermined his opinion he would simply find another reason to assert his ultimate position which is that Petitioner's claim is not compensable. No opinion put forth proved the carrying of blocks was an intervening cause, or , a clear cut basis for termination of TTD. Yes, it was very inflammatory to his case. No, it did not break the chain of causation or somehow disprove the diagnosis shown in situ during the operation.

Based upon the totality of the evidence, the arbitrator finds as a matter of fact and conclusion of law, that the condition of ill-being in Petitioner's left shoulder is causally related to his accidental injury of February 1, 2015.

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

Respondent has disputed Petitioner's claimed medical expenses on the basis of causal connection only. Inasmuch as the arbitrator has found in favor of Petitioner on the issue of causal connection, he also finds that Respondent is liable for the following medical expenses without prejudice to Petitioner to submit further medical expenses for payment at a later date:

Hinsdale Orthopaedics - $56,013.00
Silver Cross Hospital - $22,220.05
Silver Cross Hospital (Physical Therapy) - $3,366.20
Preferred Chiropractic Center - $2,663.00
DuPage Medical Group - $1,996.00

L. What temporary benefits are in dispute? TTD

Respondent disputes Petitioner's claim for TTD after March 26, 2015 on the basis of causal connection only. In view of the arbitrator's findings in favor of Petitioner on the issue of causal connection, he also finds that Petitioner is entitled to TTD benefits from October 19, 2015, the date that Dr. Burra first imposed restrictions, through May 18, 2016, the date proofs were closed in this 19(b) proceeding.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Richard Powell,

Petitioner,

vs.

NO: 15 WC 29725

17IWCC0205

Manchester Tank & Equipment Co.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical, temporary total disability, wage rate, 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).

For the reasons set forth below, the Commission modifies the time period that the Petitioner was entitled to temporary total disability. The issue of the Petitioner's wage calculation was conceded by the Respondent at the February 6, 2017 oral argument.

So that the record is clear, and there is no mistake as to the intentions or actions of this 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. We have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent. One should not and cannot presume that we have failed to review any of the record made below. Though our view of the record may or may not be different than the Arbitrator's, it should not be presumed that we have failed to consider any evidence taken below. Our review of this material is statutorily mandated and we assert that this has been completed.

17IWCC0205

The Petitioner testified on cross examination that after his work-related accident, specifically from April 2016 to the date of hearing, he was performing activities at home that went beyond his restrictions, including mowing the yard and working in the vegetable garden. The Petitioner also testified to periods of prolonged sitting at home including sitting on a lawn mower and sitting on a 4-wheeler, which aggravated his work-related back condition. He further testified on re-cross examination that when he was offered a light duty position in April 2016 with the Respondent, he declined the position due to issues with sitting. (Tr. 46-50, 66)

The Commission finds that the Petitioner is not entitled to temporary total disability from April 1, 2016 through the date of the Arbitration hearing due to the Petitioner's refusal to work in a light duty capacity for the Respondent. The Petitioner admitted during his testimony that he exceeded his work restriction of prolonged sitting while at home, yet refused to work light duty for the Respondent due to prolonged sitting. However, since Petitioner did not testify as to a specific date in April when he began participating in activities beyond his restrictions, the Commission chooses to terminate TTD as of the first day of that month. Accordingly, the Petitioner is precluded from an entitlement to temporary total disability after April 1, 2016.

Therefore, based upon the totality of the evidence and the factual findings above, the Commission modifies the Petitioner's entitlement to temporary total disability. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision, filed on July 19, 2016, is hereby modified.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act, as follows: $35.00 to Quincy medical group, $245.00 to Hannibal Regional Medical Center, $51.00 to Clinical Radiologists, $5,575.62 to Blessing Hospital, and $2,868.43 to Unity Point Health.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize the treatment proposed by Dr. Mark Gold for Petitioner's work-related lumbar condition.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability of $408.92 per week for 16 and 2/7 weeks, as provided in Section 8(b) of the Act, for the time periods that follows: September 9, 2015, October 2, 2015 through January 18, 2016, January 28, 2016 through January 29, 2016, and February 17, 2016 through February 18, 2016.

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.

17IWCC0205

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $65,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 5 - 2017

O: 2/6/2017
TJT/gaf
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

POWELL, RICHARD
Employee/Petitioner

Case# **15WC029725**

MANCHESTER TANK & EQUIPMENT CO
Employer/Respondent

17IWCC0205

On 7/19/2016, 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:

2028 RIDGE & DOWNES PC
JOHN E MITCHELL
415 N E JEFFERSON AVE
PEORIA, IL 61603

1337 KNELL LAW LLC
STEPHEN P KELLY
2710 N KNOXVILLE AVE
PEORIA, IL 61604

17IWCC0205

STATE OF ILLINOIS)
)SS.
COUNTY OF ADAMS)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Richard Powell
Employee/Petitioner

v.

Manchester Tank & Equipment Co.
Employer/Respondent

Case # 15WC 29725

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 **McCarthy**, Arbitrator of the Commission, in the city of **Quincy**, on **6/1/2016**. 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. ☐ 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 _____

17IWCC0205

FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned $**$31,896**; the average weekly wage was $**$613.38**.

On the date of accident, Petitioner was **45** years of age, ***married*** with **2** children under 18.

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

Respondent shall be given a credit of $**$8,798.50** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**$8,798.50**.

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 $35 to Quincy Medical Group, $$245 to Hannibal Regional Medical Center, and $51 to Clinical Radiologists, $5,575.62 to Blessing Hospital , $2,868.43 to Unity Point Health, 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 the treatment proposed by Dr. Gold, as explained in the attached findings of fact and conclusions of law.

Respondent shall pay Petitioner temporary total disability benefits of $408.92/week for 14.4/7 weeks, commencing on September 9, 2015 (One Day); October 2, 2015through January 18, 2016; January 28, 2016 through January 29, 2016; Feburary 17, 2016 through Feburary 18, 2016: and May 29, 2016 through June 1, 2016, as provided in Section 8(b) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

17IWCC0205

D. Dylan McCarty

Signature of Arbitrator

7/14/2016

Date

JUL 19 2016

ICArbDec19(b)

17IWCC0205

STATE OF ILLINOIS)
) SS
COUNTY OF ADAMS)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RICHARD POWELL,	)	
	)	
Petitioner,	)	
	)	
v	)	IWCC: 15WC 29725
	)	
MANCHESTER TANK & EQUIPMENT CO,	)	
	)	
Respondent.	)	

FINDINGS OF FACTS APPLICABLE TO ALL ISSUES

Richard Powell, age 47 at the time of his accident, obtained his GED and spent one year at John Wood Community College and two years at Cardinal Area Career Center in Springfield. (T9-10) His training was that of an electrician but he is not licensed as one. (T10) He does not do electrical work. (T56)

Petitioner stated he had no back problems prior to April 2015 and saw no doctor for back problems. (T32) Prior to April 2015, Petitioner does not recall ever seeing a physician for his back. (T61) He did acknowledge that he had occasional back aches when he over exerted himself. (T61) When that happened prior to the accident of 2015, he would take Tylenol. (T62) But, his history to Dr. Bernardi indicated some chiropractic care years ago. (RE 10)

Petitioner began working for the Respondent on February 28, 2011. He had various jobs with the Respondent. He went from working prefab as a welder or breaking out parts or running a robot, whatever they needed. (T10-11)

Petitioner believes his current hourly rate of pay is $16.30. He generally worked 8 hours a day unless a supervisor or lead hand asked him to work overtime. He can refuse overtime but if he does, they won't ask him to work overtime any more. (T31) His normal work week is 5 days. (T31)

In April 2015 he was performing hand welding of top plate and base ring. (T11) As a welder, he lifts top plates, base rings and he may end up breaking out parts before you can build a part. They come off the Amada machine. (T11) They are stacked in trays and you use a pry bar and slide underneath them and beat them with a hammer. (T11-12) The parts he breaks, he lifts himself. The parts coming out of the Amada machine are on big tables and they are picked up with a forklift. (T12) Petitioner himself lifts up to 90 pound plates. (T12) He bends his back all day long at times, depending on the job he is doing. (T12)

On April 8, 2015 Petitioner assisted in opening the drawer underneath the Amada machine that cuts out the parts. He was asked to help by another worker. (T13) The other employer was trying to pry the door open with a shovel but it didn't open because it was heavy. (T13) The drawer is 4 feet wide and 6 to 8 feet deep, it is about 4 inches off the ground. (T14)

While the other employee was trying to pry the door open with a shovel, Petitioner was on his knees trying to pull on the front handle and when it finally came open when suddenly something popped in his back. (T14) The door was full of scrap steel, extras like slugs or cut outs from the top plate. (T14) After his back popped, it started hurting and it got worse as the day went by. (T15) At that time his pain was limited to the low back. (T15) He reported the incident to his supervisor. (T15) He filled out accident forms. (T15) Petitioner stated that he had only one accident working at Manchester on April 8, 2015. (T36)

He was sent to Dr. Henry by his employer. (T16) Dr. Henry checked him out, never did any x-rays the first day and told him to come back in 2 weeks. (T16-17) He did not take him off work. (T17) Petitioner did not know of any problems with his back occurring off and on prior to the April 8, 2015 accident. (T35) When he returned to Dr. Henry, the pain still hadn't gone away. (T17) Petitioner was put on light duty at the second visit. (T17) X-rays were performed. Dr. Henry released him to return to work. (T35) Petitioner disagrees with the doctor's statement that he had off and on back problems. (T35)

Petitioner saw Dr. Basho two or three times. An MRI was reviewed and x-rays were taken. (T17) Dr. Basho released him to return to work. (T37)

Around June 2015 physical therapy was recommended by Dr. Basho. (T37) After seeing Dr. Basho, he was referred to Dr. DeDes, a pain management doctor, who gave Petitioner an epidural injection at L5/S1 on June 23, 2015.

Petitioner stated that he went all through the physical therapy and disagrees that he stopped voluntarily coming to physical therapy. (T37) He was not aware that he was discharged from First Choice Physical Therapy on August 6, 2015 because of non-compliance. (T38)

Petitioner sought no medical care between August 16 and August 31, 2015 until he entered the Blessing Walk In Clinic giving them a history of trimming horse hooves. (T38-39) He gave a history feeling immediate pain while he was doing and that he had an aggravation of pain. (T39) He told them that his pain had increased. (T39-40)

On September 17, 2015 Petitioner called Dr. Basho telling him that he rolled a bail of hay over. (T40) Dr. Basho wouldn't see him so he went to the emergency room. (T40-41)

On September 17, 2015, Petitioner sought care at Blessing Hospital's ER. Petitioner gave a history of moving a bale of hay. (T23-24) He rolled a square bale of hay over, the bale weighing about 30 pounds. Petitioner moved it from edge to flat. (T23-24) As he did so, he went numb. (T24) Prior to rolling the bale his pain had never gone away since the accident. (T24) Petitioner stated there was the same injury, he just aggravated it again. (T40) At the time he was working with the hay he gave a history he had a pop in his back as well as numbness in his legs. (T41) At that time it was suggested he see a neurosurgeon. (T42) The injection that was given at the emergency room when Dr. DeDes was absent, the day that he rolled the bale, the injection to the numbness away for a period of time but it came back to the same level as before. (T33)

Petitioner worked from September 10 until October 2 in light duty capacity. (T 43) Petitioner was taken off work for the period of October 2, 2015 to January 11, 2016. From January 2016 to April 2016 he was provided light duty work and was receiving medical care. (T43-44) His complaints to the doctor during that period were problems with bending and sitting. (T44)

Finally, in October 2015 Petitioner saw Dr. Taylor Moore of Quincy Medical Group. Dr. Moore referred him to Dr. Gold. (T19) Dr. Moore gave him pain medication and took x-rays. (T20)

Dr. Gold scheduled him for a fusion at L4, L5 and S1 (on May 4, 2016). (T20) He didn't get the surgery because worker's comp refused it and he couldn't afford to pay the deductible for his insurance. (T20-21) Before surgery, Dr. Gold wanted him to get fitted for a back brace. (T21) Petitioner has not seen Dr. Gold since April but did see his nurse two days before his surgery had been scheduled to occur. (T21-22)

At work, he lifts items that are heavier than those he lifts on the farm. (T27) He spends more time doing lifting activities at work than he does on his property. (T27)

Petitioner was willing to accept the surgery suggested by Dr. Gold. (T32)

The Petitioner original complaint was that of his back and left side. (T24) He had pain in the middle of his back, cross his hips, and both legs would go numb. (T24) Petitioner told Respondent he couldn't perform sitting and didn't think he could do sitting activities. (T45, 60) Any activity that he does that requires sitting does that. (T60) When Petitioner is on his feet, it doesn't bother him as bad because whatever is getting pinched in his back isn't pinching his back when he is on his feet. (T61) His feet and legs do not bother him as bad when he is on his feet. (T61)

Previously they gave him light duty work. (T64) The Petitioner has not been offered light duty work since April 2016. (T64) Petitioner calls his employer on the phone once a month. (T64) Petitioner stated his legs are numb now from sitting. (T45) It makes sense that you would avoid sitting, avoid bending, doing activities that cause problems to your back around April to present. (T45-46) Petitioner didn't want to take a light duty job because of problems sitting. (T51-52) But he does do activities at home sitting that aggravate his back. (T52)

Petitioner lives on about 2 ½ acres of land which they garden, have horses, chickens, turkeys and ducks. (T23) He does not use the animals or corps for sale, just personal use. (T23) Petitioner stated he hasn't done any heavy lifting around the house. (T51)

The bale of hay, which is rectangular, is stacked in his barn. (T62) It is stacked up in a stack, the bale was sitting on the edge of the board, he needed to roll it over into

a two wheel so that is what he did, bent over and rolled it over. (T62-63) It was one bale high, 14 or 16 inches. (T63) He used the hay to feed he horses. (T63) He rolled it over on to a two-wheel dolly across the yard, cut the bale string with a pocket knife and picked up pieces of it and threw it over the fence to the horses. (T63) He did not carry the bale at any time. (T63)

He has a vegetable garden is about 20 feet by 20 feet and requires him to bend down, weed, plant, etc., to which he took exception. (T49, 46-47) He uses the hoe to weed and a planter to plant. He agreed that type of activity could aggravate his back pain. (T47) The average time he spends hoeing is 10 to 15 minutes. (T57) The hoe is fiberglass handle and has a flat blade of steel (58) You cut off weeds with it, stick in the ground and pull it back to you. (T58) The hoe weighs about 2 ½ pounds (T58)

The Petitioner grows green beans and picks them by leaning over the row and picking them. (T24-25) You can pick a row of green beans in 20 minutes. (T25) He was picking them most of the time by standing and bending over. (T25)

The Petitioner's children ran the tiller 99% of the time but he did touch the tiller this season. (T47-48) When asked if that exceeded his restrictions, he indicated that the tiller is self-propelled, he didn't pick it up or do anything of that nature. (T48) Running a tiller sometimes can be hard work, sometimes it gets stuck and sometimes it can aggravate your back pain. (T48-49)

Petitioner has used a hoe in his garden once this year. (T58) His plant uses a push type planter, all aluminum, you put ½ pound of seed and push it across the garden, like a fertilizer two-wheel bucket. (T58) The whole thing weighs about 7 or 8 pounds and he pushes it. (T59) Before using the hoe, the planter, etc., he noticed constant (pain) all the time. (T59-60) The pain gets worse and then it goes back to its normal level. (T60)

Petitioner uses a riding lawn mower once a week, it takes about 30 minutes to do his yard. (T57) Sitting on the lawn mower can aggravate his back at times. (T50) Riding a four wheeler can aggravate his back. (T50-51) When he is on the job for his employer, he doesn't work 30 minutes and then stop. (T57)

He has three horses which require feed and he tried to trim one hoof this year which aggravated his back. (T55) He stated he tried to ride a horse but he couldn't do

it. (T52) His son saddled the horse. (T52) He would agree that riding a horse aggravates his complaints. (T52-53) He has tried not to do that since September 2015. (T53) He also cut hooves on horses by putting the hoof between his knees and trimming it with nippers. (T25) The nippers are like a large fingernail clipper. (T25-26) After the incident of trimming hooves, picking green beans or tipping a bale of hay, his pain does reduce after a period of time if he quits doing what he was doing and just lay on the floor it will relax. (T27-28)

In working on his brakes, it took him an hour and a half or two hours which would have normally taken him about 30 minutes to set the brakes. (T59) It took Petitioner about 2 ½ hours to do both sides. (T59)

Petitioner agreed that he was performing some activities that were probably beyond his restrictions. (T46) Certain activities at home exceeded his restrictions. that he exceeded his restrictions in mowing the lawn and working in the garden. (T46)

When asked if he reinjured his back in any of those activities, he stated no. (T26) He stated his back pain has never gone away, it has different degrees of pain with some days he can deal with it and some days he wants to cry because it hurts so bad. (T26) The back just doesn't get better. (T27) He stated that if he is sitting around doing nothing, he can deal with it, it is just a dull constant pain. However, if he is working, bending over, twisting it could make him cry on some days. (T27) He does bend and twist at work. (T27)

Medical records of the Petitioner's care were introduced into evidence. Petitioner was seen by Dr. Henry. He obtained a history of low back pain of an acute nature with an onset suddenly due to an incident at work on April 8, 2015 and has been occurring in a persistent pattern for a week, gradually worsening. He had low back pain described a mild to moderate dull aching, shooting, burning and electrical and tingling. Pain radiates from his lower back down to the left thigh and left foot. He received no relief from the pain.

On April 14, 2015 Dr. Henry noted that this was a work related injury.

Dr. Henry noted tenderness to palpation at the left buttock and over the sacroiliac joint on the left. Straight leg raising was negative on the right and left.

X-rays were taken. On that date, Petitioner was found able to work without any restrictions.

Petitioner returned to Dr. Henry on April 22, 2015 with the same complaints. The doctor felt that he had a low back strain and a lumbar disc displacement. In his notes for April 22 he suggested modified duties of lifting 15 pounds with no bending and suggested an MRI. However, in contradiction to his notes, his report to the employer indicated that Petitioner was able to work with no limitations. He was to return on the 5th of May, 2015. Dr. Henry marked the form indicating it was a work related injury.

At Dr. Henry's direction, an MRI was performed on April 30, 2015. It was performed at Hannibal Regional Hospital and the reviewing doctor was Emad Hamid.

After the MRI was taken, Dr. Gregory gave the Petitioner restrictions noting that he had to work with limitations. He could lift 20 pounds and needs to limit his bending. He, on that note, indicated that this was a work related injury.

On April 30, 2015 Dr. Henry again saw the Petitioner. On his examination, he found the left lower extremity to have 40 degrees with posterior and thigh calf pain. The doctor's assessment is that of low back strain and lumbar disc displacement. He confirmed the Petitioner should be lifting no more than 20 pounds and have limited bending. He is suggesting referral to a back surgeon..

Petitioner was referred to Dr. Basho, an orthopedic surgeon, by Dr. Henry with complaints of low back and numbness and tingling down the left leg. (PX 2)

The initial examination on May 26, 2015 showed the Petitioner's motor strength to be normal in the upper extremities, the hip, the knee, the tibialis anterior, AHL, and GSC sensation was intact in the cervical and lumbar regions. Reflexes in the Achilles and patellar tendons were 2+ and symmetric.

Review of x-rays and MRI taken previously, resulted in the opinion of a Grade I spondylolisthesis at L5-S1 on x-ray. The MRI showed a broad based disc bulge with slight caudal migration at L4-5 segment, severe foraminal stenosis is noted at L5-S1.

Dr. Basho's assessment was that of lumbar radiculopathy, Grade I spondylolisthesis at L5-S1 and L4-5 disc herniation.

The doctor stated that he wasn't sure if the Petitioner's pain emanated from L4-5 or L5-S1. He suggested a left side L5-S1 transforaminal injection. If that injection is

inefficacious, then he will be sent for an L4-5 translaminar epidural steroid injection. He was also t be placed in physical therapy. He could return to work with a 20-pound restriction. He is to return on June 13, 2015. Doctor's notes indicate that this was a work related injury.

Petitioner returned to Dr. Basho on July 21 in follow up to the L5-S1 injection stating that he gave him no significant or lasting relief. The doctor's assessment remained the same. The physical examination Petitioner remained unchanged. Dr. Basho noted that the injections have not enough of any diagnostic value and have given him no relief. Therefore, he concluded surgical intervention was not what he believed to be the answer. He suggested continued conservative treatment of oral medication and therapy. He is to be referred to the pain clinic.

Dr. Basho prepared a report to the employer indicating that Petitioner would return to work on July 21, 2015, that he is able to work with restrictions of lifting 20 pounds. The doctor again noted that this was a work related injury/illness.

On September 17, 2015 Petitioner called Dr. Basho's office speaking to a nurse, Ashley Kelle LPN, he explained he was rolling the bale of hay and experienced numbness in both arms and legs, his extremities are still tingling and he would like to see Dr. Basho. The nurse stated she would have to figure out how they could go about seeing him due to a previous worker's comp injury and she would have to talk to someone else about scheduling. She suggested that if was concerned and thought he needed immediate care, he could return to the walk in clinic he previously visited for pain control or call his PCP. The note goes on to indicate that the nurse talked to Dr. Basho who stated he didn't need to see the patient because he had released him from care and needed to seek treatment with pain management.

On referral from Dr. Basho, Petitioner was referred to Frist Choice Physical Therapy.

Petitioner tolerated the exercise at therapy as well as at home without any significant problems or increased pain. He continues to have symptoms after performing his work duties at a current 20-pound restriction. Patient described an incident where he bent over at work on 7/14/15 and felt a pop in his back causing

increased symptoms at that time to a level of 6/10. His thoracal lumbar junction back pain index score is 52%.

As to spine range of motion, flexion caused pain, was at 35 degrees. Extension was 20 degrees with lower lumbar and lower thoracic pain. SVR was 38 degrees, SVL, 37 degrees. Range of motion on right for internal rotation was 14 degrees and on the left 20 degrees. External rotation of the hip was 40 degrees on the right and 30 degrees on the left. Thoracic spine range of motion was extension of 23 degrees, right and left rotation was 30 degrees. Lower extremities strength myotomes were 5/5, gluteals 4/5, upper abs 4-/5, lower abs 4-/5 and oblique's 4/5.

The assessment is that he is improving with his lumbar and thoracic spine motion as well as his hips showing improvement. He tolerates exercises without increase in symptoms but continues to have pain that is relatively constant in the thoracal lumbar region. His pain will worsen after lifting activities including activities at work or household chores.

First Choice made no comments with regard to causal relationship but noted a work injury.

Rodney Brumley, PT, authored a discharge summary from physical therapy after Petitioner was seen for 8 visits for the period of June 16, 2015 through July 16, 2015. A progress note was completed on his last visit for follow up with his referring physician. A phone message left with the Petitioner did not result in contact. At that time, physical therapy was discontinued.

The therapist noted that the Petitioner met all of his short term goals with the exception of improved ability to sleep up to 4 hours as he continues to awake every 2 to 3 hours due to low back pain or not getting comfortable because of pain. The physiatrist plan was to send a progress note for follow up with physician continuing per physician recommendation.

Respondent suggests the Petitioner just quit physical therapy on his own which Petitioner denied. In a therapy note of July 16, 2015, the therapist, Rodney Brumley in the PN section of his notes, seemed to indicate he was awaiting the physician's recommendation and checking on Petitioner's status. In his note of July

21, 2015, Dr. Basho merely indicated that Petitioner was to return as necessary and makes no comment about continuing physical therapy.

The Petitioner was admitted to Blessing Hospital on August 31, 2015 with a history of his accident, and he has now and then sharp pain that comes in his lower back stating that yesterday he was trimming the feet of his horses, he bent over and the pain came back and (?) his lower back. His pain is 4/10 with intensity worse with bending side to side or turning side to side. He stated he had a previous steroid shot which decreased his pain. The practitioner Daanish Shaikh assessed him as having lower muscle spasms for which he was given shot of steroid and morphine and was sent home. The physician wrote a note excusing Petitioner form work and physical activities beginning on August 31, 2015 and allowing him to return to work on September 2, 2015.

On September 17, 2015 Petitioner was seen at Blessing Hospital Emergency Room with back pain. It was noted he had an open worker's compensation claim. He stated he moved a bale of hay and felt a pop in his back stating now he is numb and tingling all over his body. A review of symptoms seems to be normal. It was noted that on August 3, 2015 he was seen for back pain by Dr. Shaika. Clinical impression appeared to be paresthesia.

Petitioner submitted to an independent medical examination at Respondent's request on December 15, 2015. Petitioner gave the doctor history of both his accident, his subsequent occurrence regarding his back and mentions a chiropractor visit 15 years prior to the accident. Dr. Bernardi reviewed the medical records available to him covering up to October 19, 2015.

In his physical examination, he found no signs of symptom magnification nor any Waddell's signs. His positive findings were that of flexion and extension rotation of the right hip produced complaints of right lateral buttock pain. Flexion and external rotation of the left hip produced complaints of left lateral buttock pain. He notes deep tendon reflexes of 1+/4 at the knees, 1/4 on the left ankle reflex and 0/4 on the right ankle reflex. The plantar response was down going. Thereafter he reviewed the MRI performed on April 30, 2015.

Dr. Bernardi noted that he did not believe it was possible to determine whether his symptoms were due to an acute central disc protrusion at L4-5, an aggravation of a pre-existing L4-5 disc disease/stenosis, an aggravation of his L5-S1 isthmic spondylolisthesis or a blending of all of them. He notes that the waxing and waning of symptoms is normal, that is how most episodes of back/leg pain behave.

The doctor notes that it is extraordinarily unlikely that having been present for approximately 3 ½ years, the main symptoms completely subside following his appointment with Dr. Moore on July 27, 2015 only to recur again on August 30, 2015.

The doctor stated that "**were it not for his occupational accident I can see no reason to believe that this man's activities at home in late August or mid-September 2015 would have produced any type of back complaints**". He does not believe that the Petitioner has yet reached maximum medical improvement. He felt it would be reasonable to have a second and third epidural steroid injection.

Later, when queried by defense counsel, Dr. Bernardi checked on a form indicating that the activities Petitioner provided outside of Manchester Tank were types of activities that could aggravate the condition of ill being. On May 26, 2016 in response to defense counsel's fill in the blank letter, Dr. Bernardi agreed that if an individual is performing activities beyond his restrictions, those activities could be aggravating his condition of ill being. Nowhere was it mentioned that those aggravations were permanent in nature.

Petitioner was seen by Dr. Howard DeDes, a pain specialist, on June 19, 2015 with a chief complaint of low back and left leg pain, describing the accident that he sustained and noting that he was referred to them by Dr. Basho. He reviewed the imaging performed noting, among other things, that there were posterior disc bulges with degenerative changes and a right paracentral component at L4-5 producing moderate central stenosis and foraminal stenosis, left greater than right. There was also a L5-S1 bilateral foraminal stenosis. The doctor believed that the foraminal stenosis at L4-5 and L5-S1 is consistent with the lumbar radiculopathy.

On June 23, 2015 Petitioner was seen by Dr. DeDes who performed a transforaminal epidural steroid injection procedure at the left L5-S1 neuroforamen. Petitioner was given restrictions of no repetitive shoveling, no lifting over 40 pounds no

pushing or pulling over 40 pounds of force and no work requiring repetitive bending. In reviewing medical necessity, he noted that Petitioner's symptoms were consistent with the radiographic findings.

On September 14, 2015 he was again seen by Dr. DeDes who had requested Petitioner return for evaluation. His plan was to start pain management for brachial pain with Tramadol 3 times daily. For diagnostic and therapeutic options, they will provide transforaminal epidural steroid injections at L4-5 and L5-S1 on the left side. Depending upon the efficacy of those injections they will consider repeat injections within a month for a series of three. If pain does not improve, he will go back to Dr. Basho.

On September 17, 2015 Petitioner called the office at 3:17 p.m. stating that he went out to feed his horses and went to roll over a small bale of hay from the edge of the flat side. He states as he did so, something moved in his back and his whole body began tingling. The office told Petitioner that Petitioner was referred to Dr. DeDes so he needs to call that office. Dr. DeDes indicated that obviously he should go to the emergency room. A CMA called and spoke to his wife about coming to the emergency room.

September 18, 2015 Kayla Berhorst, RN spoke with Petitioner who indicated that he had a disc pushing on the nerve causing his tingling. He needed weight restrictions from Dr. DeDes as he is the attending physician. The nurse wasn't sure the doctor would comply and told the Petitioner ask that he could be referred to someone else if Dr. DeDes isn't going to give him restrictions. Dr. DeDes apparently replied indicating that he can have weight restrictions until he sees him again next scheduled visit.

Petitioner called on September 21 notified of restrictions and will move up for an objection getting approved. Petitioner came to the office about noon to pick up the restrictions.

Ultimately Petitioner stated he wanted to keep the appointment of October 27 for the injection.

On October 2, 2015 Petitioner saw Dr. Taylor Moore. Petitioner is here to establish care in his clinic and receive general health history/physical. Physical examination appears to be normal.

Assessment and orders indicate that a general medical examination was held. In addition, he has midline low back pain with sciatica, sciatica laterally unspecified.

They will get his FMLA papers. They are going to try to get him to a neurosurgeon sooner than December with his work comp will approve the visit. They were going to get flexion and extension views of his back and discuss chronic pain medications. He will follow in one month or as needed.

September 2, 2015 x-rays were taken of the lumbar spine and interpreted by Dr. Willet Pang on October 2, 2015. The x-rays compare with the earlier one of April 14, 2015. Bilateral pars defects at L5 segment with 15% anterolisthesis L5 upon S1. No added displacement with flexion or extension. No compression fracture. Disc spaces are preserved. The doctor's impression was that of bilateral pars defects. Fifteen percent anterolisthesis without instability demonstrated.

On October 7, 2015 a letter was written to Petitioner by Deborah King, RN/Dr. Taylor Moore. After reviewing the x-rays, it was stated that the pars deficit was noted. The back is more unstable. I think this is likely what happened when you were pulling on that heavy object. The 15% anterior was noted. It is not unstable however, not slipping back and forth. He would like him to be evaluated by a neurosurgeon. He conferred with their occupational medicine team and they agreed. They are going to send over a referral to neurosurgery.

On July 27, 2015 Dr. Taylor Moore gave Petitioner an excuse from work from July 27 to July 28, 2015.

On September 18, 2015 Petitioner was given a note from a doctor whose signature is not clear. He is to return to work on 9/21/15 he is to do no repetitive shoveling, no lifting overhead more than 40 pounds, no pushing or pulling over 40 pounds of force, no work requiring repetitive bending of the spine or lower back and he will be followed up for a physician's appointment on October 21.

On October 19, 2015 Petitioner was seen by Mark Gold who recited the Petitioner's history of accident which gave him severe back pain. He still has had persistent complaints of low back pain as well as pain radiating down the right hip into the leg and also has pain in the left leg but not as severe. He has the sense of his legs going numb, tingling much of the time. He does feel that his right leg is weaker than his

left. Sitting or bending make the back worse. He has undergone an epidural steroid injection without relief.

Dr. Gold indicated he reviewed the MRI and the lumbar radiographs with flexion and extension views. The MRI reveals a Grade I spondylolisthesis (anterolisthesis) at L5-S1. There are probable bilateral L5 pars defects. There is a disc degenerative change and a disc bulging/protrusion centrally at the L4-5 and L5-S1 levels with moderate severity stenosis at both of those levels. In addition, he has a disc bulge or protrusion/extrusion at L4-5 level and disc bulge centrally at L5-S1 level producing neuroforaminal stenosis bilaterally. **I do believe that it is more likely than not that the patient's injury that he describes occurring at work aggravated or exacerbated his underlying conditions, and may have produced additional disc protrusion or herniation at L4-5 level.** He does now have intractable lower back pain as well as bilateral lower extremity pain which is likely related to a combination of stenosis and mildly unstable degenerative spondylolisthesis.
He believes surgery is a reasonable alternative. His plan is to attempt surgery if and when it is approved. The proposed procedure would be L4-5 and L5-S1 360 fusion.

On Febarury17, 2016 Dr. Moore gave the Petitioner an excuse from work for the 17th through the 18th of February.

Dr. Taylor Moore saw Petitioner on return to clinic for continued management of his chronic low back pain his chronic low back pain. He has been evaluated now by two separate surgeons about his back both of them apparently recommending surgery. Worker's compensation has denied surgery thus far. His examination indicated positive for musculoskeletal tenderness to palpation over the mid line and paravertebral musculature to the lumbar spine with no step-offs noted. Diagnosis is that of midline low back pain with sciatica, sciatica laterally unspecified; displacement of lumbar intervertebral disc without myelopathy; and acquired spondylolisthesis. The doctors suggested Petitioner restart Cymbalta and take Baclofen for muscle relaxants. He would recommend work restrictions per his visit with the last surgeon.

On February 27, 2016 Petitioner was seen by Dr. Moore again. He has increasingly lower back extremity and weakness symptoms. He had increasing sciatica symptoms with shock pain going down his lower extremities and emanating from his low

back. His low back pain is still there as it has been since the original injury. He is unable to work because of increasing symptoms of weakness and numbness down his legs. Musculoskeletal examination shows strength currently bilaterally in lower extremities decreased deep tendon reflexes in the patellar tendon on the right side. He has slightly reduced sensation on the right side of the lower extremity. Assessment is the same as previously. The doctor notes that two neurosurgeons have recommended surgery and the doctor also feels it is appropriate.

On March 17, 2016 Petitioner returned to Dr. Moore for management of his chronic low back pain with sciatica symptoms. He denies any side effects from the medication and his sciatic symptoms are about 80% improved as far as the pain goes. The medical findings are still the same as are the assessment. The doctor noted Petitioner is doing well with Gabapentin. He recommended follow up with the surgeon.

Petitioner returned to Dr. Moore on April 4, 2016. Petitioner's complaints were that of bilateral numbness, weakness and tingling in the lower extremity that began in April. He suffered a back injury a year ago and is complaining of his lower back now. Petitioner appeared there with frustration with his back injury and problems with his employer. Petitioner complained to the doctor that the employer expected him to do things beyond his restrictions and then would write him up for working outside of his restrictions. It was noted that he would be seeing Dr. Gold again on the 11th. They gave him another letter for work with the same restrictions that he had previously.

The Petitioner was then seen by Dr. Gold again on April 11, 2016. Petitioner advised the doctor that he returned to work in January 2016 with the same symptoms and with some increase in back pain and feeling that his legs were going to give way while at work. After a particularly long day, spent bending over and welding, his condition worsened. Wherever he has to lift or bend frequently he experiences increased pain and feels his leg go numb. Recently his leg did give way causing him to fall face forward.

Physical examination shows tenderness across the lower lumbar spine but otherwise relatively normal. Straight leg raising and cross straight leg raising were performed and were painful bilaterally producing lower lumbosacral pain.

The doctor's assessment remained the same as previously. He felt that Petitioner has not changed and believes that he has a tractable lower back pain as well as paresthesia since the industrial injury of April 2015.

In support of Arbitrator's decision relating to __F__, the Arbitrator finds the following facts:

It is undisputed that Petitioner sustained an accidental injury arising out of and in the course of his employment on April 8, 2015. Causation is being questioned. Review of the medical records establish that most all of the practitioners found that there was causal relationship between his accident and his current condition.

Respondent argues the intervening incidents, particularly the one on September 17, 2015 when the Petitioner rolled the 35 pound bale of hay and had increased symptoms, broke the chain of causation related to the accident. The Arbitrator does not find the Respondent's argument persuasive.

The case of Vogel v. The Illinois Workers Compensation Commission is helpful in this analysis. In Vogel,a petitioner suffered a work related accident to her lower back. She later had several auto accidents which the respondent argued broke the causal chain. The Court first cited the oft cited earlier opinion in Sisbro, explaining that an accident need not be the sole or principal cause of injury so long as it was a cause. They found that the evidence supported causation because the claimant's condition had been weakened by the work accident to the point where the auto accidents, while aggravating, were not sufficient to break the causal chain. Vogel v. The Illinois Workers Compensation Commission, 354 Il. App. 3d 780, 813, (2005).

Here the evidence shows that the Petitioner had severe bilateral foraminal narrowing at L5-S1, along with severe left foraminal narrowing at L4-5, as shown by the MRI of April 30, 2015, long before any of the alleged intervening events. His symptoms noted in the medical treatment records from the Hannibal Clinic through Dr. DeDes note of September 14, 2015 are consistent with the above pathology. While the Quincy Medical Group records of September 17 and 18th show that moving the bale of hay did increase the Petitioner's radiculopathy, the subsequent records of Dr. Moore on October 2, 2015 point to the conclusion that the aggravation was in large part temporary. At that

time, the Petitioner primarily complained of back pain. While he did report that his feet and legs were asleep daily, he had neither shooting pain nor weakness down either leg. Nonetheless, Dr. Moore reiterated his earlier belief that the Petitioner needed to see a neurosurgeon based on the MRI findings referenced above. (PX 6) Also, Dr. Gold's surgical recommendation was made in large part by his review of said MRI.

Respondent also argues that surgery was not recommended until after the hay bale event. While this is true, it was not recommended because of any new symptoms. In fact, Dr. Basho's notes from May and July indicate that he was considering surgery. He did not ultimately recommend it due to his belief that the epidural steroid injection did not reduce the Petitioner's leg pain sufficiently. He did, however, continue to note the Petitioner's ongoing diagnosis of lumbar radiculopathy, spondylolisthesis and a disc herniation. (PX 2; 7/21/15 o.v.) Also, the history the Petitioner provided to Dr. DeDes on September 14, 2015 shows that the injection did, in fact, help with some of his left leg symptoms. Finally, as stated above, Dr. Gold's surgical recommendation was based in large part on the Petitioner's ongoing symptoms and the April MRI findings.

The Arbitrator finds the above evidence shows that the various instances where the Petitioner noticed increased symptoms with activities were aggravations of the underlying condition and did not break the causal chain from the work accident forward.

Dr. Taylor Moore, in his note of October 7, 2015 when commenting upon the lesion in his back being more unstable, the doctor thought it was likely something happened when he was pulling on the heavy object. Dr. Gold, a neurosurgeon to whom Petitioner was referred also found the Petitioner's condition was related to the accident of April 8, 2015.

Petitioner was examined at Respondent's request by Dr. Bernardi. Dr. Bernardi noted that Mr. Powell struck him as a credible historian and did not detect any Wadell's signs. Dr. Bernardi stated that he thinks Petitioner's symptoms are best considered work related. Petitioner volunteered that he raises animals and this requires physical exertion. Dr. Bernardi stated that it is not as if Petitioner was claiming to be disabled when he experienced flare ups in late August and mid-September. Instead, Petitioner worked from the date of accident until he was taken off in October. Dr. Bernardi noted that the waxing and waning of symptoms was normal. He couches his opinion with

regard pathology could be based upon a second MRI to be had. He further notes that **"were it not for his occupational accident I can see no reason to believe that this man's activities at home in late August or mid-September 2015 would have produced any type of back complaints".**

Letters were sent to Dr. Bernardi by Respondent's counsel months after the IME and apparently without additional medical records. Dr. Bernardi responded to supplemental inquiries about bailing hay, performing farm activities and working with horses, two of which were originally addressed in this original narrative. The most he could say was that those incidents could aggravate his complaint, he did not alter his original causation opinion. Additionally, Petitioner wasn't baling hay, he doesn't have a farm, just a large garden. Petitioner did work with horses and did have an incident but Petitioner testified that his level of pain subsided to the normal level after a short period of time after these "aggravations". Dr. Bernardi also commented in an inquiry from defense counsel, that if he was performing duties beyond his restrictions, those could aggravate Petitioner's condition. Again, he did not specifically alter his original causation position.

In addition, Petitioner received physical therapy at First Choice. They made no comments with regard to causal relationship but noted a work injury. Respondent suggests the Petitioner just quit physical therapy on his own which Petitioner denied. In addition therapy in the note of June 16, 2015, the therapist, Rodney Brumley in the PAN section of his notes, seemed to indicate he was awaiting the physician's recommendation. In his note of July 21, 2015, Dr. Basho merely indicated that Petitioner was to return as necessary and makes no comment about continuing physical therapy. It would seem clear that the Petitioner's incidents subsequent to the accident of April 8, 2015. Petitioner's unrebutted and credible testimony indicates that his condition returned to the status quo after each of the incidents discussed on both direct and cross examination.

The Arbitrator therefore finds Petitioner's condition of ill being is causally related to the accident occurring on April 8, 2015.

In support of Arbitrator's decision relating to __G__, the Arbitrator finds the following facts:

Respondent submitted into evidence a wage statement covering the period of April 10, 2014 through April 2, 2015. The exhibit lists the number of hours Petitioner worked but not the days worked consistent with those hours. There is no explanation in the statement why there are multiple listings of "regular" earning in the same week.

As directed in Section 10 of the Workers' Compensation Act, if an employee loses five (5) or more days of work, then the remainder of the 52 weeks will be divided by the number of weeks and parts thereof to determine the average weekly wage.

In this instance, the wage statement does not offer the number of days for which the total earnings were made. One cannot divide the earnings by the number of weeks or parts thereof given the wage statement offered as RX #8. The Respondent's exhibit # purports to be the Petitioner's earnings. What is clear is that the Petitioner earned $14.70/hour on April 10, 2014 and his wage was increased to $15.70/hour on and after August 14, 2014. There were 14 weeks paid at the hourly wage of $14.70. There were 18 weeks paid at the $15.70 hourly wage. The payroll records disclose Petitioner worked regularly. Not knowing how many days or parts thereof in all of the weeks, using a full week for each would be equitable.

Therefore, the yearly wage would be $31,896.00 and the average weekly wage would be $613.38. As such, the total temporary benefit rate would be $408.92.

Other issues

Respondent contested the issue of TTD and medical, past and future, based upon its arguments on causation. Having found the Petitioner's condition to be causally related to the accident, the Arbitrator awards the TTD and medical requested. The Request for Hearing requests benefits for a period of 14 4/7 weeks,

including 9/9/15; 10/2/15 to 1/4/16; 1/12/16 to 1/18/16; 1/28/16 to 1/29/16; 2/17/16 to 2/18/16 and 5/29/16 through the date of hearing 6/1/16. The Respondent has paid $8,798.05 to which they are entitled to credit.

As to Petitioner having lumbar surgery, Dr. Basho was of the opinion that the Petitioner did not need surgery. Dr. Bernardi, Respondent's evaluating physician, did not exclude it but did not recommend it either. Dr. Gold, the neurosurgeon, and Dr. Moore the family physician, agreed that surgery was necessary. Petitioner is willing to undergo surgery. Surgery appears to be a reasonable treatment option based upon the medical opinions espoused.

With regard to medical bills, Petitioner has submitted those as follows:

Quincy Medical Group 10/19/15	$ 35.00
Hannibal Regional Medical Center 4/14-4/30/15	$ 245.00
Clinical Radiologists 9/17/15	$ 51.00
Blessing Hospital 9/7/15	$2,772.21
Blessing Hospital 9/17/15	$2,235.53
Blessing Hospital 9/17/15	$ 536.68
Blessing Hospital 9/17/15	$ 31.20
Unity Point Health 6/18-10/19/15	$2,868.43

Some of the medical bills have been paid by group. Respondent shall hold Petitioner harmless for any request for reimbursement for those related to the accident and paid by Respondent's group carrier.

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

Stanislaw Jandura,
Petitioner,

vs.

NO: 15 WC 39347

United Parcel Service,
Respondent.

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DECISION AND OPINION ON REVIEW

Respondent appeals the decision of Arbitrator Bocanegra finding that Petitioner sustained an accidental injury arising out of and in the course of his employment on January 17, 2013. As a result, Petitioner is entitled to $20,554.10 in current medical expenses and Respondent shall pay for the treatment recommended by Dr. Sokolowki. The Issues on Review are whether there is a causal relationship between Petitioner's present condition of ill-being and the January 17, 2013 work accident, and if so, the extent of temporary total disability benefits, the amount of reasonable and necessary current medical expenses and whether Petitioner is entitled to future medical expenses. Additionally, at issue is whether Petitioner exceeded his choice of doctors as set forth in Section 8(a) of the Illinois Workers' Compensation Act. The Commission, after reviewing the entire record, modifies the Arbitrator's decision and finds Petitioner lost no time from work and as such is not entitled to any temporary total disability benefits. Moreover, Petitioner reached maximum medical improvement on June 20, 2013 and is not entitled to any medical expenses after June 20, 2013 or any future medical expenses. In addition, Petitioner did not exceed his choice of doctors as set forth in Section 8(a) of the Illinois Workers' Compensation Act. The Commission further finds that this case should be remanded to the Arbitrator for further proceedings pursuant to Thomas v. Industrial Commission, 78 Ill. 2d 327 (1980).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

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The Commission finds:

1. Petitioner testified that on January 17, 2013 he was sitting on a stool and using a three foot pry bar to lift a 190 pound tire onto a wheel when something snapped and he felt pain go through the right side of his low back along with pain that traveled up and down his body.

2. On January 17, 2013, Petitioner was seen at Clearing Clinic by Dr. Davison. Petitioner reported lifting a tire and feeling a sharp pain from the front of his leg on the right side. An x-ray of the lumbar spine was taken and it showed degenerative joint disease at L5-S1. Petitioner was diagnosed with a lumbar strain. He was instructed to be re-evaluated prior to next shift.

3. On January 18, 2013, Petitioner was again seen at Clearing Clinic but this time he was seen by Dr. Amir. Dr. Amir noted that Petitioner is reporting right sided foot and leg numbness in the posterior aspect of his leg. He further reported that his neck pain was better. Petitioner reported that using Ibuprofen has helped but he is having difficulty sleeping. Dr. Amir diagnosed Petitioner as having a lumbar and cervical/thoracic strain. He prescribed medication and cold packs for Petitioner's back and told him to follow up with the clinic in one week.

4. On January 25, 2013, Petitioner returned to Clearing Clinic and was seen by Dr. Sorokin who prescribed physical therapy.

5. At the January 25, 2017 physical therapy evaluation, Petitioner reported his primary complaint was pain in his lumbar region and right leg. He noted his pain was worse with flexion/bending. He reported his pain as being a five out of ten on a ten point scale. Physical therapy was prescribed 2-3 times a week for 4-6 weeks. The therapy consisted of Stm/mfr, stretching, core strengthening, job simulation, education and modalities as-needed. Petitioner underwent a total of thirteen physical therapy sessions spanning from January 25, 2013 through March 6, 2013. On March 6, 2013, Dr. Sorokin received a letter from Respondent's insurance company indicated no further physical therapy visits were being authorized. On March 6, 2013, Petitioner was discharged from physical therapy. At that time, it was indicated that Petitioner's short term goals regarding hamstring length, stretching and basic core strengthening program were all met. In addition, Petitioner's long term goals of being able to lift a 50 pound box from a cart to a shelf and lifting a 20 pound box overhead with proper technique were me. It was also noted that Petitioner had been compliant with the upgraded core strengthening program. It was noted that his reassessment was completed and his goals were met. At that time, Petitioner rated his low back pain as 0-1/10. The therapist noted Petitioner had no functional limitations.

6. On March 6, 2013, Petitioner returned to the Clearing Clinic and saw Dr. Sorokin. The doctor noted that Petitioner is currently describing no pain. Petitioner characterizes his most recent pain as mild in nature. Dr. Sorokin noted that it has been about 48 days since the onset of his initial pain. Currently, Petitioner reports that his pain is variable. He rates his pain as being a 0/10 and he reports the pain only sometimes radiates along the right lower extremity. On examination, Petitioner is doing better, he expresses no complaints and the movement of his low back does not cause any pain. His range of motion is normal and his straight leg raising is negative. Heel and toe standing and walking can be performed. Tenderness to palpation is not present on the right paraspinous muscles. His right Achilles tendon is normal. There is no bruising, joint crepitus or joint effusion. Movement of his right foot and ankle cause no pain and the Pes planus is absent. The Dorsalis pedis pulse and posterior tibialis pulse are present. His range of motion is normal. His ankle joint is stable and there is no swelling. Tenderness is absent over the lateral ankle. Dr. Sorokin diagnosed Petitioner as having a lumbar, cervical/thoracic strain. He released Petitioner from his care and to his regular work duties and instructed Petitioner to return on an as-needed basis.

7. Petitioner testified that he took no time off of work as a result of his back condition. Petitioner testified that he went to physical therapy during his work hours. He would estimate during this time he was performing physical work at the work site for one half to one hour a week. Petitioner reported that with physical therapy he gradually improved. He further stated that the doctor said after thirteen sessions he could not return. He stated that his last physical therapy visit was on March 6, 2013 and at that time he had gotten better. He felt that the leg pain was minimal and that it was going to pass. His back pain had also subsided and was minimal. He continued taking his medicine along with a sleeping aid. After he stopped seeing the doctor, he returned to full duty work. Petitioner reported approximately one month after he was released by his doctor from care his pain medication ran out and his pain returned.

8. The Commission notes that there was a three month gap in treatment between March and June of 2013.

9. On June 13, 2013, Petitioner started treating with Dr. Branovacki from Midwest Orthopaedic Consultants. At that time, Petitioner reported right hip and leg pain. More specifically, he reported experiencing right buttocks pain which went down his leg when he lifted a tire at work. He reported that he has had physical therapy and he got better. He returned to full duty work on March 20, 2013. Prior to that, he never really missed work and he only had some restrictions initially. Petitioner reported he did well up until a month or two ago when he started experiencing a lot of discomfort down his right leg which went all the way to his heel. He reported he now feels pins and needles and ants in his leg. His pain is worse with activity in general and specifically with lifting. On examination, his right hip is painless with range of motion and he has good strength. He

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is neurovascularly intact. He has a positive straight leg raising test. Dr. Branovacki ordered a lumbar MRI.

10. The June 19, 2013 lumbar MRI showed congenital lumbar spinal stenosis, mild retrolisthesis of L5/6, multilevel spinal stenosis, which was most marked at L5/6. It also showed multilevel lateral recess and neural foraminal stenosis

11. On June 20, 2013, Petitioner followed up with Dr. Branovacki who indicated that Petitioner's MRI confirmed that he has some stenosis, which is worse on the right side at the L4-5 and L5-S1 regions. Dr. Branovacki recommended Petitioner have an epidural steroid injection and that he return to see him after the injection. Petitioner testified he did not get the injection because he was afraid the injection was going to make his pain worse. The medical statement for Dr. Branovacki's services was entered into the evidence as part of Petitioner's PX2 exhibit. The statement shows that there is a zero balance due for Dr. Branovacki's services.

12. The Commission notes that there is a 9-1/2 month gap in treatment between June 2013 and April 2014.

13. The medical records show that from April 4, 2014 through May 18, 2015 Petitioner treats with Chiropractor Abu-Shanab. While the chiropractor's notes are somewhat illegible, they appear to show treatment is being giving to Petitioner's shoulders as well as his low back. Petitioner further indicated that the treatment with the chiropractor should be assigned to his group insurance plan.

14. On May 16, 2014, a chiropractor progress evaluation is completed. Petitioner indicated he was benefiting from and satisfied with his chiropractic care, was better and he rated his improvement as being 85%. On the pain, scale he made a mark ¼ away from "no symptoms".

15. Petitioner treats with Chiropractor Abu-Shanab from May 19, 2015 through July 11, 2016. Looking at the overall treatment records, Petitioner reports experiencing difficulty with various aspects of his work and home life. He registers various complaints of pain with bending, climbing stairs, exercising, driving a car and concentrating. On a pain scale, it appears that his medium pain range is 5/10. His treatment is limited to EMS, hot packs and manual therapy. On or around November of 2015 through January of 2016, a shift in treatment occurs and the therapy is reduced to EMS and hot packs while manual therapy is no longer given. On around January of 2016, all three therapies, including manual therapy, pick up again along with adding an additional component of laser therapy.

16. On July 6, 2015, a lumbar MRI is performed. It shows that at the L3-4 level there is desiccation of the intervertebral disc seen along with an annular tear which is associated

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with a small right paracentral disc protrusion. It is also noted that there is early facet arthropathy seen at this level and there is a moderate degree of central stenosis. At L4-5 level, there is severe multifactorial central stenosis. A diffuse bulging of the intervertebral disc is seen without any focal disc herniation. At L5-S1, level there is a small central annular tear associated with a shallow broad based right paracentral disc protrusion. There is also a moderate degree of central stenosis seen at this level.

17. On July 22, 2015, Petitioner starts treating with Dr. Sokolowski. Petitioner's examination is conducted in Polish, which is his native language. The doctor notes that Petitioner is complaining of lumbar pain with radiation to right buttock and right lower extremity. Petitioner is here on a consultant from Chiropractor Abu-Shanab. He was initially hurt lifting a heavy tire at work. Over time, Petitioner returned to his full duty capacity. In that capacity his symptoms persisted and he began experiencing consistent radiation to his right lower extremity. His pain has been functionally limiting. He reports that the therapy with Chiropractor Abu-Shanab does limit the severity of his symptoms, but on the days he does not attend therapy, his radiating leg pain is quite bothersome. Petitioner reports his pain remains 4/10 with radiation to his right buttock and right leg to his knee and occasionally beyond 4/10.

Dr. Sokolowski indicated that Petitioner is open to the possibility of an epidural steroid injection. Petitioner reported he had been offered this in the past but he held off due to some concerns about the injection. However, at this point, he is ready to proceed because he reports his symptoms are nearly intolerable. He rates his pain in his back and leg/buttock as being a six out of ten on a ten point scale.

Dr. Sokolowski noted that on examination Petitioner's gait pattern is mildly antalgic on the right side and his sagittal profile is mildly positive. Petitioner reported that extension beyond neutral reproduces concordant back pain with radiation to the right buttock and right leg. His straight leg raising test is positive on the right at 60 degrees and it reproduces radicular symptoms in the L5 distribution. He has sensory alternations in the right L5 distribution with pain radiating to his great toe. He is grossly normoreflexic.

Dr. Sololowski diagnosed Petitioner as having lumbar pain, lumbar radiculopathy, moderate stenosis at L3-4 and L5-S1 and severe stenosis at L4-5, which he opined was aggravated by Petitioner's work injury. In light of persistent symptoms, Dr. Sololowski recommended Petitioner undergo a right L4-5 epidural steroid injection. He recommended that Petitioner continue therapy in interim, absent approval of any other measures. He prescribed Dendracin, and instructed Petitioner to continue to perform full duty work. He noted that Petitioner remains highly motivated to work despite his symptoms. Lastly, he fitted Petitioner with lumbosacral orthosis and instructed him to use it as-needed. On September 11, 2015, November 20, 2015, February 19, 2016 and June 3, 2016, Petitioner followed up with Dr. Sokolowski who noted that things were status quo and that they were awaiting for approval for the prescribed injection.

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18. On May 17, 2016, Dr. Monaco, a board certified orthopedic surgeon, was deposed. He would estimate that 2/3 of his practice is seeing patients and 1/3 of his practice is performing independent medical evaluations or consulting.

He evaluated Petitioner and reviewed his medical records. He personally reviewed Petitioner's June 19, 2014 and July 6, 2015 lumbar MRIs. He reviewed Petitioner's job description. He examined Petitioner over 1-1/2 hours, which entailed 60% of the time being used in taking Petitioner's history via a translator and 40% of the time being used in physically examining the Petitioner.

Dr. Monaco noted that on physical examination Petitioner had a negative bilateral Faber sign, which usually indicates that there is not primary pathology involving the sacroiliac joint. He has a negative Babinski test, which measures whether there is spinal cord dysplasia of some kind that might cause an abnormal response. Dr. Monaco testified that a negative Babinski test means there is no central canal problems with the spinal cord. He noted that Petitioner's deep tendon reflexes were positive and equal bilaterally at the knee and ankles which indicates there is not any impingement of the nerve root and/or radiculopathy. Petitioner's straight leg raising was negative, which meant it did not produce any pain down his right leg.

Dr. Monaco diagnosed Petitioner as having a lumbar spinal stenosis. Dr. Monaco opined that as a result of his January 17, 2013 work injury Petitioner incurred an acute lumbar strain, which has resolved. He further opined that Petitioner incurred a temporary exacerbation of his pre-existing degenerative and congenital changes of his lumbar spine. He noted that Petitioner's MRIs showed some evidence of central spinal canal stenosis with components of congenital changes, contributing to the stenosis as well as some degenerative changes. He further noted that there was no change observed between the June 19, 2013 and July 6, 2015 MRIs. Dr. Monaco testified that in his opinion there was a temporary exacerbation of Petitioner's pre-existing condition which occurred as a result of the January 17, 2013 work accident. He noted that Petitioner had a history consistent with an injury to the low back along with radicular symptoms involving the right lower extremity. These were in turn consistent with his medical records. The medical records during the 6-7 weeks following the accident showed Petitioner had a gradual and progressive improvement of his symptomatology to the point where his pain was zero or one out of ten and all of his goals were achieved in physical therapy. He had a normal physical examination with a negative straight leg raising test. Dr. Monaco opined that Petitioner's treatment was typical of a lumbar strain. He testified that on average and according to the OGD guidelines, one can expect most lumbar strains to get better in a six week period and the patient should be able to be back to performing heavy manual labor. Even with a severe strain, this is a very typical course for Petitioner to gradually improve and actually within seven weeks Petitioner was back doing his regular duties with minimal or no complaints.

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The records he had available seem to indicate that Petitioner was seen on a regular basis from April of 2014 to January of 2016 by Chiropractor Abu-Shanab. The initial records were not legible but the records from May of 2015 forward were legible. The records span all the way to January of 2016 and they indicated that there was very little in the way of progress with the treatment Petitioner was receiving. The treatment consisted of a various modalities such as electrostimulation, heat and traction as well as manipulation and massage. Petitioner's pain level was fairly consistently being reported between 4-6 out of 10. During his treatment, there was no significant functional improvement because Petitioner was performing all of his regular work duties throughout the treatment. Only his subjected pain complaints persisted.

Dr. Monaco opined that after Petitioner incurred an acute lumbar strain which resolved and a temporary exacerbation of his pre-existing condition of degenerative changes and congenital changes, he returned to baseline on March 6, 2013 and he reached maximum medical improvement. Dr. Monaco testified that his overall impression of Petitioner was of a healthy, active person who performed hard work and he also enjoyed non-occupational activities that involved a significant stress including skiing. There was a period of time from March to June of 2013 and June of 2013 to April of 2014 where he sought no medical care at all.

Dr. Monaco testified that even after Petitioner sought chiropractic care he was still able to function normally at work and perform recreation activities including high stress activities such as snow skiing.

On cross-examination, Dr. Monaco indicated that he is a general orthopedic surgeon. His special interests are knees and shoulders. He has not performed any back surgery or administered epidural injections since 1990. He performed back surgery until he had a partner who was a spine specialist. At that point, he saw no reason for him to continue to do back surgery. Since then he has not stayed up on the advancements in that area. He believes he does not need to do so since there are pain management doctors that provide epidural steroid injections and he referred these patients to them. He agreed that his IME practice is predominantly done on behalf of Respondent or insurance carriers and he would say that 95% of his evaluations are conducted for Respondent or the insurance companies. He would estimate that 20% of this work is devoted to performing AMA ratings.

Dr. Monaco testified that spondylolisthesis is a condition usually degenerative in nature and is sometimes genetic in nature. Genetically, it arises when one fails to form a certain part of the vertebral body and this has a tendency for the vertebral body to slip forward on the level below. It can happen for degenerative reasons as well. It usually does not cause radiculopathy. In the older population, the problem is usually degenerative. There is a normal degeneration of the spine including spondylolisthesis which is found in 25% of asymptomatic 60 year olds. So it is a finding that is not relevant. It can contribute to some potential nerve root impingement depending on other factors including degenerative changes like facet joint,

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hypertrophy and foraminal stenosis, which is where the nerve root exists. He would agree that foraminal stenosis is a factor in causing nerve root impingement. He testified that the whole thing about impingement and stenosis is the tolerance issue. So in some circumstances there can be no symptoms with significant degenerative changes and severe foraminal stenosis because it just does not cause impingement to the nerve. So the presence of foraminal stenosis, spondylolisthesis, annular fissures, bulging discs—none of these are by definition going to cause nerve root impingement. One can have all of these things present that could individually possibly cause it. The reason that he does not believe that is what happened in this case is because after a period of 6-8 weeks Petitioner returned to baseline. He agreed that after someone has reached maximum medical improvement he may require palliative care in the form of exercise or medication. However, that does not mean that the problem has not resolved. He opined that Petitioner's major issue was he had a lumbar strain which in his opinion improved with appropriate treatment and there was a temporary exacerbation of his stenotic spine and degenerative changes, which returned to baseline. Petitioner saw a chiropractor for almost two years without any improvement with his pain complaints but Petitioner was functionally doing fine. The question is why are we taking someone who is functionally doing fine and whose working and recreating at a high level and we want to consider the possibility of even further treatment including invasive treatment such as an epidural steroid injection or surgery. He cannot say it is accurate for an orthopedic surgeon to say to a patient with a back injury wait until you get to the point where you cannot stand any more of the pain and then come back and we will talk about surgery.

While the physical therapist on March 6, 2013 said Petitioner still had some low back pain he was seen two days prior with a pain level of 1 out of 10 and two days later with a pain level of 1 out of 10 along with the indication that his physical therapy goals were met and there was no functional limitations.

Dr. Monaco agreed that he did not see Dr. Branovacki's records. If Petitioner told Dr. Branovacki that he was still having low back pain with pain going down to his right buttock and leg and he rated his pain as 3 out of 10 after stopping physical therapy four days prior, he would have to know more details as to whether the right leg pain was the same as before or not and whether there was a further injury or activity that might have provoked the pain. If he said L5 radiculopathy it was in error. Rather, it was L5 radicular symptoms where the symptoms were in the distribution of the L5 nerve root but there were no objective findings to confirm it. It is his opinion that there were no findings that objectively confirm the presence of L5 nerve pain. This is also consistent with the fact that the straight leg raising test was negative when it was done in certain positions. So the fact that there was negative straight leg raising test, no motor deficit, no sensory deficits, no reflex asymmetry, which are all finding one needs to be able to say this is actually an impinged nerve, indicates that there is no impingement. He believes that there has to be some more objective findings other than the clinical exam such as an EMG or MRI. Petitioner's MRI did not show an impingement of the nerve. It showed foraminal stenosis and spinal stenosis. Therefore, this is consistent with

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his opinion that Petitioner experienced a temporary exacerbation of his pre-existing condition, that it resolved and that went back to baseline.

Dr. Monaco testified that if one is going to do surgery one would like to have weakness in the big toe or numbness around the big toe on examination and not just have subjective complaints. Dr. Monaco opined that the findings on the MRIs of mild lateral recess stenosis and bilateral foraminal stenosis are perfectly normal for a 60 year old. When one starts using words like mild and one is dealing with an MRI, there are many abnormal findings that are considered to be normal and found on asymptomatic patients. If you want a smoking gun, there are no signs of one on either of the MRIs. It is his opinion that there was some form of inflammation of the nerve causing the L5 radicular symptoms. Petitioner had a completely normal neurological exam which ruled out the lumbar radiculopathy. He agrees that the radiologist found moderate right foraminal stenosis on the June of 2013 MRI. He agreed that on the second MRI he found no foraminal stenosis at L4-5. Dr. Monaco opined that Petitioner's condition is degenerative in nature and it did not get better between the first and second MRI. Rather, it was just his interpretation of what the radiologist saw. He said there is a fine line between none, mild, moderate and severe. If it was mild foraminal stenosis, it would make no difference to him. It was not a significant problem.

Petitioner testified he continues to see Chiropractor Abu-Shanab through today. Chiropractor Abu-Shanab currently stretches him. While Dr. Abu-Shanab used to do chiropractic manipulations on his back he no longer does this for him. After his treatments, his condition is better. It relieves some of his symptoms. The relief varies depending on what job he is doing at work.

Chiropractor Abu-Shanab referred him to Dr. Sokolowski. He first saw the doctor on July 23, 2015. Dr. Sokolowski also ordered an epidural injection, which he has not had. The doctor is Polish and he explained the injection to him so he now wants the injection and is no longer worried about it. He saw Dr. Sokolowski more than a month ago. Each time he sees him, the doctor prescribes medication, which he uses. Currently his low back hurts and the pain radiates down to his right foot and makes it numb. The back pain is worse when he returns home from work. Sometimes his back and right leg hurt more than others. It is worse at work. He has not taken any time off of work for his back. In terms of recreational activities, he sometimes bikes. He has been skiing for the past 43 years and he continues to ski but in a "relaxed fashion". By that, he means he does it in "slow fashion." He remembers after skiing for ½ a day his back really hurt. He agreed that as trailer mechanic for Respondent he has to bend, reach, push, pull and carry heavy objects frequently and continuously. He said most of the time the heavy objects are tires. He agreed that after March 6, 2013 he returned to work as a trailer mechanic and he is performing all of the duties of that position on a full time basis. Petitioner agreed that he did not seek treatment for 9-1/2 months between Dr. Branovacki and Chiropractor Abu-Shanab. When he was asked why if his condition was deteriorating as he described on direct examination, he did not use his group health insurance to seek treatment, Petitioner answered he had hoped that it was going to pass

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by itself. He agreed that he knew he could have used his group health insurance as he did use it with the chiropractic treatment but he did not do so later on. However, the pain eventually became unbearable and he went for treatment. He agrees that between April 2, 2014 and July 11, 2016 he had attended approximately 65 chiropractic sessions and his treatment was similar for all the sessions. He agreed that he went snow skiing while under chiropractic care.

Petitioner testified after the accident he was sent to Concentra, which is Respondent's company clinic. On June 13, 2013, he saw Dr. Branovacki. He was referred there by an acquaintance. On his intake form for Bridgeview Chiropractic he indicated that his son referred him there.

Having reviewed all of the evidence, the Commission believes that it would not be unreasonable for Petitioner to have felt some additional pain once he stopped the initial conservative care and began working on a full duty basis. While Petitioner indicates that while he did not stop working at all after the January 17, 2013 work accident, he also testified that he only worked ½-1 hour a day while received physical therapy during work hours. When he was released from physical therapy, it appears that Petitioner expressed some very minor complaints and the Commission finds that it would not be unreasonable for his pain to flare upon returning to the full duty work force. As such, the Commission finds that the fact that Petitioner sought additional care from Dr. Branovacki should be viewed as causally related and finds that Petitioner's care was reasonable and necessary at that time. However, the Commission finds that after Petitioner did not follow through with Dr. Branovacki's prescribed treatment, that Petitioner allowed 9-1/2 months to lapse prior to seeking out additional treatment and then sought out treatment of a chiropractor under his group insurance who appears to have provided additional conservative care to not only his back but his shoulders indicates that Petitioner failed to prove that the additional care is causally related and reasonable and necessary for his work accident. The Commission finds that this is especially the case given the fact that the Chiropractor Abu-Shanab duplicated the lumbar MRI, which Dr. Monaco found was essentially the same as the prior MRI and Dr. Sokolowski is offering Petitioner the same treatment he was previously offered by Dr. Branovacki. Based on the evidence as a whole, the Commission finds that Petitioner reached maximum medical improvement on June 20, 2013 and he is not entitled to any medical expenses after June 20, 2013 or any future medical expenses. More specifically, the Commission finds that the medical treatments offered by Chiropractor Abu-Shanab and Dr. Sokolowski are not causally related to and reasonable and necessary for and in some instances are duplicative of prior medical services that were conducted or were recommended. In addition, Petitioner did not exceed his choice of doctors as set forth in Section 8(a) of the Illinois Workers' Compensation Act. The Commission counts the choice of doctors as such:

Drs. Davidson-Lucas-Sorakin/Clearing House, which is Respondent's company clinic does not count as one of Petitioner's choice of doctors. Dr. Branovacki of Midwest Orthopedic does count as Petitioner's first choice of doctors while Chiropractor Abu-

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Shanab of Bridgeview Chiropractic Center and Dr. Sokolowski count as Petitioner's second choice of doctors. Given this count the Commission finds Petitioner did not exceed the choice of two doctors under Section 8(a) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner reached maximum medical improvement on June 20, 2013 and is not entitled to any medical expenses after June 20, 2013 or any future medical expenses.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner did not exceed his choice of doctors as set forth in Section 8(a) of the Illinois Workers' Compensation Act.

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.

No Bond is due.

DATED: APR 26 2017

David L. Gore

Stephen Mathis

O: 2/23/17

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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.

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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 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.

Kevin W. Lamboth

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

Nancy Perkinson,

Petitioner,

vs. NO: 16 WC 04807

17IWCC0218

Kankakee Valley Construction Co.,

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 wage 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 September 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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $16,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 11 2017
o033017
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

PERKINSON, NANCY
Employee/Petitioner

Case# **16WC004807**

17IWCC0218

KANKAKEE VALLEY CONSTRUSTION CO
Employer/Respondent

On 9/9/2016, 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 0.47% 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:

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

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

STATE OF ILLINOIS)
) SS
COUNTY OF WILL)

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

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

Case # 16 WC 04807

Nancy Perkinson
Employee/Petitioner

v.

Kankakee Valley Construction Co.
Employer/Respondent

17IWCC0218

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city **New Lenox**, on **May 5, 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. 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. ☐ 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 2, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$80,597.44**; the average weekly wage, as calculated pursuant to §10 of the Act, was **$1,915.35**.

On the date of accident, Petitioner was **59** years of age, **single** with **0** dependent children.

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

Respondent shall be given a credit of **$10,838.40** for TTD, **$ 0** for TPD for maintenance, and **$0** for other benefits, for a total credit of **$10,838.40**

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

ORDER

Temporary Total Disability

Respondent shall pay temporary total disability from **February 5, 2016 through May 5, 2016**, representing **13 weeks at the rate of $1,276.90 per 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.

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

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

Christine Moy

Signature of Arbitrator
IC ArbDec19(b)

09/08/2016
Date

SEP - 9 2016

17IWCC0218

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nancy Perkinson	)
Petitioner,	)
vs.	) **No. 16 WC 4807**
Kankakee Valley Constructions Co.	)
Respondent.	)
	)

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing in New Lenox under the provisions of §19b/§8a on May 5, 2016. The parties agree that on December 2, 2015, Petitioner and Respondent were operating under the provisions of the Illinois Worker's Compensation or Occupational Diseases Act; that their relationship was one of employee and employer; that the Petitioner had an accident that arose out of and in the course of her employment with respondent; and that Petitioner gave Respondent notice of the accident within the time limits stated in the Act. The parties agree that Petitioner's state of ill-being to date was caused by the work accident.

The only matter at issue is Petitioner's earnings as calculated pursuant to §10 of the Act.

STATEMENT OF FACTS

Petitioner testified she had been employed by respondent since 1981 as a truck driver, which required her to hold a CDL license. She is a member of the Teamsters Union. As such, her employment with respondent was dictated by the collective Bargaining Agreement between the Kankakee-Iroquois County Employers Association and Teamsters Local 179 (PX.3). She was assigned work by respondent; she did not bid on it.

Petitioner was originally hired as a dump truck and flatbed driver. In 2014, after obtaining the necessary Hazmat and TWIC certifications, she became a hot oil tanker driver. She was only one of two hot oil tanker drivers employed by respondent.

As an oil tanker truck driver, petitioner drove from Kankakee to Chicago, retrieved the hot oil and drove it back to respondent's plant in Kankakee. The round-trip took three hours or more, depending upon the wait time and traffic. When returning from Chicago, the rig weighed 80,000 pounds and the oil reached 350° Fahrenheit. Once loaded, the hot oil must be delivered. When hauling the hot oil, which is hazardous material, it is illegal to pull off on the side of the road.

As an oil tanker driver, petitioner could work as much as 16 to 17 hours a day when doing four runs. She usually did two to four per day in the oil tanker. She could start at as early as 10:30 P.M. or even 1:30 A.M. She received her assignments the night before from respondent's plant manager, Greg McMillan when driving the oil tanker. McMillan advised petitioner how much oil was needed to make asphalt for the next day. The length of petitioner's work day was different each day.

When petitioner was not needed as a hot oil tanker driver, she drove a dump truck, lowboy trailer or flatbed truck (PX.2B, 2C, 2D). When not driving the hot oil tanker, she drove locally. When driving the dump truck, lowboy or flatbed truck, she would receive her

assignments from Steve Blake the night before, which was similar to how she received the assignments from McMillan.

Petitioner testified that regardless of the type of truck she was driving for respondent, she was not able to leave until the job was finished. Petitioner testified that although petitioner was not explicitly told she had to work overtime, it was mandatory for her to stay on the job until it was finished. In fact, once she missed a doctor's appointment scheduled 10 hours after her assignment began, as she had to remain on the job until the job was completed. She was allowed to go home only after her foreman told her she was free to go.

Petitioner testified that on December 2, 2015, the day of her accident, she was driving a flatbed truck (PX.2D). She was delivering a ditch box. She injured her right shoulder while throwing a chain over the load on her truck. She is under the care of Dr. Bush-Joseph (PX.4). (The causation of the injury, period of temporary total disability and medical treatment are not presently in dispute.)

Jim Jones, respondent's vice president of finance, testified in behalf of respondent. He has been employed by respondent since 1981 and oversees office operations. He handles the money, finance, audits and insurance quotes.

Jones is familiar with the Teamsters Collective Bargaining Agreement (RX.3). Jones testified the collective bargaining agreement dictated the rules they had to live by with when hiring teamsters and paying the benefits. The agreement provided for working hours and overtime payment.

Jones testified that no overtime is forced by respondent. Jones agreee the number of runs done by oil tanker drivers depended upon how much asphalt was needed. According to Jones, the drivers are assigned three to four runs a day and can refuse to go work beyond an eight-hour day. Additionally, according to Jones, if an oil tanker driver had a previous commitment and couldn't complete the runs, then respondent could find someone else. Jones agreed the number of hours worked was dictated by the work that had to be completed. Jones agreed Greg McMillan was in charge of giving the oil tanker assignments and he agreed he was not privy to the conversations between petitioner and McMillan.

Jones confirmed that petitioner's job title remained the same regardless of the type of truck being driven, which was semi-truck driver.

Petitioner's Pay Stubs October 25, 2014 through December 31, 2015 (PX.1)

The pay stubs that are germane to the issue of earnings are from December 7, 2014 through November 29, 2015. The pay stubs confirm that during that period petitioner worked 1465.50 hours and earned a total of $80,597.44, including $49,339.91 for regular hourly pay and $31,257.53 for overtime pay.

Photos of Respondent's Four Trucks Driven by Petitioner (PX.2)

The photos depict the four types of truck petitioner drove for respondent.

Collective Bargaining Area Construction Agreement between Kankakee-Iroquois County Employers Association and Teamsters Local Union Number 179 (PX.3)

This agreement dictates, inter alia, how a union member employee is to be paid, including when overtime is to be paid and also dictates the working hours of the union member employee.

Dr. Charles A. Bush-Joseph February 5, 2016 report (PX.4)

On February 5, 2016, Dr. Bush-Joseph's provisional diagnosis of petitioner's condition was a disorder of right rotator cuff and labral tear of long head of biceps tendon. Dr. Bush-Joseph indicated petitioner had ongoing pain since December 9, 2015 and was unable to work since then. An MRI and physical therapy was ordered.

Print out of Petitioner's Wages from January 4, 2015 through December 13, 2015 (RX.1)

Respondent provided the wages for the 2015 year. It does not include payment from December 2, 2014 through January 3, 2015.

Petitioner's Time Card from December 29, 2014 through December 11, 2015 (RX.2)

The daily time cards indicate the hours petitioner worked each day; either regular or overtime, the project number and the task performed. It also indicated when petitioner drove the oil tank.

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

The Arbitrator found the petitioner to be credible.

G. With respect to the issue of what petitioner's earnings, the Arbitrator finds the following:

Petitioner was employed by respondent as a truck driver. Petitioner testified, without rebuttal from her supervisors, that she was required to work each day until the work was done. She made two to four runs per day. When driving the oil tanker truck, she would have to drive round trip from Kankakee to Chicago, which took a minimum of three hours. Some days she worked as much as 16 to 17 hours per day. She could not abandon the oil tanker on the side of the road once she reached her eight hours. In the 44 weeks petitioner worked in the year pre-dating the accident, she worked overtime in 40 of them.

The Collective Bargaining Agreement called for the work day to start at between 6 A.M. and 8 A.M. If the worker started before 6 A.M., the employee was to be paid time and a half. The Arbitrator notes petitioner testified she would begin working sometimes at 1:30 A.M.

Edward Hines Lumber Co v. Industrial Comm'n., 215 Ill. App. 3d 659, 575 N.E.2d 1234, 159 Ill. Dec. 174 (1990), provides overtime is to be included in the calculation if the overtime was mandatory and continuous. The Arbitrator finds that although overtime was not explicitly mandated, it was implicitly mandated by the nature of petitioner's job as a truck driver. She could not leave once she reached her eight hours as claimed by Jim Jones. She was required to work until the job was completed. Jim Jones, respondent's vice president of finance agreed petitioner had to work until the job was completed. The Arbitrator further finds that, although the amount of overtime was not consistent, petitioner consistently worked overtime; averaging in excess of 15 hours per week.

Based upon the foregoing, the Arbitrator finds petitioner's overtime wages, utilizing the straight hourly rate, should be included in the calculation of petitioner's average weekly wages.

The Arbitrator finds the evidence supports that petitioner worked 1465.50 hours in the year pre-dating her accident, which is 36.64 weeks, and earned $80,597.44, including $49,339.91

in regular hourly wages and $31,257.53 in overtime wages. Petitioner's wages for the year predating the accident using the straight time rate was $70,178.26 ($20,838.35 overtime using straight rate + $49,339.91 regular wages).

Thus, the Arbitrator finds petitioner's average weekly wage for the year pre-dating the accident was: $1,915.35 per week ($70,178.26 ÷ 36.64 weeks).